NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

25 APRIL 2019

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 25 April 2019

This page has been left blank

Board of Directors Meeting
Thursday, 25 April 2019

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

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration & Annual Review of Interests	✓	**C Parnell**
0935	**3.**	Opening Remarks by the Chair		**A Belton**
0940	**4.**	Staff Story		**A Lynch**
0955	**5.**	Minutes of Previous Meeting: 28 March 2019	✓	**A Belton**
1000	**6.**	Chair's Report	✓	**A Belton**
1005	**7.**	Chief Executive's Report	✓	**L Robson**
	8.	**QUALITY AND PERFORMANCE**		
1015	8.1	Performance Report	✓	**H Mullen**
1045	8.2	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • Audit Committee	✓	**Committee Chairs**
1055	8.3	Corporate Objectives – Quarter 4 2018/19	✓	**H Mullen**
1100	8.4	Strategic Staffing Review	✓	**A Lynch**
	9.	**GOVERNANCE**		
1110	9.1	Finance & Performance Committee Annual Report	✓	**F Patel / S Toal**
1120	9.2	Use of Common Seal 2018/19	✓	**C Parnell**
1125	9.3	Board Assurance Framework	✓	**A Lynch**
	10.	**DATE, TIME & VENUE OF NEXT MEETING**		
	10.1	Tuesday, 28 May 2019, 2.00pm in Lecture Theatre B, Pinewood House, Stepping Hill Hospital.		

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25 April 2019
Subject:	Register of Directors' Interests – Annual Review		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	Mrs C Parnell

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of the report is to present the Board of Directors Register of Interests for annual review.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments: Annex A: Register of Directors' Interests - April 2018

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of the report is to present the Board of Directors Register of Interests for annual review.

2. BACKGROUND

2.1 There is a legal requirement for the Trust to maintain a Register of Directors' Interests which should be available to the public. This requirement is incorporated in the Trust's Constitution. In addition, the Annual Reporting Manual requires that the annual report should disclose details of company directorships or other material interests in companies held by Directors where those companies or related parties are likely to do business with the NHS Foundation Trust. An alternative disclosure is to state how members of the public can gain access to the Register of Directors' Interests rather than listing all interests in the annual report. The Trust has adopted this latter form of disclosure.

3. CURRENT SITUATION

3.1 The Register of Directors' Interests is maintained by the Director of Corporate Affairs and is updated to reflect any amendments which may from time to time be declared during the normal course of business. In this way, an up to date register should always be available.

3.2 The current Register of Directors' Interests is included for reference at Annex A to this report. Board members are requested to review the Register and confirm that current content is accurate and up to date.

4. LEGAL IMPLICATIONS

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

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Review the Register of Directors' Interests at Annex A of the report and confirm that the content is accurate and up to date.

This page has been left blank

Stockport NHS Foundation Trust
Board of Directors - Declaration of Interests 31 January 2019

Name	Title	Interest 1	Interest 2	Interest 3	Interest 4	Interest 5	Interest 6	Interest 7	Interest 8	Interest 9
Adrian Belton	Chair	Lay Member of Sheffield University Council	Wife (Helen Phillips) Chair of Chesterfield NHS Foundation Trust							
Catherine Anderson	Non Executive Director	Director and Partner - Anderson Power Consulting	Director and Partner - Birchenough Construction	Chair and Trustee Director - South Liverpool Education Trust	Foundation Governor and Chair - Mount Carmel RC Primary School	Chair of North West Region - Institute of Hospitality	Director & Secretary - Lake District Boat Club Ltd Company Reg No 01091158	Director of John Paul II Multi-Academy Trust	Commo-dore of Lake District Boat Club Ltd	
Catherine Barber-Brown	Non Executive Director	Interim Director Organisational Strategy - NHS Transformation Unit (until 30 Apr 18)	Member of Greater Manchester General Assembly and Nominations Committee	Parent Governor - Gorsey Bank Primary School						
Mike Cheshire	Non Executive Director	Patron ME Trust	Trustee - Beth Johnson Foundation							
David Hopewell	Non Executive Director	Tenure as Non-Executive Director with Mid-Cheshire Hospitals NHS Foundation Trust completed 31 January 2019								
Angela Smith	Non Executive Director	Shareholder - Angela Smith Advisory Limited	Shareholder - SAL Property Services Limited	Non-Executive Director - PossAbilities Social Enterprise						

Stockport NHS Foundation Trust

Board of Directors - Declaration of Interests 31 January 2019

Name	Title	Interest 1	Interest 2	Interest 3	Interest 4	Interest 5	Interest 6	Interest 7	Interest 8	Interest 9
Malcolm Sugden	Non Executive Director	Chair of the Electricity North West Group of the Electricity Supply Pension Scheme	Full Member of the LTE Group Board	Chair of Novus Cambria						
Louise Robson	Chief Executive	Nil								
Colin Wasson	Medical Director	Director - Wasson Medical Services								
Alison Lynch	Director of Nursing & Quality	Nil								
Feroz Patel	Director of Finance	Nil								
Sue Toal	Chief Operating Officer	Nil								
Hilary Brearley	Interim Director of Workforce	Company Secretary - Poppies UK Development Ltd	Director - HBhr Consulting Ltd							
Hugh Mullen	Director of Support Services	Nil								

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
Thursday, 28 March 2019
9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Ms H Brearley	Interim Director of Workforce & OD
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mr H Mullen	Director of Strategy, Planning & Partnerships
Mr F Patel	Director of Finance
Mrs L Robson	Chief Executive
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director
Mr D Hopewell	Non-Executive Director

In attendance:

Miss K Walker	Discharge Coordinator
Mrs E Rogers	Matron for Patient Experience
Mr M Reed	Head of Capital Projects
Mrs H Cubitt	Head of Communications
Mrs H Howard	Deputy Chief Nurse
Mrs J Griffin	Discharge Coordinator
Mrs S Curtis	Membership Services Manager
Mrs S Katema	Committee Secretary

ACTION

48/19 Apologies for Absence

Apologies for absence were received from Dr Cheshire; Mrs Barber-Brown and Mrs Parnell.

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

49/19 Declaration of Interests

There were no declarations of interest in relation to the agenda items

50/19 Patient Story

The Chief Operating Officer invited the Matron for Patient Experience and Discharge Coordinators with the Integrated Transfer Team (ITT) to present the Patient Story. She advised that the patient story illustrated the effect of the ITT on length of stay for patients with complex discharges.

The Board was advised that the ITT was a multidisciplinary team which consisted of nurses, social workers, charities such as Age UK and Red Cross and CCG partners. Referrals to the ITT were mostly done through emails and member of staff could refer patients. The panel meets with senior managers from different

teams who are key decision makers. The aims of the panel are to reduce length of stay, facilitate an early discharge plan and prevent readmission.

The Board was provided with details of a patient story relating to 73year old lady who had learning disabilities and lived alone. The patient required respiratory help and used a nasal cannula which delivered supplemental oxygen. Following a period of illness, a package of care was arranged to enable the lady to get health support at home. Community nurses had visited the patient and found the cannula inserted but not plugged into the concentrator. The team raised concerns and highlighted that due to the continuous oxygen requirement, it would not be in the best interest of the patient to stay at home.

It was noted that on admission to the Emergency Department (ED), the patient had presented her Health Passport. She had been frustrated at the start with the number of people asking her questions and had reiterated that she did not wish to in hospital.

The patient had been in hospital for 62 days at the time the ITT panel was convened. A collaborative multi-disciplinary team approach was agreed and the patient was presented with two options which were either to fund a qualified nurse or to move into a nursing home. The patient agreed to be transferred to a nursing home and funding was provided for four weeks by the CCG.

Within 48hours of the panel review, the patient had been discharged to a nursing home of her choice. Oxygen was delivered to the nursing home and a robust care plan reviewed by doctors was put in place. The social worker brought clothing and the woman's personal possessions to the nursing home. It was noted that the discharge process reinforced the Proud2Care ambition of keeping the patient central to the process.

Mrs Anderson questioned what would take place in relation to the four week funding by the CCG. In response, it was noted that the CCG had Continuing Health Care teams which looked into ongoing care packages for people assessed as requiring funding.

The Medical Director advised the Board that the story exemplified the benefits of ITT to the health economy. It reflected the complexities that the teams are faced with on discharging patients, and the impact that ITT could make on a number of patients. He stated that had the ITT referral not been made, the patient would have remained in the hospital.

The Chief Executive commented that she was proud to have a discharge facilitation model which others were keen to replicate. She acknowledged that the team needed to be nurtured and given more authority when working on wards and discharge.

The Board thanked the Matron for Patient Experience and the Discharge Coordinators for presenting the Patient Story

The Board of Directors:

- Noted the Patient Story.

(20 mins)

Ms Walker, Ms Griffin and Mrs E Rogers left the meeting.

51/19 Minutes of the previous meeting

The minutes of the previous meeting held on 28 February 2019 were agreed as a true and accurate record of proceedings.

The action log was reviewed and annotated accordingly.

(5 minutes)

52/19 Chair's Report

The Chair presented his report to the Board which outlined activities undertaken since the previous Board meeting. He highlighted that this would be Ms Smith's last meeting as she would be stepping down from her role on 31 March 2019. The Chair led the Board in thanking Ms Smith for the major contributions she had made to the Trust in her role as a non-executive director. The Board noted her focussed efforts on key strategic issues and ensuring there was effective triangulation on the work of the People Performance Committee which she chaired, with other committees of the board.

The Chair informed the Board that Mr Jenkins, Lead Governor of the Council of Governors, had expressed his intention to step down from the role. Elections to choose his successor were underway with a view that results would be announced at the next Council of Governors meeting. The Board formally noted its gratitude and acknowledged the work that Mr Jenkins had undertaken in fulfilling the role of Lead Governor.

The Chair highlighted that the Trust had received formal recognition in relation to the work undertaken to improve the quality and safety in delivering patient care. He commended the Chief Nurse and Director of Quality Governance and all members of staff, for the sustained efforts and focus on achieving the Quality Improvement Priorities.

The Board of Directors:

- Received and noted the Chair's Report.

(2 minutes)

53/19 Report of the Chief Executive

The Chief Executive provided an update on the strategic and operational developments at both local and national levels. Reflecting on her first three months with the Trust, Mrs Robson advised that she was privileged to be undertaking this journey with the Trust.

In terms of operations, winter performance had been better than predicted despite the Trust having reached Operational Procedure Escalation Level (OPEL) 3 on many occasions including the previous week. Work to address the performance against the four hour A&E standard was ongoing, with average performance increasing from 58% to around 85%. There was also continued focus on 'flow' throughout the hospital as well as collaborative work with partners across Stockport.

The Chief Executive highlighted that in conversations with members of staff, it appeared they were cognisant of the ongoing challenges. However, there undoubtedly was a genuine sense of excitement and growing confidence that the organisation was progressing.

The Chief Executive outlined her commitment to strengthening relationships with external stakeholders including commissioners, Viaduct, Mastercall, and neighbouring Trusts. Some of this work included her role as joint chair of Greater Manchester Elective Care Reform Programme. Dr Cath Briggs, Chair of Stockport CCG was the other chair. She added that as early adopters of the programme it was expected that this work would offer a great opportunity for clinical leaders and individuals from across the system to help shape cutting edge transformation of local services for the benefit of the local population.

In conclusion, the Chief Executive drew attention to the acknowledgement and accreditation that the Trust was receiving externally. She highlighted that the Getting It Right First Time (GIRFT) team had requested to use the Trust as an exemplar site for other trusts to visit. This followed the Trust having maintained elective work during winter which had impressed the GIRFT team. The external recognition would make a real difference to how the Trust was perceived and would be essential for the recruitment and retention of a range of key posts in the future.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

(8 *minutes)*

54/19 Performance Report – Month 11

The Director of Strategy, Planning & Partnerships presented the Trust Performance Report for Month 11.

Quality and Safety

The Chief Nurse and Director of Quality and Governance provided an overview of performance against the following indicators:

- The Trust had made significant improvements regarding responses to complaints.
- Patient safety incidents for every 1000 bed days had reduced slightly in month.
- The number of STEIS reportable incidents reduced for the second month in a row with 12 incidents reported in February.

The Medical Director highlighted that the number of reported medication errors had decreased for the fourth month in succession, with the Trust set to meet the improvement trajectory. In addition, all medication incident reviews were conducted weekly by a Trust Executive at the Patient Safety Summit. The weekly patient safety summit update, which is circulated to all staff, also continued to be a useful mechanism of highlighting medication issues. The Board commended the great leadership provided by the Chief Pharmacist, Dr Buckley.

The Medical Director advised that a marginal improvement had been recorded

for inpatients that had diabetes reviews. Whilst the issue remained a challenge for the organisation, there was assurance that the all diabetes metrics and performance were being closely monitored.

Mr Belton advised that he had attended a chairs event where the National Patient Safety Strategy had been discussed. The Chief Nurse confirmed that whilst the publication date had not been confirmed, a gap analysis would be undertaken to ensure the Trust Strategy was aligned with the National Patient Safety Strategy.

Finance Performance

The Director of Finance advised that the Trust position was favourable against the financial plan at this stage of the financial year. The mitigated forecast out-turns had improved in line with the planned deficit. There continued to be significant assurance that the operational plan would be delivered at the end of 2018/19.

The Director of Finance drew attention to the percentage variance between planned elective income and the actual elective income in month. He commended the Surgical Business Group for the continued focus on the elective activity noting that as a result of these improvements, ED performance was improving.

In terms of the Trust's financial outlook, this remained challenging with the Trust not set to deliver recurrent savings against the Cost Improvement Plan (CIP). The Director of Finance highlighted that the Trust would be continuing to borrow throughout 2019.

Operational Performance

The Chief Operating Officer outlined the key issues and provided an overview of the Trust's Operational Performance against the following indicators:

- Stranded patients had reduced to 25% compared to the equivalent period in the previous year
- There had been improvement on the A&E 4hr Standard in February and the early indication was that there would be further improvements in March.
- Three breaches were recorded against the 12 hour trolley breaches in February with no breaches recorded in March.
- The diagnostic six week standard had improved significantly due to the great effort in delivery activity. It was noted that issues in Cardiology, which were under review, were likely to affect the achievement of this standard.

The Chief Operating Officer made reference to clinical correspondence adding that an external review would be completed in the following month. In terms of assurance to the Board, outsourcing had been approved for a proportion of letters that needed typing for the specialties which had the longest delays.

Mr Sugden observed that it was encouraging to see the amount of work undertaken to improve the number of stranded patients and Delayed Transfer of Care (DTOC). He queried if there were plans for collaborative work with the wider health economy to improve patient outcomes.

Mrs Robson responded that these were some of the key workstreams of the Urgent and Emergency Care Board. The Board agreed to hold a winter evaluation workshop reflecting on some of the work undertaken under emergency care, as well as considering associated developments in this area.

Action: The Chief Operating Officer to facilitate a Winter Evaluation Workshop.

Ms Toal

Workforce Performance

The Interim Director of Workforce and Organisational Development provided an update on the Trust Workforce Performance against the following indicators:

- Sickness absence rates improved in line with the previous year's profile. She added that main challenge would be to review and gain an understanding of the key drivers.
- Appraisal rates for medical staff continued to be above the Trust target. However, appraisal rates for non-medical staff decreased to 87.7%. Action plans were in place to recover the position by the end of March.
- A reduction in agency spend had been recorded. Actions remained in place to reduce the level of spend in line with the agency ceiling.
  The Board acknowledged the work undertaken to reduce agency spend.
- The Director of Workforce and OD drew attention to the Safer Staffing Report and improvement on the vacancy rates for nursing staff.

The Board of Directors:

- Received and noted the Trust Performance Report for Month 11.

(33 minutes)

55/19 Key Issues Reports

The Chair invited Committee Chairs to raise any key issues that had not been covered during consideration of the Performance Report.

Quality Committee

Ms Smith referred the Board to the 'Alert' items which included the following:

- Microbiology vacancies impacted on the investigations and uploading of information to the Mandatory Enhanced Surveillance System (MESS) database. The issue remained a key focus of attention.
- A potential breach of duty of candour had been reported to the CQC within the required timescales.
- Staff shortages at Pennine Care Trust had impacted the development of the Memorandum of Understanding in relation to delivery of Care24.

The following items had provided assurance to the Committee:

- The Quality improvement journey outlined the significant progress as well as the process for setting priorities for 2019/20.
- Continued focus on the level of work undertaken to increase complaints response rates from 5.6% at the start of the year to 52% in February.
- Exploring the increase in caesarean rates in year, which was being monitored locally and regionally.

The Board was referred to the 'Advise' item noting that following an inquest earlier in the month, the Trust had received a Regulation 28 letter and had responded within the required timescale.

Finance and Performance Committee

Mr Sugden informed the Board that the Finance and Performance Committee had noted considerable progress against the Cost Improvement Plan (CIP) for 2019/10.

The Committee took limited assurance but noted the progress made regarding the ongoing development of the Clinical Services Efficiency Programme. A formal report would be presented to the Committee in May.

Risks identified by the Committee included the Clinical Services Efficiency Programme for 19/20 and the delivery of the Cost Improvement Plan.

People Performance Committee

Ms Smith informed the Board that the Committee took positive assurance from the People Strategy Update Report and noted the progress against its priorities.

She referred the Board to the 'Advise' section of the report which included the following items :

- noting the collective efforts to reduce the £11.2m forecast level of agency spend.
- the key findings from the Gender Pay Gap report.
- progress and actions delivered following results of the Staff Survey. The communications team would be sharing the results and actions with staff.

The Board of Directors:

- Received and noted the Key Issues Reports from its sub-committees.

(9 mins)

56/19 Quality Improvement Priorities

The Deputy Chief Nurse delivered a presentation on the current progress made in achieving the Quality Improvement Priorities and the progress made in relation to patient safety. She highlighted that progress in working towards the target for Pressure Ulcers was to achieve a 50% reduction in avoidable stage 2, 3 and 4 pressure ulcers.. The Deputy Chief Nurse acknowledged that this was testament to the work of the tissue viability nurses.

A 10% target for reducing inpatient falls had had improved with 929 falls recorded against the target threshold of 1378. The current position of the MUST screening tool indicated that the position at the end of Q3 would be 71% with the objective set at 100% compliance by March 2019 marking a significant improvement.

In terms of effectiveness, a dashboard had been produced for discharge planning which was expected to streamline the referral process in relation to discharge planning. Incidents were reviewed and monitored weekly at the Patient Safety Summit. The Ward Accreditation programme was gaining traction with a total of 26 assessments having been completed to date. It was expected that this would be extended to include Community, Maternity and Paediatrics.

Overall the Board noted the significant progress with regards to the Quality Improvement priorities. It was agreed that having clear, SMART objectives defined at the start and supporting metrics was a useful mechanism of measuring progress.

The Deputy Chief Nurse highlighted the 2019/20 indicators which had been agreed following planning workshops.

Mr Belton asked how the Board would get assurance that these improvements would be sustainable. The Chief Nurse responded that the Board would see continued reduction in numbers presented each month. These indicators would be triangulated and measured in different places of the organisation. There was added assurance that the Trust would continue to learn from experience.

The Board:

- Received and noted the progress across the Quality Improvement Priorities from 2018/19
- Received and noted the proposed priority indicators to be taken forward 2019/20

(19 Mins)

57/19 People Strategy Quarterly Update

The Interim Director of Workforce and Organisational Development presented the People Strategy Quarterly Update. The People Strategy Map detailed the workforce and organisational development priorities for the next five years and would be subject to annual review. Progress on achieving these improvements would be monitored by the PPC. The Board noted that the Trust had been ranked first out of 436 trusts in regards to the data quality (Workforce) on Electronic Staff Records.

The Director of Workforce and OD highlighted that the development of the culture and engagement plan symbolised that the Trust was listening and responding to issues raised by staff. Work had commenced to develop the culture and engagement plan. The Trust was engaged with the NHSI culture programme and had joined the NHS Leadership Academy Talent Management Programme as a Diagnostic Pilot Site. The project plan and the full implementation of the eRostering systems would be presented to the PPC.

The Director of Workforce and OD advised that PPC had welcomed the transparency and acknowledged that the strategy provided useful information that the Trust had to work with. In terms of looking ahead, a review of the priorities would be undertaken to ensure that emerging changes were effected. These included independent reviews, such as the Kark Review and Topol Review.

A deep dive would be conducted to outline the specific workforce implications stemming from the NHS Long Term Plan.

The Director of Workforce and OD drew attention to the summary of the statutory and mandatory training compliance. She added that this remained a priority for the Trust and actions were continuously reviewed to enable maximum compliance in all areas

The Board of Directors:

- Received and noted progress against the People Strategy Priorities for quarter 4, 2018/19.

(9 mins)

58/19 Staff Survey Results

The Director of Workforce and OD presented the report providing the Board of Directors with analysis and detail in relation to the findings of the 2018 staff survey results. The report also provided an update on agreed actions and benchmarking data.

The survey had been undertaken as a sample of 2000 staff rather than the full census. The level of responses equated to 30% of staff, which marked a 10% reduction on performance from the previous year. The Board was advised of the actions delivered since the previous year's staff survey which included introduction of a Clinical Leadership Programme and Triumvirate leadership development programme for clinical business groups. Further plans were in place to finalise the development plan, which would sit alongside the People Strategy.

Ms Smith observed that PPC had acknowledged that there was a need for investing in how information was disseminated to staff. She highlighted that a suitable model for communicating the actions taken following surveys would be a 'you said we did' statements.

The Board:

- Received and noted the Staff Survey results.

(8 mins)

59/19 Estates Strategy Progress Report

The Head of Capital Projects presented the Estates Strategy Progress Report. This provided details on the progress made to date with the short-term actions of the Estates Strategy and the development of the Strategic Outline Case, which supported the transformational changes to the estate as described within the Estates Strategy.

It was noted the Strategic Outline cases were split into three phases: the short term, medium term and the long term. In regards to the short term work underway this included the demolition of A12 & A15. It was expected that this would cost£200k but would remove £2.5m of backlog maintenance work. Other notable progress on the proposals included the refurbishment of C3, which had

been well received by patients and staff.

The Chief Executive observed that the presentation provided a good overview of the Trust position and priorities on site with regards to Estates.

Action: To go to Board forward planner next month.

The Board:

- Received and noted the Estates Strategy

(26 minutes)

Mr Reed left the meeting.

60/19 Operational Plan 2019/20

The Director of Strategy, Planning and Partnerships presented the Operational Plan for 2019/20. He provided an overview of the changes and the rationale to key performance trajectories relating to the following:

- Referral to Treatment
- Cancer waiting times which included the 62 day cancer standard and two week wait.
- Revised bed profile;
- Proposed changes to the ED four hour wait performance trajectory
- Profile of CIP delivery.

The Director Strategy, Planning & Partnerships commended Kay Wiss (Deputy Director of Finance), and Andrew Bailey (Associate Director Strategy, Planning & Partnerships) for the work undertaken in drafting the Operational Plan. He advised that the current process was much more robust and any risk to the plan would be raised with Finance and Performance Committee. He proposed delegating approval of any changes to Executive Team

The Board of Directors:

- Endorsed the revised activity plans;
- Approved the changes made to the Operational Plan, and
- Delegated responsibility to the executive team to ensure these are reflected in the final operational plan narrative due for submission to NHSI on 4 April 2019.

(10 minutes)

61/19 2019/20 Annual Budget

The Director of Finance presented the 2019/20 Annual Budget paper, which provided a summary of the underlying assumptions, contractual agreements and financial summaries. These were aligned with the Final Operational Plan, which would be submitted on 4 April 2019. He advised a contract agreements had not been reached with North Derbyshire CCGs despite contract proposals being issued on time.

Discussions with Stockport CCG were ongoing in relation to the change in commissioning of Bluebell Ward and the additional resource for winter beds. The Directors of Finance was in conversation with his peers as part of the contract discussions with Stockport Together and to progress agreements for 2019/20.

The Director of Finance highlighted the delivery of the £14.2m CIP programme on a recurrent basis was one the main risks to delivery of the financial projections. He advised that achieving the control total would remain a big challenge to the new financial year. A development fund of £1.6m had been agreed by the Executive Team, which would be used to address continual investment in quality and safety.

The Director of Finance advised that the plan was a live document until submission on 4 April 2019. The incoming Director of Finance had been apprised of the development and was included in the discussions that had taken place. He advised that further changes following finalisation of the contracts or NHSI feedback would be provided to the Finance and Performance Committee in April.

The Board of Directors:

- Received and noted the underlying assumptions in the Operational Plan
- Received and noted the current contract discussions and agreements
- Received and noted that the tables in the document will be updated following completion of the templates
- Approved the Annual Budget for 2019/20, and
- Agreed to receive an update to the Operational Plan at the Board of Directors in April 2019.

62/19 Capital Plan 2019/20

The Director of Strategy, Planning and Partnerships presented the capital plan for 2019/20 advising that the Trust currently held £1.8m in cash resources. The Trust's on-going capital plan remained restricted in light of the deficit position and requirement for external cash support. A risk based approach had been taken on prioritisation of capital expenditure.

The Board of Directors:

- Approved the recommendation of the capital programme for 2019/20
- Noted the significant pressure upon funding and difficult choices on prioritisation
- Noted the potential impact of Health Together funding and decision to be made on cash resources.

(5 minutes)

63/19 Going concern declaration

The Director of Finance presented the Going Concern Declaration for 2018/19. He advised that further to the Trust accepting the 2019/20 financial control total of £3.6m deficit, the Trust became eligible for additional funding. However, given that some of the funding was paid quarterly and in arrears, payment in Q4 payments would not be received until 2020/21.

It was noted that the report analysis identified several significant business risks that the Trust would face in the coming year. However, this was consistent with previous years and the experience of other acute NHS trusts. The Director of Finance informed the Board that the report had been shared with auditors and requested the Board to consider the Going Concern Declaration.

Mr Hopewell observed that the declaration reflected that Directors had a reasonable expectation in relation to adequate resources to continue operations. He expressed uneasiness at the statement given the caveats attached to the funding.

The Board of Directors:

- Received and noted the Going Concern declaration report.
- Agreed to the going concern declaration.

(5 minutes)

64/19 Committee Annual Reports and TOR Reports

Quality Committee

The Chief Nurse and Director of Quality and Governance presented the Annual Committee Effectiveness Report, which outlined how the statutory responsibilities and duties of the Quality Committee had been achieved during the period from April 2018 to March 2019.

The Board of Directors:

- Received and noted the progress and assurance against the duties and responsibilities achieved by the Quality Committee from April 2018 to March 2019.
- Approved the Terms of Reference for the Quality Committee for 2019/2020.

People Performance Committee

The Director of Workforce and OD presented the report, which described how the People Performance Committee evaluated its effectiveness and performance during the period April 2018 to March 2019. The report demonstrated robust and embedded governance structures and reflected how the Committee fulfilled its responsibilities. These included effective assurance on matters relating to workforce, education & learning, equality and diversity, and organisational development.

The Board of Directors:

- Received and noted the progress and assurance against the duties and responsibilities of the People Performance Committee.
- Approved the Terms of Reference for the People Performance Committee for 2019/2020.

(2 minutes)

65/19 Trust Risk Register March 2019

The Chief Nurse and Director of Quality and Governance advised that she would be working with the Interim Director of Corporate Affairs to review the Trust Risk Register. It was expected that there would be a change in approach to how risks were reported and recorded. This would be underpinned by training.

The Board of Directors:

- Received the Trust Risk Register and noted the identified actions to mitigate the risks.

(2 minutes)

66/19 Date, time and venue of next meeting

The Board noted feedback from a member of the public in attendance, regarding using patient screens to display content highlighting changes taking place at the Trust. He cited the demolition of A12 and A15 and other planned changes as issues that some members of the public may not be privy to but would welcome the information.

There being no further business, the Chair thanked all for attending and brought the meeting to a close at 12.35. He advised that the next public meeting of the Board of Directors would be held on Thursday, 25 May 2019, commencing at 9.30am in Lecture Theatre A, Pinewood House.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

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

05/19	28 Mar 19	54/19	Performance Report – Month 11	The Chief Operating Officer to facilitate a Winter Evaluation Workshop	Ms Toal
06/19	28 Mar 19	59/19	Estates Strategy Progress Report	Estates Strategy to be included on the Board forward planner next month.	Mr Mullen

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25 April 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

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

Attachments: Board Business Cycle 2019-20

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

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

- A forward look
- Council of Governors
- My engagements
- External news

2. FORWARD LOOK

In my report to the Board of Directors last month I reflected on the challenges and progress we had made during 2018-19, but I think it is important to keep reminding ourselves of how far we have come in the last year.

We now have a clear view of what we need to do to tackle the issues facing the local health and care system, and thanks to the commitment, skills and enthusiasm of our staff we have seen some real improvements in both the hospital and community services we provide. This has been recognised by the CQC, NHS Improvement and the Stockport Improvement Board.

During 2018-19 we worked hard to achieve our financial plans for the year, which we delivered without compromising the quality of our services. We have invested in new equipment for the benefit of our patients and staff, and have robust plans in place to achieve a much reduced deficit of £3.6m in 2019-20. This is a significant improvement on where we have been in recent years.

It is this consistent focus on improving the quality and safety of our services, as well as making sustained progress against performance standards and achieving our financial plans that means we can look forward to the next 12 months with increased confidence.

But we are not complacent. We know that we will need to continue to maintain a constant focus on the quality of our services, delivering the improvement targets we have set ourselves and supporting colleagues across the Trust in their endeavours to make positive and sustained change to services for the benefit of the local communities we serve.

We will also need to deliver on performance and financial targets, which we have agreed with our external regulators. Over the last 12 months we have demonstrated that we can make real progress in delivering against agreed budgets, and a lot of that has been down to the commitment and focus of staff in our business units. We need to build on that success and keep a tight control on our spending to work towards a break even position that will allow us to invest further in new equipment, buildings and services in the future.

Some of our performance targets have been a real challenge to achieve in recent years, and a number will continue to be so over the next 12 month, as we try to manage the demand of an ageing population often with complex needs, the national scarcity of staff with the

right skills in some key specialities, and increasing need for services, such as the national drive towards earlier detection of cancer.

We are not alone in facing these challenges and remain convinced that the key to managing much of the competing demand for our services is through effective partnership working. I know the Board of Directors is equally committed to building and maintaining relationships with a number of statutory and voluntary agencies who all work to meet the needs of the local communities we serve.

Over the coming months I am looking forward to finding more ways that we can connect with those agencies either as a Board or individuals, together developing strong and effective networks focused on achieving complementary aspirations.

I am particularly keen to see us develop the neighbourhood model of working, and I think our Council of Governors could have a key role to play in helping us to link into the members in local areas that they represent. My report contains details of the recent Council of Governors meeting, but I know that our governors are keen to enhance their understanding of the organisation and develop their roles further. So over the next year we will be making changes to those meetings to give them more in-depth knowledge about the challenges that are facing the Trust, as well as supporting them to build greater links with our membership to seek the views on how we are tackling those issues.

There is lots of evidence that we made significant progress in 2018-19, and I believe that we are well placed to consolidate those improvements in 2019-20 and further develop our strategy for a successful future for the Trust and our hospital and community services.

3. COUNCIL OF GOVERNORS

The Council of Governors met on 8 April 2018 and they discussed the following items:

- My report
- The Chief Executive's report
- Nominations Committee report
- Terms of reference for the Council's Membership Engagement Committee and Quality in Care Committee.

Mr Les Jenkins has been our lead governor for more than five years but he recently announced his intention to stand down from the role. Two candidates put themselves forward for the position and Mrs Eve Brown was elected to the role by the Council of Governors.

I am delighted to report that our Governors agreed to extend Dr Mike Cheshire's term of office as a Non-Executive Director for a further 12 months and Mrs Catherine Barber-Brown's term of office as a Non-Executive Director for a further three years. They also approved arrangements to recruit to a vacant Non-Executive Director post, which is now out to advert.

4. CHAIR ENGAGEMENTS

As well as chairing the Council of Governors meeting I have also met with colleagues in Stockport Clinical Commissioning Group and Viaduct, and attended part of the HSJ Summit. As the Board-lead for Equality and Diversity I was delighted to join Trust colleagues in presenting the work colleagues have done around the diversity agenda to the judging panel of the Equality, Diversity & Inclusion HPMA Awards. We are one of three short listed entries for this award and it is great to see the efforts so many of our colleagues have put into this important area being recognised nationally. We look forward to hearing the judging panel's decision in June.

5. EXTERNAL NEWS

- A new suicide bereavement information service has been launched in the region. Commissioned by the Greater Manchester Health and Social Care Partnership, the service provides advice and information for bereaved families that can be accessed via www.shiningalightonsuicide.org.uk/bereaved
- An NHS Assembly has been established with representatives from clinical and managerial NHS staff, patients, carers, volunteers, charities and third sector organisations to advise on the delivery of improvements in health and care outlined in the NHS Long Term Plan. This includes representatives from the North West.

6. RECOMMENDATIONS

The Board of Directors is recommended to receive this report.

This page has been left blank

BOARD BUSINESS CYCLE 2019/20

	April	May	June	July	September	October	November	December	January	February	March
Core Agenda Items	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.		Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.
Strategy & Planning	Q4 Corporate Objectives. Approve Operational Plan. People Strategy Progress Report. Winter Plan Review	Estates Strategy Progress	Theme 3&4 Update.	Trust Strategy Progress. Q1 Corporate Objectives. Winter Planning.	Winter Plan.	Q2 Corporate Objectives. Winter Plan. People Strategy Progress	Estate Strategy Progress Winter Planning.		Trust Strategy Progress. Q3 Corporate Objectives. Theme 3&4 Update.	Draft Operational Plan.	Approve Corporate Objectives. Theme 3&4 Update.
Financial		Annual Accounts.									Revenue Budget. CIP Programme. Capital Programme Going Concern Statement.
Governance & Regulatory	NED Independence Statement. Register of Interests. Use of Common Seal.	Annual Governance Statement. Annual Report. Code of Governance Compliance. Governance Declarations [inc. self-certification against Conditions G6(3) and CoS7(3)].	Corporate Governance Declaration [inc. self-certification against Conditions G6(4) and FT4(8)]. Board Assurance Framework.	EPRR Annual Report.	Board Assurance Framework.	EPRR Assurance Statement.	Board Assurance Framework.		Board Assurance Framework.	Registration Authority - Annual Report.	Board Assurance Framework.
Quality	Patient Story. FTSUG Report. Strategic Staffing Review.	Patient Story. Annual Quality Report. Quality Improvement Plan.	Patient Story. Staff Survey Plan.	Patient Story. Learning from Deaths. Freedom to Speak Self-Assessment.	Patient Story. PLACE Assessment.	Patient Story. FTSUG Report.	Patient Story. Strategic Staffing Review		Patient Story. Learning from Deaths.	Patient Story.	Patient Story. Staff Survey Results.

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25 April 2019
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

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

Attachments:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

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

2. GENERAL SUMMARY

Partnership working has been a key theme for me over the last month. In preparation for Easter a huge amount of planning had been undertaken in the Trust to prepare for the Bank Holiday and what can be a very busy time for our services. We had continued a number of our winter schemes and launched the Home for Easter initiative, encouraging our staff to trial new ideas and identify obstacles to effective patient flow to try to manage the bed capacity over the Easter weekend.

However, a surge in acutely ill people needing our emergency care in the run up to the Bank Holiday highlighted that while we may have been planning ahead, ensuring that the same rigour is applied across our system is critical. Availability of alternatives to hospital and packages of care would have made it possible for more patients awaiting discharge from hospital to go home or to other care settings.

Our staff worked really hard to manage the demand, and help to get those patients ready for discharge back home as soon as possible. While reflection on the situation will invariably highlight areas where we could have done more or had a consistent focus on patient flow throughout all of our services, the issues across the health and care system in Stockport will be something that we will be heavily focusing on in the Urgent and Emergency Care Board that I chair for the system.

That Board is developing a real focus on how partners are working together and it is being supported by some great business intelligence that our Finance and Performance Committee saw a snapshot of at the last meeting. I am keen for all of our Board of Directors to see the developing information that is supporting our urgent and emergency care work with partners, and this will be the subject of a Board development session soon.

The improvements that we have made over the last year to the quality, safety and performance of our services have not only been recognised by NHS Improvement, but also by the Stockport Improvement Board. Although a small number of issues external to the Trust still need to be addressed, the Board has now been stood down. This is testament to the huge amount of work our staff across the Trust have put into the improvements that have been made and which we must sustain for the benefit of the local people we support.

Another key area of partnership working that is developing is the Greater Manchester Elective Care Programme Board that I lead in partnership with D Cath Briggs, Clinical Chair of Stockport Clinical Commissioning Group (CCG). The programme is starting to take shape, with a key GM-wide engagement event being planned, and I am excited about the opportunities that this work will bring.

The future of Stockport Together has had some coverage in the local media over the last month and contrary to reports I am continuing to meet regularly with my counterparts in the local authority and CCG to work together on common concerns and aspirations. Our

most recent discussions have been about how we may be able to tackle collective estate issues.

The work we have done in partnership with other organisations has paid dividends over the last year, and has helped to address a number of the challenges faced by the local health and care system. I remain committed to working with our partners to make a positive difference to the lives of local people, and we are continuing to make progress on transforming health care via the Stockport Health Partnership Board.

As well as working with local partner colleagues I am also starting to meet with the new regional director teams that are emerging from NHS Improvement and NHS England coming together. It will be interesting to see how this new body develops in the coming months, but I am confident we can build effective working relationships with the regional director teams.

One of the best things about being a Chief Executive is the opportunity to visit services and meet our staff, who work so hard to provide high quality safe care to local people. This month I have had fascinating visits to our maternity and paediatric services in Stepping Hill Hospital, and I was really impressed by the amazing efforts of the staff at Swanbourne Gardens. This service, which is the only centre in the North West to provide short breaks for children and young people with learning disabilities and complex conditions, is very much part of the local community. It was great to see the allotment where the youngsters can grow their own fruit and vegetables, and all the wonderful fund raising efforts going on to support the service, including the newly refurbished bathroom funded ASDA. A very different, but no less impressive experience, was my visit to our pharmacy services, the pharmacy production and aseptic units, as well as the "subsidiary" pharmacy on the main hospital corridor.

3. AWARDS, EVENTS AND NEWS

- Health Service Journal Awards – The Trust's Enhanced Recovery After Surgery (ERAS+) team has been shortlist for an HSJ Patient Safety Award. The hospital based team has been recognised in the perioperative and surgical care category for the way its surgical medical, nursing and physiotherapy staff work together to ensure patients are in the best possible physical health before and after major abdominal surgery. The winner will be announced at the awards ceremony in Manchester on 2 July.
- ISO surveillance visit – we had a recent visit to our microbiology service where the inspector congratulated staff on the marked improvements they had made since the last inspection. The team have worked very hard to make changes and it is credit to them that the inspector will be recommending that microbiology should retain its ISO accreditation.
- Experience of Care Week – the Trust has been running a series of events this week for patients, staff and visitors. This morning there is pet therapy in the hospital and this afternoon music therapy and afternoon tea at Bluebell. Tomorrow there will be an afternoon tea dance in the restaurant featuring a local dance group.
- Great Manchester 10k run – 97 members of staff, including some of our Board members, will be taking part in the run on May 19 raising money for the Trust charity and other good causes.

- Lullaby Hour – with the support of Music in Hospitals our neonatal unit has introduced lullaby hour. The first session featured a classical guitarist, who also played in our intensive care unit and future sessions will be funded by the Trust's charity.

4. RECOMMENDATIONS

The Board of Directors is recommended to receive the report.

This page has been left blank

Report To:	Trust Board	**Date:**	25 Apr 2019
Subject:	Integrated Performance Report		
Report of:	Deputy Chief Executive	**Prepared by:**	BI, Performance Team & Executive Directors

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

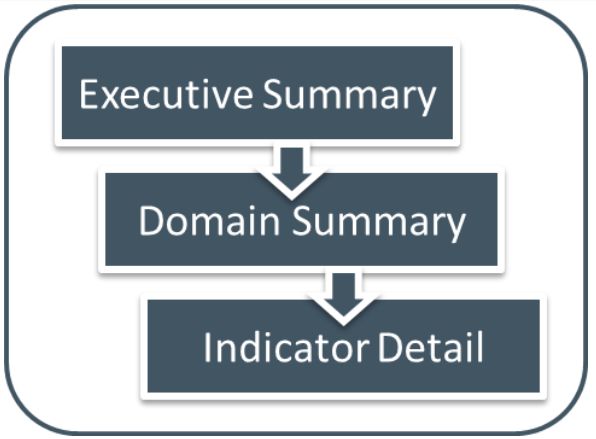
Attachments:

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:



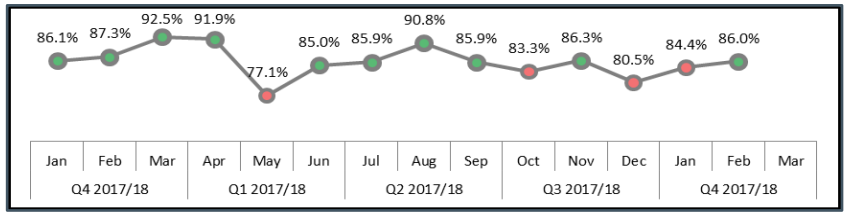
Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

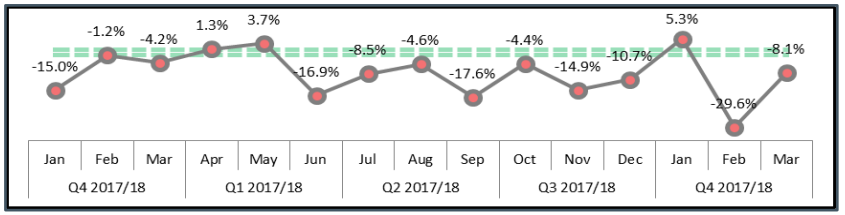
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

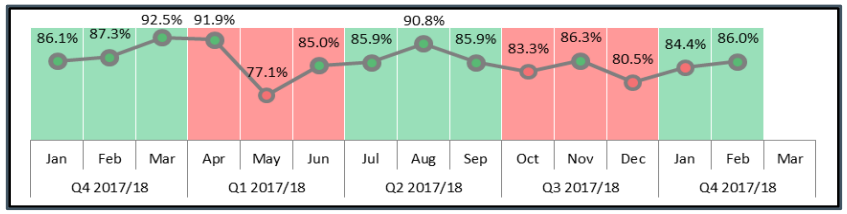
The following chart types are in use throughout the report:



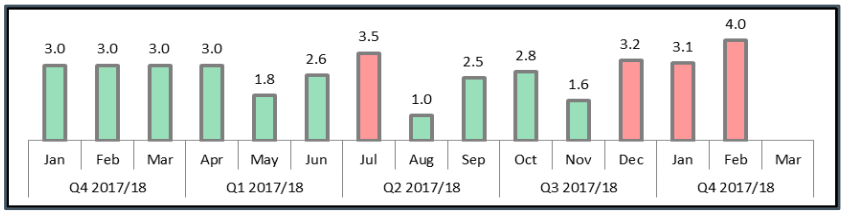
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



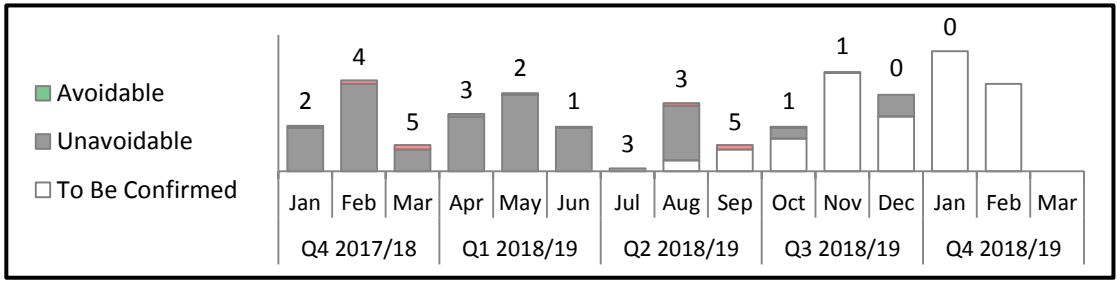
For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



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

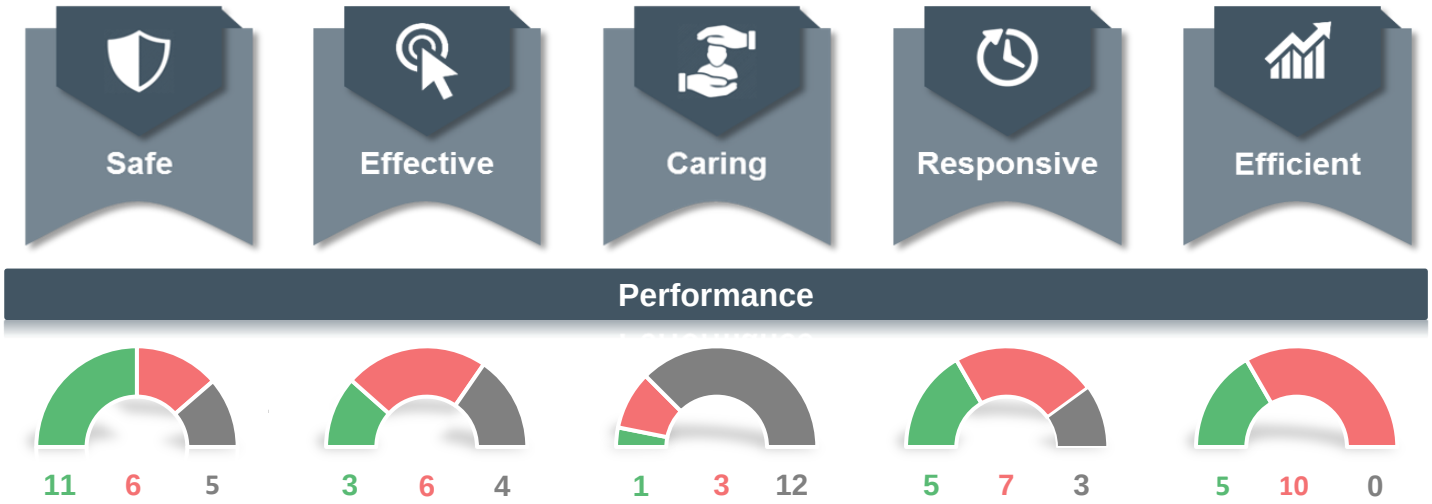


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.



Executive Summary

Stockport NHS Foundation Trust



Key Changes to the indicators in this period are:

Metrics changing from green to red in month:
- Patient Safety Alerts
- Emergency readmission rates
- Diagnostic: 6 week standard
- Mandatory Training

Metrics changing from red to green in month:
- 12hr trolley waits
- Elective Income v Plan

Areas of notable improvement:
- Complaints response rate -
- ED performance
- Emergency readmission rate

Areas of notable exception:
- Clinical correspondence turnround
- Bank & Agency spend

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Feb-19		13.32							9.85		11
C.Diff Infection Count (lapses in care)	CN&DQG	Feb-19	<= 15 *	0							4		11
MRSA Infection Rate	CN&DQG	Feb-19		0.00							0.54		12
MSSA Infection Rate	CN&DQG	Feb-19		5.97							6.66		12
E.Coli Infection Rate	CN&DQG	Feb-19		17.92							17.09		13
E.Coli Infection Count	CN&DQG	Feb-19	<= 34 *	2							34		13
Falls: Total Incidence of Inpatient Falls	CN&DQG	Mar-19	<= 1378 *	105							1281		14
Falls: Causing Moderate Harm and Above	CN&DQG	Mar-19	<= 31 *	3							29		14
Pressure Ulcers: Hospital, Avoidable Category 2	CN&DQG	Feb-19	<= 12 *	0							19		15
Pressure Ulcers: Hospital, Avoidable Category 3	CN&DQG	Feb-19	<= 5 *	0							11		15
Pressure Ulcers: Hospital, Avoidable Category 4	CN&DQG	Feb-19	<= 1 *	0							4		16
Pressure Ulcers: Community, Avoidable Category 2	CN&DQG	Feb-19	<= 37 *	0							12		16
Pressure Ulcers: Community, Avoidable Category 3	CN&DQG	Feb-19	<= 10 *	0							5		17

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Avoidable Category 4	CN&DQG	Feb-19	<= *3* *	0							1		17
Safety Thermometer: Hospital	CN&DQG	Mar-19	>= *95%*	95.8%							95.8%		18
Safety Thermometer: Community	CN&DQG	Mar-19	>= *95%*	96.9%							96.3%		18
Medication Errors: Overall	CN&DQG	Mar-19		79							1089		19
Medication Errors: Moderate Harm and Above	CN&DQG	Mar-19	<= *4%*	0.0%							3.5%		19
VTE Risk Assessment	CN&DQG	Mar-19	>= *95%*	96.7%							97.0%		20
Clinical Correspondence	COO	Mar-19	>= *95%*	52.3%							62.6%		20
Flu Vacination Uptake	DoW&OD	Feb-19	>= *75%*	75.3%									21
Discharge Summaries	MD	Mar-19	>= *95%*	90.6%							89.8%		21

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	Mar-19		57.04									22
Emergency C-Section Rate	CN&DQG	Mar-19	<= 15.4%	16.3%							17.0%		22
Never Event: Incidence	CN&DQG	Mar-19	<= 0	0							1		23
Duty of Candour Breaches	CN&DQG	Mar-19		0							33		23
Stranded Patients	COO	Mar-19	<= 35%	56.6%							50.9%		24
Delayed Transfers of Care (DTOC)	COO	Mar-19	<= 3.3%	3.7%							3.9%		24
Medical Optimised Awaiting Transfer (MOAT)	COO	Mar-19	<= 40	100							1167		25
Bank & Agency Costs	DoW&OD	Mar-19	<= 5%	17.9%							12.4%		25
Mortality: HSMR	MD	Dec-18	<= 1	1.09									26
Mortality: SHMI	MD	Sep-18	<= 1	0.96									26
Mortality: Deaths in ED or as Inpatient	MD	Mar-19		124							1461		27
Mortality: Case Note Reviews	MD	Mar-19		32							490		27
Emergency Readmission Rate	MD	Jan-19	<= 7.9%	7.6%							8.8%		28

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Caring													
Patient Safety Alerts: Completion	CN&DQG	Mar-19	>= 100%	90.9%							81.6%		28
DSSA (mixed sex)	CN&DQG	Mar-19	<= 0	0							4		29
Complaints Rate	CN&DQG	Mar-19		0.9%							0.7%		29
Complaints: Response Rate 45	CN&DQG	Mar-19	>= 95%	65.7%							43.6%		30
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	Mar-19		1							11		30
Complaints Closed: Overall	CN&DQG	Mar-19		35							445		31
Complaints Closed: Upheld	CN&DQG	Mar-19		6							104		31
Complaints Closed: Partially Upheld	CN&DQG	Mar-19		17							222		32
Complaints Closed: Not Upheld	CN&DQG	Mar-19		12							119		32
Compliments	CN&DQG	Mar-19		151							733		33
Friends & Family Test: Response Rate	CN&DQG	Feb-19		24.0%							25.4%		33
Friends & Family Test: Inpatient	CN&DQG	Feb-19		95.5%							94.9%		34
Friends & Family Test: A&E	CN&DQG	Feb-19		88.8%							88.0%		34

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: Maternity	CN&DQG	Feb-19		98.2%		↑					95.2%		35
Staff Friends & Family Test	CN&DQG	Dec-18		64.2%		↓					71.5%		35
Diabetes Reviews	MD	Feb-19	>= 90%	80.0%		↑					79.6%	△	36

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Feb-19	>= 90%	92.2%							93.5%		36
Dementia: Assessment	CN&DQG	Feb-19	>= 90%	100.0%							100.0%		37
Dementia: Referral	CN&DQG	Feb-19	>= 90%	100.0%							100.0%		37
Serious Incidents: STEIS Reportable	CN&DQG	Mar-19		15							199		38
Litigation: Claims	CN&DQG	Mar-19		3							71		38
Litigation: Key Risk Claims Rate	CN&DQG	Mar-19		100.0%							100.0%		39
A&E: 4hr Standard	COO	Mar-19	>= 95%	81.0%							76.8%		39
A&E: 12hr Trolley Wait	COO	Mar-19	<= 0	0							66		40
Cancer: 62 Day Standard	COO	Mar-19	>= 85%	77.1%							78.2%		40
Referral to Treatment: Incomplete Pathways	COO	Mar-19	>= 92%	83.2%							84.8%		41
Referral to Treatment: Incomplete Waiting List Size	COO	Mar-19	<= 22346	23897									41
Diagnostics: 6 Week Standard	COO	Mar-19	>= 99%	98.7%							99.1%		42
Elective Activity vs. Plan	COO	Mar-19	>= -1%	-3.0%							-3.0%		42

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Elective Income vs. Plan	COO	Mar-19	>= -1%	-0.3%							-0.3%		43
Outpatient Activity vs. Plan	COO	Mar-19	>= -1%	-1.2%							-1.2%		43

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Efficient / Well Led													
Financial Efficiency: I&E Margin	DoF	Mar-19	<= 2	4									44
Financial Controls: I&E Position	DoF	Mar-19	>= 0%	5.9%									44
Cash	DoF	Mar-19	+/- 1%	-1.2%									45
Financial Use of Resources	DoF	Mar-19	<= 3	3									45
CIP Cumulative Achievement	DoF	Mar-19	>= 0%	-15.0%									46
Capital Expenditure	DoF	Mar-19	+/- 10%	-21.3%									46
Financial Sustainability	DoF	Mar-19	<= 2	4									47
Sickness Absence Rate	DoW&OD	Mar-19	<= 3.5%	4.3%							4.4%		47
Appraisal Rate: Non-medical	DoW&OD	Mar-19	>= 95%	91.2%							93.0%		48
Appraisal Rate: Medical	DoW&OD	Mar-19	>= 95%	98.1%							97.6%		48
Statutory & Mandatory Training	DoW&OD	Mar-19	>= 90%	88.0%							90.2%		49
Workforce Turnover	DoW&OD	Mar-19	<= 13.94%	13.3%									49
Staff in Post	DoW&OD	Mar-19	>= 90%	91.7%							90.5%		50

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

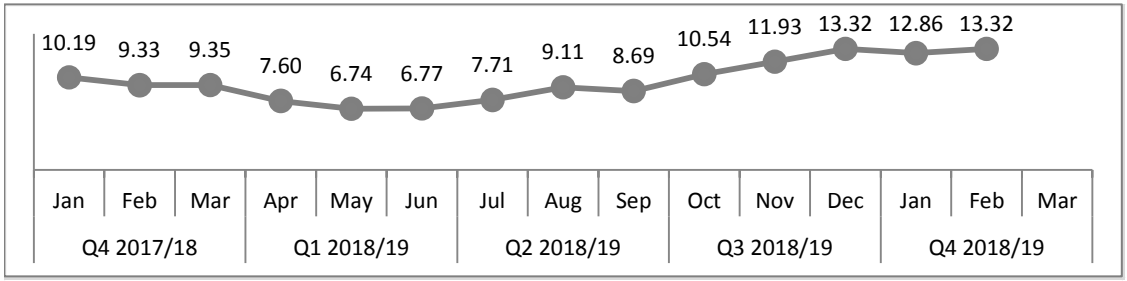
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	Mar-19	<= 0	1077							11250		50
Agency Spend: Distance From Ceiling	DoW&OD	Mar-19	<= 3%	6.5%							6.5%		51

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

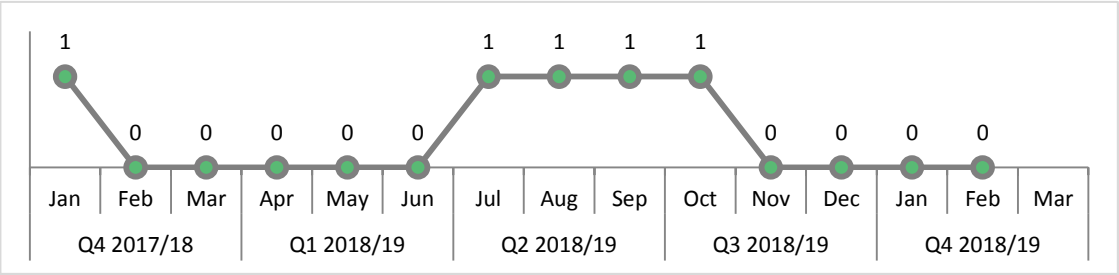
Indicator Detail

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



Actions
During February there were 4 cases of Clostridium difficile Full investigations currently in progress for all cases The target rate is monitored through the infection prevention & Control group Support is being offered from NHS Improvement due to the increase in cases over the last few months New investigation tool introduced this month

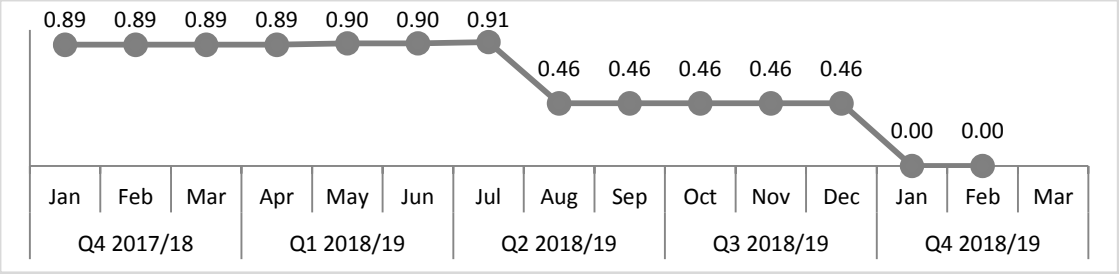
Feb-19	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care, in February we have had no lapses in care as the cases are still under investigation. Four cases during July, August, September and October have been deemed to be lapses in care.
<= 15 *	



Actions
Work is continuing with the site coordinator team around isolation of patients and updating of the side room database Following a Clostridium difficile investigation the case is being presented to the harm free care panel. Business groups have been reminded about outstanding RCA's and the importance of timely investigations Investigation documentation has been reviewed and changed

Indicator Detail

Feb-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

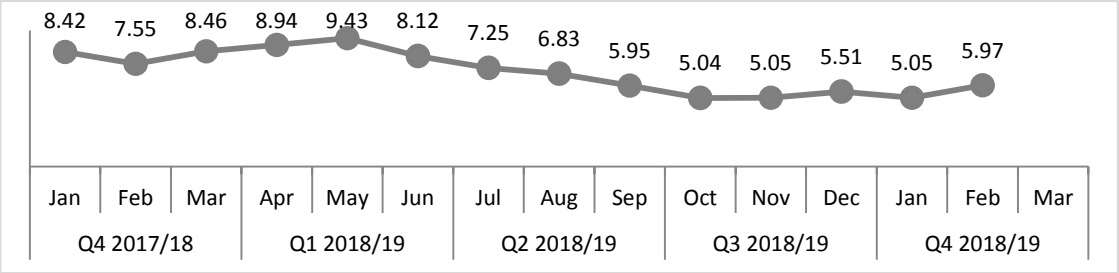


Actions

The MRSA target remains zero for 2018/19, in February there were zero cases of MRSA

The target is monitored through the infection prevention group

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



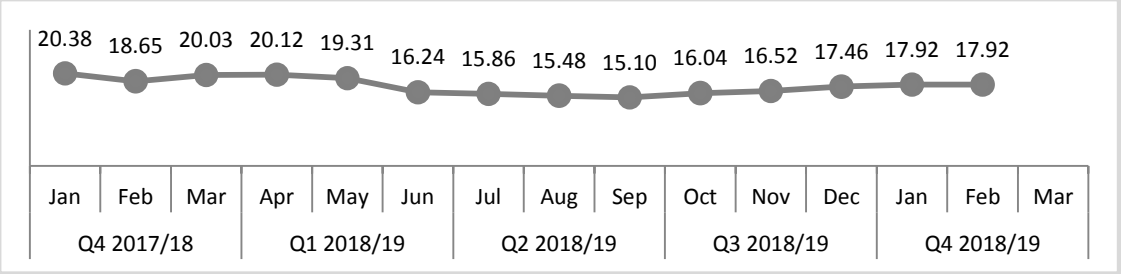
Actions

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

This is monitored through the Infection prevention & control group

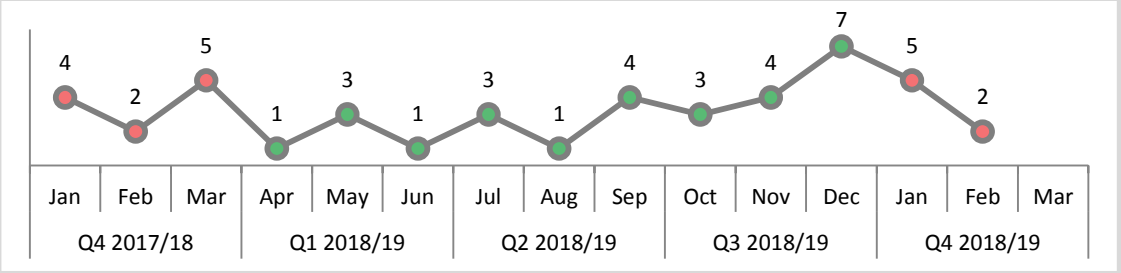
Indicator Detail

Feb-19	E.Coli Infection Rate
17.92	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 Discussions remain on going with pathology services to ensure there is a robust plan in place for clinical review information to be obtained which becomes mandatory in April 2019.

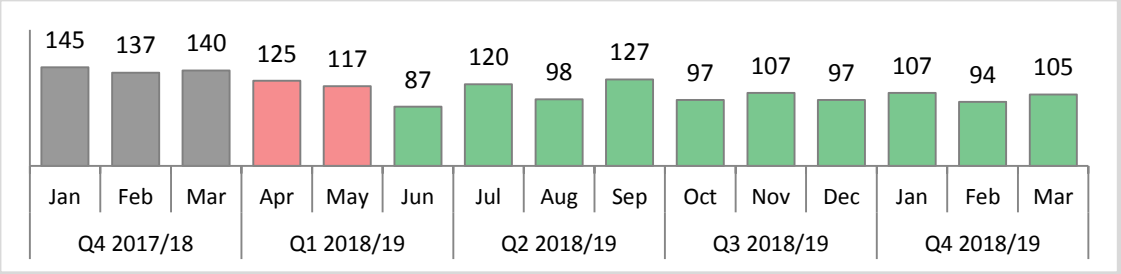
Feb-19	E.Coli Infection Count
2	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases
<= 34 *	



Actions
This is monitored through the Infection prevention & control group

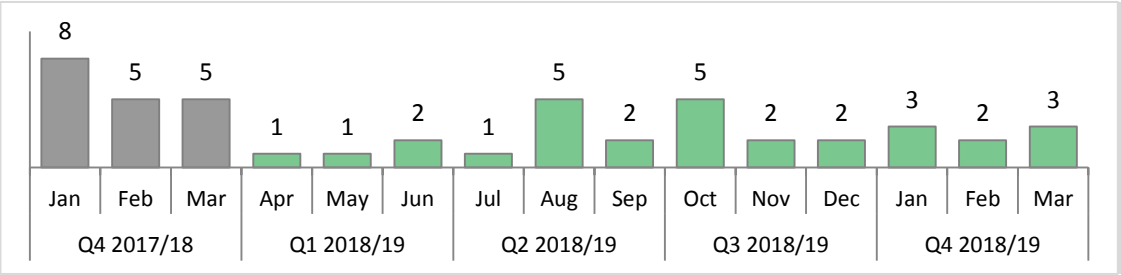
Indicator Detail

Mar-19	Falls: Total Incidence of Inpatient Falls
105	Total number of Inpatient falls
Target	The Trust set a target of 10% reduction in in-patient falls for 2018/19 in comparison to the previous year. Target achieved and exceeded with total reduction of 20% for 2018/19
<= 1378 *	



Actions
March 19 continues the trend noted since December 18 with a month on month reduction in comparative data from the previous year (March 18- 127 falls; March 19- 105 falls). Further 10% reduction target set for 2019/20

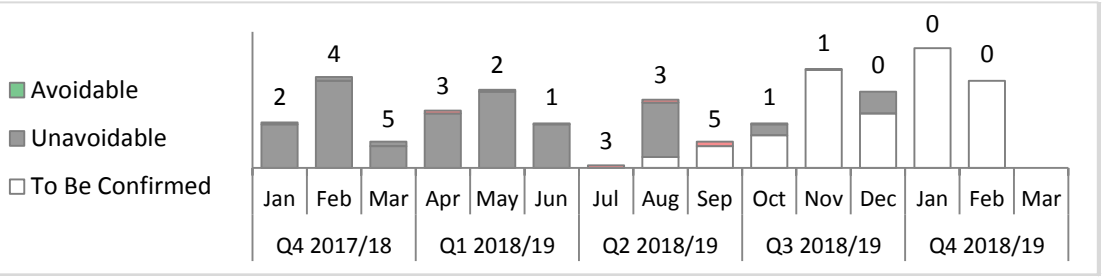
Mar-19	Falls: Causing Moderate Harm and Above
3	Total number of falls causing moderate harm and above.
Target	The Trust set a target of 25% reduction of in-patient falls resulting in moderate or above harm level for 2018/19 in comparison to the previous year. Target achieved and exceeded with total reduction of 29% for 2018/19
<= 31 *	



Actions
There have been 3 falls in month resulting in Moderate or above harm to the patient. These investigations are currently on-going. 2 are within Surgery GI and Critical Care and 1 within Medicine and Clinical Support

Indicator Detail

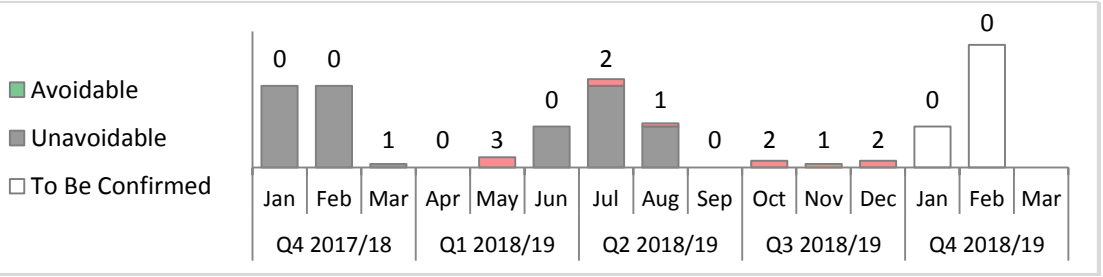
Feb-19	Pressure Ulcers: Hospital, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there has been a total of 12 category 2 pressure ulcers reported in the hospital Avoidable = 0, Unavoidable = 0, TBC = 12. YTD = There have been 19 avoidable category 2 pressure ulcers reported.
<= 12 *	



Actions

We have now reached the threshold for numbers of avoidable pressure ulcers (PU) for the hospital, with the outcome of 45 hospital incidents still to be confirmed. Though we will not see the 50% reduction that we hoped for we will still see some reduction, however the actual percentage reduction cannot be determined until the outcome of all outstanding investigations has been determined.
- A refreshed 3 hour pressure ulcer prevention update session is on-going evaluating well.
- Purpose T screening and risk assessment tool introduced
- Medical device tool box training has commenced
- 250 electric beds have been purchased and delivered into the Trust in March and a programme of toolbox training on the effective use of profiling beds from April onwards.
- An algorithm has been devised to support clinical decision making on how and when to offload heels.

Feb-19	Pressure Ulcers: Hospital, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there have been 3 category 3 pressure ulcers reported in the hospital. Avoidable = 0, Unavoidable = 0, TBC =3. YTD = There have been 11 avoidable category 3 pressure ulcers reported.
<= 5 *	

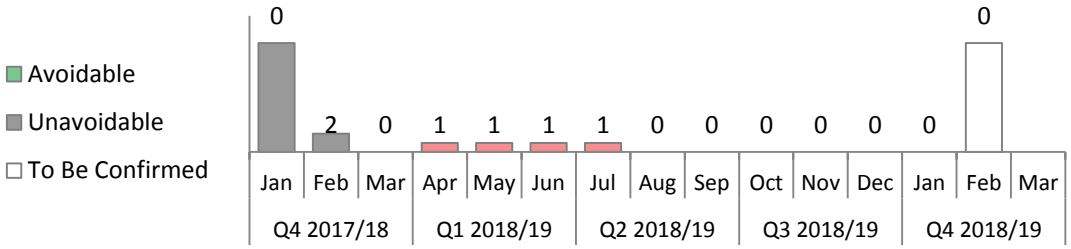


Actions

We have now reached the threshold for numbers of avoidable pressure ulcers (PU) for the hospital, with the outcome of 45 hospital incidents still to be confirmed. Though we will not see the 50% reduction that we hoped for we will still see some reduction, however the actual percentage reduction cannot be determined until the outcome of all outstanding investigations has been determined.
- A refreshed 3 hour pressure ulcer prevention update session is on-going evaluating well.
- Purpose T screening and risk assessment tool introduced
- Medical device tool box training has commenced
- 250 electric beds have been purchased and delivered into the Trust in March and a programme of toolbox training on the effective use of profiling beds from April onwards.
- An algorithm has been devised to support clinical decision making on how and when to offload heels.

Indicator Detail

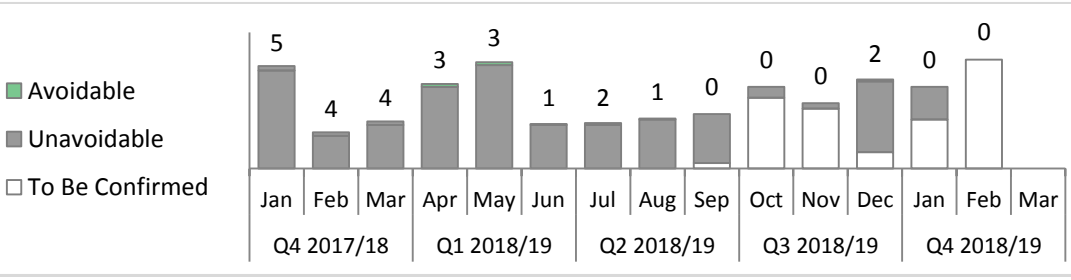
Feb-19	Pressure Ulcers: Hospital, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there has been one category 4 pressure ulcer reported in the Hospital. YTD = There have been no 4 avoidable category 4 pressure ulcers reported.
<= 1 *	



Actions

We have now reached the threshold for numbers of avoidable pressure ulcers (PU) for the hospital, with the outcome of 45 hospital incidents still to be confirmed. Though we will not see the 50% reduction that we hoped for we will still see some reduction, however the actual percentage reduction cannot be determined until the outcome of all outstanding investigations has been determined.
- A refreshed 3 hour pressure ulcer prevention update session is on-going evaluating well.
- Purpose T screening and risk assessment tool introduced
- Medical device tool box training has commenced
- 250 electric beds have been purchased and delivered into the Trust in March and a programme of toolbox training on the effective use of profiling beds from April onwards.
- An algorithm has been devised to support clinical decision making on how and when to offload heels.

Feb-19	Pressure Ulcers: Community, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there has been a total of 20 category 2 pressure ulcers reported in the community. Avoidable = 0, Unavoidable = 0, TBC =20. YTD = There have been 12 avoidable category 2 pressure ulcers reported.
<= 37 *	



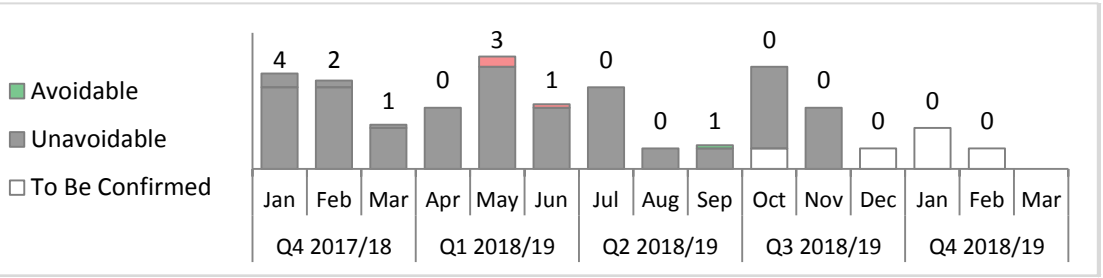
Actions

We are currently on trajectory for achieving our target for a 50% reduction in avoidable pressure ulcer s in the community setting, although the outcome of 65 incidents is still to be determined.

- A refreshed 3 hour pressure ulcer prevention update session is on-going and is evaluating well.
- Purpose T screening and assessment tool has been introduced
- Skin inspection mirror with prompts provided to nursing staff to support skin inspection
- Medical device tool box training has commenced.
- An algorithm has been devised to support clinical decision making on how and when to offload heels
- A new higher specification static air cushion called Equazone is now available to order via the community equipment contract.

Indicator Detail

Feb-19	Pressure Ulcers: Community, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there has been one category 3 pressure ulcer reported in the community Avoidable = 0, Unavoidable = 0, TBC =1. YTD = There have been 5 avoidable category 3 pressure ulcers reported.
<= 10 *	

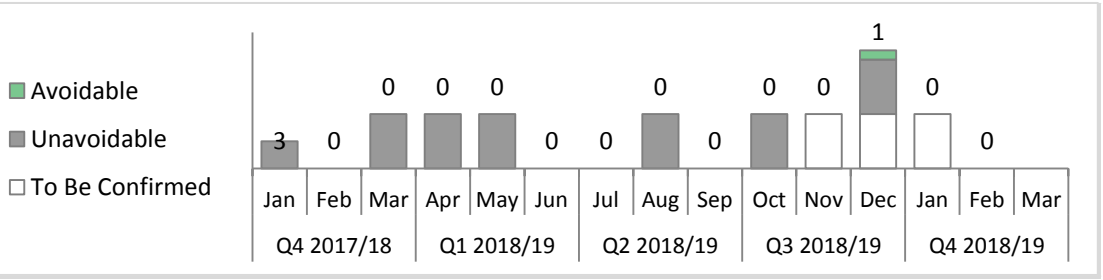


Actions

We are currently on trajectory for achieving our target for a 50% reduction in avoidable pressure ulcer s in the community setting, although the outcome of 65 incidents is still to be determined.

- A refreshed 3 hour pressure ulcer prevention update session is on-going and is evaluating well.
- Purpose T screening and assessment tool has been introduced
- Skin inspection mirror with prompts provided to nursing staff to support skin inspection
- Medical device tool box training has commenced.
- An algorithm has been devised to support clinical decision making on how and when to offload heels
- A new higher specification static air cushion called Equazone is now available to order via the community equipment contract.

Feb-19	Pressure Ulcers: Community, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (February data) there has been no category 4 pressure ulcers reported in the community. YTD = There have been one avoidable category 4 pressure ulcers reported in the community.
<= 3 *	



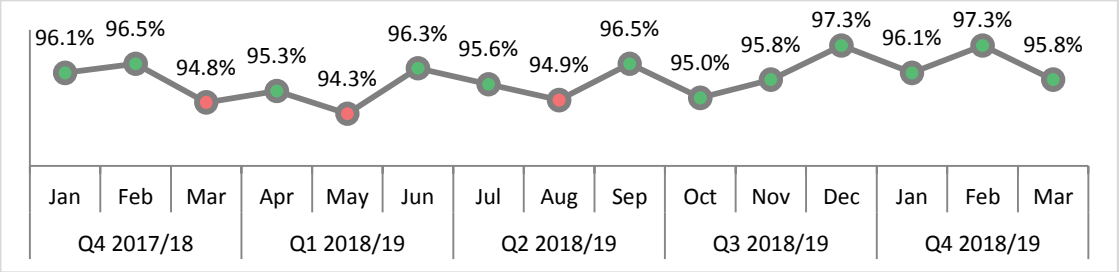
Actions

We are currently on trajectory for achieving our target for a 50% reduction in avoidable pressure ulcer s in the community setting, although the outcome of 65 incidents is still to be determined.

- A refreshed 3 hour pressure ulcer prevention update session is on-going and is evaluating well.
- Purpose T screening and assessment tool has been introduced
- Skin inspection mirror with prompts provided to nursing staff to support skin inspection
- Medical device tool box training has commenced.
- An algorithm has been devised to support clinical decision making on how and when to offload heels
- A new higher specification static air cushion called Equazone is now available to order via the community equipment contract.

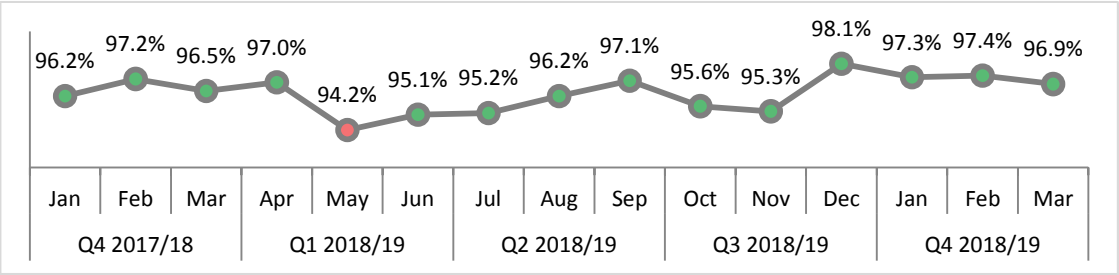
Indicator Detail

Mar-19	Safety Thermometer: Hospital
95.8%	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 March show that we have achieved 95.8%.
>= 95%	



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

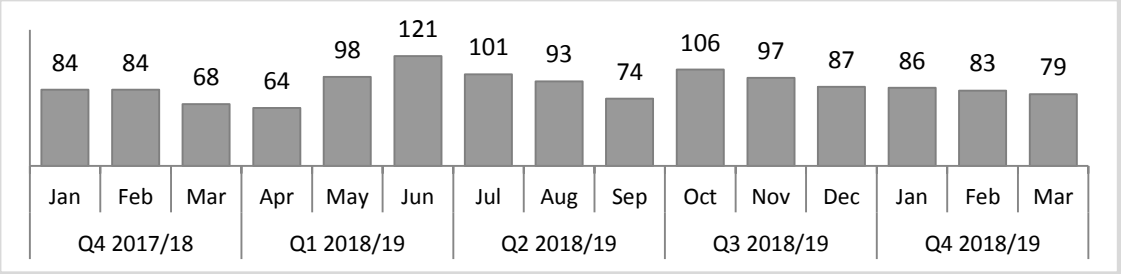
Mar-19	Safety Thermometer: Community
96.9%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for March show that we have achieved 96.9%
>= 95%	



Actions
The target has been achieved this month.

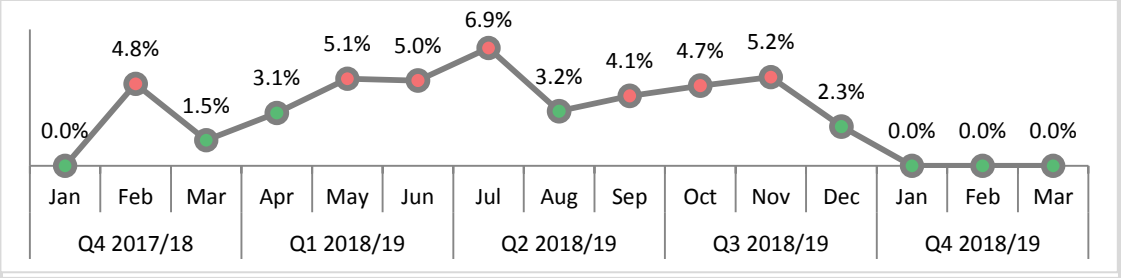
Indicator Detail

Mar-19	Medication Errors: Overall
79	Total number of Medication Errors.
Target	There were 79 medication incidents reported in March 2019



Actions
All medication incidents are reviewed weekly at the patient safety summit. Medication issues are highlighted in the weekly patient safety summit update In March updates included; - The importance of locking medications away and that they are safety stored within the ward/department. - The importance of taking a patient's weight into consideration when prescribing medications, particularly if they weigh less than 50kg.

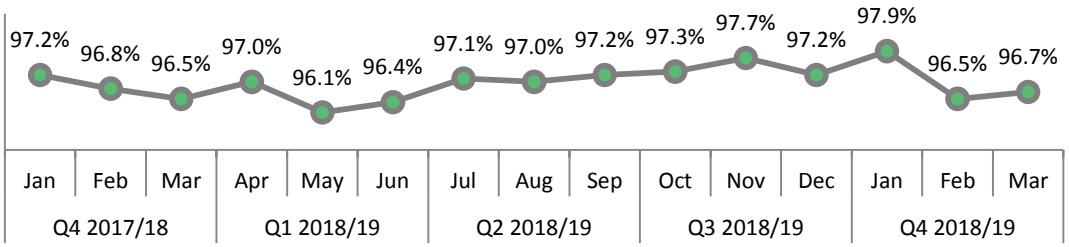
Mar-19	Medication Errors: Moderate Harm and Above
0.0%	The percentage of medication errors causing moderate harm and above.
Target	This month there have been no medication errors that have caused moderate harm or above.
<= 4%	



Actions
The trust has met the improvement trajectory set, and reduced the percentage of medication incidents causing moderate harm or above to below 4%.

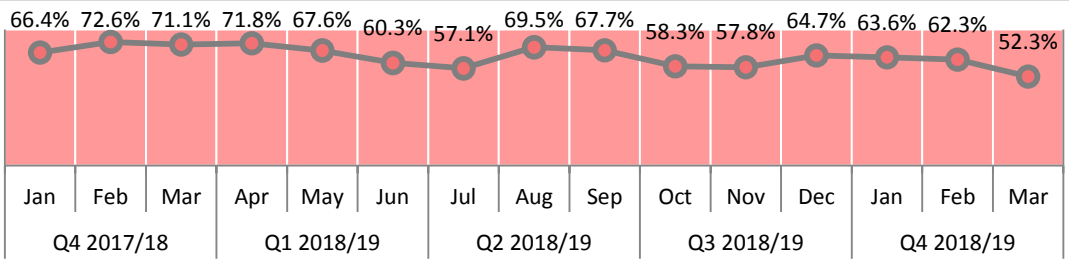
Indicator Detail

Mar-19	VTE Risk Assessment
96.7%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).
>= 95%	



Actions
The target has been achieved in month.

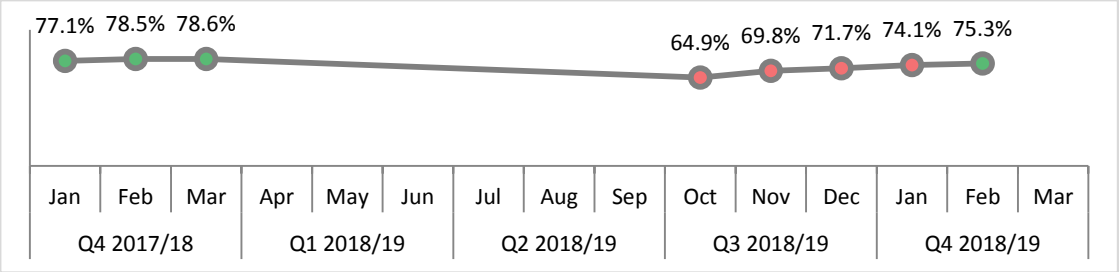
Mar-19	Clinical Correspondence
52.3%	The percentage of clinical correspondence typed within 7 days.
Target	A review is currently underway with option appraisals being developed. Outsourcing has now commenced. This will result in a significant improvement in the longer term, though performance will deteriorate in the short term as we clear the backlog.
>= 95%	



Actions
Clinical correspondence options appraisal will be ready for decision for EMG on 14/5/19. The short delay has been the result of annual leave and the supply of workforce information. Collaborative approach to 'top & tailing' the outsourced letters is being adopted within the hub.

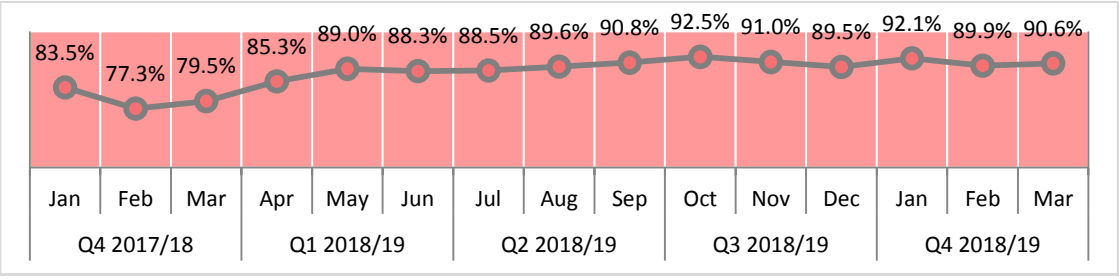
Indicator Detail

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



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

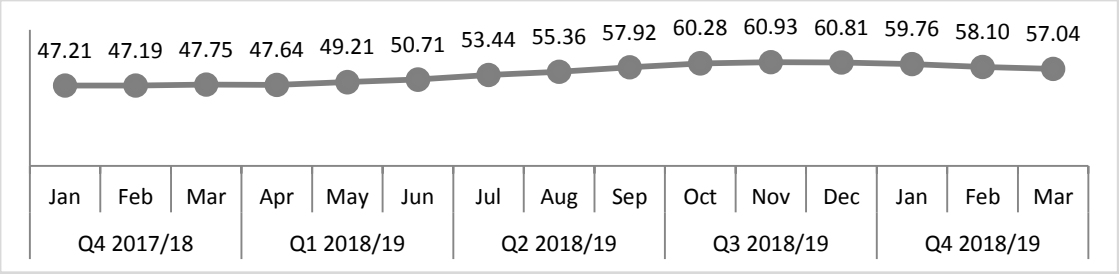
Mar-19	Discharge Summaries
90.6%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Good improvements on last year.
>= 95%	



Actions
Continued focus upon acute areas, where consistent deliver is most challenging.

Indicator Detail

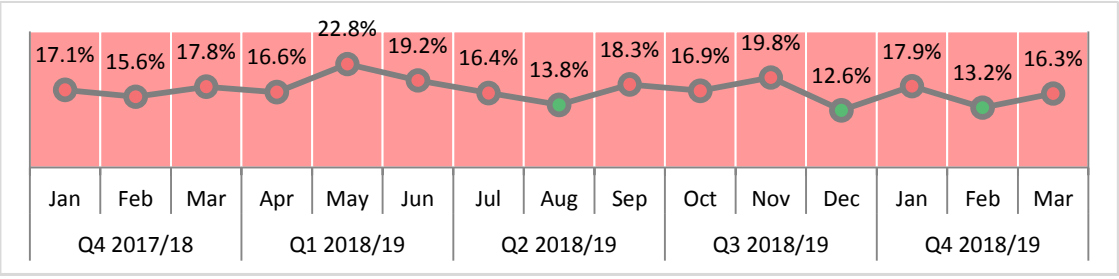
Mar-19	Patient Safety Incident Rate
57.04	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The number of patient safety incidents for every 1000 bed days has slightly reduced this month. However the rate remains in a range that signifies a good reporting culture.



Actions

There were 1356 incidents reported in March 2019. All incidents have a severity rating in place.
- Staffing issues are the highest number of reported incidents this month.
- The top 4 categories of incidents are the same as last month; staffing, pressure ulcers, slips trips and falls, and uncooperative patient behavior.
- The missing patient category is the fifth highest reported category for the month with 46 incidents reported; an increase from 33 incidents reported in the previous month.

Mar-19	Emergency C-Section Rate
16.3%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	
<= 15.4%	

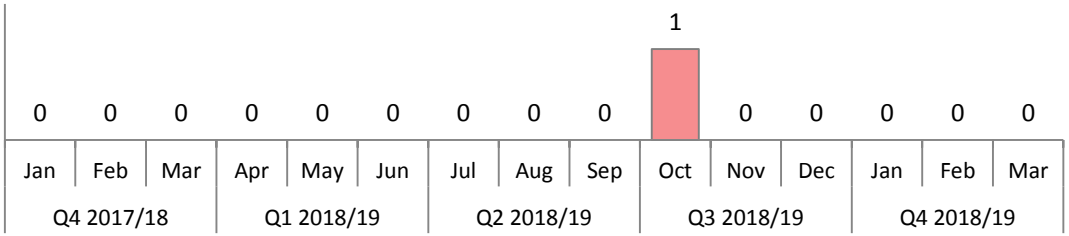


Actions

Indicator Detail

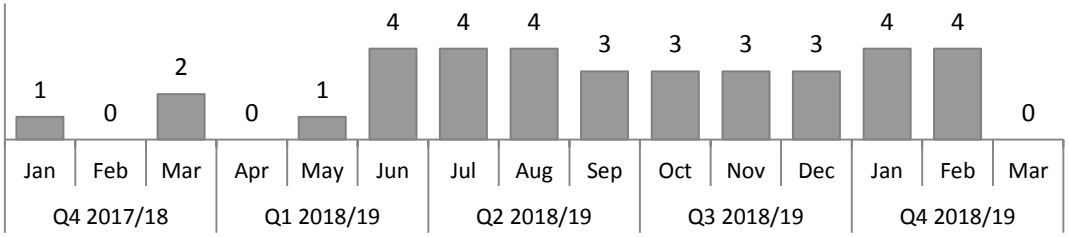
Mar-19	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There have not been any never events reported in March.
<= 0	

Actions
The last never event occurred in October 2018.



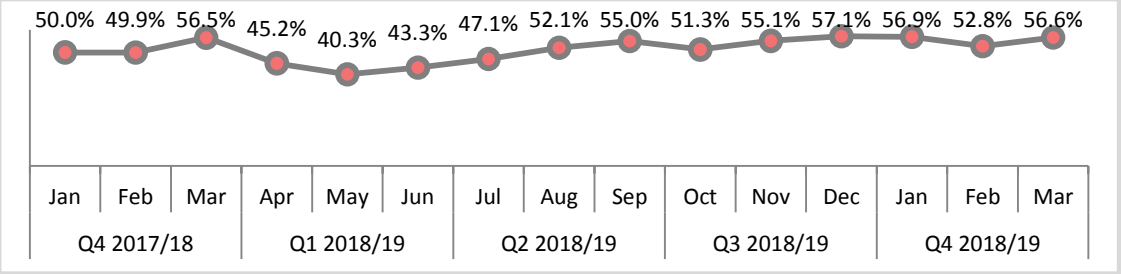
Mar-19	Duty of Candour Breaches
0	Total number of Duty of Candour breaches in month.
Target	There have been no breaches of Duty of Candour for the month of March 2019.

Actions
Duty of Candour compliance is monitored on a weekly basis.



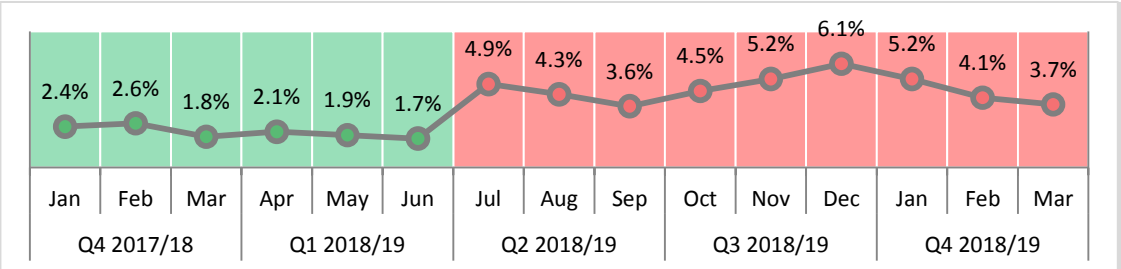
Indicator Detail

Mar-19	Stranded Patients
56.6%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	In March the number of super stranded patients reduced significantly with correlating improvement in performance of the 4 hr standard. Bed occupancy rates and the number of stranded patients improved for most of the month but the last couple of days of March saw a deterioration as the acuity of admissions increased.
<= 35%	



Actions
Improvement actions continue within the ITT. Recruitment is underway for new head of service. A number of winter schemes have been extended to include the Easter weekend. The MADE event commences 15/4/19. The 'Activation Centre' will run throughout this period.

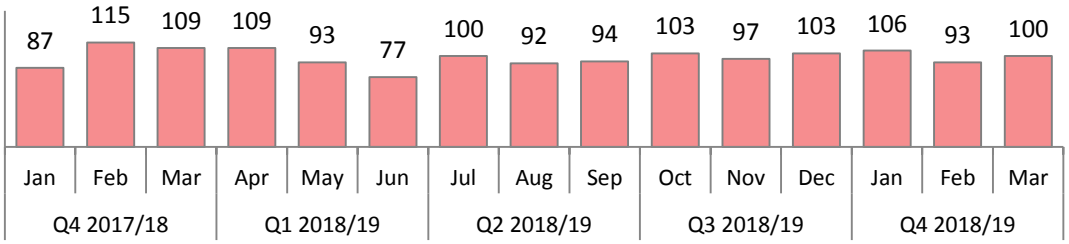
Mar-19	Delayed Transfers of Care (DTOC)
3.7%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	There was an improvement in the number of DTOC patients throughout March.
<= 3.3%	



Actions
Actions to further improve this position are linked to the stranded patient work including the MADE event and the activation centre. Of note, DTOC numbers in April to date appear to be on the rise.

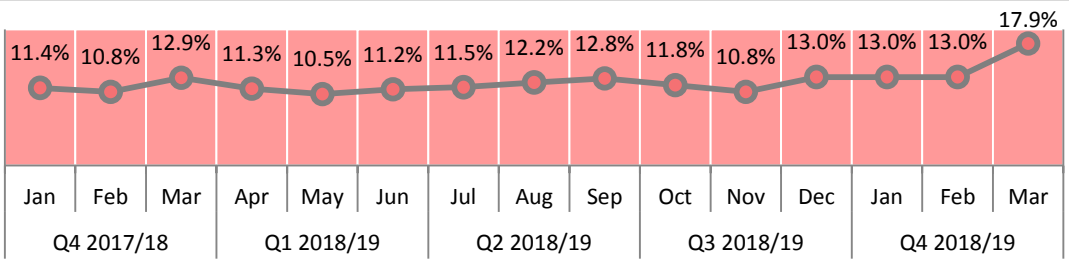
Indicator Detail

Mar-19	Medical Optimised Awaiting Transfer (MOAT)
100	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	MOAT numbers remain static.
<= 40	



Actions

Mar-19	Bank & Agency Costs
17.9%	The total bank & agency cost as percentage of the total pay costs
Target	Total spend on bank staff in March 2019 was £2.10M, which is 12% of the total pay spend. Agency spend was 5.84% of total pay expenditure (£1.01M). Bank and agency costs in March 2019 account for 17.89% (£3.12M) of the £17.47M total pay costs. This is a £780K increase from the position reported in February 2019 (£2.34M).
<= 5%	



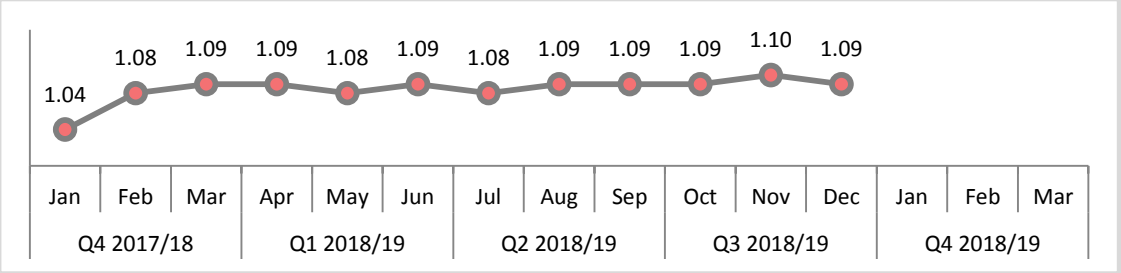
Actions

The Medicine & CS Business Group bank and agency spend has increased by £164K to £986K & continues to have the highest spend on bank and agency equating to 5.65% of the Trust overall bank and agency spend.

Work programmes continue to help reduce medical and nursing agency usage, and include:
- Successful substantive recruitment from within the UK, particularly to nursing vacancies. We currently have 167 nurses recruited to our vacancies.
- International recruitment to attract individuals from overseas to our hard to fill vacancies.
- Growth of the medical bank to reduce the reliance on agencies and avoid the commission payments. Overall the current bank to agency ratio for all staff groups is 65:35.
- Additional Physician Associate roles recruited.
- Medical rota re-design in General Medicine.
- CSEP processes to ensure timely actions in place to recruit to posts and avoid unnecessary agency spend.

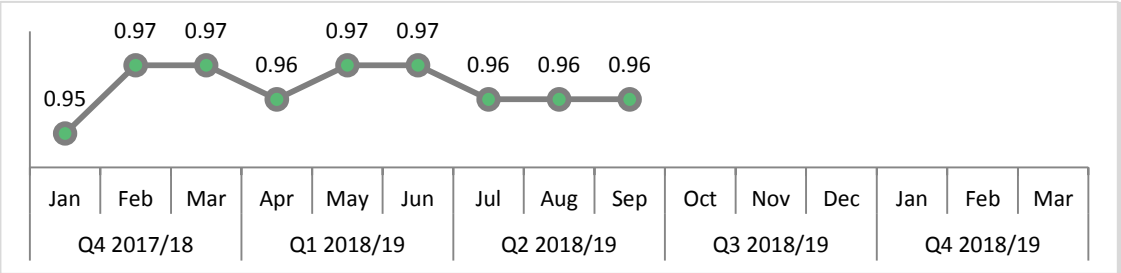
Indicator Detail

Dec-18	Mortality: HSMR
1.09	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	Deep dive into HSMR undertaken in december. Ratio maintained at static level.
<= 1	



Actions
Projects currently under development; Coding depth Palliative care coding review Facilitation of patients dying in their preferred place of death. Reviewing our pneumonia coding Improving clinical outcomes; NEWS 2 Sepsis Falls and pressure ulcer management 7 day working program. ED flow through winter. Reducing length of stay Learning from deaths.

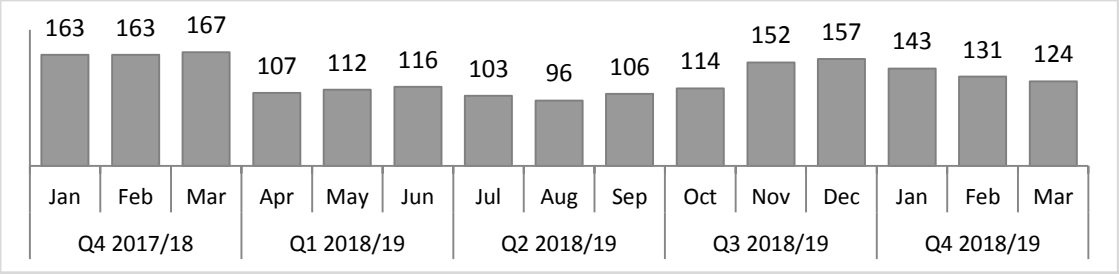
Sep-18	Mortality: SHMI
0.96	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	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



Actions
Actions as for HSMR

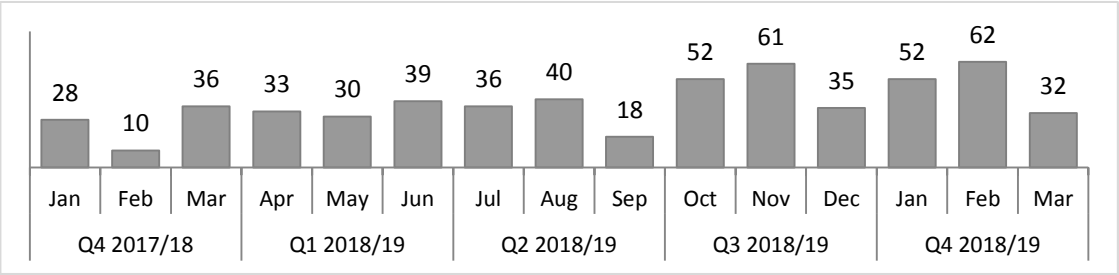
Indicator Detail

Mar-19	Mortality: Deaths in ED or as Inpatient
124	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	



Actions

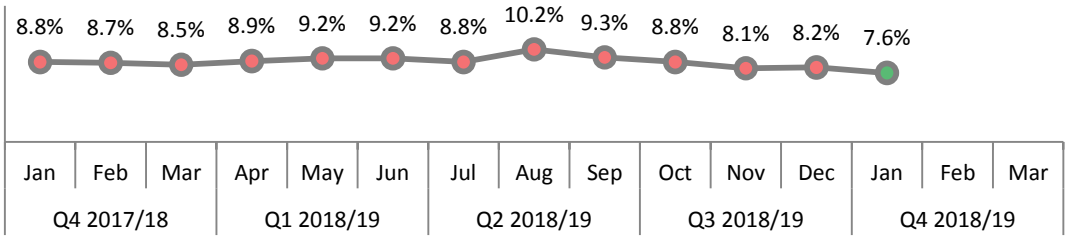
Mar-19	Mortality: Case Note Reviews
32	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	Reduced number of reviews in march, but we are consistently delivering above our 30% goal. The LFD process is going from strength to strength, and offering excellent feedback and education on patient care.



Actions

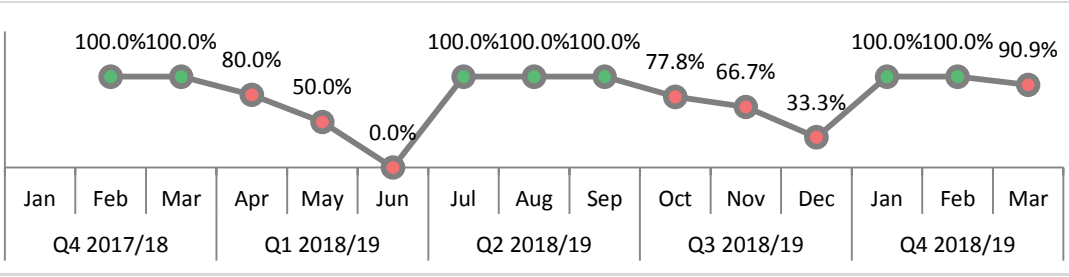
Indicator Detail

Jan-19	Emergency Readmission Rate
7.6%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	This marker is an illustration of the function of alternatives to admission, such as crisis response. 8% target delivered for the first time - but only for one month, so far.
<= 7.9%	



Actions

Mar-19	Patient Safety Alerts: Completion
90.9%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	There were 11 alerts due for completion for the month of March. 10 alerts were completed on time. The final alert was not relevant to the trust, but was not completed within the timescales.
>= 100%	

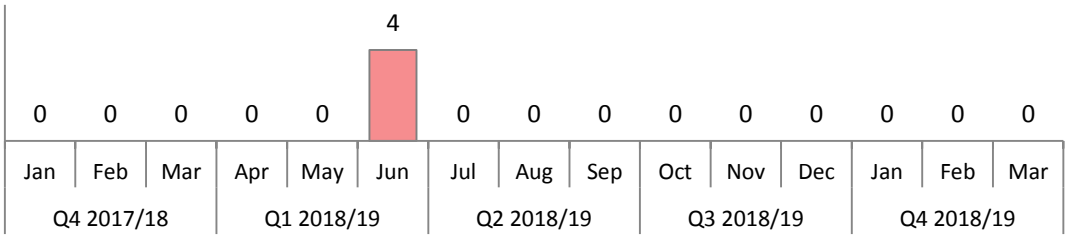


Actions
Work continues with business groups to ensure appropriate information is returned to the risk team in a timely manner.

Indicator Detail

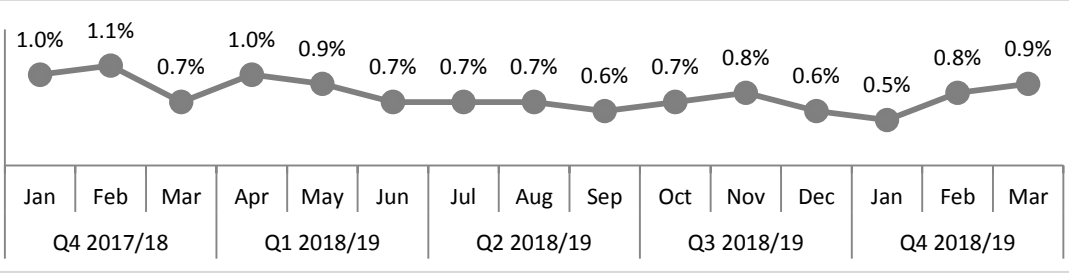
Mar-19	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	Total number of occasions that sexes were mixed on same sex wards.
<= 0	

Actions
No patients were affected by a mixed sex breach in the month of March



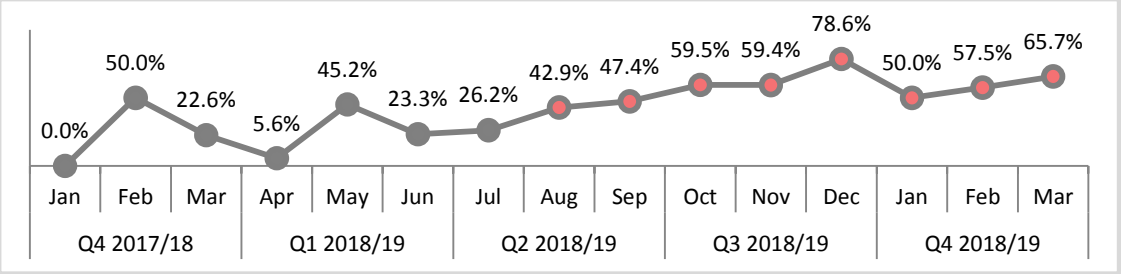
Mar-19	Complaints Rate
0.9%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	45 complaints were received in March 2019: Integrated Care = 7, Medicine = 9, Surgery = 15, WCDS = 13 and Estates & Facilities 1

Actions
It is hoped that by resolving concerns informally, where possible, the number of formal complaints will reduce. This has proven successful with the number of formal complaints being logged showing an annual reduction over the last couple of years.



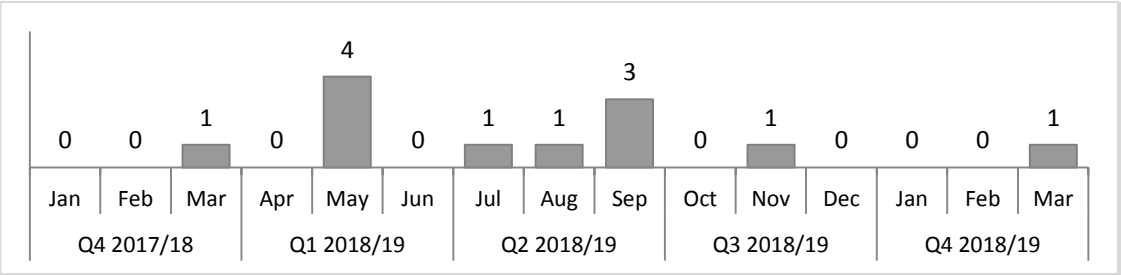
Indicator Detail

Mar-19	Complaints: Response Rate 45
65.7%	The percentage of formal complaints responded to within 45 days.
Target	For March 2019, 26 responses were due out , 19 were responded to on time resulting in a 73.1% response rate. The business group response rate is as follows: integrated care: 100%, WCDS: 85.7%, surgery: 62.5% and medicine: 50%
>= 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

Mar-19	Complaints: Parliamentary & Health Service Ombudsman Cases
1	The total number of open Ombudsman cases.
Target	In March 2019, the Trust received 1 new referral from the Parliamentary and Health Service Ombudsman for the integrated care business group.

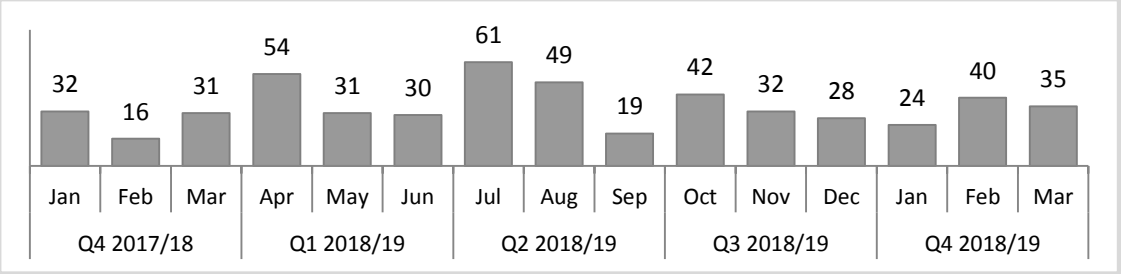


Actions
The PALS and Complaints Team Lead is responsible for liaising with the Ombudsman to ensure continuity and a seamless service. It is hoped that by improving the quality of responses, the number of cases upheld by the Ombudsman will remain low.

Indicator Detail

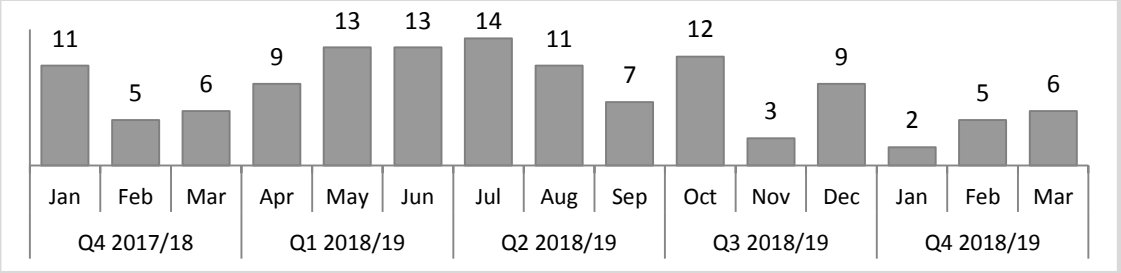
Mar-19	Complaints Closed: Overall
35	The total number of formal complaints that have been closed.
Target	In the month of March 2019, 35 responses were closed in month: integrated care closed 6, medicine closed 14, surgery closed 8 and women, children & diagnostic services closed 7.

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



Mar-19	Complaints Closed: Upheld
6	The total number of upheld formal complaints that have been closed.
Target	For March 2019, 6 cases were upheld out of the 35 closed.

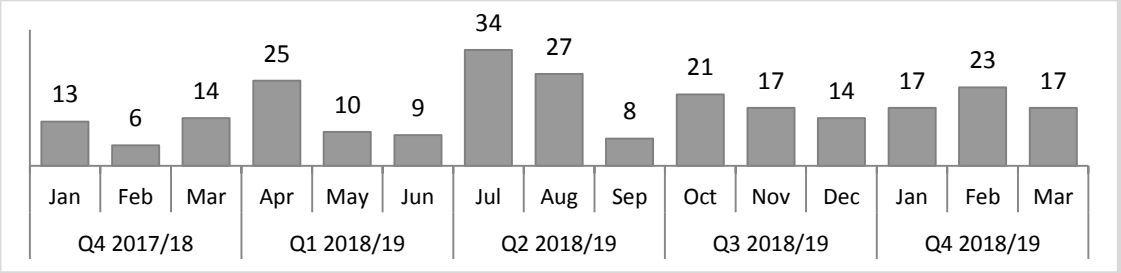
Actions
The chief nurse & director of quality governance continues to monitor the learning from complaints requests that this is always shared with the complainant.



Indicator Detail

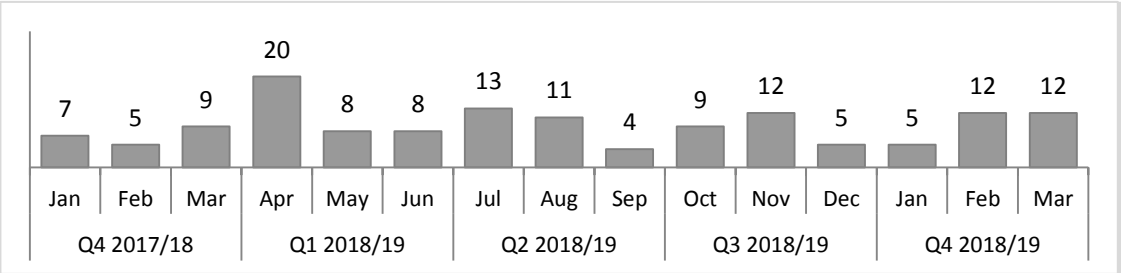
Mar-19	Complaints Closed: Partially Upheld
17	The total number of partially upheld formal complaints that have been closed.
Target	In March 2019, 17 of the cases were partially upheld of the 35 closed in month.

Actions
Complaints that are partially upheld should have identified learning for the Trust. If this is the case, this will be shared with the complainant and fed back to appropriate staff.



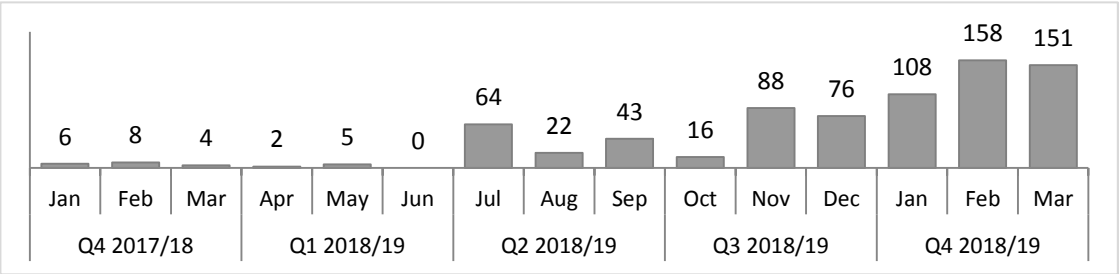
Mar-19	Complaints Closed: Not Upheld
12	The total number of not upheld formal complaints that have been closed.
Target	In March 2019, 12 of the cases were not upheld of the 35 closed in month.

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.



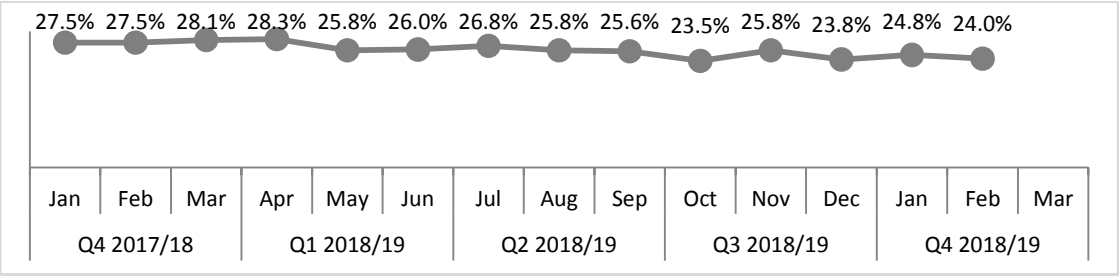
Indicator Detail

Mar-19	Compliments
151	Total number of compliments received.
Target	For March 2019, 157 compliments have been received by the Trust.



Actions
The matron for patient experience and quality improvement continues to work with business groups and wards to ensure compliments are being captured on the Datix system. The information recorded on Datix is populated on a dashboard for each clinical area and their respective business group. Themes from the compliments are centred around compassion, caring, committed and professional staff.

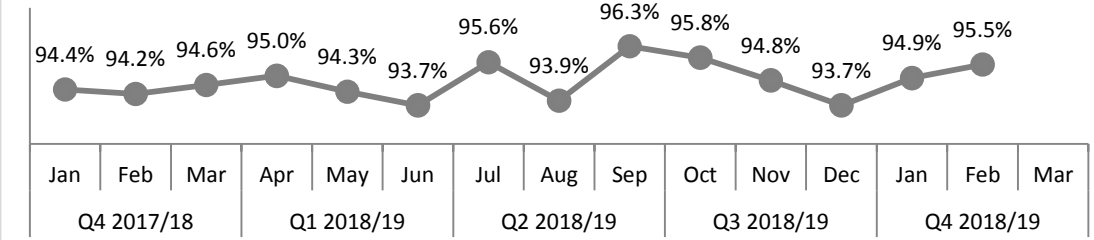
Feb-19	Friends & Family Test: Response Rate
24.0%	The percentage of eligible patients completing an FFT survey.
Target	The percentage of surveyed patients who are extremely likely or unlikely to recommend the Trust for care.



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

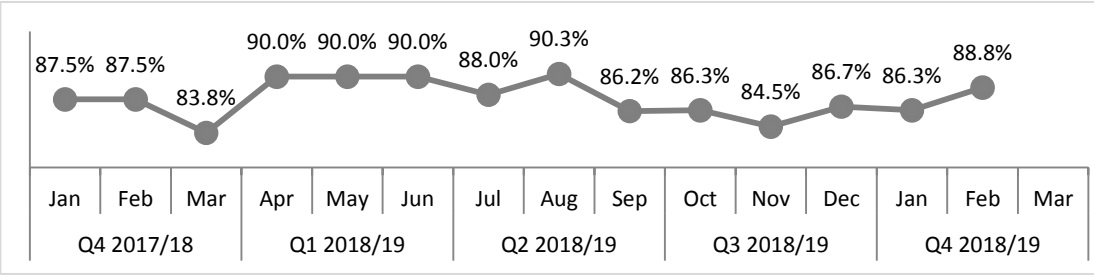
Indicator Detail

Feb-19	Friends & Family Test: Inpatient
95.5%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



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

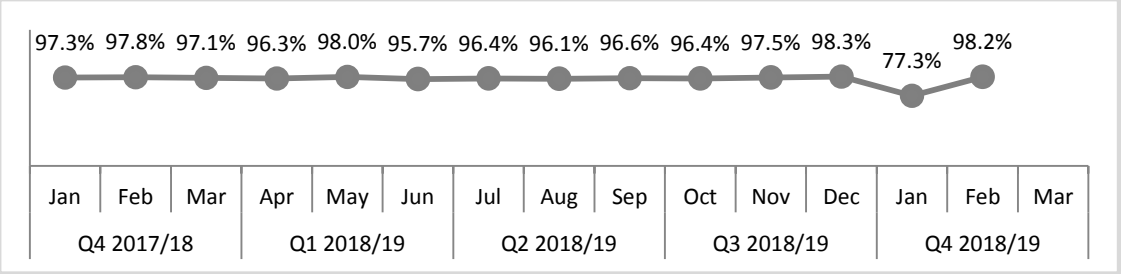
Feb-19	Friends & Family Test: A&E
88.8%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



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

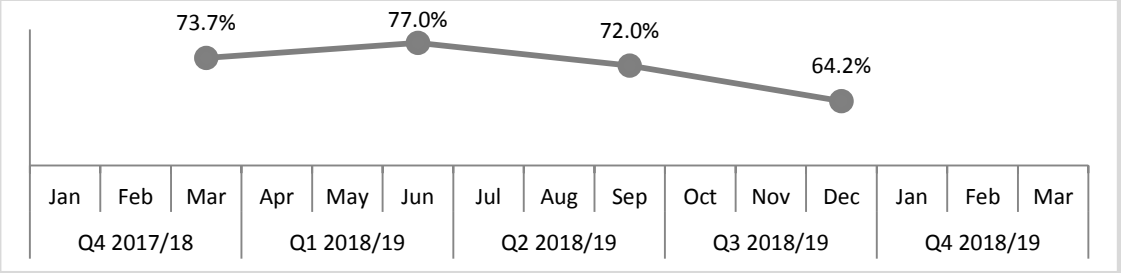
Indicator Detail

Feb-19	Friends & Family Test: Maternity
98.2%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



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

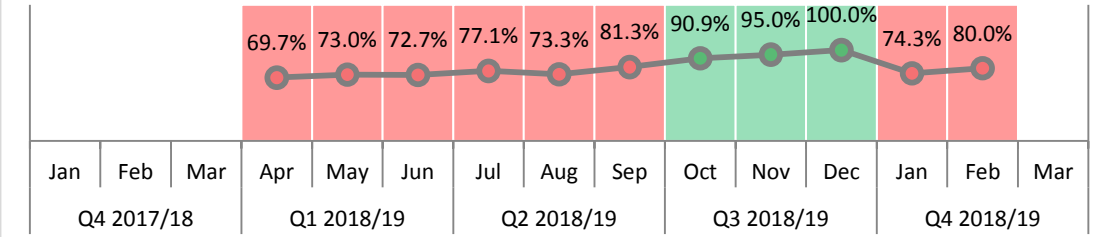
Dec-18	Staff Friends & Family Test
64.2%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The overall trust staff response rate for the Friends and Family test is 64.00%.This data was taken from the national staff survey for Qtr 3 where 598 staff responded.



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

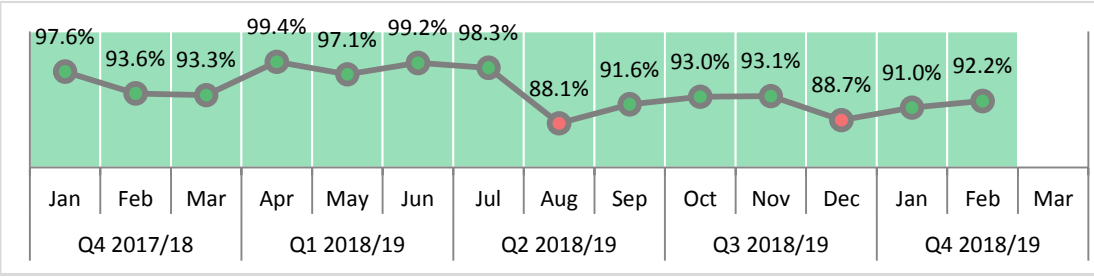
Indicator Detail

Feb-19	Diabetes Reviews
80.0%	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	A marginal improvement on last month, but short of the 90% standard.
>= 90%	



Actions
Diabetes team currently developing medium term plan following resignation of one of our three consultants. Support and restructure of the team is planned, with close monitoring of all diabetes metrics / performance.

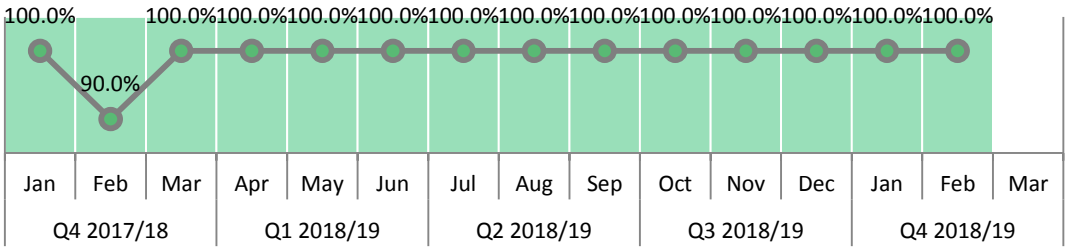
Feb-19	Dementia: Finding Question
92.2%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	Target achieved in month
>= 90%	



Actions
No actions required

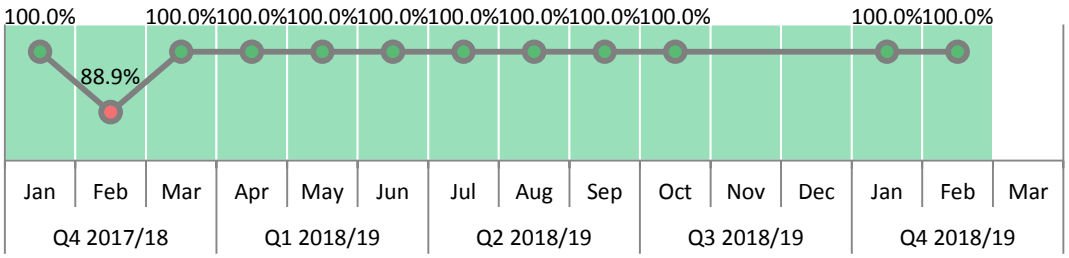
Indicator Detail

Feb-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

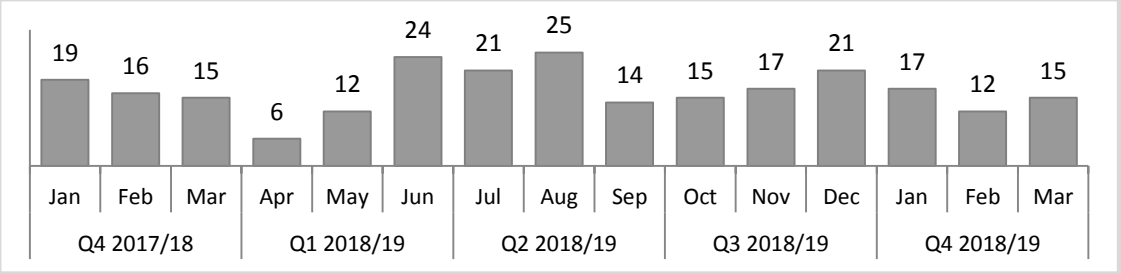
Feb-19	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target has been achieved in month
>= 90%	



Actions
No actions required

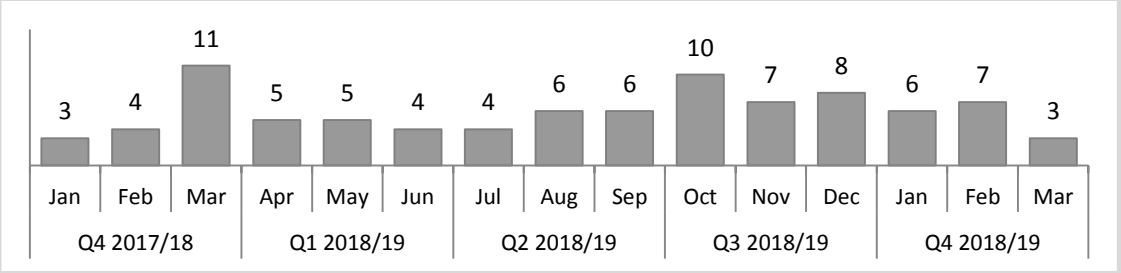
Indicator Detail

Mar-19	Serious Incidents: STEIS Reportable
15	The total number of STEIS reportable incidents.
Target	There were 15 incidents that required reporting on StEIS during the month of March.



Actions
Investigations are underway in accordance with trust policy. - 5 incidents relating to pressure ulcers. There were 4 cases of category 3 pressure ulcers and 1 case of a category 4 pressure ulcer. - 3 incidents relating to a maternity divert due to increased activity and reduced staffing levels - 2 instances where patients had falls that resulted in a fractured neck of femur - 1 incident where during a robot assisted operation the probe was inserted incorrectly - 1 missed diagnosis regarding temporal artritis - 1 case where sub-optimal care was provided to a deteriorating patient - 1 incident where there has been poor processing of tissue sampling - 1 antepartum stillbirth

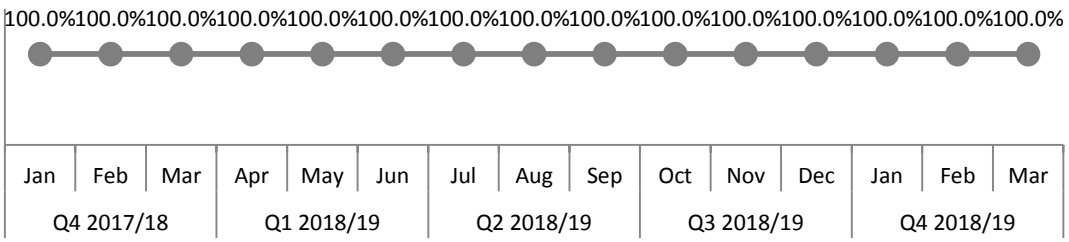
Mar-19	Litigation: Claims
3	Total number of claims opened in month.
Target	There were 3 litigation claims received in the month of March: 1 medical negligence claim was received 2 employment liability claims were received.



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

Indicator Detail

Mar-19	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	In March, 4 claims were settled.

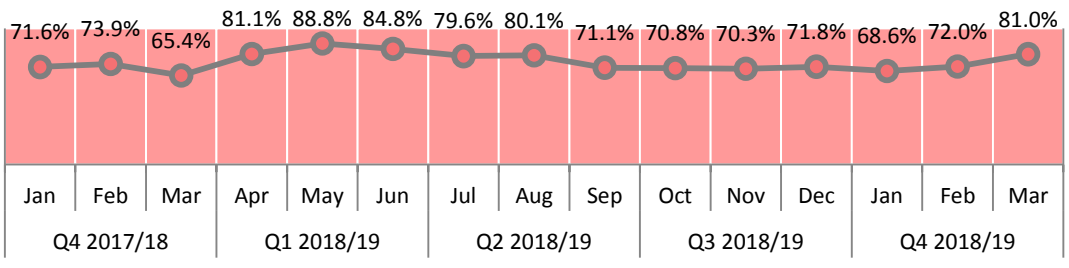


Actions

Key risk claims include:
Obstetrics
Slips trips and falls
Failure or delay in diagnosis
Failure or delay in treatment

The claims settled this month included;
2 delays in treatment
1 slip, trip or fall
1 post operative infection

Mar-19	A&E: 4hr Standard
81.0%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance in March was improved at 81.0%. The Trust ranked well against GM peers for Type 1 attends. Whilst performance has deteriorated in April the same has been reflected across GM. The deterioration in performance had a direct correlation with an increase in patient acuity.
>= 95%	



Actions

ECIST review undertaken and action plan to be collated to ensure improvement points are initiated. This will be managed through the Urgent Care Operational Group. A summary of actions is to be shared with EMG.

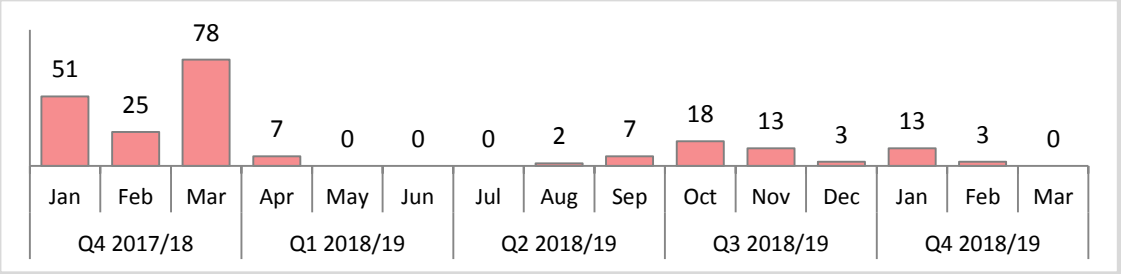
Work to improve flow across the trust will continue e.g. Safer implementation.

Redesign of Urgent Care footprint will also support improved streaming and assessment

A robust Easter Plan was ratified at the system wide U&EC Board on 9/4/19. A MADE event will run 15/4/19 - 23/4/19.

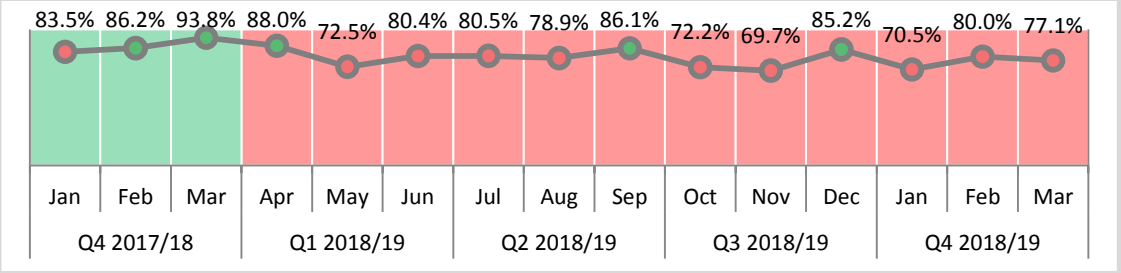
Indicator Detail

Mar-19	A&E: 12hr Trolley Wait
0	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	There were no 12 hour trolley waits reported this month
<= 0	



Actions

Mar-19	Cancer: 62 Day Standard
77.1%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	The latest position for March is 77.1% against the 85% standard.
>= 85%	



Actions

The Trust has ratified the improvement trajectory for 2019/20 anticipating compliance by the end of Q3.

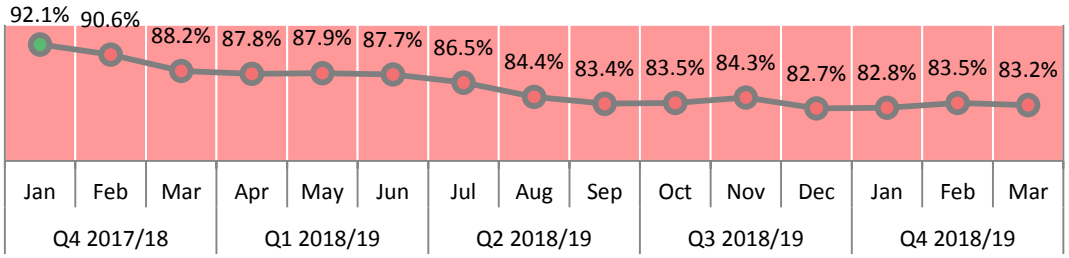
Work is progressing on the straight to MR pathway, with the aim of implementing in June.

The Trust has had successfully bid for Transformational monies from GM Cancer which will help to fund key posts to enable further pathway improvements.

There is a GM-wide workshop on the 10th May to look at solutions across the system. The key areas of focus are capacity to see patients for their first appointment (or test) within 7 days, and improving diagnostic capacity, including reporting, across the system.

Indicator Detail

Mar-19	Referral to Treatment: Incomplete Pathways
83.2%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	Performance for RTT remains relatively static.
>= 92%	

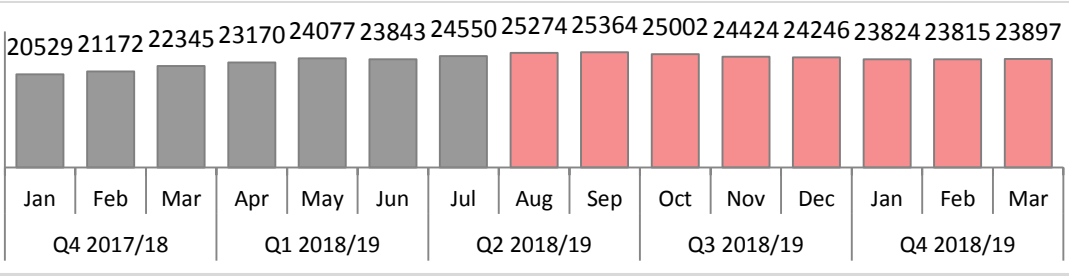


Actions

The Outpatient programme enablers continue to be rolled out and embedded across the Directorates.

RTT masterclasses are being developed and rolled out to key staff groups across the Organisation. This will include improved pathway management skills to ensure patients are being progressed along their pathway in the most timely manner.

Mar-19	Referral to Treatment: Incomplete Waiting List Size
23897	The total number of patients on an open pathway.
Target	The total waiting list size has increased slightly this month. However, a number of specialties are back to their baseline figure. Oral Surgery, Orthodontics and Gastroenterology are the specialties with the highest variance from the March 2018 baseline waiting list size.
<= 22346	



Actions

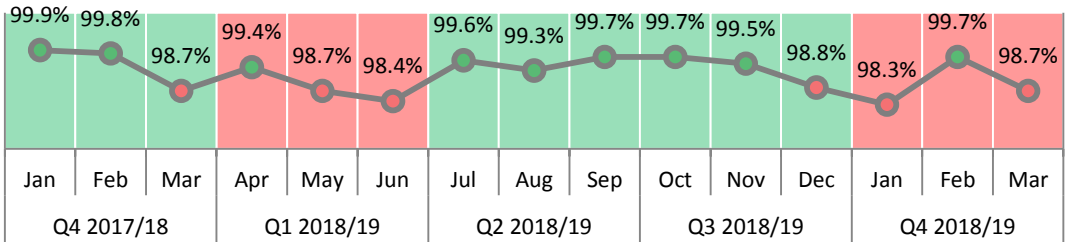
Data quality checks and processes continue to be refined and embedded.

Oral, Orthodontic and Gastroenterology have seen significant growth in referrals over the last 12 months.

The impact of Oral and Orthdontic services ceasing at neighbouring Trusts is being discussed with NHS England along with options for future service models.

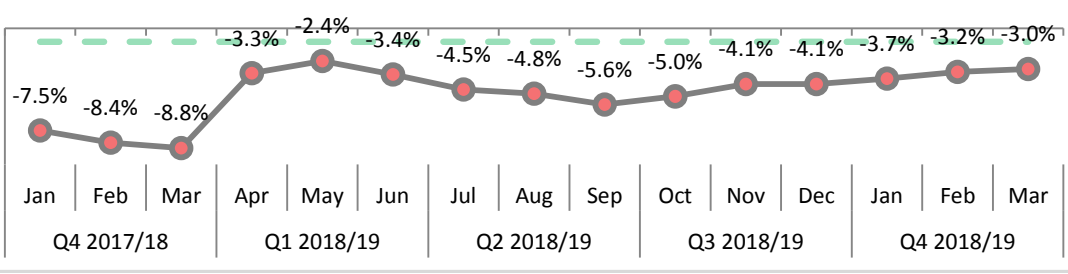
Indicator Detail

Mar-19	Diagnostics: 6 Week Standard
98.7%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Diagnostic standard was not achieved this month. This related to capacity issues within Echocardiography due to sickness absence.
>= 99%	



Actions
A capacity & demand of the service is being undertaken which will inform the longer-term sustainable options.

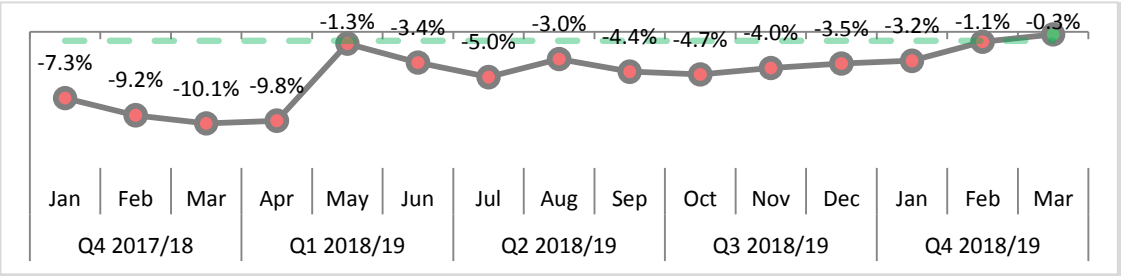
Mar-19	Elective Activity vs. Plan
-3.0%	The percentage variance between planned elective activity and actual elective activity.
Target	The Trust was 6 cases adverse to plan in March, however, income overachieved.
>= -1%	



Actions
Plans for 2019/20 have been agreed and assurance against delivery is being sought through 'Start of the Week' review of the latest position and the monthly Performance Review meetings. Theatre productivity is being monitored via monthly scrutiny of performance by the COO with the theatre leadership team.

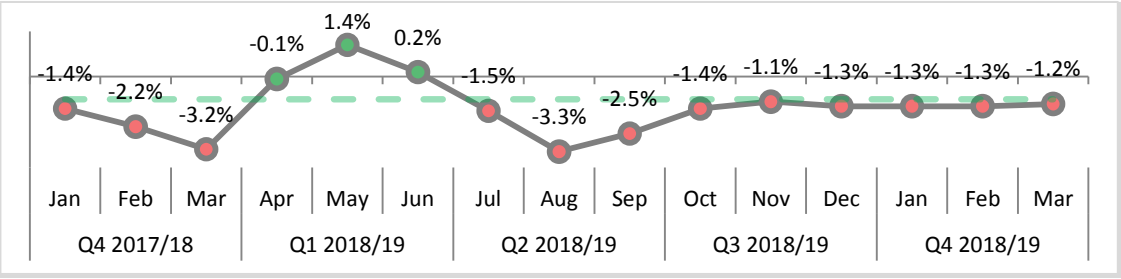
Indicator Detail

Mar-19	Elective Income vs. Plan
-0.3%	The percentage variance between planned elective income and the actual elective income.
Target	Elective Income was above plan in month, with the year end position 0.3% adverse.
>= -1%	



Actions
Plans for 2019/20 have been agreed and assurance against delivery is being sought through 'Start of the Week' review of the latest position and the monthly Performance Review meetings. Theatre productivity is being monitored via monthly scrutiny of performance by the COO with the theatre leadership team.

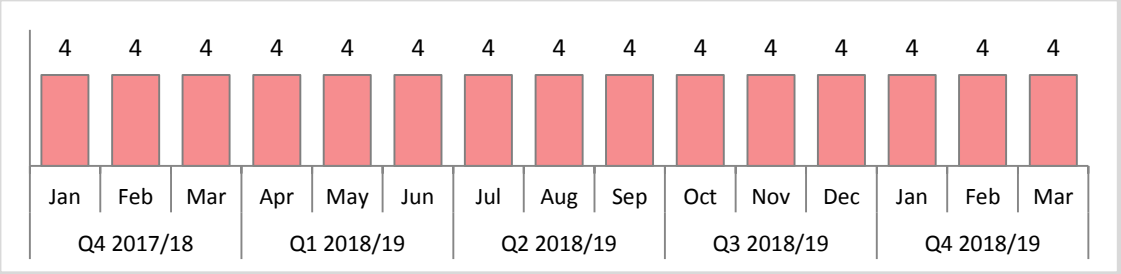
Mar-19	Outpatient Activity vs. Plan
-1.2%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Whilst there was an overall underperformance against plan this was a consequence of reduced Anticoagulation clinic activity in line with best practice. Without this underperformance the Trust would have exceeded plan.
>= -1%	



Actions

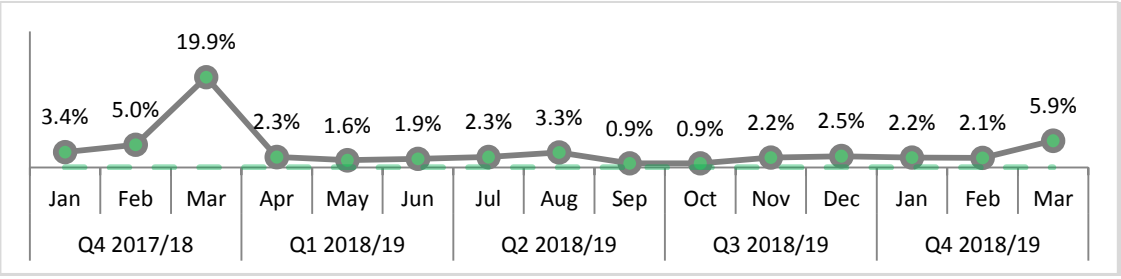
Indicator Detail

Mar-19	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	The Trust's 2018/19 Operational Plan does not deliver the target of a score of a 2 or better, as the planned deficit of £34m is a deficit of 12%. To improve from a 4 to a 3 the planned deficit would need to be within 1% of planned operating income.
<= 2	



Actions
The Trust has delivered a draft deficit of £32.0m against a planned deficit of £34.0m, so is £2.0m favourable to plan. This position remains draft until the final accounts and schedules have been completed and approved by external audit for final accounts submission on 29th May 2019. Successful achievement of the planned full year deficit to 31st March 2019 has been delivered through a mixture of grip and control reductions to the expenditure run-rate, and non-recurrent mitigations and one-off accounting provisions. The financial outlook for 2019-20 and beyond remains extremely challenging. The CIP required in 2019/20 is £14.2m, and achieving the full value of the planned cost reduction is vital to the Trust reaching the control total and associated £24.5m of external support funding in 2019/20.

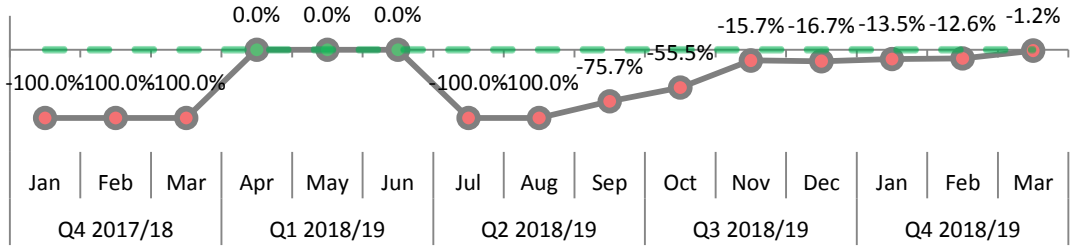
Mar-19	Financial Controls: I&E Position
5.9%	The percentage variance between planned financial position and the actual financial position.
Target	The Trust has lost of £31.5m with one month to go in the financial year, an average loss of £94,000 per day. The planned deficit was £22.2m so this is £0.7m favourable to the profiled plan. The Trust is reporting significant assurance on the delivery of this metric.
>= 0%	



Actions
As the Trust is favourable against the financial plan at this stage of the financial year, the Trust is scoring a 1 (best) under the NHSI use of resources (UoR) metric within the Single Oversight Framework. The mitigated forecast out-turn for the Trust has improved in line with the planned deficit, and there continues to be significant assurance that the operational plan will be delivered at the end of 2018/19. The grip and control actions undertaken across the business groups are having a positive impact and forecast winter spend remains within the expected envelope, and the Trust feels secure in confirming the forecast out-turn position for the financial year. This has been further supported through non recurrent mitigations and one off accounting provisions which will not be available in 2019/20.

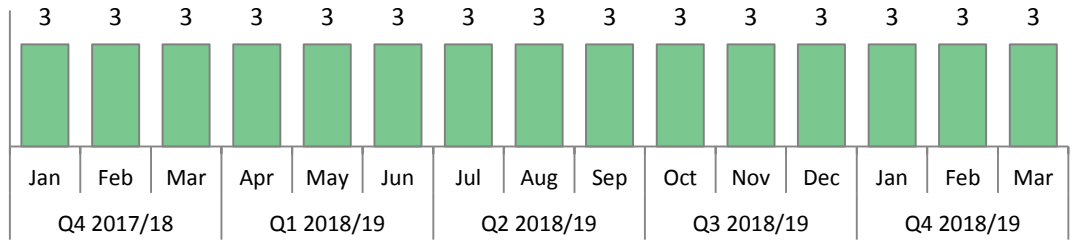
Indicator Detail

Mar-19	Cash
-1.2%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st March 2019 was £4.9m. The graph shows that the Trust has accessed borrowing each month since September 2018. The forward risk is forecasted as a green, as the Trust has applied and received confirmation of revenue support.
+/- 1%	



Actions
Cash in the bank on 31st March 2019 was £4.9m, which is £3.2m less than last month. Although the Trust is in a revenue financing situation this is higher than the present minimum cash balance to be maintained. The Trust borrowed £5.5m in March, increasing the total borrowed to date to £24.4m. Cash borrowing is £2.0m less than the £26.4m anticipated borrowing in financial year to 31st March 2019. The cash action group continues to monitor a series of actions which maximises the cash position of the Trust and these are enhanced during March in order to agree as many debtor and creditor positions as possible for the financial year end.

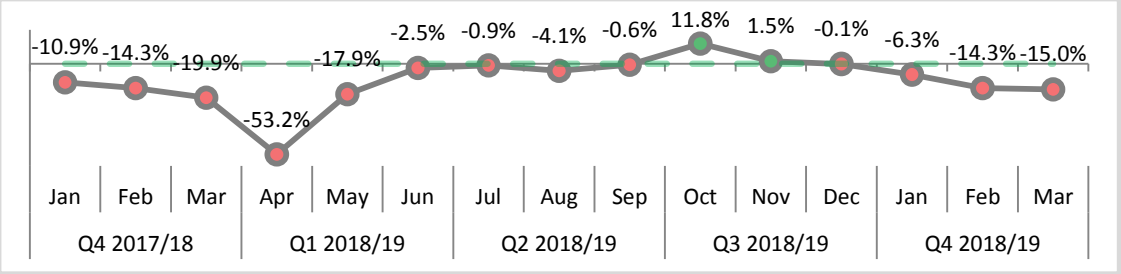
Mar-19	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's overall Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns.
<= 3	



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

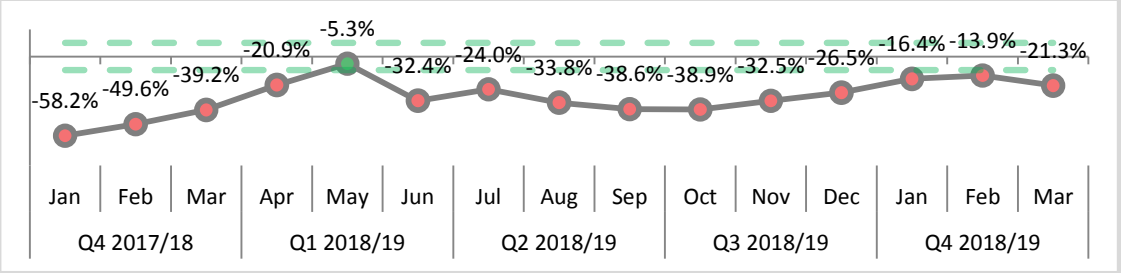
Indicator Detail

Mar-19	CIP Cumulative Achievement
-15.0%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) ended the financial year £2.2m behind plan, with £12.8m delivered against the £15.0m in year target. The unidentified gap reduced slightly from £2.3m to £2.2m in the final month.
>= 0%	



Actions
The challenge to deliver recurrent CIP remains paramount for the Trust. Continued reliance on non-recurrent measures to achieve financial positions in the current and previous years mean that the financial outlook for 2019-20 and beyond remains extremely challenging. The CIP required in 2019/20 is £14.2m. Achieving the full value of the planned cost reduction is vital to the Trust reaching the control total and associated £24.5m of external support funding in 2019/20. This will be a significant challenge for the organisation in reducing the underlying deficit level, and the cash position of the Trust. Business groups plans are in various stages of development and are being overseen at the weekly Clinical Services Efficiency group.

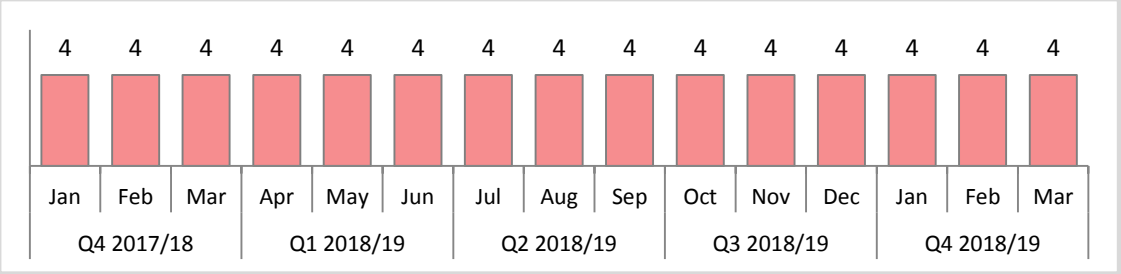
Mar-19	Capital Expenditure
-21.3%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £8.0m have been incurred to date against a plan of £14.8m so is £6.8m behind plan.
+/- 10%	



Actions
The capital position for the Trust is not yet final and there is potential significant change in relation to asset impairment. The full funding of Healthier Together schemes was fundamental to the delivery of the capital programme but these have not been incurred in the current financial year, so results in a £5.3m underspend in the Trust's capital plan, reducing the Trust's overall capital plan to £10.1m for 2018/19.

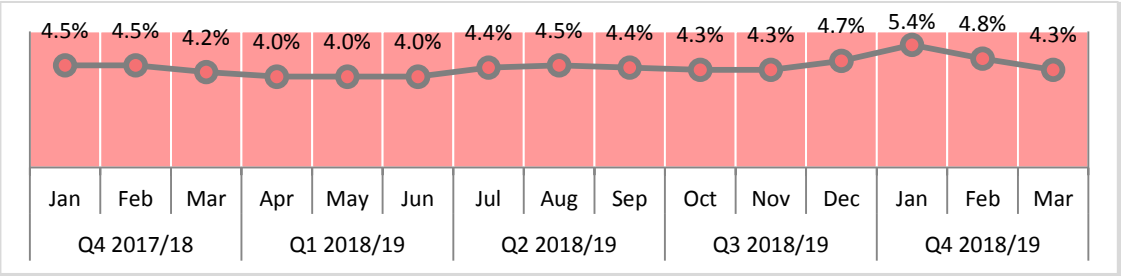
Indicator Detail

Mar-19	Financial Sustainability
4	A calculated score based on the Capital Service Capacity (the degree to which the Trust's generated income covers its financial obligations) and Liquidity in days (the number of days of operating costs held in cash or cash-equivalent).
Target	For the two metrics on financial sustainability the Trust scores a 4 (worst). This is not expected to change.
<= 2	



Actions

Mar-19	Sickness Absence Rate
4.3%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for March 2019 is 4.31%; a decrease of 0.52% compared to the adjusted February 2019 figure of 4.83%. The unadjusted cost of sickness absence in March 2019 is £522,151; a decrease of £5,418 from the adjusted figure of £527,569 in the previous month. This does not include the cost to cover the absence.
<= 3.5%	



Actions

The unadjusted short term sickness for April 2018 to March 2019 is 1.15%. The long term sickness for the same period is 3.26%.

The top three reasons for sickness remain as Stress/Anxiety, Back/Muscular Skeletal problems including Injury/Fracture, and Cough/Cold/Influenza respectively.

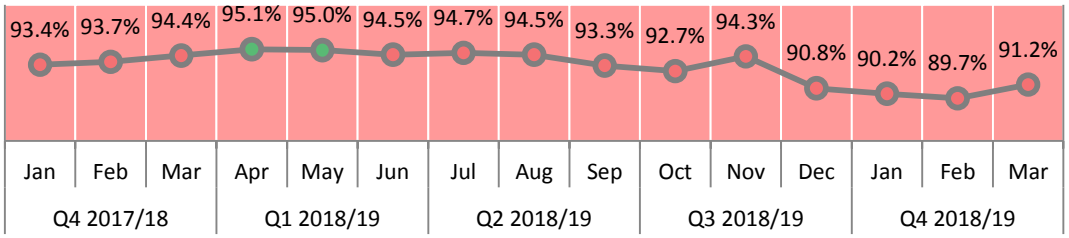
All Business Groups have seen a decrease on the previous month with Integrated Care Business Group having the largest decrease (1.04%).

All staff groups have seen a decrease on the previous month with Healthcare Scientists having the largest decrease (1.17%).

Ongoing dedicated HR support is provided to assist managers with the management of attendance; in addition a review of the attendance management policy and supporting procedures and initiatives is underway.

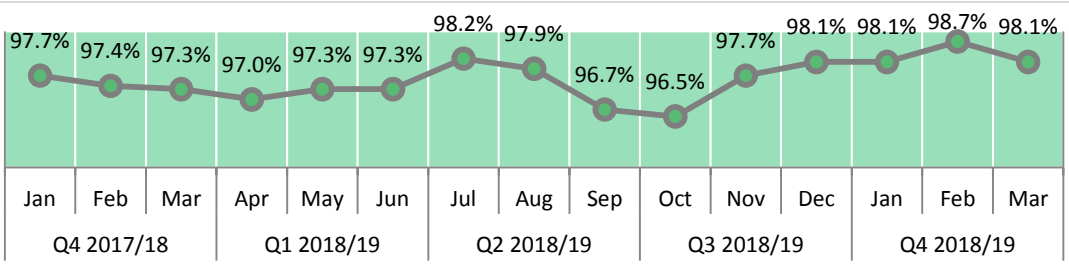
Indicator Detail

Mar-19	Appraisal Rate: Non-medical
91.2%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for March 2019 is 91.17%, an increase from the previous month's data which was 89.69%, and is 3.83% below target.
>= 95%	



Actions
An improved report will be provided to managers mid-month detailing the areas which are below the compliance level and assisting in identifying area which require targeting. A task and finish group for appraisal has commenced, which is looking at improving both the appraisal experience and processes, including maintaining compliance.

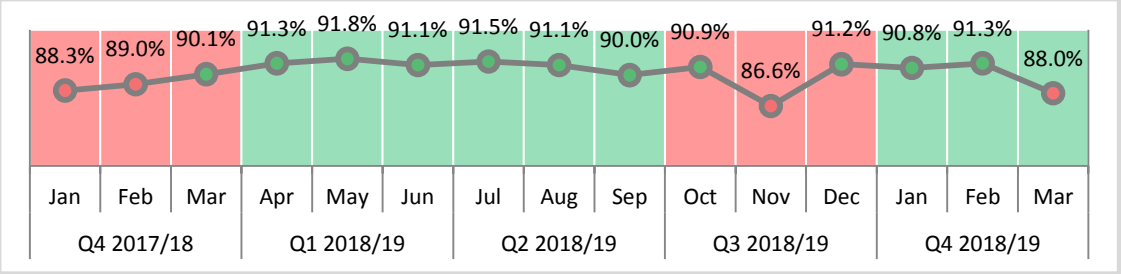
Mar-19	Appraisal Rate: Medical
98.1%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for March 2019 is 98.08%, a marginal decrease on the last month's figure of 98.74%; however remains significantly above the Trust target of 95%.
>= 95%	



Actions
Action to maintain compliance are in place.

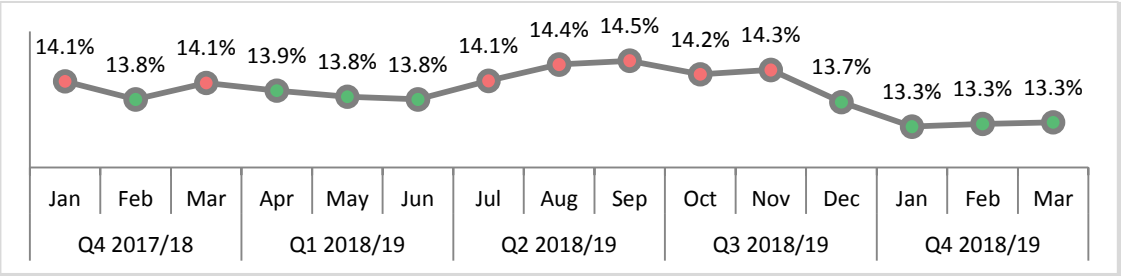
Indicator Detail

Mar-19	Statutory & Mandatory Training
88.0%	The percentage of statutory & mandatory training modules showing as compliant.
Mar-19	Statutory and Mandatory training has not achieved the compliance standard in March 2019 (87.97%) for the first time.
>= 90%	



Actions
Monthly reports continue to be sent to managers to enable them to monitor staff compliance and encourage completion of e-learning updates. Going forward a trajectory will be provided to each business group in order to support planning to release staff to complete the required training.

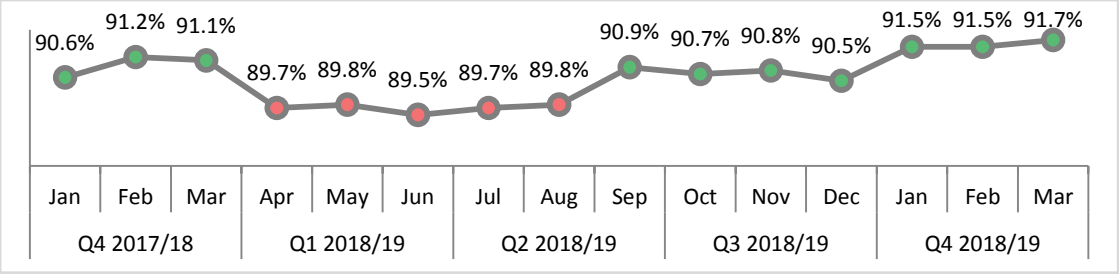
Mar-19	Workforce Turnover
13.3%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of March 2019 is 13.33%. The adjusted rolling 12-month permanent headcount turnover figure for the same period is 12.30%, both of which fall below the Trust target.
<= 13.94%	



Actions
The top adjusted leaving reasons are: Relocation 17.28%, Work Life Balance/Dependents 16%, Promotion 14.88%, and Retirement 13.92%. Integrated Care has the highest overall turnover rate at 18.50%, and when adjusted is 16.87%. Of the 192 leavers within the last 12-months in this Business Group, 80 (42%) are in Urgent Response, from which 49 (61%) are Registered Nurses, and the two highest known reasons given are relocation and work life balance. Activity to address hot spot areas of turnover continue; with a refreshed nursing recruitment campaign supporting substantive recruitment from within the UK; undertaking international recruitment to attract candidates from overseas to our hard to fill vacancies and development of 'new roles'.

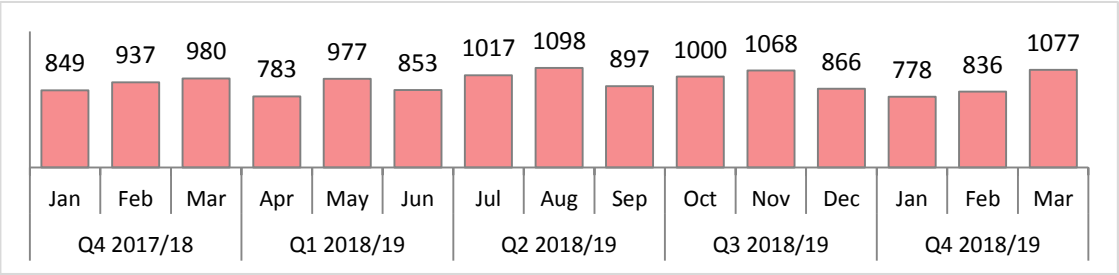
Indicator Detail

Mar-19	Staff in Post
91.7%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for March 2019 is 91.73% of the establishment, which is a decrease of 0.13% from 91.86% the previous month, however is above our target of 90%
>= 90%	



Actions
Recruitment to all vacancies continues to be progressed, supported by a programme of recruitment days and retention activities; overseen by the recruitment and retention steering group.

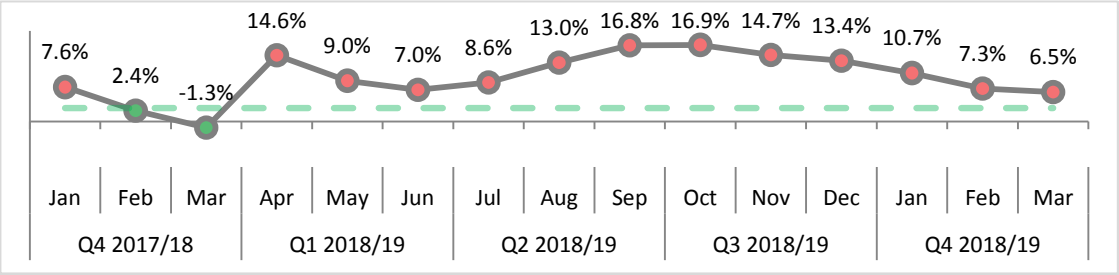
Mar-19	Agency Shifts Above Capped Rates
1077	Number of agency shifts above above the provider spend cap.
Target	There were a total of 1,077 shifts paid above the NHSI cap rate during the 5 week period from 25th February to 31st March 2019 (196 shifts March 2018). This equates to an average of 215 shifts per week, an increase of 5 shifts per week compared to February's figures.
<= 0	



Actions
Medicine & Clinical Support continue to have the highest number of agency cap breaches with an average of 90 shifts per week, followed by Integrated Care with 57 shifts per week, however, Integrated Care have seen a decrease from 66 shifts per week in February. The total number of agency shifts worked in this period, including shifts under cap, was 2,182 – an average of 436 per week. This is an average increase of 20 shifts per week compared to February. There were a total of 269 shifts paid at or above £100 per hour, which required Chief Executive approval, which is an average of 54 shifts per week, compared to 46 shifts per week in February. Actions to address this position include: - An increased senior challenge of locum rates and requirements at ECP. - Using the information from the Liaison booking rate index to identify high cost outliers and serve notice or renegotiate rates where possible.

Indicator Detail

Mar-19	Agency Spend: Distance From Ceiling
6.5%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	Agency spend was 5.84% of total pay expenditure, a figure of £1.01M. The year-end spend was £685,000 over the 2018/19 ceiling, however, the Trust spent £759,000 less this year than in 2017/18.
<= 3%	



Actions
Additional scrutiny through ECP and CEO approval processes have resulted in number of improved rates being agreed.

Safer Staffing Report

Mar-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
AMU	4,092	3,468	3,348	3,186	3,720	2,972	3,069	2,814	84.8%	95.2%	79.9%	91.7%	1621	4.0	3.7	7.7	0	1	0	0
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	165	4.3	4.3	8.6	0	0	0	0
D4	1,163	1,005	791	776	682	671	682	682	86.5%	98.1%	98.4%	100.0%	475	3.5	3.1	6.6	0	0	0	0
A3	1,442	1,187	977	999	1,023	858	682	671	82.3%	102.3%	83.9%	98.4%	703	2.9	2.4	5.3	0	0	0	0
A10	2,880	2,144	2,046	2,189	2,046	1,650	1,364	1,573	74.4%	107.0%	80.6%	115.3%	769	4.9	4.9	9.8	0	0	0	1
A11	1,581	1,353	1,628	1,560	682	583	682	924	85.6%	95.9%	85.5%	135.5%	814	2.4	3.1	5.4	0	0	0	0
A12	1,209	1,146	713	737	682	682	682	1,001	94.7%	103.3%	100.0%	146.8%	441	4.1	3.9	8.1	0	0	0	0
B4	1,209	827	605	899	682	682	682	682	68.4%	148.6%	100.0%	100.0%	505	3.0	3.1	6.1	0	0	0	0
B2	1,442	1,416	1,302	1,431	682	693	1,023	1,375	98.2%	109.9%	101.6%	134.4%	671	3.1	4.2	7.3	1	0	0	0
B6	1,209	1,011	2,077	1,849	682	622	682	658	83.6%	89.0%	91.2%	96.5%	669	2.4	3.7	6.2	1	1	0	0
Bluebell Ward	1,674	1,479	868	951	682	670	682	823	88.4%	109.5%	98.2%	120.7%	414	5.2	4.3	9.5	0	0	0	0
C4	1,209	864	605	1,119	682	682	682	979	71.5%	185.0%	100.0%	143.5%	498	3.1	4.2	7.3	1	0	0	1
Coronary Care Unit	837	837	465	383	682	682	341	320	100.0%	82.3%	100.0%	93.8%	151	10.1	4.7	14.7	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,070	1,064	2,000	1,958	682	682	682	858	99.4%	97.9%	100.0%	125.8%	550	3.2	5.1	8.3	0	0	0	0
E1	1,940	1,392	2,310	2,235	1,023	891	1,364	1,650	71.8%	96.8%	87.1%	121.0%	934	2.4	4.2	6.6	0	0	1	0
E2	2,279	2,228	1,581	2,015	1,023	1,012	1,023	1,364	97.8%	127.5%	98.9%	133.3%	1036	3.1	3.3	6.4	0	0	0	0
E3	2,279	2,217	1,581	1,586	1,023	967	1,023	1,397	97.3%	100.3%	94.5%	136.6%	1065	3.0	2.8	5.8	1	0	0	0

Safer Staffing Report

Mar-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
A1	1,395	1,052	1,209	1,223	1,023	726	682	880	75.4%	101.1%	71.0%	129.0%	946	1.9	2.2	4.1	0	0	0	3
B3	927	933	837	807	682	682	682	737	100.6%	96.4%	100.0%	108.1%	531	3.0	2.9	5.9	0	0	0	0
C6	927	1,071	1,097	1,151	682	847	682	660	115.5%	104.9%	124.2%	96.8%	627	3.1	2.9	5.9	0	0	0	0
D1	1,671	1,311	1,349	1,337	682	682	1,023	1,012	78.5%	99.1%	100.0%	98.9%	693	2.9	3.4	6.3	0	0	0	0
D2	1,612	1,183	1,442	1,310	682	598	682	990	73.4%	90.9%	87.7%	145.2%	612	2.9	3.8	6.7	0	0	0	0
D6	1,299	1,220	1,037	973	682	526	682	682	93.9%	93.9%	77.1%	100.0%	660	2.6	2.5	5.2	0	0	0	0
M4	1,217	1,081	977	905	682	682	572	561	88.9%	92.6%	100.0%	98.1%	579	3.0	2.5	5.6	0	0	0	0
SAU	1,829	1,762	729	637	1,023	857	682	671	96.3%	87.4%	83.8%	98.4%	443	5.9	3.0	8.9	0	0	0	0
Short Stay Surgical Unit	1,856	1,619	792	766	858	801	682	671	87.3%	96.7%	93.4%	98.4%	610	4.0	2.4	6.3	0	0	0	0
ICU & HDU	4,674	4,194	372	366	4,092	3,924	341	341	89.7%	98.4%	95.9%	100.0%	303	26.8	2.3	29.1	1	0	0	0
Birth Centre	930	870	465	465	620	540	310	310	93.5%	100.0%	87.1%	100.0%	23	61.3	33.7	95.0				
Delivery Suite	2,790	2,610	465	435	1,860	1,800	310	300	93.5%	93.5%	96.8%	96.8%	176	25.1	4.2	29.2				
Maternity 2	1,628	1,568	930	905	682	682	341	341	96.3%	97.3%	100.0%	100.0%	420	5.4	3.0	8.3				
Jasmine Ward	930	930	465	550	620	620	0	0	100.0%	118.3%	100.0%	na	211	7.3	2.6	10.0	0	0	0	0
Neonatal Unit	2,325	1,958	0	0	1,628	1,313	0	0	84.2%	na	80.7%	na	321	10.2	0.0	10.2	0	0	0	0
Tree House	3,255	3,210	465	465	2,170	2,177	0	0	98.6%	100.0%	100.3%	na	698	7.7	0.7	8.4	0	0	0	0
	57,146	50,578	35,894	36,533	35,687	32,797	23,357	26,268	88.5%	101.8%	91.9%	112.5%	19334	4.3	3.2	7.6	5	2	1	5

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : March 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.**	88.5% of expected Registered Nurse hours were achieved for day shifts. This is the 7th Month that staffing has been below the 90% benchmark. Any Registered Nurse numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Director of Quality & Deputy Chief Nurse. 17 areas indicate below 90% RN levels in month.	March 88.5% February 87.5% January 89.9%	The lowest RN staffing levels during the day were on Ward B4 at 68.4%. This was supported by non-registered levels of 148.6% to provide safe staffing. There were never less than 2 Registered nurses on duty. Harm free care metrics in month are optimal.
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	91.9% of expected Registered Nurse hours were achieved for night shifts. 11 areas report below 90% RN levels in month	March 91.9% February 94.6 % January 94.5%	The lowest RN night staffing levels are reported on Ward A1 at 71.0% staffing levels, the second consecutive month this ward has reported lowest levels . Night duty non registered cover was increased to 129.0% to support safe staffing. Never less than 2 RN on duty at any time. Closely supported by business group Matron and Associate Nurse Director. Harm free care metrics alongside staffing levels are reviewed to assure safe care. The business group will review the harm free care outcomes in month as new VTE has been reported.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	101.8% of expected Non-registered hours were achieved for day shifts. 3 areas report below 90% levels in month.	March 101.8% February 101.5% January 99.6%	The lowest non registered staffing levels for day duty are on the coronary care unit at 82.3%. The non-registered staff were supported by 100% Registered nurse levels. Harm free care levels in month are optimal.

BOARD PAPERS – Quality, Safety & Experience Section : March 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.**	125.9 % of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed by matrons. It is predominately due to wards requiring 1:1 support for patients following a risk assessment, or to support RN staffing numbers when there are unfilled shifts. No areas reports below 90% level in month.	March 112.5% February 125.9% January 111.6%	All areas report non registered night staffing levels above 90% in month.

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25th April 2019
Subject:	Integrated Performance Report – Annual Review of Metrics		
Report of:	Director of Support Services	**Prepared by:**	J Pemrick

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** The report outlines the proposed changes to the Trusts' Integrated Performance Report for the new financial year 2019/20. The proposal includes: • changes to the report format and sequencing • indicators to be removed, amended or added • new targets, as applicable The Board are asked to note the proposed changes.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. Background

1.1 The Integrated Performance Report (IPR) underwent significant review and change at the start of 2018/19. This was partly as a response to the CQC inspections, which raised concerns regarding quality and safety governance.

The current report has been in use for twelve months now, and so is subject to annual review to ensure that the indicators remain relevant and provide appropriate oversight to the Board of Directors.

2. Proposed changes

2.1 Changes to the Report Format

It has been proposed that the indicators be grouped by named Executive, instead of by Domain. This change should alleviate the switching back and forth between sections as each Executive delivers their section of the report.

The suggested order is:

- CN&DQG
- MD
- COO
- DoF
- DoW&OD

2.2 Indicator Changes

Each Executive Director has reviewed their current suite of indicators for the coming year. The proposed changes are:

Current Area	Indicators added	Indicators removed	Indicators Amended
Performance	Outpatient DNA rate Outpatient Clinic utilisation Outpatient Hospital Cancellation rate Outpatient new:fup ratio Super stranded Length of stay Theatre utilisation - in session Theatre utiliastion - touch-time OP Income v plan % Discharges before midday: Medical wards		
Quality	Litigation: claims closed Smoking in pregnancy Term babies admitted to Neonatal Unit Induction of Labour Rate Sepsis: Timely identification Sepsis: Timeley treatment Safeguarding: LD reasonable adjustment care plans	Mortality: deaths in ED or as Inpatient Emergency readmission rates Complaints closed (overall, upheld, partially upheld, not upheld Complaints: returned Complaints response rate 45 days Litigation: Key risk claims rate	Pressue Ulcers - remove avoidable/unavoidable. Total count to remain Mortality: Case note reviews - show as % of all deaths in ED or Inpatient Medication errors: Incidence per 1000 bed days Medication errors: incidence of harm Duty of candour - change descriptor to say breach of regulation Litigation: claims - change descriptor to say claims opened Falls & CDiff: targets to be revised
Workforce	Friends & Family: 'Place to work'		Agency ceiling: cap - align to HR from Finance Flu: amend target to 80% from October
Finance	Elective Inpatient Income v plan Daycase Income v plan Elective Inpatient Activity v plan Daycase Activity v plan	I&E Margin Financial Sustainability Elective (total) Income v plan Elective (total) Activity v plan	Cash - amend target so that <0% is red Income & Activity targets - amend target so that below plan is red. Capital: Plan v actual - assign to DoSS from DoF

2.3 **Review of Indicator Domains and Executive Portfolios**

Executive leads are requested to review the domains within which of the indicators reside, to assess whether this is still appropriate or requires reallocating.

Similarly, a review of the Executive lead for each indicator is requested, to assess whether this is still appropriate.

3.0 Recommendations

3.1 The Board are asked to note the proposed changes to the Integrated Performance Report for 2019/20.

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 17/04/19		**Report of:** Quality Committee
Date of last meeting: 16/04/19		**Membership Numbers:** Inquorate – no decisions were reached in the meeting which would warrant ratification at the next meeting.
1.	**Agenda**	The Committee considered an agenda which included the following: • Medicines Business Group Presentation • IPR - Quality Metrics • Quality Improvement Plan Report • Quality Improvement Priorities Q4 Update • SHQCIP update • Monthly Clinical Governance Report • Pharmacy and Medicines Optimisation Plan Annual • Learning from Deaths Report • Attach to Learning from Deaths Report • Medicines Optimisation Group Key Issues Report • QGG Key Issues Report • Quality Governance Group Annual Effectiveness • Patient Experience Group Key Issues Report • Trust Risk Register April 2019 • Board Assurance Framework (BAF)
	Alert	• The Committee received the Safe High Quality Care Improvement Plan update which outlined the progress to date. It noted that one 'should do' action relating to the Trust improving Governor's understanding of the Trust Strategic Plan was still outstanding and had breached the March 2019 milestone. • The Committee was informed by the Medical Director that there were challenges with psychiatric support for patients with eating disorders. The issue was presented to the Nutrition and Hydration Group.
	Assurance	• The Committee received positive assurance on quality governance arrangements in place in the Medicine and Clinical Support Services Business Group, through a presentation delivered by Ms N Armitage, Business Group Director. In line with the Quality Improvement Priorities, the Business Group had achieved its target on delivering harm free care which included reducing falls and pressure ulcers. 4 wards had received Gold under the Ace Ward Accreditation programme included Bluebell Ward. The briefing demonstrated a clear understanding of effective governance arrangements together with the key

		risks, mitigations and priorities for the Business Group. • The Committee received a detailed report from the Deputy Chief Nurse which highlighted progress made against the key themes from the Quality Improvement Plan in Q.4. The Committee was assured as five of the seven themes had been achieved and were expected to stay that way. • The Committee took positive assurance following an update by the Deputy Director of Quality Governance that no Subject Access Requests were overdue as the backlog had been cleared. The current turnaround was 14 days against the statutory response time of 30 days. The Committee noted the significant improvements from the 500 which were outstanding previously. • The Committee was advised that Stockport CCG had provided a report following its visit to the Devonshire unit. The feedback further endorsed the findings within the CQC report and provided positive assurance to the Committee. • The Committee took assurance from the Learning from Deaths report which outlined the leaning that is shared following case note reviews. • The Committee took assurance from the Pharmacy and Medicine Optimisation Plan Annual Report from the Chief Pharmacist and endorsed the priority areas for 2019 which included: o Improved antibiotic stewardship o Progression of ambient room temperature monitoring in treatment rooms o Introduction of medical gas training o Self-administration of medicines in the Trust o Extension of clinical pharmacy services across the Trust o Improved pharmacy discharge turnaround times • The Committee took assurance and noted progress in relation to the effectiveness of the Quality Governance Group's fulfilment of its delegated duties during the financial year.		
	Advise	• The Committee was informed by the Deputy Chief Nurse of the upcoming risks in relation to the Quality Improvement Plan. The Committee acknowledged that both the Urgent Care Delivery and Safe Staffing issues were progressing and would require substantial work as they were interlinked. • The Committee was advised that the Trust would be getting final verification which sought to confirm the Trust's compliance with the Nasogastric tube misplacement alert. An update report would be presented in September.		
2.	Risks Identified	Nil		
3.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Committee Secretary

NHS
Stockport
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 18/04/19		**Report of:** Finance & Performance Committee
Date of last meeting: 17/04/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Financial Performance Report • Operational Performance Report • Agency Utilisation Report • Business Intelligence / System Developments: Outpatients and Urgent Care • Performance Review Meetings – Key Issues Reports • Service Efficiency Programme Update • CT and Endoscopy Business Case Investment – Executive Summary • Finance & Performance Committee Annual Report • Finance and Performance Risks
	Alert	The Committee was advised that Trust had been asked to reconsider trajectories for Q.4 in relation to the A&E 4 hour target. The Committee noted ongoing challenged performances regarding the 2 weeks Breast service standard and Diagnostics. The Committee noted the continued pressure in Clinical Correspondence across a range of specialty areas. The Chief Operating Officer highlighted that a report would be presented to the May meeting detailing the options taken to address this. The Committee received an update on the progress made to date on the development of the Service Efficiency Programme noting that planning was at a much more advanced stage in compared to previous years due to increased ownership from the business group directors and corporate service leads. The Committee took low assurance pending receipt of the phased trajectory and confirmation of that programmes had gone through the Quality Impact Assessment Process.
	Assurance	The Committee took assurance from Business Intelligence presentation which showcased how data could be used to drive programmes. The presentation highlighted the System Urgent Care Improvement Plans which were based on the Greater Manchester Health and Social Care Partnership (GM) mandated models. The presentation also reflected the

		programme priorities for Outpatient Improvement including reducing inappropriate referrals, unnecessary or wasted appointments as well as optimising efficiency of clinics and processes. The Committee noted the collaborative work undertaken with business intelligent colleagues in Stockport CCG and Stockport MBC.		
	Advise	The Committee received and noted the Finance and Performance report which set out the progress made against the financial objectives of the Trust. The report outlined the draft trading position and key financial issues for 2018/19. It was expected that the final position would be submitted for audit on 24 April and presented to the Trust Board on 28 may. The Committee received and noted the Trust's agency usage and expenditure for month 12 noting that whilst the Trust had exceeded the agency ceiling for 2018/19, the amount spent was less than the previous year. The Committee received an update on the CT and Endoscopy Business cases. The report provided an assessment of the capital profile for the two schemes including the expenditure for 2019/20. The Committee requested a post investment appraisal which would outline the measures of success for both cases prior to submission to the Board. The Committee received the Risk register and noted that work to review the risk management process was underway. This review would be underpinned by training for all staff to ensure risks were properly articulated and scored.		
2.	Risks Identified	• Delivery of the cost improvement programme • Achievement of the national standard for RTT performance • Compliance with the Cancer 62-day standard. • Clinical services efficiency programme for 19/20. • Diagnostic performance • Breast service		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Committee Secretary

Board of Directors' Key Issues Report

Report Date: 18/04/19		**Report of:** Audit and Risk Committee
Date of last meeting: 27/03/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Follow Up Tracker • Anti-Fraud Progress Report • Standards for NHS Providers: Fraud, Bribery & Corruption • Self-Review Toolkit Submission • External Audit Plan 2018/19 • Risk Management Framework Update • Key issues within the Annual Accounts • Accounting Policies for 2018/19 • Losses and Special Payments • Waiver Report • Approval of Costing Processes • Going Concern Declaration • MIAA Insight Report The Internal Audit Contract Award was discussed in the private session of the meeting.
	Alert	The Committee was informed that Internal Audit had completed a Safe Staffing Review. The review had highlighted a few key issues which included: • Different performance against statutory and mandatory training and role essential training • Continued delay in eRostering system roll out The Chief Nurse and Director of Quality Governance presented Risk Management Framework update which provided a position statement against the six priorities for 2018/19. She advised that there was a group and committee structure in place ensuring that key issue reporting had been adopted across the groups. The Committee was assured with the progress in relation to the Risk Management Framework. an
	Assurance	The Committee considered a report regarding the Trust's Going Concern Declaration 2018/19, which provided the basis for completion of the Annual Accounts. The Committee reviewed the report in detail and, in particular, considered the implications associated with the Trust's reliance on a revenue financing facility at some point in 2018/19.

		The Committee received the Internal Audit Progress Report which provided an update on assurances, key issues and progress against the Internal Audit Plan for 2018/19. The Committee reviewed the Internal Audit Progress Report which detailed the following audit outcomes: o Safe Staffing Review – (Moderate Assurance) o Financial Systems Review (including Financial Integrity) (Substantial Assurance) o Data Security & Protection Toolkit (Substantial Assurance) o Assurance Framework Review (n/a) The Committee was assured that the Assurance Framework was structured to meet the NHS requirement and was and clearly reflected the risks discussed by the Board. The Internal Audit Manager informed the Committee that there would be no request for changes to the Audit plan for the following year. The Associate Director of Finance presented a report detailing the draft Accounting Policies for 2018-2019 which would be included in the notes to the financial statements of the Consolidated Annual Accounts of the Trust and its subsidiaries.		
	Advise	The Committee was provided with a summary of outstanding actions on the tracker.		
2.	Risks Identified	With the exception of risks noted in the Trust Risk Register, no further risks were identified.		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	David Hopewell, Chair	Minutes available from:	Committee Secretary

Report to:	Trust Board	**Date:**	25th April 2019
Subject:	Corporate Objectives: 2018/19 – Q4 Update – Year End		
Report of:	Chief Executive	**Prepared by:**	Assistant Business Manager, Strategy and Planning

REPORT FOR NOTING

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

Summary of Report

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

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

Recommendations:

- Discuss and agree the position year end
- Discuss and agree process for updates 2019/20

Attachments: Appendix One– Objectives Update Q4 2018/19

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK –

1. INTRODUCTION

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

2. BACKGROUND

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

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

Objectives are shown as follows:

- Green – Achieved
- Red – Not achieved

3 CURRENT SITUATION

3.1 Objectives for the this year focus on:

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

3.2 Progress for Quarter four is demonstrated in appendix one for each objective. Objectives

not achieved in 2018/19:

- Corporate Objective 1a
  To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy
- Corporate Objective 3a
  To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.
- Corporate Objective 3b
  To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.
- Corporate Objective 4a
  i. To implement the new integrated service solution model of care working with our key partners
  ii. To realise the financial and non-financial benefits of the Stockport together business cases
  iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate
- Corporate Objective 5b
  The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018
- Corporate Objective 5c
  The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan
- Corporate Objective 7a
  To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience

4. RECOMMENDATIONS

4.1 The Trust Board is recommended to:

- Note updates for year end
- Agree process for updates on Corporate Objectives 2019/20

NHS Stockport NHS Foundation Trust

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

Key for progress	Forecasted to achieve	
	Not forecasted to achieve	

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:	Progress				Narrative on progress
				Q1	Q2	Q3	Q4	
Strategic Objective 1	**To achieve full implementation and delivery of the Trust's Refreshed Strategy 2018/22**	**Chief Executive**						
Corporate Objective 1a	To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** The consultation process is now complete with over 680 staff seen. Prior to the final draft of the Trust Strategy going through Trust Board the Chief Executive has requested a Board development session to establish the Trust position on the wider GM context and locality developments, to then frame the development of the clinical services strategies
Corporate Objective 1b	To lead the annual operational planning cycle in line with NHSI guidance	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** The Operational plan was submitted on the 04/04/2019
Strategic Objective 2	**To deliver outstanding clinical quality and patient experience**	**Chief Executive**						
Corporate Objective 2a	To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q4 Update** - QIP has delivered improvements across a range of metrics. The quality governance framework and RMF have supported staff to deliver improvements from ward to board, however strengthening the implementation the understanding of these frameworks continues to be required particularly around risk management.
Corporate Objective 2b	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q4 Update** - Quarter 4 saw external recognition for the improvements to the quality and safety of the services delivered . Key focus areas have been identified to take forward to the next interaction of the quality improvement plan.

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

Key for progress	Forecasted to achieve	
	Not forecasted to achieve	

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:	Progress				Narrative on progress
				Q1	Q2	Q3	Q4	
Strategic Objective 3	**To strive to achieve financial sustainability**	**Chief Executive**						
Corporate Objective 3a	To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q4 Update -** All Business Groups are delivering the required levels of Grip and Control actions to ensure the delivery of the 2018/19 financial plan except in the Surgery and Critical Care Business Group. A further review is being undertaken to ensure lessons are learnt for future cases. The Trust has been able to manage the winter escalation requirements within the financial envelope
Corporate Objective 3b	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q3 Update** - After eleven months of the financial year, the Trust has delivered £11.9m of the £15m target, this equates a recurrent delivery of £8.3m. The Trust has also identified a further £2m of recurrent savings which would increase the recurrent delivery to £10.3m at this stage. The recurrent shortfall against the £15m is creating a pressure in 2019/20 and therefore requires the Trust to deliver a 4% cost improvement compared to the 1.6% assumed nationally. As part of NHSIs Financial Oversight Meeting, the Trust has identified a number of contingency plans to meet the shortfall and deliver the 2018/19
Corporate Objective 3c	To review and monitor a revised performance management framework	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** The revised framework was agreed at the end of quarter two. Implementation of this framework is on-going
Strategic Objective 4	**To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including;** **a. Stockport Together/ Stockport Neighbourhood Care/ Integrated Service Solution** **b. Healthier Together** **c. Theme 2 & 4 Programmes (GM Health & Social Care Partnership)**	**Chief Executive**						

NHS Stockport NHS Foundation Trust

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

Key for progress	Forecasted to achieve	
	Not forecasted to achieve	

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:	Progress Q1	Q2	Q3	Q4	Narrative on progress
Corporate Objective 4a	i. To implement the new integrated service solution model of care working with our key partners ii. To realise the financial and non-financial benefits of the Stockport together business cases iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate	Chief Operating Officer	Provider Board					**Q4 Update -** Stockport Health Partnership Board has been formed, which includes the senior leaders of all the health providers only. SMBC have withdrawn from the Stockport Together programme. Stockport Together brand has been superseded by Stockport Health Partnership. We are continuing to work as a system to deliver the best outcomes for patients. There are Terms of Reference, for the partnership, however the governance structures have not been defined. We are currently undertaking an evaluation of the benefits realisation to date.
Corporate Objective 4b	To progress with planning for the realisation of the Healthier Together decision in line with GM defined timescales and investment	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** The Healthier Together business case has been signed off by Greater Manchester and NHSI. The case has been taken forward to the Department of Health
Corporate Objective 4c	To progress work streams relating to a)Theme 3 and b) Theme 4 in line with the GM Transformation Strategy	Director of Strategy, Planning and Partnerships/ Chief Operating Officer	Finance and Performance Committee					**Q3 Update -** Theme three - McKinsey modelling of theme three specialities and DGH archetypes has now been completed. Further work has been identified for Orthopaedics, Cardiology and Benign Urology. The Trust is fully engaged in all these specialities. Theme four - The finance team are preparing a proposal regarding the ledger system. A decision has been reached to outsource payroll which, subject to the appropriate due diligence and tender process is anticipated to take place with effect from 1st July 2019
Strategic Objective 5	**To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements (non-financial)**	**Chief Executive**						
Corporate Objective 5a	The Trust will complete an independently assessed Well Led Review by 30 September 2018	Director of Corporate Affairs	Audit Committee					**Q4 Update** - The Trust Board agreed not to proceed with this subject due to the proximity of a likely CQC well-led review in Q3 2018/19
Corporate Objective 5b	The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018	Chief Operating Officer	Finance and Performance Committee					**Q4 Update -** The agreed recovery plan with Stockport CCG on RTT/waiting list size was above plan but much improved position despite an increase in GP referrals. There is a trajectory in place to achieve RTT standards by the end of Q3 2019/20 The cancer standards were not met for Q4. The breast service fragility continues to impact on achieving the 2 week wait standard. The Trust is exploring other options to current service provision. A trajectory to become compliant with 62 day standard is in place by end of 19/20.

NHS Stockport NHS Foundation Trust

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

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Corporate Objective 5c	The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan	Chief Operating Officer	Finance and Performance Committee					**Q4 Update -** Despite a challenging January and February March 2019 achieved 81% with improvements to length of stay for stranded patients and overnight breaches. Evaluation of the system wide winter plan is currently underway.
Corporate Objective 5d	The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week	Medical Director	Quality Committee					**Q4 Update -** Dedicated funding for 7DS implementation was considered but not in the trust investment plan priorities for 2019-20 . It was agreed in the 7DS implementation meeting that incremental and small changes that support 7DS delivery would be the way forward. The new board level assurance process is in place now with the next submission being in June 2019 which will give us the Trust performance position against the standards.
Strategic Objective 6	**To develop and maintain an engaged workforce with the right skills, motivation and leadership**	**Chief Executive**						
Corporate Objective 6a	To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum	Medical Director	Quality Committee					**Q4 Update -** Two of the four modules of the Triumvirate development programme have been delivered. The last two modules will be delivered May and June 2019. The Trust has commissioned a 360 leadership programme for Clinical Directors based on the leadership academy model. This quarter, the Clinical Director forum will have three 'deep dive' sessions – finance (April), Quality improvement (May) and Quality (June). Further to this, we are planning two more leadership development sessions for July and September.
Corporate Objective 6b	To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement	Director of Workforce & Organisational Development	People Performance Committee					**Q4 Update -** Development map produced for business group triumvirates including development of key leadership skills such as resilience and compassionate leadership. Business Manager/Ward Manager and Clinical Director programme likely to commence in summer 2019
Corporate Objective 6c	To develop programmes of work to ensure the Health and Wellbeing Strategy is embedded across the trust and supports all staff in improving their health and wellbeing, delivering an environment where staff wellbeing is integrated into day-to-day practices	Director of Workforce & Organisational Development	People Performance Committee					**Q4 Update -** The Health and Wellbeing agenda now forms part of our Culture and Engagement plan, and has been included in the People Strategy and implementation plan. The occupational health team will be supporting a review of the programme to align with our People Strategy objective. The Trust has launched a team to participate in the Manchester run in May 2019 with good levels of support from all levels of the organisation.

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

Key for progress	Forecasted to achieve	
	Not forecasted to achieve	

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:	Progress				Narrative on progress
				Q1	Q2	Q3	Q4	
Corporate Objective 6d	To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage	Director of Workforce & Organisational Development	People Performance Committee					**Q3 Update -** Progress against KPI targets continues to be positive with the recruitment and retention matrix improving. There has been a downward trend on agency spend. The Trust has completed its first progress report against the peoples strategy map with operational plan in place for year two target delivery as planned
Strategic Objective 7	**To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality**	**Chief Executive**						
Corporate Objective 7a	To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** Discussions are on-going at Trust Board regarding options going forward
Corporate Objective 7b	To refresh the Estates Strategy based on the six facet survey and master planning information	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q4 Update -** The Estates Strategy was agreed at Trust Board in September with a further update given in March 2019.
Corporate Objective 7c	To manage investment relating to the Trust's capital programme relating to; i. Medical equipment ii. IT iii. Estates iv. ED Patient Streaming	Director of Support Services/ Director of Finance	Finance and Performance Committee					**Q4 Update -** The Capital Programme was completed by year end. There were some slippage in the year for Estates and Equipment projects. These projects were: *Gamma Camera * ED patient streaming * HSDU extension * NICU UPS replacement * Site Generator Control Replacement ED, HSDU and NICU schemes are due for completion April 2019. Medical equipment schemes financial risk of underspend was mitigated by bringing other schemes forward

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date of Meeting:**	25 April 2019
Subject:	Strategic Staffing Review Report April 2019		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	H Howard, Deputy Chief Nurse, P Enstone, Assistant Chief Nurse for Workforce.

REPORT FOR INFORMATION / ASSURANCE

Corporate objective ref:	SO2, 2a.2b, 6d
Board Assurance Framework ref:	SO2, SO3 SO5, SO6
CQC Registration Standards ref:	Regulation 12,18
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This report provides a comprehensive update to the the Board of Directors in relation to nurse and midwifery staffing across in-patient wards/departments and community teams. The report is based on the six monthly acuity assessments and establishment reviews undertaken in February and March 2019. .

The Board of Directors are asked to note/support:

- The assurance of safe staffing across the Trust provided through this Strategic Staffing Review by the Chief Nurse & Director of Quality Governance.
- Despite the intense focus on staffing levels, nurse recruitment and retention remains a challenge and continues to be highlighted as a significant organisational risk on the Trusts Board Assurance Framework (BAF) and Risk Register.
- Support the actions to be undertaken following the staffing reviews in Q4 2018/19.
- Support the recommendation that registered nursing and midwifery levels need to be subject to continued scrutiny and that any incremental investment is to be made in line with recommendations that must follow Trust governance processes.

Attachments:

none

This subject has previously been reported to:

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

Strategic Staffing Review Report April 2019

This report provides the Board of Directors with a comprehensive update on nurse and midwifery staffing across all areas of the Trust. The report includes an overview of the current staffing position across the wards, departments and community based on the results of planned six monthly acuity assessments undertaken in December 2018 and three repeated in February 2019, and establishment reviews undertaken in February and March 2019.

Despite the intense focus on staffing levels, nurse recruitment and retention remains a challenge and continues to be highlighted as a significant organisational risk on the Trusts Board Assurance Framework (BAF) and Risk Register.

The report is grounded in the need to ensure safe nurse and theatre practitioner staffing levels and has been reinforced through the following publications / resources:

- National Quality Board - Safe, sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospitals. 2016 (2017 approved)
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England. 2013
- The Model Hospital Portal - A new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities; key nursing information is contained within the portal. https://improvement.nhs.uk/news-alerts/updates-model-hospital/
- NHS Improvement-Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing October 2018
- NHS Long Term Plan (2019)
- Five Year Forward View (& Next Steps) (2014)
- General Practice - Forward View (2016)
- New Models of Care/ Vanguards (2015)
- Sustainability and Transformation Plans (STPs) (2015)
- Reducing Urgent & Emergency Care (2013)
- Reduced LOS & unplanned hospital admissions- Kings Fund (2010)
- Closing the Gap: Key areas for action on the Health and Care Workforce – Kings Fund 2019
- The Value of the Specialist Practitioner Qualification (District Nursing) - QNI (2016)
- Transition to Apprenticeships 2020
- Understanding safe caseloads in the District Nursing service- QNI (2016)
- An improvement resource for the District Nursing Workforce - National Quality Board (2018)
- BAPM (British Association of Perinatal Medicine)
- AfPP (The Association for Perioperative Practice)
- GPICS (Guidelines for the Provision of Intensive Care Services)

1. Executive Summary

This paper provides the required assurance that Stockport NHS Foundation Trust plans safe nurse, theatre practitioner and midwifery staffing levels and that there are appropriate systems in place to manage the demand for nursing, theatre practitioners and midwifery staff. This includes all areas within the Surgery, GI and Critical Care, Medicine, Integrated Care, Diagnostics, Women and Children's business groups.

In order to provide greater transparency the paper provides current and previous details of the Strategic Staffing Reviews undertaken (in line with the National Quality Boards requirements) from December 2017 and June 2018 as well as the current review. Comparisons incorporate reviews of nurse, theatre practitioner and midwifery staffing as a quality and performance measure and details the patient acuity data from December 2018 and 3 re- audits in February 2019.

From May 2018 the Board of Directors have received data and analysis relating to safe staffing within the Integrated Performance Report. This includes triangulation with indicators from the monthly point prevalence indicators within the Safety Thermometer.

The 'Hard Truths Commitments Regarding the Publishing of Staffing Data' (Care Quality Commission, March 2014) states '*data alone cannot assure anyone that safe care is being delivered. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increases the risks of patient safety incidents occurring*.' In order to assure the Board of safe staffing on wards this report takes into consideration a range of information including in the acute sector :

- Acuity and dependency data
- Skill Mix
- Nurse to bed ratio
- Incidence of pressure ulcers
- Incidence of falls
- Incidence of medication incidents
- Incidence of complaints relating to nursing care
- The Friends & Family Test results

And in the community setting :

- Safety Thermometer
- ANTT compliance
- Friends and Family Test results
- Annual Patient Experience survey
- Bi annual KPI dementia carers satisfaction survey
- Community sector audits such as Caseload Management, Nursing bag content audit.
- Controlled Drugs audits
- Record keeping / Nursing documentation and core care plans audit.

2. National Quality Board Safe, Sustainable & Productive Staffing Summary & Developing Workforce Safeguards

The Safe, Sustainable and Productive Staffing (SSPS) resource describes that the key to high quality care for all is our ability to deliver services that are sustainable and well led. For nurse staffing, this means continuing our focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles set out in the SSPS document:

- Right care
- Minimising avoidable harm
- Maximising the value of available resource

The paper reports on the bi-annual acuity and dependency reviews and the in-depth reviews during February and March 2019 to the 'Safe Sustainable and Productive Staffing' (SSPS) document, published by the National Quality Board. The document aims to support NHS Providers to deliver the right staff, with the right skills in the right place at the right time and builds on previous guidance.

A proforma was developed (see Appendix 1) which took into account the detailed requirements of the NQB guidance, and was used to provide a 360 degree review of wards and departments Between February and March 2019. 35 separate staffing reviews took place with the Ward/Department Manager, Matron and Associate Nurse Director (when available) for each clinical area with the Deputy Chief Nurse.

Each Manager spent time analysing their individual information, and presenting their findings and recommendations during their own staffing review. The reviews were led by the Deputy Chief Nurse and attended by the Assistant Chief Nurse for Recruitment and Retention. The Business Group Accountants and Human Resource Advisors provided business intelligence to support the completion of the preformats.

In line with the NQB recommendations, the reviews took account in each ward/department of the following:

- Bed or departmental occupancy rates
- Ward attenders / outpatient attendance
- Total budgeted establishment
- WTE based on December 2018 acuity and dependency
- Ward based registered nurses
- Ward based HCAs
- Skill mix
- WTE per bed
- RN ratio per bed Mon-Fri
- RN ratio per bed Sat/Sun
- RN ratio per bed nights
- Care Hours per Patient Day (*average number of actual nursing care hours spent with each patient per day - all nursing including support staff).*
- Medical Staff
- Allied Health Professionals
- Pharmacy staff (including medication administration)
- Advanced Nurse Practitioners / Clinical Nurse Specialists
- Assistant Practitioners
- Technicians
- Ward Clerk
- Housekeeper
- Hostess / Support Staff
- Phlebotomy

And for community areas :

- Registered Nurses
- Unregistered Staff
- Caseload size
- New referrals
- Team contacts in month face to face
- Team contacts in month telephone assessments
- Duration of visits

As we have further developed and refined our processes, we will adjust the staffing review proforma to reflect Outpatients, ED and ICU areas.

2.1 Background to Assuring Safer Caseloads in District Nursing

Patients cared for by the district nursing service, often have complex care needs. The care environment adds to that complexity. The reference for the community is to safe caseloads rather than safe staffing as this is a better reflection of determining the required staffing levels. A variety of caseload management tools exist and as a result the benchmarking across services is challenging. The district nurses at Stockport NHS Foundation Trust developed a tool which captured their case loading activity.

The district nursing teams monitor service quality and performance by reviewing :

- ANTT compliance
- Safety Thermometer - Key Issues report to Business Group Quality Board
- F&F Test
- Annual Patient Experience survey
- KPI -Twice yearly - Dementia Carers' satisfaction survey
- Audits - Nursing bag audit, Clinical content audit (incorporating record keeping audit) - rolling programme
- Most recently CD audit following updates to Controlled Drugs Policy
- Update & development of Policy / Guidelines / SOP's / PIL's e.g. Verification of Death, Syringe Driver McKinley T34
- Core Care plans, nursing documentation

3. Background to Assuring Safe Staffing Levels on Acute Wards

In 2001 the Audit Commission recommended that establishment setting, regardless of the method, must be simple, transparent, integrated, benchmarked and linked to ward outcomes.

NICE Guidance in July 2014 (NICE Guidance: Safe Staffing for nurses in adult in-patient wards SG1) described that there is **no single nursing staff-to-patient ratio** that can be applied across the whole range of wards to safely meet patients' nursing needs.

Each ward has to determine its nursing staff requirements to ensure safe patient care. The guideline made recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment. It recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period.

Further guidance published in 2015 (Safer Nursing Care Tool: Shelford Group) described an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. At Stockport NHS Foundation Trust, we have utilised this model which measures patient dependency and is then supported by the professional judgement of the senior nursing leaders.

The Trust adopted this tool in 2014 in recognition of its sensitivity and ability to provide information based on actual patient needs as opposed to averages and bed ratios and that this information could be aligned to other patient experience, safety and outcome data. However, this report is the first that has triangulated the data from acuity, dependency and a range of patient and staff outcomes over time.

In addition, our establishments meet the need to have built within them uplifts that enable the compliment of staff to absorb annual leave, short term sickness and study leave without the need to use temporary staff. The Trust's ward budgets are uplifted as below in Table 1 to support training, annual leave and sickness.

Registered Nurses	% uplift to provide cover	Care Support Workers	%uplift to provide cover
Annual Leave	11.41%	Annual Leave	11.34%
Training	2.7%	Training	1%
Bank Holidays	3.07%	Bank Holidays	3.07%
Sickness	3.5%	Sickness	3.5%

Table 1 Ward Budget uplifts

4. Current Staffing Position across Wards Based on Results of Acuity Assessment

4.1.1 Adults

We have looked at the results of the acuity data undertaken in December 2018. We have also included a re-audit of three areas in February 2019. Data has been triangulated as previously described. As always, it is important that data must be considered over time due to changing acuity and seasonal variation in activity.

The WTE (whole time equivalent) multiplier attributed to each level of care is as below in Table 2:

Level of care: Each patient is assessed as to their 'level'	WTE
0 patient requires hospitalisation needs met b provision of normal ward cares	0.99
1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate	1.39
1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living	1.72
2 May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	1.97

Table 2: Acuity and dependency multipliers.

4.1.2 Paediatrics

The paediatric senior nursing team developed an approach to assessing nursing requirements in children's in-patient areas, using a modified version of the Shelford Tool, in the absence of an agreed national model. Acuity and dependency has been measured since March 2018, this is enabling the team to bench mark acuity and dependency against staffing and skill mix ratio's to ensure minimal safety against local and national staffing guidance for paediatrics.

4.1.3 Maternity

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making that has been used within UK maternity units since 1988.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings,

and have been endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG).

BR+ measures the workload for midwives arising from the needs of women, from admission to the labour ward. The tool identifies the establishment required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour.

Birthrate Plus methodology was applied to the number of annual births and activity that occurred during the period and suggested ratios for safe practice standards were applied.

The Intrapartum Acuity Tool provides an objective assessment of the complexity and risk of women during Intrapartum care, in order to calculate the number of midwives required to achieve the agree staffing standard of one midwife to one woman during labour and delivery. Labour Ward calculate the acuity for the High Risk (HR Acuity) area alone for the Labour Ward Suite (Escalation Acuity) every 4 hours, using the escalation guideline to manage risk in real time.

The report suggested that the Registered Midwifery funded establishment should be 127.74 WTE and highlighted that additional staffing resources were required in Antenatal Clinic, Delivery Suite and Ward M2.

The current funded position for midwifery staffing is 113.01 WTE with a deficit of 11.31 WTE midwives when compared with shifts worked. The contracted deficit is currently 5.26 WTE. This deficit must be considered along with the recommendations and subject to the Trust governance processes.

The Head of Midwifery and Women's Health has produced and presented a business case for increased midwifery establishment at SMT – initially in 2018 there was agreement to increase by 8 WTE within vacancy slippage and maternity leave backfill, but increased diverts and staffing related incidents have demonstrated a need for a further increase and this is being discussed at EMG in April 2019.

The Intrapartum Acuity Tool provides an objective assessment of the complexity and risk of women during intrapartum care, in order to calculate the number of midwives required to achieve the agreed staffing standard of one midwife to one woman during labour and delivery. The Labour Ward calculate the acuity for the High Risk (HR Acuity) area alone and for the Labour Ward Suite (Escalation Acuity) every 4 hours, using the escalation guideline to manage risk in real time.

June 2018	Acuity needs met or exceeded 64% of time.
February 2018	Acuity needs met or exceeded 69% of time.
December 2018	Acuity needs met or exceeded 56% of time.
February 2019	Acuity needs met or exceeded 73% of time.

4.2 Acuity Results by Business Group

4.2.1 Medicine and Clinical Support Services Business Group

Medicine and Clinical Support Services Business Group Acuity Data is detailed below following December 2018 assessment. Please note that this review does not include escalation beds opened during the period December 2018 to March 2019.

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool (WTE) Acuity Assessment
February 2019	432.66 WTE	424.42 WTE (C3 is not counted in this number as no comparison could be made when they reduced beds moving from A12 in December 2019)
December 2018	458.36 WTE budgeted establishment (including A10 Stroke Ward)	450.69* WTE acuity audit recommended (including A10 Stroke Ward)
June 2018	460.45 (realignments of establishments due to reconfiguration programme in medicine)	469.20 WTE
December 2017	472.44 WTE	472.01 WTE CCU & Devonshire Ward included, where the acuity tool can be unreliable & have underestimated staffing requirements by approx. 20 WTE

The acuity data collected in December 2018 for the medical wards shows an establishment of + 8.24 WTE relating to acuity and dependency results. The figures include a +14.46* WTE result above the Shelford Acuity Audit results for Ward A10, which is an acute stroke ward and as such meets the national criteria for stroke ward staffing levels.

The professional judgement of the senior nursing team is that, whilst in the majority of the wards, there is sufficient staffing establishment following previous investment supported by the Board of Directors, three areas Wards E2, E3 and Bluebell require investment through the agreed process.

4.2.2 Surgery, Gastrointestinal (GI) and Critical Care Business Group

Surgery, GI and Critical Care Business Group Acuity Data is detailed below following December 2018 assessment

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool (WTE) Acuity Assessment
December 2018 (and Wards D1, D2 & M4 re-audit February 2019)	286.99 WTE established including ITU	286.56* WTE required as at December 2018/February 2019 acuity audit including ITU * Please note ICU figures distort the Shelford figures as GPICS staffing levels are more appropriate therefore this would mean the business group overall deficit is 24 WTE)
June 2018	302.63* (Funded	259.09* WTE (*36.54 WTE above

	establishment reduced as bed reduction since last audit in Trauma & Orthopaedics & Urology)	establishment equates to ICU)
December 2017	319.63 WTE	303.87 WTE

The acuity data collected in December 2018 shows a positive position in staffing relating to acuity and dependency overall. The figures* include a positive balance of +24.WTE above acuity requirements for ITU which must be taken into consideration. In December 2018 patients being cared for on Ward B3 were those with medical conditions rather than surgical spinal patients. Despite this, the acuity audit results do not impact or distort the overall business group results as the acuity data versus established was balanced.

Three wards D1, D2 and M4 requested that the acuity assessment was repeated to reflect the reconfiguration in year related to elective and non-elective orthopaedics that resulted in agreed changes in establishments.

Therefore all 3 wards had a revised acuity audit starting in February 2019 and the results new figures are reflected above**.

The professional judgement of the senior nursing team is that 3 areas Wards D1, D2 and C6 will require a further review following the next planned acuity audit outcomes. Overall there is sufficient staffing establishment following previous investment in some areas supported by the Board of Directors,

4.2.3 Integrated Care Business Group

Integrated Care Business Group Acuity Data is detailed below following the December 2018 assessment

	Funded Establishment (WTE staff providing clinical care)	**Safer Nursing Care Tool (WTE) Acuity Assessment**
December 2018	125.96 WTE budgeted establishment AMU SSOP (plus 138.71 WTE Emergency Department)	118.98 WTE recommended (AMU & Short Stay for Older People acuity only.) Acuity and dependency tools are not specific to emergency areas, therefore professional judgement & assessment of a range of patient outcomes are utilised.
June 2018	118.48 WTE AMU SSOP (plus 138.71 Emergency Department total 257.19 WTE)	104.25 AMU & Short Stay for Older People acuity only. Acuity & dependency tools are not specific to emergency areas, therefore professional judgement & assessment of a range of patient outcomes is utilised.
December 2017	280.85 (uplifted WTE for winter pressures Emergency Department)	Acuity and dependency tools are not specific to acute medicine or emergency areas, therefore professional judgement and assessment of a range of patient outcomes is utilised

The professional judgement of the senior nursing team is that, following significant investment in staffing, there is sufficient staffing establishment as a result of previous investment supported by the Board in AMU and SSOP.

4.2.4 Women's, Children's and Diagnostic Services Business Group

Women's, Children's and Diagnostic Services Acuity Data is detailed below following December 2018 assessment

Women's Health Acuity

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool (WTE) Acuity Assessment
December 2018	18.08	Acuity and Dependency tools are not specific to assessment areas that include both clinic areas and in-patient beds. Therefore professional judgement and assessment of a range of patient outcomes is utilised
June 2018	15.73	10.80 WTE (Jasmine Ward only additional WTE to support gynaecology assessment area)
December 2017	18.08	Acuity and Dependency tools are not specific to assessment areas that include both clinic areas and in-patient beds. Therefore professional judgement and assessment of a range of patient outcomes is utilised

The Jasmine Ward staffing establishment provides staffing cover for the pregnancy assessment unit, the termination of pregnancy service and the fertility clinic. The Business Group is currently reviewing the staffing cover within the clinical area as there is a noted lack of unregistered staffing support on the night shift currently which is impacting upon care provision.

Paediatric Acuity

The senior nursing team have developed the methodology by which professional judgement, acuity and dependency, staff and patient outcomes can be assessed. This is the paediatric Shelford tool and was completed for the first time in March 2018. The tool provides more robust data when used in clinical areas with over 10 beds, the 32 inpatient beds had been split over three wards within Treehouse, which made the data less reliable, form April 1st 2019 the ward is now one 32 bedded unit, which will facilitate a much more reliable data capture and analysis.

The senior team, are now also collating and recording the critical care data set, which records patients nursed on the wards but whose level of care requires HDU, this matched with the acuity and dependency data for HDU level care.

The paediatric unit is current bed capacity is flexed and matches activity as well as dependency to ensure patient safety, there is a robust escalation plan in place, and considerations are also given on the demand from across GM.

	Funded Establishment (WTE staff providing clinical care)	Shelford Tool- Acuity Assessment
December 2018	37.01	Acuity and Dependency tools are not specific to assessment areas that

		include both clinic areas and in-patient beds. Therefore professional judgement and assessment of a range of patient outcomes is utilised
June 2018	36.02	Acuity and Dependency tools are not specific to assessment areas that include both clinic areas and in-patient beds. Therefore professional judgement and assessment of a range of patient outcomes is utilised

The December 2018 Acuity data does not reflect the activity in the Assessment Unit and therefore is not reliant on its own when reviewing safe staffing; professional judgement and triangulation with patient outcomes is more reliable. A service review has been recommended at the Strategic Staffing Meeting which is annotated in the recommendations column.

5. Establishment and Strategic Staffing Reviews – agreed actions

The nursing actions following the establishment reviews undertaken in February and March 2019 Strategic Staffing Reviews are as follows:

5.1 Medicine and Clinical Services Business Group

Ward	Agreed Business Group Actions
A3 and CCU	*Transformation plans for the Heart Care Unit* *Review phlebotomy service across Business Group* *Consider Nurse Associates in line with findings from audit*
A10	*Compare CHPPD with HASU commissioner data* *Review roster compliance* *Review housekeeper role*
A11	*Review phlebotomy service across Business Group* *Ensure protected supervisory time* *Ward manager to ensure breaks are taken*
C3	*Review housekeeper role* *Increase number of mentors* *Review phlebotomy service across Business Group*
B4	*Recommend funding of 0.6 Ward Manager Supervisory time* *Review health roster management*

	Consider Nurse Associates in line audit findings
B6	*Nursing Associates to be built in to funded establishment* *Review of 1-1 enhanced care provision* *Cascade Student booklet*
Bluebell	*Recommend a review of establishment based upon acuity data*
C4	*Recommend funding of 0.6 Ward Manager Supervisory time* *Review health roster management* *Consider Nurse Associates in line with audit findings*
E1	*Recommend review of establishment based upon acuity data and future bed modelling within the Business Group* *Business group reviewing stroke pathway* *Develop activity coordinator role for the ward within budgeted establishment* *Recruit to ward clerk role*
E2	*Recommend review of establishment based upon acuity data and future bed modelling within the Business Group* *Develop plans toward employing RMN/LD and Nursing associates (to be within current establishment)* *Review housekeeper role* *Review roster compliance*
E3	*Recommend review of establishment based upon acuity data and future bed modelling within the Business Group* *Develop plans toward employing RMN/LD and Nursing associates (to be within current establishment)* *Review housekeeper role* *Review roster compliance*
Devonshire	*To review therapy services based upon recommended guidelines* *Develop housekeeper role* *Review Botox clinic provision* *Recruitment leaflet required*
Outpatients	*Review health roster management* *Develop housekeeper role*

	Review staffing across outpatients including activity and room usage with consideration for additional clinic activity *Develop a recruitment leaflet* *Roll out Bookwise across all outpatient areas* *Quality and safety boards to be progressed*

5.2 Surgery, GI and Critical Care Business Group

Ward	Agreed Business Group Actions
A1	*Review phlebotomy service across Business Group* *Recommend a review of establishment based upon acuity data and Establishment Genie review* *Review health roster management* *Develop housekeeper role*
B3	*Ensure break allocation is maintained* *Review phlebotomy service across Business Group*
C6	*Recommend review of establishment based upon acuity data and future bed modelling within the Business Group* *Review phlebotomy service across Business Group* *Review health roster management* *Improve incident reporting* *Noted last pressure ulcer June 2016*
D1	*Review health roster management* *Rerun acuity audit March 2019* *Review phlebotomy service across Business Group*
D2	*Rerun acuity audit March 2019* *Review phlebotomy service across Business Group* *Review health roster management* *Nurse Associate role allocation for future*
D5	*Review ward manager supervisory time* *Review phlebotomy service across Business Group* *Review health roster management* *Consider succession plan for the ward* *Review nurse led discharge criteria* *Nurse Associate role allocation for future*
D6	*Review of budgeted establishment* *Review of ward staffing levels*

	Review health roster management *Ensure ward attenders are captured*
ICU	*Consider supernumerary coordinator role as per Guidelines for Provision of Intensive Care Services (GPICS)* *Break allocations to be adhered to* *Address appraisal rate* *Review AHP provision in ICU* *Review ILS provision for ICU staff*
Theatres	*Consider contingency plan for maternity theatres* *Review of theatre activity and staffing establishment in line with Associate for Perioperative Practice (AfPP) guidance* *Review provision for ILS for theatre staff* *Review of patient escort provision*
M4	*Review health roster management* *Re-run acuity and dependency February 2019* *Develop housekeeper role* *Cross reference with peers re: number of falls.*
SAU	*Review methods by which acuity and dependency may be more meaningfully adopted in assessment areas* *Review phlebotomy service across Business Group* *Deep dive of staffing rosters*
SSU	*Review health roster management* *Review ward manager supervisory time* *Review nurse led discharge criteria*

5.3 Integrated Care Business Group

Ward	Agreed Business Group Actions
Acute Medical Unit	*Review supervisory time for ward manager* *BG to review the establishment of the 6 PCRU beds and consider amalgamation with AMU establishment* *BG to consider the use of the pharmacy technician* *Develop training and competency assessments*

	Consider housekeeper role *Review phlebotomy service across Business Group* *Increase number of mentors* *Nurse Associate role allocation for future*
Ambulatory Care Unit	*Recruit to vacancy* *Develop/adapt an acuity and dependency tool for use in assessment area* *Develop recruitment brochure*
Emergency Department	*Recruit to housekeeper role* *Confirmation of staffing establishment based upon increase in number of beds in CDU*
Short Stay for Older People	*Review phlebotomy service across Business Group*
Community district nursing teams	*Pilot ward accreditation for the community setting* *Consideration for filming patients stories in community setting*

5.4 Women, Children's and Diagnostic Services Business Group

Ward	**Agreed Business Group Actions**
Jasmine Ward	*Break allocations to be adhered to* *Review of staffing establishment alongside service review modelling* *Review of staffing to support the weekend cover*
Maternity services	*Review of the ward for postnatal readmissions* *Birthrate plus review of staffing to support supernumerary co-ordinator role* *Progress the development of PROMPT training* *Review health roster management* *Undertake a deep dive for all babies readmitted* *Review mentorship and preceptorship programme* *Review and develop a rotation programme for staff*
Paediatrics	*Recording of all patients including ward attender to capture activity*

	Review health roster management *Review supervisory time for ward manager*
Neonatal unit	*Consider UNICEF Baby Friendly Accreditation scheme* *Development of transactional care model* *Review of staffing against BAPM standards*

6. Vacancies

As of February 2019 the Trust has 158 WTE vacancies, which is an improvement on figures reported in January 2018 of 200 WTE.

Current Registered Nurse and Registered Midwife vacancies by Business Group are as below: (please note that this is *ALL* registered RN and RM staff and not just those working in in-patient areas)

Business Group	Number of Vacancies
Medicine and Clinical Support	55.30 RN
Integrated Care	64.42 RN
Surgery, Gastro-enterology and Critical Care	33.86 RN
Women, Children and Diagnostics	6.02 RN / RM
Corporate Services	(-1.19) RN

It is recognised nationally that there is a shortage of registered nurses and that many care organisations are facing the same challenges in filling registered nursing vacancies. To help address this, the Trust has a number of on-going long and short term initiatives which have demonstrated a reduction in RN turnover of 0.9% in the 12 months of the NHSi support programme. Initiatives to support improved retention and reduce turnover, includes:

- Taking part in the NHS Improvement collaborative to support Recruitment and Retention Strategy, with four main work-streams:
    1. Career crossroads – supporting our staff when they feel they have 'Itchy Feet'
    2. Turnover rates – a reduction of turnover in the top 10 reported departments
    3. Graduate Nurse programme – retaining our newly registered nurses
    4. Retire and Return

Other initiatives include:

- Development of the Associate Nurse role in identified areas
- Ward specific adverts on NHS jobs, newspapers and social media including Facebook and Twitter.
- Planned recruitment drives, specific to business groups partnering with an external company to boost UK recruitment.
- Closer working with the partner universities to improve Stockport NHS Foundation Trust profile with potential recruits.
- Flexible working arrangements where possible
- Trust attendance at job fairs and school career fairs

- Recent attendance at universities open days other than Manchester to widen our pool of potential students
- Overseas recruitment
- Offering alternative career pathways to registered staff to encourage retention, such as specialist nurse and advanced nurse practitioner posts
- Review of alternative professions to provide support to wards, such as physiotherapists and pharmacists

To assure safe staffing levels the Trust works closely with our temporary staffing providers via NHSP to provide workers to support our rosters. In February 2019 with 158 RN vacancies, 154 WTE RN via NHSP/agency staff were provided. Additional to this 150 WTE non-registered staff were provided via NHSP to cover 50 WTE vacancies and to support enhanced care requirements.

7. Care Hours per Patient Day

Care hours per patient day (CHPPD) was introduced in April 2016 following the independent report for the Department of Health by Lord Carter of Coles, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (February 2016). CHPPD is calculated by adding the total amount of Nursing (RN and non-registered staff) available during a day, and dividing this by the number of patients present on the in-patient areas at midnight. This gives an overall average for the daily care hours available per patient (all nursing and midwifery staff).

During the Carter pilot stages, 25 trusts were included and their results showed CHPPD range from 6.3 to 15.48 CHPPD and a median of 9.13. For February 2019 the report shows an average CHPPD of 7.6.

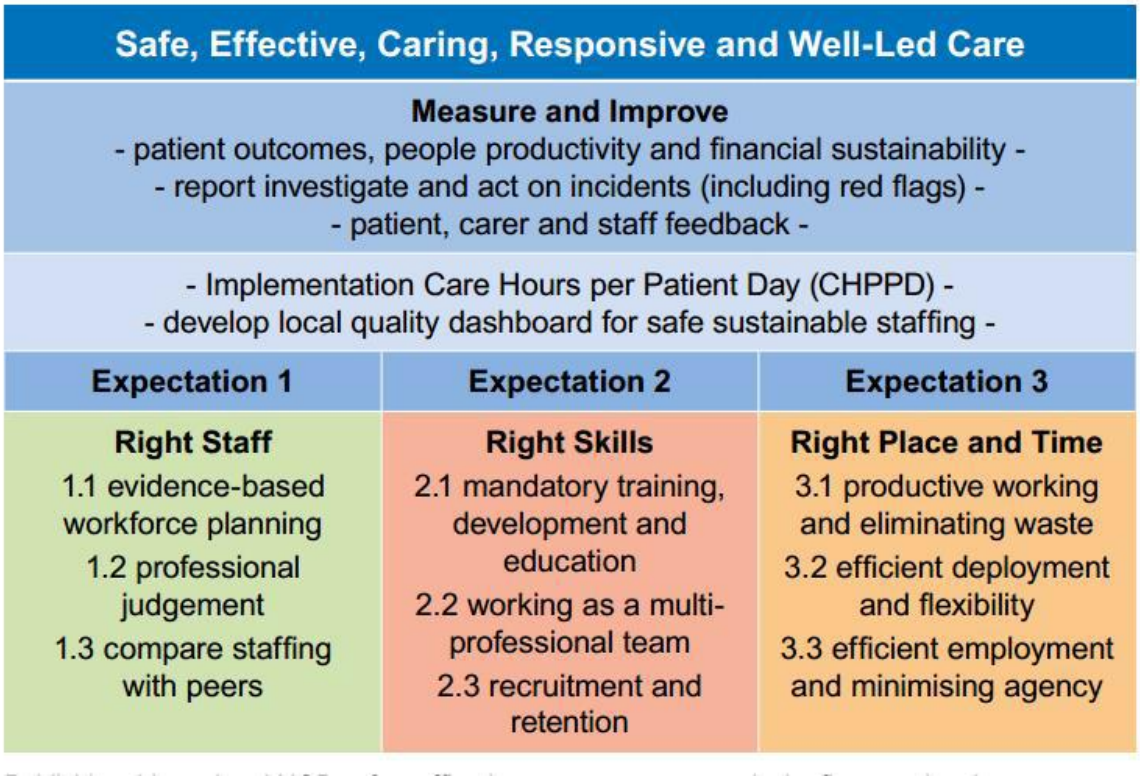
8. National Quality Board Safe, Sustainable & Productive Staffing Summary and Developing Workforce Safeguards

This section provides a summary to the recently published 'Safe Sustainable and Productive Staffing' (SSPS) paper published in July 2016 and the 'Developing workforce Safeguards' published in October 2018 by the National Quality Board which aims to supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time and builds on previous guidance.

The SSPS document describes that the key to high quality care for all is our ability to deliver services that are sustainable and well led. For nurse staffing, this means continuing our focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles set out in the SSPS document:

- Right care
- Minimising avoidable harm
- Maximising the value of available resource

The document also describes the importance of measurement and improvement of safe and sustainable staffing and the use of Care Hours per Patient Day as a measure over time. The Trust has been using CHPPD as a measure since June 2016. Guidance is offered in the SSPS on using other measures of quality, alongside care hours per patient day (CHPPD), to understand how staff capacity may affect the quality of care. It is important to remember that CHPPD should not be viewed in isolation and does not give a complete view of quality.



8.1 Expectation 1 – *Right Staff*

The document describes that Boards 'should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of **all healthcare professional groups** and is in line with financial plans. This should be followed with a comprehensive staffing report to Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Specific recommendations of Expectation 1 are:

Boards should ensure that the Trust has in place	
Evidence based workforce planning	*The Trust uses validated workforce planning tools that are endorsed by NICE, RCN, RCM, RCO, BAPM and AfPP and applies NQB guidance to Strategic Staffing Reviews.*
Professional judgement	*Professional judgement is determined by utilising the skills of the ward manager and matron in collaboration with the most senior nursing leaders.*
Compare staffing with peers	*The Model Hospital data is accessed for comparison when undertaking Strategic Staffing Reviews.*

8.2 Expectation 2 – *Right Skills*

The document describes that Boards 'should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical

leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap'

Specific recommendations of Expectation 2 are:

Boards should ensure that the Trust has in place	
Mandatory training, development and education	*The Interim Director of Workforce & OD reports mandatory training compliance to the Board of Directors on a monthly basis via the People and Performance Committee*
Working as a multi-professional team	*Multi-professional working is in place across the wards and departments. This is evident from the Strategic Staffing Reviews & Services Reviews, & within staffing business cases.*
Recruitment and retention	*We are part of Cohort 2 of NHSi's Retention Program. We have completed year 1 and achieved a reduction in turnover of 0.9%. We embark from March 2019 on year 2 with a refreshed approach to achieve an overall 2 year reduction of 1.5% in RN turnover. We have reduced RN WTE vacancies from 187 to 158 and aim to reduce to 100 WTE in April 2020.*

8.3 Expectation 3 – *Right Place*

The document describes that Boards 'should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Chief Nurses, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations'

Specific recommendations of Expectation 3 are:

Boards should ensure that the Trust has in place	
Productive working & eliminating waste	*Evidence of lean methodology approaches, quality improvement methodology is utilised to support staff productivity.* *In 2018 the Trust appointed an external review of 7 wards and 3 departments of their rostering practices as well as a review of previous internal acuity audit results to provide assurance. (This company was called Establishment Genie). The objective was also to advise of safe staffing rosters to take into consideration of the new associate nurses due to qualify in March 2019. This review provided detailed guidance as to how to safely incorporate this new workforce. A further aim was to reduce the usage of costly agency staff, to improve quality by ensuring improved shift fill rates & to ensure the correct safe balance between RNs, associate nurses, non-registered staff and temporary workers.*

Efficient deployment and flexibility	*Staffing reviews take place in the Business Groups up to three times per day Monday to Friday, with a main on-site meeting at 11am each day. A forward planning review takes place every Friday which takes into account staffing requirements for the weekend.* *Staffing deployment is an agenda item at every site meeting, with use of the Staffing in Extremis Guidance during times of surge.* *This could be made much more efficient by improving the use of the E-Rostering system. Plans are in place to address this with a paper to SMT for funding for SafeCare live, a Band 7 lead supporting a Band 3 in each business group to ensure improved roster practice.* *Improvements are to be made to daily staffing review processes to ensure inclusion of community staffing in the onsite review.*
Efficient employment and minimising agency	*There is close collaboration with regional NHS partners via the North West NHSP/agency client user group to address improving qualitative measures with agency staff as well as addressing financial issues. There is a robust escalation policy in place across the Trust.*

Additional areas important for monitoring are that Boards should ensure there is sufficient investigation and learning from patient safety incident and serious incident data; workforce metrics are in place that demonstrate staff capacity; and workload metrics that provide context to CHPPD. These areas have been reported to Board from May 2018.

9. Recommendations

Included in Section 5 are individual ward/department recommendations.

A number of emerging key themes or significant issues that need to be highlighted via this report are as follow:

9.1 Phlebotomy

In a number of the acute wards A1, D5, B3, SAU, C6, AMU and SSOP sub-optimal phlebotomy service provision was highlighted. This impacted on service delivery in the ward areas placing additional pressure on ward contracted substantive staff.

A review of the phlebotomy provision across areas highlighted should be considered.

9.2 Breakfast Delivery

A number of wards report that breakfast delivery requires a review in relation to food temperatures. It is recommended that the Hotel Services division (Catering Manager) reviews this situation in support of improving patient experience.

9.3 Supervisory Ward Manager time

A number of areas C4, B4, SSSU and D5 reported insufficient budgeted supervisory hours. This requires review by the Business Groups.

9.4 E-roster

All acute wards and departments indicate that the understanding and application of e-roster is suboptimal with many areas reporting incorrect establishments loaded.

Staff require additional support in the use of the e-roster. Also Health roster currently does not have interface functionality with e-roster confusing the situation further. It is anticipated that with the implementation of Safe Care Live the additional 'e-roster' team will be able to go back to basics and retrain the wards and department staff to enable improved utilisation of the system.

9.5 Taking Breaks

A consistent theme is reported that in particular unit managers are not taking breaks. Reinforcement of the health and well-being aspects of regular breaks plus leadership example is requested from business groups.

9.6 Reporting via electronic reporting system

It was noted that not all areas recording compliments consistently via the electronic reporting system (Datix). It is recommended that all areas commence this data collection with immediate effect.

9.7 Competencies

A number of areas C5, SSSU and AMU report that nursing competencies require review and ratification. The Business Groups reported that they are working with the Education teams to ensure all nurse led competencies are appropriately supported.

9.8 Suitability of Audit

The proforma for the strategic staffing is noted to be ward focussed and further development is required. Adaptations will be made from summer 2019 onwards to reflect the need to be relevant to the Community, Outpatients and departments such as ED, ICU

and Theatres. The Assistant Chief Nurse for Recruitment and Retention will liaise with the Business Groups to support this development for July 2019 reviews.

The Trust continues to see a growing acuity/dependency of patients across a number of adult inpatient wards, with a number of areas having agreed investments for 2019/20. The priority area of focus remains the recruitment and retention of registered nurses and health care assistants, as it is agreed that recruiting to establishments will have the greatest impact on our ability to provide safe, cost effective nursing, midwifery and community care. The innovative approaches to recruitment as this paper describes, will continuing in a planned way.

The ambition for nurse staffing remains unchanged: aiming for 7/7 consistency across all wards. Acuity and dependency will continue to be the ultimate driver to ensure sustained safe staffing levels.

The National Quality Board recommendations have been reviewed and embedded in practice, with this paper representing our third strategic staffing review that took place between February and March 2019.

10. Conclusion

The Board of Directors are asked to:

- Note the assurance of safe staffing across the Trust provided through this Strategic Staffing Review by the Chief Nurse & Director of Quality Governance.
- Note that despite the intense focus on staffing levels, nurse recruitment and retention remains a challenge and continues to be highlighted as a significant organisational risk on the Trusts Board Assurance Framework (BAF) and Risk Register.
- Support the actions to be undertaken following the staffing reviews in Q4 2018/19. Support the recommendation that registered nursing and midwifery levels need to be subject to continued scrutiny and that any incremental investment is to be made in line with recommendations that must follow Trust governance processes.

Helen Howard, Deputy Chief Nurse

Pauline Enstone, Assistant Chief Nurse for Recruitment and Retention.

April 2019

Appendix 1

Safe, Effective, Caring, Responsive and Well-led Care – Strategic Staffing Review

Ward Name	
Business Group	
Specialty	
Number of beds & layout	
Matron	
Ward Manager	
Clinical Lead	
Occupancy rates	
Average LOS	
Ward attenders	
Right Staff	
Total budgeted establishment	
Establishment providing clinical care	
Ward Manager Supervisory allocation	
WTE *(based on December acuity & dependency)*	
Difference	
Ward based registered nurses	
Ward based HCA's	
Skill mix	
WTE per bed	
RN ratio per bed Mon - Fri	
RN ratio per bed Sat & Sun	
RN ratio per bed nights	
CHPPD *Average number of actual nursing care hours spent with each patient per day (all nursing and midwifery staff, including support staff)*	
Acuity and Dependency Results	
Agreed actions following meeting	
To be discussed at the meeting	
Then include:	Numbers and time spent on wards
Medical Staff	

AHP's	
Pharmacy staff (including medication administration	
Assistant Practitioners (including band)	
Ward Clerk	
Housekeeper	
Hostess / Support Staff	
Phlebotomy	
HR Metrics	
Sickness levels	
Annual leave	
Parenting leave	
Secondments	
Student placements	
Patient Outcomes:	
Falls (including conversion to harm)	
Pressure Ulcers	
HCAI's	
Medication Errors (including conversion to harm)	
EWS audit results	
Cardiac arrest incidents	
Serious incidents Level 1 investigations Level 2 investigations Never Events	
Total incident numbers and conversion to harm	
Patient Experience Measures:	
FFT results	
Compliments	
Complaints	
Staff Outcomes:	
Exit interview themes / reasons given for leaving	
Staff FFT	
Staffing incidents	
Process Measures	
Nursing Metrics results & actions	
Patient Safety Audit & actions	
Ward attenders:	
Benchmarking (CHPPD) via Model Hospital	
Tameside & Glossop NHS FT	
Wrightington, Wigan and Leigh NHS FT	
Bolton NHS FT	
Right Skills	
Delivery of care	
What is the care and treatment to be provided on the ward	
What competencies are required to deliver that care / treatment	
Which staff member is competent and best	

placed to deliver that care / treatment	
Can aspects of the care / treatment be safely delegated with appropriate education and training (if so, to whom)	
What are all members of the team responsible for: Including service manager, matron, ward manager etc	
What is the skill mix	
Training levels (mandatory, PDR)	
Clinical training specific to the care delivery	
How do staff access training	
How have the ward leaders been prepared for their role and given on-going support	
Recruitment and retention	
Vacancy rate	
Turnover	
Age profile	
Recruitment plans	
Right Place, Right Time	
Work processes should be reviewed annually	
Shift patterns	
Sufficient rest periods	
Evidence of any lean methodology approaches?	
Part of a collaborative?	
Are there any new or redesigned roles	
Multi-professional documentation?	
Documentation reviews?	
Roster compliance	
Latest audit results of roster compliance	
Flexible use of the establishment	
Escalation processes	
Staff aware of process to escalate staff shortage / other concerns	

Measure and improve	
Plans to measure and improve outcomes	
To be completed during the meeting	

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date of Meeting:**	25 April 2019
Subject:	Finance and Performance Committee – Committee Effectiveness Report		
Report of:	Finance and Performance Committee	**Prepared by:**	COO / Deputy Coo DoF / Deputy DoF

REPORT FOR INFORMATION / ASSURANCE

Corporate objective ref: C12, C13 **Board Assurance Framework ref:** S05 **CQC Registration Standards ref:** **Equality Impact Assessment:** ☐ Completed ☒ Not required	**Summary of Report** It is regarded as "*best practice*" and a demonstration of robust, embedded governance structures for the Finance and Performance Committee to report formally each year to the Board of Directors and the wider trust organisation; on how it has fulfilled its statutory responsibilities and duties regarding effective assurance on matters relating to financial performance and operational delivery at Stockport NHS Foundation Trust. This report describes how the statutory responsibilities and duties of the Committee have been achieved during the period from April 2018 to March 2019. The Board of Directors are asked to note the progress and assurance against the duties and responsibilities that have been achieved by the Finance and Performance Committee from April 2018 to March 2019.
Attachments:	
This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☒ Finance & Performance Committee ☐ People and Performance Committee ☐ Executive Management Group ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

- THIS PAGE IS INTENTIONALLY BLANK -

1. Purpose of the Report

1.1 It is regarded as "*best practice*" and a demonstration of robust, embedded governance structures for the Finance and Performance Committee to report formally each year to the Board of Directors and the wider trust organisation; on how it has fulfilled its statutory responsibilities and duties regarding effective assurance on matters relating to financial performance and operational delivery at Stockport NHS Foundation Trust.

1.2 This report describes how the statutory responsibilities and duties of the Committee have been achieved during the period from April 2018 to March 2019.
It is regarded as "*best practice*" and a demonstration of robust, embedded governance structures for the Quality Committee to report formally each year to the Board of Directors and the wider trust organisation; on how it has fulfilled its statutory responsibilities and duties regarding effective quality related processes at Stockport NHS Foundation Trust.

1.3 The Board of Directors are asked to note the progress and assurance against the duties and responsibilities that have been achieved by the Finance and Performance Committee from April 2018 to March 2019.

2. Responsibilities of the Committee

2.1 The Finance and Performance Committee is responsible for advising, alerting and assuring the Board of Directors of Stockport NHS Foundation Trust pertaining to the:

- effective development and delivery of the Trust's financial plans; and
- delivery of key operational performance metrics and the effectiveness of management action to address any areas of underperformances.

2.2 The group has the powers to investigate any financial and operational activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

3.1 The membership for the April 2018 – March 2019 period comprised of:

- Non-Executive Director (Chair)
- Non-Executive Director x 3
- Director of Finance
- Chief Operating Officer
- Director of Workforce & Organisational Development
- Director of Planning, Strategy and Partnerships
- Chief Nurse (until November 2018)

In attendance:

- Director of Corporate Affairs
- Deputy Director of Finance
- Deputy Chief Operating Officer

Source of assurance: The Finance & Performance Committee Terms of Reference and attendance register

4. Meetings

4.1 The Committee met on 11 occasions during the period of April 2018 – March 2019. This was in accordance with the terms of reference, where no meeting is planned in August.

4.2 Meeting dates were scheduled and held as follows:

- 18 April 2018
- 16 May 2018
- 20 June 2018
- 18 July 2018
- 19 September 2018
- 24 October 2018
- 21 November 2018
- 12 December 2018
- 23 January 2019
- 20 February 2019
- 20 March 2019

Source of assurance: Attendance Record of the Finance and Performance Committee meetings.

5. Compliance with the Terms of Reference

5.1 The Committee has an annual work plan, which sets out the matters to be considered by the Committee. These have been categorised under the following headings:

- Financial Performance
- Annual Planning
- Strategic, Significant or Material Investments
- Capital Programme Management
- Commercial Activities
- Operational Performance
- Strategic Planning and Delivery

Source of assurance: The Finance and Performance Committee annual work-plan 2018 and meeting agenda's. The plan has been adhered to, and review against this plan has informed the proposed plan for 2019.

6. Brief Narrative Summary of Committee Progress in Year

6.1 April 2018 to March 2019 has been a period of intense activity, scrutiny, development and challenge for the Finance and Performance Committee; that can be demonstrated through the annual work-plan. Examples of key areas of focus have been:

a) Financial Performance

Assurance of Financial Performance is provided on a monthly basis through a report presented by the Director of Finance. The Financial Performance Report includes a summary of on month and year to date performance, progress against the Cost Improvement Programme, an update on Agency usage and performance against contracted levels of activity at all Points of Delivery. In addition, the report includes, on a less than monthly frequency, information on Service Line Reporting, Reference Costs and Procurement.

As the Trust has required revenue support from 2018/19 the committee received further information on the management of cash and the approval process for Treasury loans.

Source of Assurance: Monthly Financial Performance Report presented by the Director of Finance.

b) Operational Performance

The Finance & Performance Committee receives an Operational Performance Report each month that covers a core suite of metrics, aligned to the Trust Board Integrated Performance Report. This report includes the key performance indicators in the Single Oversight Framework, as well as key metrics associated with Urgent and Planned Care. Key risks highlighted in 2018/19 include performance against the Emergency Department 4 hour standard, the Cancer 62 day standard, Breast symptomatic 2 week wait, clinical correspondence and the Referral to Treatment targets.

Source of Assurance: Operational Performance Report presented by the Chief Operating Officer

c) Strategic Planning & Delivery

The Committee retains oversight of the development and delivery of the Trust Operational Plan, receiving assurance on progress through a series of draft reports and triangulating the accuracy of its contents with further information received on external strategic change programmes. In 2018/19, the Committee has overseen a review of the process for the development and submission of the 2018/19 Operational Plan and ensured lessons learnt were incorporated into the process for 2019/20.

The Committee considered the development of the Medium Term Financial Strategy prior to approval at the Board of Directors.

Source of Assurance: Progress against the development of the Operational Plan presented by the Director of Planning, Strategy and Partnerships. The Medium Term Financial Strategy presented by the Director of Finance.

d) Annual Planning

Annual Planning has included an annual review of the Financial Strategy and Treasury Management procedures. In addition, the Register of finance and performance-related risks is reviewed on a monthly basis to ensure mitigating actions are being taken and to understand the residual risk remaining. Progress against the relevant Strategic Objectives is also reported and overseen on a monthly basis and assurance is provided to the Committee.

e) Business Group Reports

The Committee receives Business Group specific reports on a cyclical basis to ensure it has a clear view of any emerging performance or finance risks. In 2018/19, the Committee have had deep dive reports into the RTT / waiting list recovery plan, cancer 62 day standard and the clinical correspondence performance.

Source of Assurance: Reports from the Chief Operating Officer to the Committee

f) Strategic, Significant or Material Investments

The Finance & Performance Committee considers Business Cases that require strategic, significant of material investments; this includes those cases that require investment of greater £1m. In addition to, the Committee receives the benefit realisation and post-implementation appraisal of projects and business cases. Examples of such Business Cases received in 2018/19 include Fluoroscopy scanner and CT scanner and Endoscopy room expansion in March 2019.

Source of Assurance: Report to the committee presented by the Director of Planning, Strategy and Partnerships

g) Capital Programme Management

The Finance & Performance Committee has oversight of the Capital Programme. This role includes receiving recommendations for the expenditure of the capital budget and making appropriate recommendations to the Board. In addition, the Committee has oversight of the progress of the delivery of the programme and receives regular updates through the Capital Programme Report. Further to this, the Committee undertakes an annual review of the Estates Strategy, the Electronic Patient Record Development (EPR) and the IM&T Infrastructure.

Source of Assurance: Capital Programme Report and other exception reports presented by the Director of Planning, Strategy and Partnerships

h) Commercial Activities

The Committee invites members of the Pharmacy Shop Board to update the Committee on the progress and performance of Stepping Hill Enterprises. These are due quarterly.

7. Terms of Reference:

7.1 The Finance and Performance Committee has carried out a review of its Terms of Reference which was approved by the Board of Directors in November 2018.

7.2 The Committee is able to escalate matters in a timely, effective manner to both the Board of Directors.

8. The Annual Work-Plan

8.1 The Annual work plan has been adhered to except in circumstances where deferral would provide greater information and degree of assurance or coincided with regional or national publications and guidance.

9. Key Objectives for Next Year: April 2019 – March 2020

9.1 Following the Interim Report of NHSI's Support, the Committee will be looking to:

a) Further development of the use of productivity and benchmarking metrics in Operational Reporting; and
b) The adoption of a more strategic, longer term, planning horizon for the delivery of the Service Efficiency Programme.

10. Recommendations

10.1 The Board of Directors are asked to note the progress and assurance that the Finance and Performance Committee has fulfilled its duties and responsibilities in line with its terms of reference, and to agree the key objectives for 2019/2020.

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25 April 2019
Subject:	Use of Common Seal		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

Corporate objective ref: -----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2017/18.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:	Nil

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2018-19.

2. USE OF COMMON SEAL

2.1 Authority to apply the Seal to relevant documents is detailed at Section 38 of the Trust's Scheme of Reservation and Delegation. Section 38 identifies that authority to apply the Seal is delegated to the Chair / Chief Executive or two Executive Directors. It is recognised good practice to report the occasions of use of the Seal to the Board of Directors on an annual basis.

2.2 During the period 1 April 2018 – 31 March 2019, the Trust's Common Seal was applied on a total of one occasion. This was:

Reg No	Date	Reason
135	15/2/10	ICD 2016 Intermediate building contract – ED patient streaming
136	15/2/19	MWD 2016 Minor works building contract – extension to HSDU

2.3 A Register of Use of the Common Seal is maintained by the Director of Corporate Affairs and includes both authorisation signatures and details of the final distribution of the relevant documentation. The Director of Corporate Affairs is responsible for the safe custody of the Common Seal. The Board of Directors can be assured that compliance with the requirements of Section 38 of the Scheme of Reservation & Delegation is being maintained.

3. LEGAL IMPLICATIONS

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

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note the occasions of use of the Common Seal as detailed at s2 of the report.

This page has been left blank

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	25 April 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
Board Assurance Framework ref:	SO 2
CQC Registration Standards ref:	10,17,18
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

The purpose of this report is to present the Quarter 4 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

The risk ratings against 4 principle risks have decreased this quarter; 3 remain unchanged.

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

The Board of Directors is asked to note the contents of the report.

Attachments: Annex A – Board Assurance Framework

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this report is to present the Quarter 4 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

2. BACKGROUND

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

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

3. CURRENT SITUATION

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

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

- Risk: Failure to achieve the 2018/19 developments set out in the Quality Improvement Plan
- Movement from 20 to 10
- The decreased risk rating is based on improved engagement both internally and externally and the ongoing work in order to provide sustained demonstrable improvements. The Quality Improvement Plan has delivered improvements across a range of metrics.

3.1.2 Strategic Objective 3: To strive to achieve financial sustainability

- Risk: Failure to maintain financial stability
- Movement from 12 to 4
- the decreased risk rating is based on the actions that have been enacted in order to deliver the financial plan

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

- Risk: Failure to deliver the operational performance metrics
- Movement from 20 to 15
- The decreased risk score is due to the improvement in performance around the 4 hour standard and occupied bed days by stranded patients.

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

- Risk : Failure to deliver the trust capital programme
- Movement from 16 to 8

- The decreased risk score related to the delivery of the revised capital programme.

3.2 Across the 7 strategic objectives, 2 did not meet or exceed their target risk score for the end of year.

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

- Risk: Failure to deliver the operational performance metrics
- Final risk score of 15 where the target was 10
- The likelihood of the risk occurring is higher than the target rating due to the 2 week wait breast service not being compliant and the 18 week RTT

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

- Risk: Failure to recruit develop and retain suitably skilled and motivated workforce
- Final risk score of 15 where the target was 10
- The likelihood of the risk occurring is higher than the target rating due to the continued work to embed the people strategy, culture and engagement work.

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

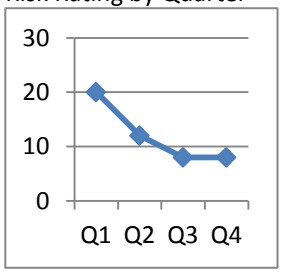
5.1 The Board of Directors is asked to note the contents of the report and support the proposed developments.

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

Principal risk	**There is a risk that if the strategy is not implemented it will result:** - **in missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience** - **inability to modernise services** - **delays in delivering integration** - **failure to engage effectively and lead developments with key partners** - **adverse partner perceptions of working with Stockport NHS Foundation Trust**

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
11 June 2018	July 2018	October 2018	Well Led NHSI – Use of Resources	Deputy Chief Executive & Director of Support Services	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	5	20	4	2	8	4	1	4	March 19

Executive commentary for the Current Risk Score

The mitigated score relates to the progress made and comments received from trust staff.

Corporate objectives

1a. To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy
1b. To lead the annual operational planning cycle in line with NHSI guidance.

Links to other Strategic Objectives:	SO2, SO3, SO4, SO5, SO6, SO7
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Strategy has not been finalised and embedded. Trust has sought external support from ATTAIN to assist with final product
Quarter 2 Commentary:	The draft refreshed trust strategy was approved at the Board in September 2018 and agreed to go out a three month consultation with staff and stakeholders.

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

Quarter 3 Commentary:	Consultation is in progress. Approximately 40 meetings with staff and stakeholders have been undertaken and more are planned in January. There have been face to face discussions with over 600 staff and as a result of their feedback, changes will be made. The revised strategy will be taken to the Board of Directors in February.
Quarter 4 Commentary:	The first phase of developing the trust strategy has been completed. An extensive engagement exercise took place with over 670 staff. Detailed feedback will be given to staff groups over April, May and June. This will run in conjunction with the development of the clinical services element of the strategy. This will require clinician engagement to ensure that it takes into consideration potential changes to clinical services over the next 5 years

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	No risks identified above 15						

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

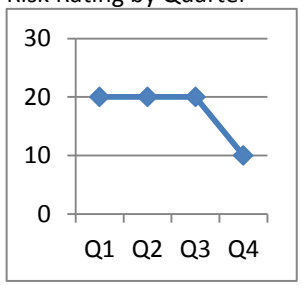
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

Principal risk	There is a risk that the Trust will fail to achieve the 2018/19 developments set out in the Quality Improvement Plan resulting in not consistently providing the safest, highest quality care to patients, their families and carers.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
13 April 2018	n/a as 1st assessment	October 2018	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Chief Nurse & Director of Quality Governance Medical Director	Quality Governance Group Patient Experience Group Safeguarding Group Medicines Management Group Infection Prevention and Control Group	Quality Committee

Risk Rating by Quarter



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	2	10	5	2	10	March 2019

Executive commentary for the Current Risk Score

The mitigated risk score is 10 which relates to improved engagement internally and externally. Current action plans are ongoing around the risk management strategy and framework and the quality governance framework, in order to provide sustained demonstrable improvements and associated assurances at ward, department and business group levels.

Corporate objectives

2a. To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy

2b. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.

Links to other Strategic Objectives:	SO3, SO4, SO5, SO7
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Clinical Services review was completed on the second of July to asses our position and improvement journey. Positive assurance for delivery of care. Areas of concern identified included safeguarding, polices and documentation. Safety and Quality Leadership meetings have

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

	commenced. Walk rounds by senior teams and governors have given positive assurance about patient experience.
Quarter 2 Commentary:	CQC unannounced inspection has been undertaken. Feedback has been mainly positive. Review and progress update has been undertaken on the Quality Governance Framework and Risk Management Framework and been viewed by sub-board committees. Review demonstrated partial assurance with both frameworks with further work to be undertaken
Quarter 3 Commentary:	CQC Well-led inspection has been undertaken. The final report was received in December. Significant improvements in core services with removal of inadequate ratings in safe and well-led. 12 "must dos" and 45 "should dos" in HSCA regulations; 5, 9, 15, 17 and 18. QIP on track to deliver
Quarter 4 Commentary:	QIP has delivered improvements across a range of metrics. The quality governance framework and RMF have supported staff to deliver improvements from ward to board, however strengthening the implementation the understanding of these frameworks continues to be required particular around risk management. Quarter 4 saw external recognition for the improvements to the quality and safety of the services delivered . Key focus areas have been identified to take forward to the next interaction of the quality improvement plan.

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
46	There is a risk that the telepath server will fail	20	06/04/2018				
130	Failure to deliver the 4 hour target	20	01/09/2017				
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	20	02/07/2018		Approved		↑ 20 from 16
457	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	20	19/04/2018			↑16 from 12	↑20 from 16
183	Failure to meet the 62 day Cancer target standards	16	20/04/2010		16 ↓ from 20		
618	There is a risk of a failure to recognise and adequately treat sepsis within our organisation	16	14/08/2018			↑16 from 12	
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	14/02/2018				
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
78	Registered Nurse Vacancies	16	21/11/2016	↓ from 20			
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			Approved	
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	05/10/2018			Approved	
869	There is a risk of harm to patients with current medical staffing levels and	16	03/12/2018				Approved

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

	threat to sustainability of Neonatal Unit						
872	There is a risk to patient experience and safety due to endoscopy capacity	16	04/12/2018				Approved
934	There is a risk of reduced critical care capacity due to staffing shortages	16	28/01/2019				Approved
231	Lack of consultant microbiologists and nursing team in IP service	15	02/10/2017				15 ↓ from 20
476	There is a risk of not achieving empiric review of antibiotic prescriptions and reduction in antibiotics CQUIN 18/19	15	09/05/2018		approved		
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non-confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
576	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	01/06/2018				
499	There is a risk that complaints responses are not being completed within Trust timescales	15	07/06/2018				
363	There is a risk that that lack of Laryngoscopy and Microlaryngoscopy sets are causing theatre time to be extended	15	06/02/2018				↑9 from 15
905	There is a risk of severe service disruption if we have failures of flexible endoscopes	15	10/01/2019				Approved
286	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	15	22/11/2017			Closed	
96	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	23/03/2017			12↓	
75	Lack of consultant in palliative care team	16	02/11/2016				Closed
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017		Closed		
506	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	11/06/2018			Closed	
126	Surges in demand in the Emergency Department	16	11/05/2016	↓ to 12			
137	Pressure ulcers	16	01/09/2016	↓ to 9			
160	Policies and procedures	15	17/11/2011	↓ to 8			
288	Central Venous Access Device Service	15	27/11/2017	↓ to 9			
362	Ketone Testing	15	04/02/2018	↓ to 9			
296	Blood Pressure monitors	15	06/12/2017	Closed			
358	Location of the AI unit	15	26/01/2018	↓ to 9			

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

346	Use of escalation beds	15	09/01/2018	Closed			

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Quality Governance & 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 Governance oversight*	• 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 Governance Report: Partial	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*

				throughout the document)	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-		

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

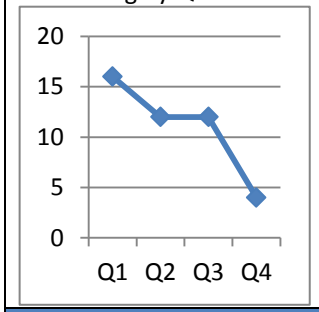
					January 2015 • CQC RI rating- October 2017 • Quality Account- April 2019 • Quarterly Review Meetings with NHSI		
13	Learning from Deaths Policy & Mortality Review Process	Report to Quality Committee	• Mortality and Morbidity Reviews • Learning from Deaths Process • 1:1 Meetings • Patient Safety Summit • 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 Safety Collaborative April 2018
13	7 Day Clinical Services	Clinical Directors Forum	1:1 / Team meetings Business Group Quality Boards Monthly Performance Meetings	• Quality Governance Group			

Strategic Objective 3:
To strive to achieve financial sustainability

Principal risk	Risk of failure to maintain financial stability which may impact on the Trust's compliance with the NHS Improvement Provider Licence

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led NHSI -Finance and use of resources	Director of Finance	Executive Management Group Financial Improvement Group	Finance and Performance Committee

Risk Rating by Quarter



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	1	4	4	1	4	31/03/2019

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, through grip and control actions across all business groups, use of one off non recurrent resources and expected level of winter escalation costs being lower than anticipated

Corporate objectives

3a. To ensure full compliance with the NHSI Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services
3b. To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services
3c. To review and monitor a revised performance management framework

Links to other Strategic Objectives:	SO1
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	The trust has achieved its Q1 financial performance and is slightly behind on the CIP performance in the period. The trust faces considerable financial risk described above and needs to continue with close monitoring
Quarter 2 Commentary:	The Trust has delivered the financial plan at the end of quarter 2. Whilst the Trust delivered the CIP plan to the end of September, there remains a

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

	significant shortfall for the financial year. The Trust has drafted a recovery plan to provide high level assurance in delivery of the plan. However, due to a number of risks including: i) Winter escalation plan ii) Elective and day case performance iii) Impact of penalties The trust is only able to forecast a moderate level of assurance. This issue is discussed at Finance and Performance committee, Board of Directors and NHSI Enhanced Oversight meetings.
Quarter 3 Commentary:	At the end of Q3, the trust has achieved its financial plan. There are still a number of risks to the delivery of year-end financial plan which are being managed in the following way. i) Grip and control actions within the Business Groups ii) Agreement with commissioners on the remuneration of winter costs alongside not evoking penalties iii) A review of the all available reserves and provisions to mitigate the risks. The trust has been rated as inadequate against use of resources in the latest CQC report. The report highlights number of improvement opportunities which are expected to be implemented through the clinical services efficiency programme
Quarter 4 Commentary:	At this stage of the financial year, the trust is presenting a significant assurance of the delivery of the 2018/19 financial plan. The trust has delivered against all the key risks summarised in the Q3 Commentary. Attention is now turning towards the development nd delivery 2019.20 financial plan and the medium term fianial sustainability plan.

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018		approved		
461	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19	16	23/04/2018				
466	There is a risk that the BG will fail to deliver the CIP Target	16	28/04/2018				
127	There is a risk that the BG overspends due to agency costs	16	22/06/2017				
469	There is a risk that the Trust will not deliver its 2018/19 financial performance	15	30/04/2018				↓15 from 20
476	There is a risk of not achieving empiric review of antibiotic prescriptions and reduction in antibiotics CQUIN 18/19	15	09/05/2018		approved		
458	There is a risk of not achieving the Theatre & Endoscopy CIP Programme 2018-19	16	19/04/2018			Closed	
101	There is a risk that the Trust will not have sufficient cash reserves to operate	20	05/07/2017		10↓		
305	There is a risk that the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements	15	14/11/2017		↓10		
469	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	30/04/2018		↓10		

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

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Long term health economy with clear governance structure	• COO & DOF bi-weekly meetings with SRO's • 1:1 / Team Meetings • Business Group Accountants 1:1s • Bi-weekly Exec-BG finance meetings • FIG • *FIG minutes/KIR* • EMG	• Monthly Performance Meetings • Finance & Performance Committee • Internal Audit Reports to Audit Committee • Board of Directors • Board of Directors minutes • F&P Minutes/KIR • Annual budget/planning • Monthly Integrated Performance Report Contracting and activity finance group Quality Governance Committee	• NHS Improvement Segment 3 (July 2017) (Segment 3= Providers identified as 'Challenged' status). • NHS Improvement-submitted annual plans & feedback provided • Internal Audit Programme • NHSI enhanced financial oversight meetings monthly • External interim CIP support • Executive contract Group with CCG	• Use of Resources metric assessment • Routine use of Model Hospital • Wider understanding of the Trust's financial challenge	• Transformation projects • Cost Improvement Plan • Quality Impact Assessments • CCG contract in place.
2	Identified CIP schemes	• Well-Led / Use of Resources initial review required (NHSI Framework).						
3	Monthly finance & activity review meetings	• Review of financial /activity delivery						
4	Performance management reporting systems	• Review of delivery and identification of improvement plan						
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					

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

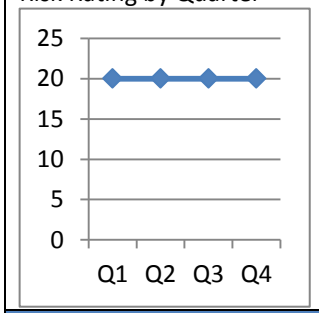
			• Business Group Accountants 1:1s • Weekly CIP development meetings chaired by COO • Operational performance group to hold Business Group directors to account				

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

Principal risk	**Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial sustainability and viability due to:** - **Lack of full engagement – being a key partner** - **Failure to engage effectively and lead the development of the local health economy** - **Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change** - **Partners perceptions of working relationships with Stockport NHS Foundation Trust**

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Safe, effective, responsive and well led NHSI – Quality of care, operational performance, strategic change	Chief Operating Officer	Executive Management Group	Alliance Provider 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	5	20	31/03/2019

Executive commentary for the Current Risk Score

The governance arrangements have been reviewed and a revised provider board is in place; however there is still ongoing delay with implementing the new models of care within the neighbourhoods and within outpatients. There is also the need to review progress with the ambulatory care model.

Corporate objectives

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Revised arrangements are in place, however timescales within this are ambitious and may lead to further delay in expected outcomes

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

Quarter 2 Commentary:	The governance arrangements have been reviewed a revised provider board is in place; however there is still ongoing delay with implementing the new models of care within the neighbourhoods and within outpatients. There is also the need to review progress with the ambulatory care model.
Quarter 3 Commentary:	The provider board has been unable to meet in the later part of Q3, thus resulting in little progress. Leadership and governance arrangements are being reviewed by Stockport System Senior Leadership (CEOs) in January to refocus priorities.
Quarter 4 Commentary:	Stockport Health Partnership Board has been formed, which includes the senior leaders of all the health providers only. SMBC have withdrawn from the Stockport Together programme. Stockport Together brand has been superseded by Stockport Health Partnership. We are continuing to work as a system to deliver the best outcomes for patients. There are Terms of Reference, for the partnership, however the governance structures have not been defined. We are currently undertaking an evaluation of the benefits realisation to date.

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)		
1	Engagement in Stockport Provider Alliance Board	• Trust Strategy	• 1:1's • Team meetings	• Executive Management Group • Board of Directors	Greater Manchester Combined Authority	• Scale & pace of change • Relationship building with key partners • Governance Arrangements	

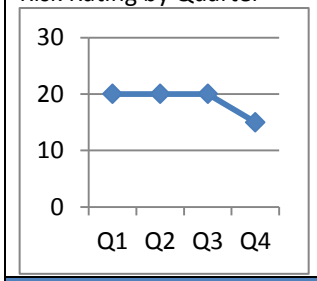
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led, safe NHSI Leaderhip and improvement capability	Chief Operating Officer	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter



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	3	15	5	2	10	31/10/2018

Executive commentary for the Current Risk Score

The mitigated score is due to the improvement in performance around the 4 hour standard and occupied bed days by stranded patients. Breast 2 week wait is no longer compliant.

Corporate objectives

5a. The Trust will complete an independently assessed Well Led Review by 30 September 2018
5b. The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improves access to care by 30 September 2018
5c. The Trust will comply with its trajectory for improvement against the 4 hour A&E target, with actions identified in the Stockport System Urgent Care Plan
5d. The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Emergency department performance met improvement trajectory. RTT diagnostics and Cancer did not meet target. Quarter 2 trajectories have been realigned for improved performance. Significant assurance for diagnostics and cancer for quarter 2
Quarter 2 Commentary:	There has been a deterioration in the emergency department performance which has a direct correlation to the increased number of stranded patients which represent more than 50% of the acute trust bed base. The Board has agreed that patient flow will be the prime focus for improvement by reducing overnight breaches, earlier in the day discharges and stranded patients. It is recognised that the reduction of stranded

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

	patients requires a system wide solution. Diagnostics is compliant. Improvement trajectories for cancer are in place for Q3. The area of concern would be breast 2WW and this has been escalated to GM and NHSI for partner support and resolution. The RTT recovery plan has been complied in partnership with colleagues from the CCG based in the reduction of GP referred activity through CCG-led referral management schemes. Comprehensive data validation. A clinical review of discharge criteria and clinical management. We have commenced a review of inpatient medical ward management. The delivery director has commenced and has undertaken a full review of flow across the organisation and implemented a robust monitoring system to meet expected standards. Well led review in October.
Quarter 3 Commentary:	Benefit realisation of system wide plans have not come to fruition. Performance regarding the 4 hour target remains under trajectory. This is unacceptable. System wide stranded patient board is reviewing in-hospital, out of hospital and out of areas drivers. Winter plans have not been able to be fully implemented due to staffing constraints. Cancer performance has seen a significant improvement in the later part pf Q3 with an expected continued improvement on Q4. Breast 2 week wait is now compliant. Focus has been on reducing the RTT waiting list size to March 18 levels. The trust remains at a 4%behind improvement trajectory but has seen an increase in GP referrals of 4.5%.
Quarter 4 Commentary:	Q4 has seen improvement in performance around the 4 hour standard and occupied bed days by stranded patients. Breast 2 week wait is no longer compliant and remains a fragile service. Review is being undertaken of options in terms of future delivery by SFT. Cancer 62 day remains a challenge within trajectory into 2019/20. Focus has been on reducing the RTT waiting list size to March 18 levels. The trust remains at a 4% behind improvement trajectory but has seen an increase in GP referrals of 4.5%. Developing consistent services across 7 days remains one of our fundamental challenges. During service developments, we ensure that provision across seven days is a major consideration. In line with national standards, we have introduced a quarterly board update on progress against this important and challenging agenda. We have seen the benefit of this approach over this year, and will continue to seek opportunities for stepwise improvements towards the consistent delivery of all ten national standards.

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
130	Non delivery of ED 4 hour performance	20	01/09/2017				
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	20	02/07/2018		Approved	↑20 from 16	
872	There is a risk to patient experience and safety due to endoscopy capacity	16	04/12/2018				Approved
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
183	Failure to meet the 62 day cancer target standards	20	20/04/2010		↓16		
506	There is a risk that winter pressure son ED, patient flow and capacity will affect the delivery of the 2018 – 19 elective plan in ortho	16	11/06/2018			Closed	
96	There is a risk of lack of capacity for timely outpatient reviews in the ophthalmology department	16	23/03/2017			12↓	
286	There is a risk to patient experience due to Endoscopy capacity and demand	15	22/11/2017			Closed	
162	There is a risk to the Trust maintaining unconditional CQC registration which	15	06/07/2017			12 ↓	

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

	may have a detrimental effect on patient safety, quality experience and Trust reputation						

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Bi- Monthly Performance Reports	• External influences on medically fit for discharge patients • Insufficient community capacity • Failure to deliver sustainable Stockport Together programme •	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Monthly Performance Management Group Meetings • Operational Performance Group • OPG minutes and KIR	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors • Executive Management Group	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • Urgent and Emergency Care Delivery Board • Internal Audit Programme:	•	
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	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG		

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

			Boards • Monthly Performance Management Group Meetings • Finance improvement Group • Operational Performance Group • OPG minutes and KIR	• Executive Management Group	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 Group Meetings • Financial Improvement Group (FIG)	• 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	
4	Emergency Planning (EP) & Business Continuity	•	• 1:1 meetings • Desktop exercises	• Emergency Planning Group • Board of Directors • NHSE Emergency Preparedness, Resilience and Response Self-	• Emergency Preparedness, Resilience and Response NHS England submitted-when did we submit?		

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

				Assessment Substantial Assurance Return-October 2017 – did that go in			
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 management Group • 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	• Operational performance group • Cancer Board	• Executive management Group • Finance and performance committee	• CQC • NHSI • GMCA		

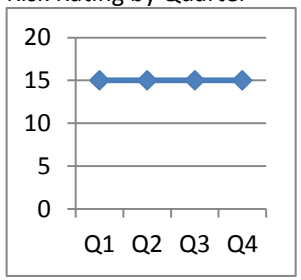
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

Principal risk	There is a risk that the trust fails to recruit, develop and retain suitably skilled and motivated workforce

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July	n/a as 1st assessment	October 2018	Safe, effective responsive caring NHSI – use of resources	Director of Workforce & Organisational Development	Workforce efficiency Group Culture and Engagement Group	People and Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	3	15	5	2	10	31/03/2019

Executive commentary for the Current Risk Score

Current mitigation includes recruitment and retention strategy, comprehensive 3-5 year People Strategy, comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work using the NHSi Culture Programme. Direction of travel is positive and further delivery will reduce the risk score.

Corporate objectives

6a. To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum

6b.To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement

6d. To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage

Links to other Strategic Objectives:	SO2, SO3
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Good performance against workforce KPI's and significant progress in the development of the people strategy with active engagement from workforce groups

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

Quarter 2 Commentary:	Key workforce KPIs remain stable. Recruitment to key medical posts. Agencies spend above cap. Enhanced retention strategy and culture plan.
Quarter 3 Commentary:	Progress continues on KPI performance and recruitment strategies that have been implemented have started to reduce agency spend. Culture programme has been launched. Enhanced retention strategy continues to be a priority.
Quarter 4 Commentary:	We have delivered and reported to Board that we are on target to deliver the people strategy trajectory for 18/19 Culture programme – signed up and launch date in May 2019 Leadership and development – delivered the planned board development programme for 18/19. We have commenced the Business group triumvirate development programme and have plans and funding in place for a parallel deputies programme and Business Manager / ward manager level programme is currently under development International recruitment is in progress Significant reduction of the use of agency and have met the trajectory for staff in post at end of 18/19. 91.5%

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
124	Use of temporary staffing	20	07/01/2016		↑20 from 12		
457	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	20	19/04/2018			↑16 from 12	↑20 from 16
869	There is a risk of harm to patients with current medical staffing levels and threat to sustainability of Neonatal Unit	16	03/12/2018				Approved
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
78	Registered Nurse Vacancies	16	21/11/2016				
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	05/10/2018			Approved	
934	There is a risk of reduced critical care capacity due to staffing shortages	16	28/01/2019				Approved
231	Lack of consultant microbiologists and nursing team in IP service	15	02/10/2017				↓15 from 20
587	There is a risk to the operation of the Trust electronic systems due to the need to recruit senior IT Technical support	15	25/05/2018		approved		
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
75	Lack of consultant in palliative care team	16	02/11/2016				Closed
108	Failure to provide a robust imaging service due to reduced radiographer	16	01/08/2016		↓8		

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

	staffing						

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Recruitment and retention strategy: Building line manager capability Using reward in recruitment and retention Targeted recruitment	• GM theme 3 – employer 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.	• WEG • CEG • Staff survey • Workforce reports • Staff friends and family • Workforce KPI's • Temporary staff meetings • JLMC • JNC • Training needs analysis • Schwartz rounds	• People and performance Committee • Executive management board • Trust Board	• Greater Manchester Combined authority • NHSI • CQC	• Employment market – key skills shortage • Building leadership skills to support change and improvement	• Workforce remodelling • Proactive workforce plan • Just culture programme

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

	campaigns Socially responsible employer Develop the organisation as a socially inclusive employer Maintaining links with Jobcentre Plus Induction	• 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 • 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					

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

	Development and career planning	• 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 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	• NHSI culture programme ○ Culture dashboard					

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

	programme	○ Diagnostic ○ Focus groups ○ Action planning • Triumvirate leadership programme • Ongoing coaching and development and support					
3	People strategy: Education & Practice Development Culture & Engagement Leadership Development Resourcing	• Signed off strategy • Develop skills & competencies to ensure the highest levels of patient care • Fully developed coaching framework that offers skilful coaching support to individuals and teams • Equality advocate role developed to support EDS2/WRES/WDES, and used to develop proactive EDI approach • 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					

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

	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					

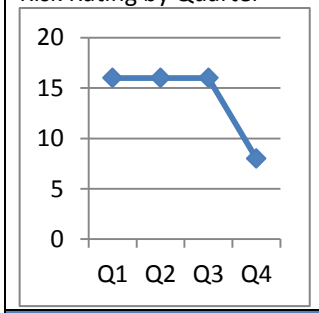
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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 in not delivering the trust capital programme in a planned and efficient manner

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	Not applicable	October 2018	Well led NHSI finance and use of resources	Director of Support Services / Deputy Chief Executive	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	3	12	4	2	8	4	3	12	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score is 8 which relates to the delivery of the capital programmes. Benefits of EPR have not yet been realised and there is a delay in go live.

Corporate objectives

7a. To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology
7b. To refresh the Estates Strategy based on the six facet survey and master planning information
7c. To manage investment relating to the Trust's capital programme to:

I. Medical equipment
II. IT
III. Estates

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	There is a reduced planed spend, agreed capital programme against risk assessed concerns. Benefits of EPR have not yet been realised and there is a delay in go live.

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

Quarter 2 Commentary:	Use of resources has been completed. Our service improvement strategy is being developed to incorporate model hospital and other benchmarking systems. These will then be linked to the cost improvement programme. Financial risk around the capital programme
Quarter 3 Commentary:	The capital programme is on track across each of the 3 areas; IM&T, estates and medical equipment. The estates programme has been influenced by the estates strategy during 2018/2019 but particularly for future years. The only area where the capital programme is behind plan are the healthier together schemes as the monies have not yet been allocated. In order to create the environment that maximises the use of resources, a significant amount of capital will be required to improve the estate. The trust was informed last month that the wave four bid had not been supported and therefore the first step for the strategic change that is required is not in place. However the trust is preparing a number of strategic outline cases to support the estates strategy. However the cases will require a significant amount of cash
Quarter 4 Commentary:	The revised capital programme was delivered as planned across estates, IT and medical equipment. However the revised capital allocation has led to the Trust doing very little in the way of developments, as the bulk of spend is on remedial work and equipment coming to the end of its life.

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018		approved		
46	There is a risk that the telepath server will fail	20	06/04/2018				
513	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards	15	14/06/2018		approved		
363	There is a risk that that lack of Laryngoscopy and Microlaryngoscopy sets are causing theatre time to be extended	15	06/02/2018				↑9 from 15
905	There is a risk of severe service disruption if we have failures of flexible endoscopes	15	10/01/2019				Approved
638	There is a risk to non-compliant with HSE guidelines due to CL3 room access and sealing	15	28/08/2018		approved		↓12 from 15
167	Due to Lack of secure storage facilities on wards / units causing insecure patient records leading to failure of CQC / ICO standards in relation to confidentiality of patient information	16	29/09/2017			Closed	
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017		closed		
399	There is a risk to patient care due to the potential Failure of PACs Infrastructure	15	27/02/2018	Closed			
354	The risk of abduction or paediatric patient absconding.	16	18/01/2018		closed		

SO2	

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

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

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

This page has been left blank