NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

28 FEBRUARY 2019

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 28 February 2019

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NHS Stockport NHS Foundation Trust

Board of Directors Meeting
Thursday, 28 February 2019

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

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		**A Belton**
0935	**4.**	Patient Story		**A Lynch**
	5.	**OPENING MATTERS**		
0955	5.1	Minutes of Previous Meeting: 31 January 2019	✓	**A Belton**
1000	5.2	Chair's Report	✓	**A Belton**
1005	5.3	Chief Executive's Report	✓	**L Robson**
	6.	**PERFORMANCE**		
1020	6.1	Performance Report	✓	**H Mullen**
1050	6.2	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
1055	6.3	Strategic Planning Approach	✓	**H Mullen**
	7.	**FINANCE & QUALITY**		
1120	7.1	Seven Day Service – Board Assurance Submission	✓	**C Wasson**
	8.	**GOVERNANCE**		
1130	8.1	Trust Risk Register	✓	**A Lynch**
1140	8.2	Registration Authority – Annual Report	✓	**H Mullen**
	9.	**DATE, TIME & VENUE OF NEXT MEETING**		
	9.1	Thursday, 28 March 2019, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.		

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STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public on Thursday, 31 December 2019 9.30am in Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Ms H Brearley	Interim Director of Workforce & OD
Mr P Buckingham	Director of Corporate Affairs
Dr M Cheshire	Non-Executive Director
Mr D Hopewell	Non-Executive Director
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
Mr M Sugden	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

In attendance:

Mrs S Curtis	Membership Services Manager
Mrs H Howard	Deputy Chief Nurse
Mr D Malcangi	Patient
Mr L O'Brien	Business Change Manager
Mrs E Rogers	Matron for Patient Experience

01/19 Apologies for Absence

An apology for absence was received from Ms A Smith.

The Chair welcomed Board members and observers to the meeting.

02/19 Declaration of Interests

There were no interests declared.

03/19 Chair's Opening Remarks

The Chair welcomed Mrs L Robson to her first Board meeting since her appointment as Chief Executive of the Trust.

Mrs H Howard, Mr D Malcangi, Mr L O'Brien and Mrs E Rogers joined the meeting.

04/19 Patient Story

The Chair reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board providing real and personal examples of the issues within the Trust's quality and safety agendas. The Chief Nurse welcomed Mr D Malcangi (patient / war veteran), Mr L O'Brien (Business Change Manager), Mrs H Howard (Deputy Chief Nurse) and Mrs E Rogers (Matron for Patient Experience) to the meeting. She provided a brief overview of the Veteran's Passport project, noting that the project had commenced as a result of comments left by Mr D Malcangi on the Care Opinion in July 2018 where he had raised concerns about his care. The Board watched brief films of 'Daniel's Story' and an educational video that would be used to raise awareness of the Veteran's Passport. Mr L O'Brien advised that the idea behind the passport was to stop veterans having to answer potentially difficult questions. He guided the Board through a 'roadmap' which detailed the journey of the project. Mrs E Rogers then provided an overview of next steps which included awareness raising and staff education.

In response to a question from Dr M Cheshire, Mr D Malcangi explained the difference the new approach had made from his perspective, noting that the Veteran's Passport provided a 'safety net' that hadn't previously been available. In response to a comment from Mrs C Anderson, The Medical Director noted the importance of clinical staff understanding patients' needs to enable them to treat and support patients with complex needs. He also commented that the story had highlighted how relatively simple changes could make a big difference to patient experience. Mrs H Howard advised that the support of Dr D Sandher, Associated Medical Director for Trauma & Orthopaedics, had been instrumental in moving the project forward and noted a multi-disciplinary team approach to the project.

In response to a question from Dr M Cheshire, Mrs H Howard advised that once the project had been embedded into practice, consideration would be given to ways in which the model could be implemented in other areas. Mr D Malcangi wished to thank the Trust for the excellent care he had received, making particular reference to his experience with the Orthopaedic department. The Board of Directors thanked Mr D Malcangi for sharing his story and for being an instrumental part of the Veteran's Passport project.

The Board of Directors:

- Received and noted the Patient Story.

(14 minutes)

Mrs H Howard, Mr D Malcangi, Mr L O'Brien and Mrs E Rogers left the meeting.

05/19 Minutes of the previous meeting

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

(10 minutes)

06/19 Chair's Report

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. He noted the continuing adverse weather conditions and, on behalf of the Board, wished to thank all staff for making extra efforts to get to work. The Medical Director endorsed these comments and noted examples of some clinical staff that had come to work on their days off to enable continuation of services. The Chair also noted the imminent retirement of the Director of Corporate Affairs and, on behalf of the Board of Directors and the Council of Governors, thanked him for his tremendous support and advice and wished him the very best for his retirement.

In response to a question from Mr M Sugden, the Director of Strategy, Planning & Partnerships advised that the Finance & Performance Committee would have oversight of tracking progress against the recently published NHS Long Term Plan. He also noted that a report on the subject matter would be considered later on the agenda. Mrs C Anderson advised the Board of changes to Patient-Led Assessments of the Care Environment (PLACE) assessments following a major review and noted that, as a consequence, the next assessment had been rescheduled for September 2019. The Chief Nurse advised that the next Strategic Staffing Review would be presented to the Board of Directors in April 2019, and not in March as previously indicated.

The Board of Directors:

- Received and noted the Report of the Chair.

(5 minutes)

07/19 Report of the Chief Executive

The Chief Executive presented a report which provided an update on national and local strategic and operational developments. She briefed the Board on the content of the report and provided a detailed overview of developments relating to:

- Chief Executive – General Summary
- Cheshire East Place
- Brexit Preparations.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

(8 minutes)

08/19 Key Issues Reports

The Chair noted that, as previously agreed by the Board, the Committee Key Issue Reports would be referred to during consideration of the Trust Performance Report. He welcomed Committee Chairs to raise any key issues that were not covered in the report content.

Quality Committee

Dr M Cheshire presented a Key Issues Report which detailed matters considered at a meeting of the Quality Committee held on 22 January 2019. He referred the Board to the 'Alert' section of the report wished to draw the Board's attention to preparation of a proposal for a revised Safeguarding Structure to provide more robust and sustainable services in the support of vulnerable adults and children. The Chief Nurse advised that a separate report on this subject matter would be considered later on the agenda.

Dr M Cheshire then referred the Board to the 'Advise' section of the report and advised that the Committee had noted a Limited Assurance outcome from an audit on the Sepsis bundle carried out on the Acute Medical Unit. He noted that, following triangulation of this information with an adverse position on the Sepsis Inpatient CQUIN, the Committee would be looking to seek assurance on progress being made in this area by the Sepsis Steering Group. Finally, Dr M Cheshire advised the Board that the Committee had taken positive assurance from a report on National Joint Registry Results via a Key Issues Report from the Quality Governance Group. He advised that the report had detailed compliance with data input and the maintenance of excellent results and revision rates across a range of trauma and orthopaedic procedures.

Finance & Performance Committee

The Board of Directors received and noted the Finance & Performance Committee Key Issues Report from a meeting held on 23 January 2019.

People Performance Committee

Mrs C Anderson presented a Key Issues Report which detailed matters considered at a meeting of the People Performance Committee held on 24 January 2019. She advised that the Committee had taken positive assurance on the effective working of the Trust's Freedom to Speak Up arrangements from a report presented by the Freedom to Speak Up Guardian. Mrs C Anderson also advised that the Committee had received an excellent presentation from Physician Associates regarding their role. Both Mrs C Anderson and the Chief Executive commended the presentation and noted, in particular, future opportunities provided by the role and the positive impact the role had on continuity of care.

The Board of Directors:

- Received and noted the Key Issues Reports.

(5 minutes)

09/19 Trust Performance Report – Month 9

The Director of Strategy, Planning & Partnerships presented the Trust Performance Report for Month 9 and provided an overview of key changes to the indicators as detailed in the Executive Summary. The Chief Nurse then briefed the Board on the Quality section of the report and provided an overview of the following subject areas:

- Emergency C-Section Rate
- Falls
- Hospital Acquired Pressure Ulcers
- Community Pressure Ulcers
- Medication Errors
- Strategic Executive Information System (STEIS) reported incidents

The Medical Director then briefed the Board on mortality indicators. He advised the Board that the Quality Committee had recently undertaken a deep dive into mortality metrics and it had been noted that the HSMR metric was more likely to be affected by recording and coding issues rather than high death rates in hospital. The Medical Director briefed the Board on developments in this area and noted that he would be leading Cohort 3 Quality Improvement Programmes regarding the improvement of mortality metrics. The Chief Executive commended this approach and noted that the Medical Director leading the programme would send a strong signal to the organisation regarding the importance of this subject area.

In response to a question from Mrs C Barber-Brown, the Chief Nurse briefed the Board on maternity-related incidents reported on the Strategic Executive Information System (STEIS) and noted that the Trust was in line with the region with regard to maternity diverts. She advised that further review was to be undertaken regarding the reporting criteria. The Chair made reference to a number of performance improvements and queried how the Board would receive assurance that the improvements were embedded and sustained. The Director of Corporate Affairs noted that a good example was the work on the CQC Improvement Plan and the associated approach. He advised that the Quality Committee had received a report at its most recent meeting closing off majority of the actions and that any remaining actions were brought forward to the 2019/20 action plan. The Chief Nurse made reference to the Transactional Action Plan and noted that transformational work would ensure that actions were embedded.

The Medical Director noted the significant improvement of the Trust's governance structure and the consequent clarity of key focus areas. The Interim Director of Workforce noted the importance of gaining 'hearts and minds' of staff as they would be key in taking the improvements forward. This comment was endorsed by the Chief Executive who noted a link to an important cultural and leadership piece of work.

The Chief Operating Officer then briefed the Board on key issues relating to Operational Performance and reported a deterioration in the Diagnostics 6-week standard. She briefed the Board on issues regarding this standard and advised that the failure to achieve the target was mainly due to a national shortage of contrast medium which was required to undertake MR examinations. She also noted that the

significant increase in referrals, particularly regarding 2-week waits, had an adverse impact on the target. The Chief Operating Officer was pleased to report a significant improvement in performance against the Cancer 62-day standard, which had improved by 12.6% since November 2018. She noted, however, that diagnostic capacity and the sustained increase in referrals continued to challenge compliance with the standard. The Chief Operating Officer commented that, while the Trust performed favourably compared to the Greater Manchester (GM) average, the 22% increase in referrals would form part of contract discussions with the CCG as it was unlikely that the continued growth would be mitigated any time soon.

With regard to Clinical Correspondence, the Chief Operating Officer noted the far reaching ramifications of this standard on performance in areas such as Cancer and Referral to Treatment. She briefed the Board of work in this area and noted that an associated report would be presented to the Finance & Performance Committee in March 2019. The Chief Operating Officer advised the Board that three 12-hour trolley waits had been reported in December 2018, but that no patient harm had been identified as a result of the breaches. She provided assurance to the Board that elective activity was improving in January 2019, particularly around surgical activity against plan. With regard to Urgent Care, the Chief Operating Officer advised that future Performance Reports would include information on the key targets relating to stranded patients, overnight performance and early discharges. She also advised that the Trust's Type 1 performance was improving compared to the GM average which was deteriorating.

In response to questions from Mr D Hopewell, the Chief Operating Officer briefed the Board on actions to improve Urgent Care performance and acknowledged the need for the Board to be better sighted on work in this area. She also advised that detailed analysis was ongoing to obtain a clearer understanding of Type 1 benchmarking. With regard to ambitions in this area, the Chief Executive commented that further clarity was required regarding targets and timescales but noted the significant work that was ongoing to improve the position. In response to a question from Dr M Cheshire, the Chief Operating Officer briefed the Board on issues relating to the increase in Cancer referrals and noted a need to ascertain whether GPs were using the 2-week referral pathway appropriately. The Director of Strategy, Planning and Partnerships reiterated that the continued increase in referrals would form part of contract negotiations. Mr M Sugden made reference to a report presented to the Finance & Performance Committee on issues regarding the 62-day Cancer target and noted that the Committee had requested that the recommendations detailed in the report be implemented.

In response to a question from Mrs C Barber-Brown, regarding an increase in 12-hour trolley waits, the Chief Operating Officer and Medical Director briefed the Board on mitigating actions in this area, noting that the key to resolving the issue was improving patient flow. The Chief Operating Officer noted that, whilst not ideal from a patient experience perspective, sometimes the Emergency Department was the safest place for a patient, for example on occasions when the hospital was inundated with cases of flu. In response to a question from Mrs C Anderson, the Chief Operating Officer advised that urgent work was ongoing with partners to establish alternative service provision to take the pressure of the Emergency Department. She noted that one piece of work that required urgent commissioning was the Urgent Treatment Centre model. The Chief Executive commented that the Stockport Urgent & Emergency Care

Board, which she chaired, was an important vehicle to progress developments in this area. She noted that system-wide commitment was required to increase out of hospital service provision. 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.

The Director of Finance briefed the Board on Finance key issues. He provided an overview of the Income & Expenditure position and reported significant assurance regarding the delivery of the 2018/19 Financial Plan. With regard to the Cash position, the Director of Finance reported that the Trust was forecasting to borrow £26.6m in the current Financial Year. He noted that the plan was to borrow much less in the 2019/20 Financial Year. The Director of Finance then provided an overview of Capital Expenditure and commented that the Trust's Capital Plan would show a variance for the Healthier Together schemes later in the year. He advised that NHS Improvement had requested a more realistic forecast for the remainder of 2018/19, without the inclusion of Healthier Together schemes.

The Interim Director of Workforce briefed the Board on Workforce key issues and was disappointed to note a decline in Appraisal compliance. She briefed the Board on mitigating actions in this area and advised that Business Groups were committed to having recovery plans in place by March 2019. The Interim Director of Workforce also reported an increase in sickness absence in December 2018 and noted a focus on sickness absence management and the Health & Wellbeing Programme. The Interim Director of Workforce reported a significant increase in Agency expenditure in December 2018 and briefed the Board on actions in place to reduce agency expenditure, including workforce remodelling. With regard to the Flu Vaccination Uptake target, the Interim Director of Workforce was pleased to report that the Trust had slightly exceeded the 75% target with performance at 76% in January 2019.

The Chief Nurse referred the Board to the Safe Staffing Report and noted a nurse staffing fill rate of 89.8%. She advised that, while safe staffing had been achieved, staffing continued to be extremely challenging. On a more positive note, the Chief Nurse briefed the Board on the outcome of a recent successful recruitment event which had resulted in the recruitment of 34 nurses.

The Board of Directors:

- Received and noted the Trust Performance Report for Month 9.

(48 minutes)

10/19 Trust Strategy Update

The Director of Strategy, Planning & Partnerships presented a report which provided an update on the consultation process with staff and partners on the refreshed Trust Strategy. He briefed the Board on the content of the report and advised that, as at 24 January 2019, a total number of 653 staff and partners had received the briefing in person. The Director of Strategy, Planning & Partnerships referred the Board to s3.2 of the report and provided an overview of the common themes emerging from the consultation. He then referred the Board to s3.4 of the report and noted the importance of the Clinical Service Strategy to ensure clinical leadership. Finally, the

Director of Strategy, Planning & Partnerships referred the Board to s4 of the report and sought Board support on the proposed Next Steps detailed in that section. He noted that a revised version of the refreshed Trust Strategy would be presented to the Board in February 2019.

The Chief Executive noted the importance of the Clinical Service Strategy as well as engagement of staff and partners to ensure wider ownership of the Strategy. She also commented that further work was required to ensure development of interconnected and interdependent strategies with partners. In response to a question from Mr D Hopewell, the Director of Strategy, Planning & Partnerships briefed the Board on engagement with partners and community staff to ensure alignment of the strategy. He also noted that an Estates Strategy was being developed for all community premises. In response to a question from the Chair, the Director of Strategy, Planning & Partnerships advised that partner engagement was part of the ongoing work. The Chief Executive commented that the long term plan could be used as a vehicle for partner engagement as it would require both commissioners and providers to consider and review their long term strategies.

The Board of Directors:

- Received and noted the Trust Strategy Update Report.
- Supported detailed development of the Clinical Services Strategy as a next priority.
- Supported Next Steps set out at s4 of the report and agreed that a version of the Strategy document would be presented to the Board on 28 February 2019.

(11 minutes)

11/19 Operational Plan 2019/20 – Progress Report

The Director of Strategy, Planning & Partnerships presented a report which provided an update on progress regarding the preparation of the Trust's Operational Plan. He briefed the Board on the content of the report and advised that a draft activity submission had been made on 14 January 2019. He reported that, as a consequence of contract negotiations with the CCG and system partners, updates to the Trust's planned activity template would form part of the draft submission due by 14 February 2019 and the final submission due by 4 April 2019. The Director of Strategy, Planning & Partnerships noted that the Trust's Control Total offer would be discussed at the Private Board meeting. He then briefed the Board on next steps detailed at s4 of the report and the Board subsequently delegated authority to the Chair and the Chief Executive to approve the final version of the Plan narrative prior to submission on 12 February 2019.

Mr M Sugden noted that the Trust's assumptions appeared robust and queried timescales for resolution and any consequent impact on the Trust's ability to deliver next year. The Director of Strategy, Planning & Partnerships commented that the Trust had been very clear and transparent with the CCG and noted that the anticipation was to reach a resolution by early March 2019. The Chief Executive agreed with Mr M Sugden's comment regarding the robustness of the Trust's assumptions and noted that the Trust was focusing its efforts to reach an agreement with partners. The Director of Strategy, Planning & Partnerships briefed the Board on the process of signing off

activity numbers. In response to a comment from Mr D Hopewell, the Director of Strategy, Planning & Partnerships advised that the Trust had been very transparent regarding Stockport Together in the operational planning process and noted the need to remain realistic regarding Stockport Together benefits realisation in next year's plans.

In response to a comment from Mrs C Barber-Brown, the Director of Strategy, Planning & Partnerships advised that the corporate objectives were aligned to the plan but that the issue highlighted to the Board's attention related to elective throughput. In response to a comment from the Chair, it was agreed that the documents for approval by the Chair and Chief Executive would be circulated to Board members for information as soon as available.

The Board of Directors:

- Received and noted the Operational Plan Report.
- Delegated authority to the Chair and Chief Executive to approve the final version of Plan narrative prior to submission on 12 February 2019.

(15 minutes)

12/19 NHS Long Term Plan

The Director of Strategy, Planning & Partnerships presented a report advising the Board of a NHS Long Term plan, which had been released on 7 January 2019. He provided a brief overview of the content of the plan and noted potential opportunities and implications for the Trust and the wider system. He advised that an NHS Providers 'On the Day Briefing', which provided a comprehensive summary of the plan, had been included at Annex A to the report. The Chair advised that the plan had been referenced at a recent Stockport Health & Wellbeing Board meeting where system partners had noted their willingness of working together on the opportunities and priorities detailed in the plan.

The Board of Directors:

- Received and noted the NHS Long Term Plan report.

(2 minutes)

13/19 Corporate Objectives – Quarter 3 Progress Update

The Director of Strategy, Planning & Partnerships presented a report which provided an update on progress on the 2018/19 Corporate Objectives as at the end of Quarter 3. He provided a brief overview on the content of the report and noted that a full list of the strategic and corporate objectives, along with a progress update, had been included at Appendix 1 of the report.

The Board of Directors:

- Received and noted the Corporate Objectives – Quarter 3 Progress Update Report.

(1 minute)

14/19 Safe, High Quality Care Improvement Plan 2019

The Chief Nurse presented a report which detailed the Safe, High Quality Care Improvement Plan 2019. She briefed the Board on the content of the report and advised that the Plan document had been submitted to the Care Quality Commission (CQC) by the required deadline date of 23 January 2019. The Chief Nurse advised that the CQC was aware that the Plan document would be presented to the Board of Directors for ratification on 31 January 2019 and that the timescales may result in submission of an amended Plan document following Board consideration. The Chief Nurse reported that the Quality Committee had considered the Plan document in detail and noted the transactional nature of the Plan.

The Chief Executive advised that the Plan had also been considered by the Stockport Improvement Board and noted a collective commitment from system partners. She commented that it was particularly important to ensure that the right care was provided to the most vulnerable patients. In response to a question from the Chair, the Chief Nurse acknowledged the comment regarding the most vulnerable patients and confirmed that the Plan would be monitored by the Quality Committee.

The Board of Directors:

- Received and noted the Safe, High Quality Care Improvement Plan 2019
- Ratified the Improvement Plan.

(4 minutes)

15/19 Adult Safeguarding Report

The Chief Nurse presented a report which provided a comprehensive summary of the current position across a range of Adult Safeguarding activities. She advised that the Quality Committee had also undertaken a detailed review of the report. The Chief Nurse briefed the Board on the content of the report and provided assurance on progress to date in addressing safeguarding concerns highlighted by the CQC. In response to questions from Mr D Hopewell, the Chief Nurse confirmed that Safeguarding training was a mandatory requirement for staff and noted that the quality of training and its practical application had improved. In response to a question from Mrs C Barber-Brown, the Chief Nurse provided further clarity regarding Safeguarding training and advised that each ward would have a nominated Safeguarding Champion.

In response to a question from Dr M Cheshire, the Chief Nurse advised the Board of ongoing triangulation of incidents with inpatient surveys and complaints to ensure that Safeguarding policies and training were appropriately embedded in practice. In response to a comment from the Chief Executive, regarding resource implications, there followed a discussion regarding costs associated with the proposed Safeguarding structure and it was noted that the proposal would be one of a number of potential developments for 2019/20 in the context of limited availability of funding. The Director of Corporate Affairs commented that it was important to note that the report

was not requesting Board approval at this stage as the resource requirements would be subject to business case approval process and a prioritisation process to be undertaken by the Executive Team. He commented that, once the prioritisation work had been completed, it would be important for the Board to be sighted on both the developments that did not 'make the cut' as well as the ones that did.

In response to a comment from Dr M Cheshire, the Director of Corporate Affairs advised that the outcome of the prioritisation work would form an integral part of next year's operational planning and budget setting. He noted that any associated risks would be brought to the attention of the appropriate Board Assurance Committees.

The Board of Directors:

- Received the report and noted assurance provided on Adult Safeguarding developments since April 2018.

(15 minutes)

16/19 Learning from Deaths Report

The Medical Director presented a report which provided an update on progress against National Quality Board standards on Learning from Deaths and advised that the report had also been considered by the Quality Committee. He briefed the Board on the content of the report and noted that, overall, good progress was being made against the standards. The Medical Director made particular reference to s3.2, s3.3, s3.4, s3.6, s3.7 and s3.8 of the report and provided an overview of the following subject headings: Clinical Governance and the Learning from Deaths Policy; Morbidity & Mortality meetings; Learning from Deaths Newsletter; Using Learning from Death Reviews to investigate areas of excess mortality; Family Involvement; and Involvement of Wider Clinical Teams.

In response to a question from Mrs C Anderson, the Chief Operating Officer and the Medical Director briefed the Board of a significant, multi-disciplinary piece of work on End of Life Care in the community. The Chief Nurse advised that further information on the project would be reported to the Quality Committee in March 2019.

The Board of Directors:

- Received the Learning from Deaths Report and noted the assurance provided on progress against national standards.

(8 minutes)

17/19 Medium Term Financial Strategy

The Director of Finance presented a report which summarised governance and monitoring arrangements for the delivery of the five key objectives included in the Medium Term Financial Strategy (MTFS). He briefed the Board on the content of the report and made specific reference to s3.3, s3.5 and s3.6 relating to the Clinical Services Efficiency Programme; Stockport Together; and Partnerships and Federation. He advised that the Board was asked to note the content of the report and that an

updated MTFS would be presented to the Board of Directors in March 2019, once NHS Improvement had completed a review of the Trust's 2019/20 Operational Plan.

With regard to operational planning, Mr D Hopewell noted that it was important to establish financial targets to ensure accountability for delivery. Dr M Cheshire noted that it would be prudent to take a conservative view with regard to Stockport Together benefits, given the slow progress and lack of benefits realisation to date. Both of these comments were endorsed by the Chief Executive. In response to a question from Mrs C Anderson, the Director of Finance briefed the Board of ongoing conversations to ensure the development and execution of transformational plans. The Chief Executive noted the need to adopt a 'step change' approach in this area and that progress against the plans would require monitoring by the Board.

In response to a comment from Mrs C Barber-Brown regarding MTFS governance arrangements, the Director of Finance acknowledged that there were associated implications for all of the Board Assurance Committees. In response to a comment from the Chief Executive, who noted the importance of Quality Impact Assessments in assessing the granular level detail, the Medical Director endorsed this comment and advised the Board of progress in this area.

The Board of Directors:

- Received and noted the Medium Term Financial Strategy report.

(11 minutes)

18/19 Charitable Funds Annual Accounts and Annual Report 2017/18

The Director of Finance presented a report which sought Board approval of the Charitable Funds Annual Accounts and Annual Report 2017/18 together with the Deloitte External Audit Opinion. He briefed the Board on the content of the report and advised that the Board of Directors, as Corporate Trustee, was asked to approve the Charitable Funds Annual Accounts and Report 2017/18 and sign the Statement of Trustee Responsibilities, the Balance Sheet and Letter of Representation on the Accounts to the External Auditors. He noted that the Trust was required to submit the Accounts and Report to the Charity Commission by 31 January 2019 in accordance with the Charity's statutory duties.

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.

The Board of Directors:

- Received and noted the report and approved the Charitable Funds Annual Accounts and Annual Report 2017/18.

(3 minutes)

19/19 Trust Risk Register

The Chief Nurse presented the Trust Risk Register and briefed the Board on its content. She noted an overall number of 379 live risks with 38 risks having a risk score of 15 or above. In response to a question from Mrs C Barber-Brown, the Chief Nurse advised the Board that the Audit Committee would receive a report in April 2019 regarding the effectiveness of the risk management framework. The Chief Executive acknowledged the improvements made to the Risk Register content but noted that there was still a lot of work to do in this area, particularly around the Board risk appetite and mitigations.

The Board of Directors:

- Received and noted the Trust Risk Register.

(4 minutes)

20/19 Board Assurance Framework

The Chief Nurse presented the Quarter 3 Board Assurance Framework (BAF) and briefed the Board on its content. She advised that the risk rating for one of the seven principle risks had decreased and noted that work continued to further refine the presentation and content of the BAF. The Director of Corporate Affairs made reference to a discussion at the most recent meeting of the Audit Committee where a number of suggestions had been made regarding the balance and format of the BAF document, which would be taken forward by the Chief Nurse and her team.

The Board of Directors:

- Received and noted the report and approved the Quarter 3 Board Assurance Framework.

(2 minutes)

21/19 Consent Agenda

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

- Approved the Terms of Reference for the Remuneration Committee.

22/19 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next public meeting of the Board of Directors would be held on Thursday, 28 February 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
30/18	31 Oct 18	245/18	Patient Story – Fractured Neck of Femur Presentation	It was agreed that the Chief Operating Officer would lead on responding to actions set out in the presentation. **Update 29 Nov 18** – The Chief Operating Officer advised the Board that she was meeting with Mr D Johnson in December 2018 to consider the actions and anticipated that the action would be closed by January 2019. **Update 31 Jan 19** – The Chief Operating Officer briefed the Board on the status of this action and noted that he had met with Mr D Johnson. She advised that a further meeting had been scheduled and that the action would be closed by the February Board meeting.	S Toal (Chief Operating Officer)
33/18	31 Oct 18	251/18	Stockport Neighbourhood Care	In response to a comment from Ms A Smith, the SNC Programme Director agreed to provide the Board with a follow up report, which would summarise key themes from neighbourhoods. **Update 29 Nov 18** – The Chief Operating Officer advised the Board that the Stockport Neighbourhood Care (SNC) Programme Director had left the position earlier than anticipated. A number of Board members raised concerns regarding the consequent lack of leadership and the impact on the SNC work. The Chief Operating Officer acknowledged the concerns and briefed the Board on initial interim arrangements. The Deputy Chief Executive agreed to prepare a briefing for Board members on SNC management arrangements by 14 December 2018. **Update 31 Jan 19** – The Chief Executive advised the Board of meetings held with senior leaders of Stockport Together partners to prepare a 'single view' document which would pull together information on Stockport Together, including areas such as resources and impact. She noted that this was still work in progress and the Board would receive an update at the February meeting.	S Ferguson (SNC Programme Director) / S Toal (Chief Operating Officer) H Mullen (Deputy Chief Executive) L Robson (Chief Executive)
35/18	29 Nov 18	277/18	Performance Report	In response to a request from Mr M Sugden, it was agreed that assurance	S Toal (Chief

				on CIP Planning for 2019/20 would be reported to the Finance & Performance Committee in December 2018 and the Board of Directors in January 2019. **Update 31 Jan 19 –** The Director of Finance advised that the Finance & Performance Committee had received an update on CIP Planning for 2019/20 and had noted limited assurance in this area. He noted that, following the Committee discussions, corporate teams had generated further Cost Improvement ideas and that associated targets had been set for the delivery of the projects. The Chief Operating Officer advised that new ideas continued to be developed. Action closed.	Operating Officer) / Mr F Patel (Director of Finance)
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.	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.	S Toal (Chief Operating Officer)
02/19	31 Jan 19	10/19	Trust Strategy Update	The Board supported Next Steps set out at s4 of the report and agreed that a version of the Strategy document would be presented to the Board on 28 February 2019.	H Mullen (Director of Strategy, Planning & Partnerships)
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.	F Patel (Director of Finance)

NHS
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Report to:	Board of Directors	**Date:**	28 February 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

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

Attachments:

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

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1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 The Trust continues to work to manage the challenge of maintaining patient flow through the hospital during the Winter period and these pressures continue to have a consequent impact on our performance against key national targets and, in particular, performance against the A&E 4-hour standard. In this context, I would like to reiterate the Board's thanks to colleagues and partner organisations, especially to our staff working in the Emergency Department, for their efforts in maintaining safe care during this period.

3. BOARD DEVELOPMENT

3.1 Following a successful interview and selection process, I am pleased to confirm the appointment of Mr G Moores and Mr J Graham to the posts of Director of Workforce and Director of Finance respectively. We will look to confirm start dates at the earliest opportunity.

3.2 Board members participated in a Development Session on 21 February 2019 on the theme of Equality, Diversity & Inclusion and Freedom to Speak. The session was well-facilitated by Mrs S Nadeem, EDI Manager, and Mr P Gordon, Freedom to Speak Up Guardian.

4. CHAIR ENGAGEMENTS

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

29 January 2019	Attended a Greater Manchester Chair's meeting
29 January 2019	Visited Viaduct Care CIC
30 January 2019	Met with Dr J Idoo, Chair, Viaduct Care
5 February 2019	Attended a Stockport Health & Wellbeing Board meeting
7 February 2019	Visited Bracondale Medical Centre
7 February 2019	Met with Dr C Briggs, Chair, Stockport CCG

14 February 2019	Visited Wards B2, B3, A3 and the Trust Switchboard
14 February 2019	Attended an Enhanced Oversight meeting with NHS Improvement.

5. REGULATORY DEVELOPMENTS

5.1 The draft Operational Plan 2019/20 was signed off by the Chair and Chief Executive for submission to NHS Improvement on 12 February 2019. Part of the Plan sign-off included acceptance of the financial Control Total 2019/20.

5.2 The Kark Review was published this month and makes recommendations in respect of competence of health provider organisation Board Directors. Some of the recommendations, if and when adopted by Government, will supersede the Fit & Proper person regulations which are being increasingly seen as unfit for purpose.

6. FORWARD LOOK

6.1 The Trust has the opportunity to develop the approach to longer term strategic planning over the coming months, in the context of the NHS Long Term Plan. Through this process we intend to fully engage with partner organisations and refresh the vision for the Trust, Stockport and surrounding areas. This subject will be considered further as part of the agenda for the meeting on 28 February 2019.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

NHS
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Report to:	Board of Directors	**Date:**	28th February 2019
Subject:	Report of the Chief Executive		
Report of:	Chief Executive	**Prepared by:**	Louise Robson

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 advise the Board of Directors of national and local strategic and operational developments.
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 Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Exec Management Group ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. **INTRODUCTION**

I have been in Stockport for over a month and I am continuing to meet teams within the Foundation Trust and many of our partners across the patch, including across Greater Manchester, East Cheshire and North Derbyshire. Among many of the opportunities I have had to meet people, I was pleased to attend our Clinical Directors' Forum; a session with some great energy and potential for the future. This was followed by a meeting between some of our Consultants, Clinical Leaders and GP Leads from Stockport Neighbourhood Care; this must surely be the way forward for focussing on clinical pathway redesign for the future. My programme of meetings and visiting our services in the community and on our Stepping Hill site throughout the coming months will continue. I look forward to meeting as many people as possible.

2. We are heading into the last month of the financial year and it is really important that we all maintain our focus on delivering high quality, safe and efficient services if we are to get the next year off to the best start.

3. We are continuing our relentless work on ensuring "flow" so that our patients receive care in the most appropriate setting. In the Trust, we have designed a video (link) which helps our teams understand what they need to do to ensure patient flow and there is a real focus on embedding best practice throughout out Trust. We are also working with our partners in Stockport seven days a week to help ensure all appropriate options for care are considered. Having taken on chairing the Urgent and Emergency Care Delivery Board for Stockport, we have begun to refresh our approach to ensure coherent planning and action across the system; this will provide an important vehicle for developing partnership and system wide working.

4. Since coming to Stockport I have been really impressed by the commitment and skills of the staff I have met, but we do not have the monopoly on good ideas and I am keen that we learn from best practice elsewhere. So I was really pleased to be invited to judge a category of this year's Health Service Journal awards – many of the finalists were organisations facing very similar challenges to us, particularly in relation to transforming urgent care. Once the awards are announced, I will be contacting them to see how we can learn from their transformation journeys.

5. A number of external organisations that have been supporting our improvement journey over a period of time are starting to wind down their involvement with us, and while it has been great to learn from their experiences with other organisations, it is time for us to take control. I would particularly like to thank Caroline Griffiths for all her work and support as Improvement Director, her help has been much appreciated by the Trust. I am convinced that we absolutely have the capability to shape a successful future for the Trust, and it is the role of the Executive Team to help staff throughout the organisation break down the barriers that may stop them from delivering our plans for the future.

6. We will shortly be welcoming two new members to the Executive Team. John Graham will be our new Director of Finance and he will be joining us on a part-time basis very soon to focus on our medium to long term financial planning before taking up the role permanently.

In May, Greg Moores will join us as our new Director of Workforce and Organisational Development, and he has particular experience in service transformation and empowering staff. It is excellent news for us that both John and Greg are very experienced Directors, who are keen to join our improvement journey.

7. Since joining the Trust I have been busy getting to know many of the partners that will be so important to our future success. A key part of our future is the development of the Greater Manchester Improving Specialist Care Programme, so I was particularly pleased to be asked, on behalf of the Provider Federation Board, to lead its elective care work. This will be an important opportunity to demonstrate how Stockport NHS Foundation Trust can work as an effective partner and lead transformational change, and I will be looking for staff across the Trust to support me in this programme.

8. It is obvious to me that there are many people in the organisation that have the drive and determination to make positive changes, and none more so than Jo Conway and the team that have been working so hard over the last year on reducing harm from pressure ulcers. Jo gave a presentation to our Quality Committee about this important patient safety issue, and it was truly impressive to see such passion, commitment and enthusiasm focused on preventing harm to our patients – and with really positive results. Everyone involved should be very proud of what they are achieving for our patients.

9. It is this sort of focus that I would like the organisation to bring to another important patient safety issue. Sepsis can have devastating consequences for patients and their families, and nationally there is increasing awareness of the symptoms and importance of prompt identification and treatment. However, our performance currently is not what it should be – sepsis screening and the administration of antibiotics within an hour has dropped since September and we did not meet the CQUIN target for the last quarter of 2018. We have introduced a new screening tool and processes to try to address issues, but we all have a duty to ensure we give sepsis the focus it deserves, as I know if one of our relatives had suspected sepsis, we would want everything possible done for them.

10. Turning to our future plans, we are working with our commissioners to finalise the detail of our activity, finance and performance requirements for 2019/20. We have focussed on constructive partnership working to achieve the best for our patients and to the people of Stockport and neighbouring areas.

11. Earlier this year, some really helpful work was undertaken to begin development of our Strategic Plan; this included engagement with over 650 of our staff. We will be keeping everyone involved up to speed with current progress. In addition, we will be taking the opportunity to further develop our Strategy in the light of the publication of the Long Term Plan for the NHS (7th January 2019). We will consider and the articulate our strategy at three key strategic levels; our Trust; a place-based strategy for our work with partners in Stockport; and, our engagement with partners in Greater Manchester, East Cheshire and North Derbyshire. This next phase of development will be based around clinically-led visions for our services and alignment with the developing strategies of our partners.

12. On 7th February we hosted a Screening Quality Assurance visit to our Colposcopy Services. This NHS-wide assurance programme aims to ensure minimum standards and continuous improvements are maintained. During the visit, the caring, patient centred focus of our staff was warmly praised and particular mention was made about our outstanding staff; their work to make services accessible with early and late clinics and a focus on succession planning for service continuity. However, we were advised of one immediate concern in relation to one of our colposcopy rooms which is particularly cramped and is therefore unable to accommodate the requirements for nursing staff in attending to patients. I am pleased to confirm that immediate action was taken; changes to processes were implemented (12th February) to improve space utilisation; work on redesign of a new colposcopy room has begun which will improve access to a re-provided recovery room and equitable use of Dysis equipment; these changes will be overseen by the Clinical Director and Head of Midwifery.

13. **RECOMMENDATION**

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

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Report To:	Board of Directors	**Date:**	28 Feb 2019
Subject:	Integrated Performance Report		
Report of:	Deputy Chief Executive	**Prepared by:**	Performance, B&I and Executive Directors

REPORT FOR ASSURANCE

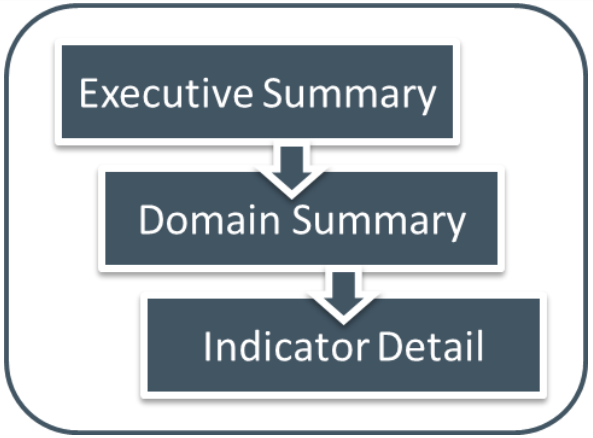
Corporate Objective Ref:	SO2, 2a, 2b, 3a, 3b, 5a, 5c, 6a	**Summary of Report** The Board is asked to note the performance against the reported metrics, particularly noting the key areas of change from the previous month.
Board Assurance Framework Ref:	SO2, SO3, SO5, SO6	
CQC Registration Standards Ref:	10, 12, 17, 18	
Equality Impact Assessment:	☐ Completed ☑ Not Required	

Attachments:

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

Introduction

The Board report layout consists of three sections:



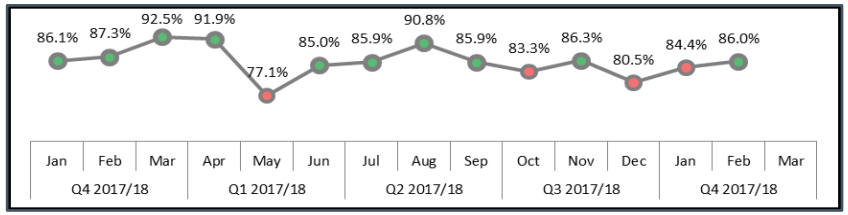
Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

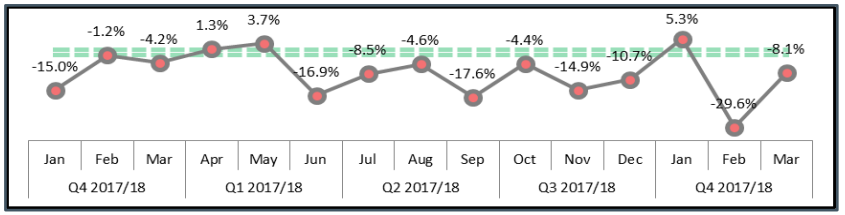
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

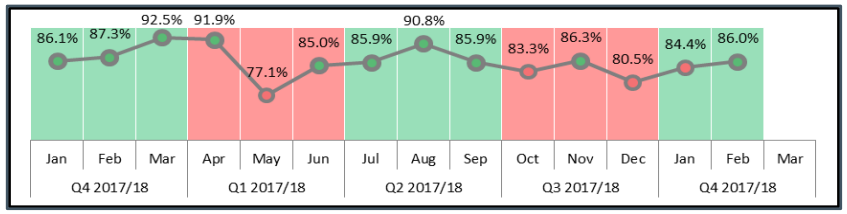
The following chart types are in use throughout the report:



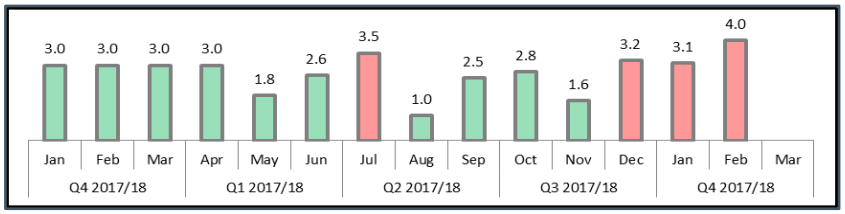
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



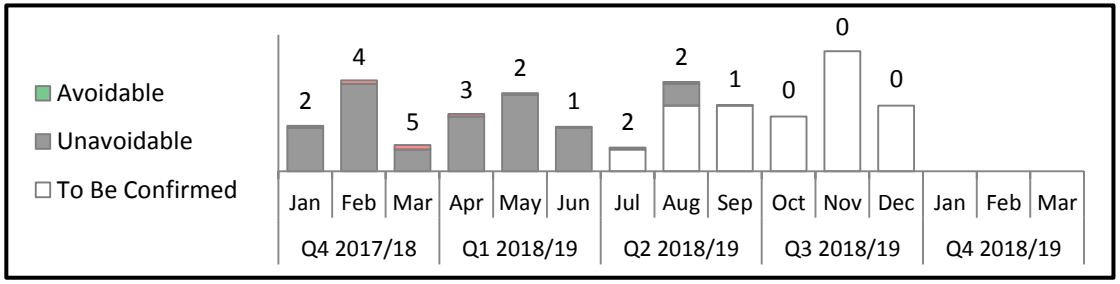
For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



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

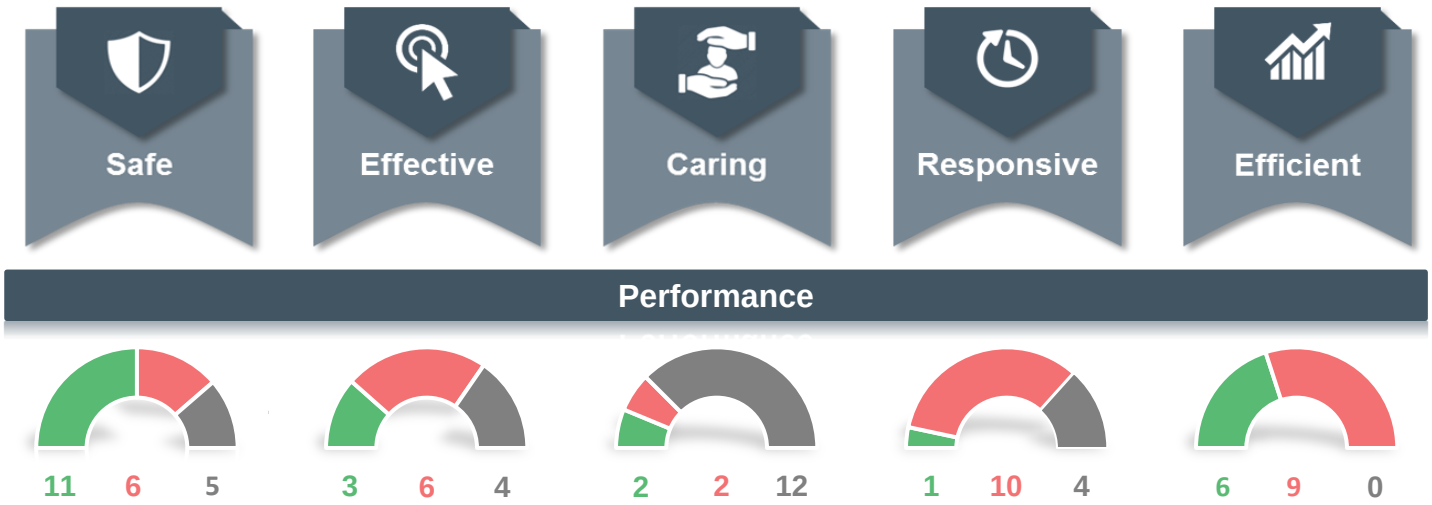


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.



Executive Summary

Stockport NHS Foundation Trust



Key Changes to the indicators in this period are:

Metrics changing from green to red in month:
- Emergency C-Section rate increased in month to 17.9%
- Reduction in compliance against completing the FAIR Case Finding Dementia Question
- Cancer 62 day performance
- Diabetes reviews

Metrics changing from red to green in month:
- Emergency readmission rate decreased to 7.8% in month
- Completion of Patient Safety Alerts within set timescales in month

Areas of notable improvement:
- number of medication errors where moderate harm or above is reported
- RTT Incomplete Waiting List Size.
- Agency shifts above cap
- Agency spend - distance from ceiling

Area of notable exception
- Sickness absence rate increase in month.

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Dec-18		13.32							9.14		11
C.Diff Infection Count (lapses in care)	CN&DQG	Dec-18	<=12 *	0							3		11
MRSA Infection Rate	CN&DQG	Dec-18		0.46							0.66		12
MSSA Infection Rate	CN&DQG	Dec-18		5.51							6.92		12
E.Coli Infection Rate	CN&DQG	Dec-18		17.46							16.91		13
E.Coli Infection Count	CN&DQG	Dec-18	<=28 *	7							27		13
Falls: Total Incidence of Inpatient Falls	CN&DQG	Jan-19	<=1148 *	107							1082		14
Falls: Causing Moderate Harm and Above	CN&DQG	Jan-19	<=26 *	3							24		14
Pressure Ulcers: Hospital, Avoidable Category 2	CN&DQG	Dec-18	<= 10 *	0							11		15
Pressure Ulcers: Hospital, Avoidable Category 3	CN&DQG	Dec-18	<= 4 *	0							8		15
Pressure Ulcers: Hospital, Avoidable Category 4	CN&DQG	Dec-18	<= 1 *	0							3		16
Pressure Ulcers: Community, Avoidable Category 2	CN&DQG	Dec-18	<= 30 *	0							10		16
Pressure Ulcers: Community, Avoidable Category 3	CN&DQG	Dec-18	<= 8 *	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	Dec-18	<= *3* *	0							0		17
Safety Thermometer: Hospital	CN&DQG	Jan-19	>= *95%*	96.1%							95.7%		18
Safety Thermometer: Community	CN&DQG	Jan-19	>= *95%*	97.3%							96.1%		18
Medication Errors: Overall	CN&DQG	Jan-19		86							927		19
Medication Errors: Moderate Harm and Above	CN&DQG	Jan-19	<= *4%*	0.0%							4.1%		19
VTE Risk Assessment	CN&DQG	Dec-18	>= *95%*	97.2%							97.0%		20
Clinical Correspondence	COO	Jan-19	>= *95%*	63.6%							63.6%		20
Flu Vacination Uptake	DoW&OD	Jan-19	>= *75%*	74.1%									21
Discharge Summaries	MD	Jan-19	>= *95%*	92.1%							89.7%		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	Jan-19		59.76									22
Emergency C-Section Rate	CN&DQG	Jan-19	<= 15.4%	17.9%							17.4%		22
Never Event: Incidence	CN&DQG	Jan-19	<= 0	0							1		23
Duty of Candour Breaches	CN&DQG	Jan-19		4							29		23
Stranded Patients	COO	Jan-19	<= 35%	56.9%							50.1%		24
Delayed Transfers of Care (DTOC)	COO	Jan-19	<= 3.3%	5.2%							3.9%		24
Medical Optimised Awaiting Transfer (MOAT)	COO	Jan-19	<= 40	106							974		25
Bank & Agency Costs	DoW&OD	Jan-19	<= 5%	13.0%							11.8%		25
Mortality: HSMR	MD	Dec-18	<= 1	1.09									26
Mortality: SHMI	MD	Mar-18	<= 1	0.97									26
Mortality: Deaths in ED or as Inpatient	MD	Jan-19		142							1205		27
Mortality: Case Note Reviews	MD	Jan-19		52							396		27
Emergency Readmission Rate	MD	Nov-18	<= 7.9%	7.8%							9.0%		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	Jan-19	>= 100%	100.0%							74.2%		28
DSSA (mixed sex)	CN&DQG	Jan-19	<= 0	0							4		29
Complaints Rate	CN&DQG	Jan-19		0.5%							0.7%		29
Complaints: Response Rate 45	CN&DQG	Jan-19	>= 95%	50.0%							40.3%		30
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	Jan-19		0							10		30
Complaints Closed: Overall	CN&DQG	Jan-19		24							370		31
Complaints Closed: Upheld	CN&DQG	Jan-19		2							93		31
Complaints Closed: Partially Upheld	CN&DQG	Jan-19		17							182		32
Complaints Closed: Not Upheld	CN&DQG	Jan-19		5							95		32
Compliments	CN&DQG	Jan-19		108							424		33
Friends & Family Test: Response Rate	CN&DQG	Dec-18		23.8%							25.7%		33
Friends & Family Test: Inpatient	CN&DQG	Dec-18		93.7%							94.8%		34
Friends & Family Test: A&E	CN&DQG	Dec-18		86.7%							88.1%		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	Dec-18		98.3%		↑					96.8%		35
Staff Friends & Family Test	CN&DQG	Dec-18		64.2%		↓					71.5%		35
Diabetes Reviews	MD	Jan-19	>= 90%	74.3%		↓					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	Dec-18	>= 90%	88.7%							94.0%		36
Dementia: Assessment	CN&DQG	Dec-18	>= 90%	100.0%							100.0%		37
Dementia: Referral	CN&DQG	Dec-18	>= 90%								100.0%		37
Serious Incidents: STEIS Reportable	CN&DQG	Jan-19		17							172		38
Litigation: Claims	CN&DQG	Jan-19		6							61		38
Litigation: Key Risk Claims Rate	CN&DQG	Jan-19		100.0%							100.0%		39
A&E: 4hr Standard	COO	Jan-19	>= 95%	68.4%							76.8%		39
A&E: 12hr Trolley Wait	COO	Jan-19	<= 0	13							63		40
Cancer: 62 Day Standard	COO	Jan-19	>= 85%	71.7%							78.3%		40
Referral to Treatment: Incomplete Pathways	COO	Jan-19	>= 92%	82.8%							85.1%		41
Referral to Treatment: Incomplete Waiting List Size	COO	Jan-19	<= 22346	23824									41
Diagnostics: 6 Week Standard	COO	Jan-19	>= 99%	98.3%							99.1%		42
Elective Activity vs. Plan	COO	Jan-19	>= -1%	-3.7%							-3.7%		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	Jan-19	>= -1%	-3.2%							-3.2%		43
Outpatient Activity vs. Plan	COO	Jan-19	>= -1%	-1.8%							-1.8%		43

* 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													
Financial Efficiency: I&E Margin	DoF	Jan-19	<= 2	4									44
Financial Controls: I&E Position	DoF	Jan-19	>= 0%	2.2%									44
Cash	DoF	Jan-19	+/- 1%	-13.5%									45
Financial Use of Resources	DoF	Jan-19	<= 3	3									45
CIP Cumulative Achievement	DoF	Jan-19	>= 0%	-6.3%									46
Capital Expenditure	DoF	Jan-19	+/- 10%	-16.4%									46
Financial Sustainability	DoF	Jan-19	<= 2	4									47
Sickness Absence Rate	DoW&OD	Jan-19	<= 3.5%	5.2%							4.4%		47
Appraisal Rate: Non-medical	DoW&OD	Jan-19	>= 95%	90.2%							93.5%		48
Appraisal Rate: Medical	DoW&OD	Jan-19	>= 95%	98.1%							97.5%		48
Statutory & Mandatory Training	DoW&OD	Jan-19	>= 90%	90.8%							90.3%		49
Workforce Turnover	DoW&OD	Jan-19	<= 13.94%	13.3%									49
Staff in Post	DoW&OD	Jan-19	>= 90%	91.5%							90.3%		50

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

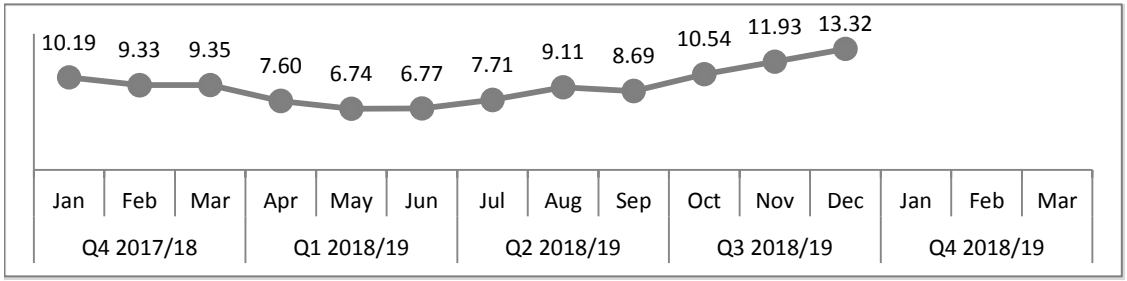
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	Jan-19	<= 0	778							9337		50
Agency Spend: Distance From Ceiling	DoW&OD	Jan-19	<= 3%	10.7%							10.7%		51

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

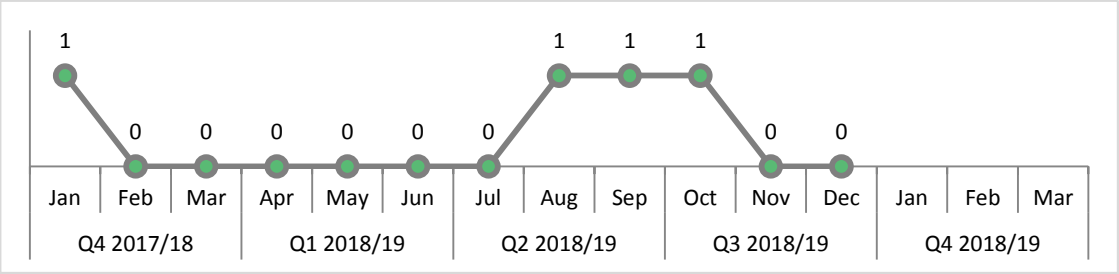
Indicator Detail

Dec-18	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 December there were five cases of Clostridium difficile Full investigations currently in progress for all cases The target rate is monitored through the infection prevention group Support is being offered from NHS Improvement due to the increase in cases over the last few months

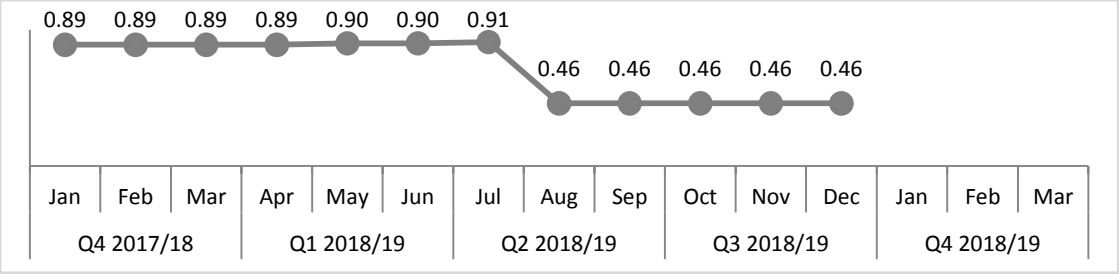
Dec-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care, in December we have had no lapses in care as the cases are still under investigation. Three cases during August, September and October have been deemed to be lapses in care.
<=12 *	



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

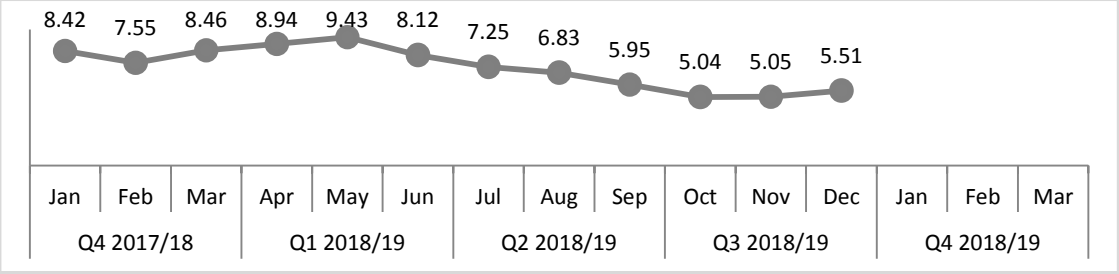
Indicator Detail

Dec-18	MRSA Infection Rate
0.46	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 December there were zero cases of MRSA The target is monitored through the infection prevention group A community MRSA bacteraemia case on a 1 month old baby is currently under investigation by the business group to determine apportionment

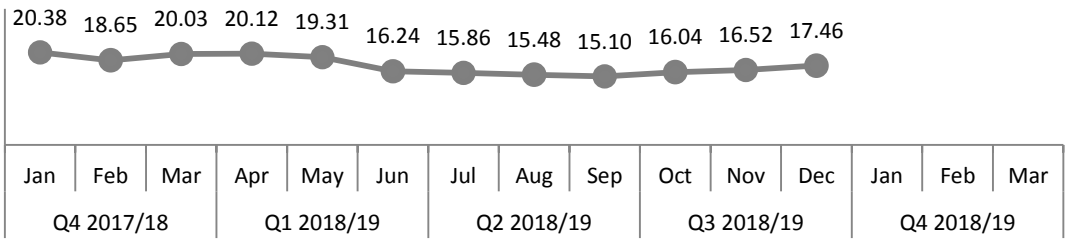
Dec-18	MSSA Infection Rate
5.51	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections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

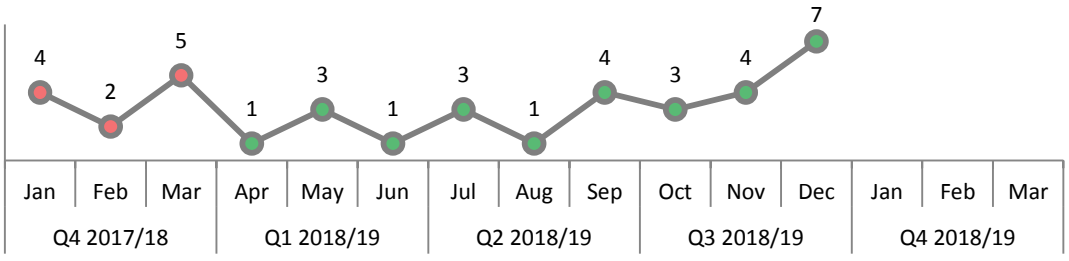
Indicator Detail

Dec-18	E.Coli Infection Rate
17.46	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 regarding the clinical review of each case and how that can be achieved before April 2019 as it then becomes mandatory

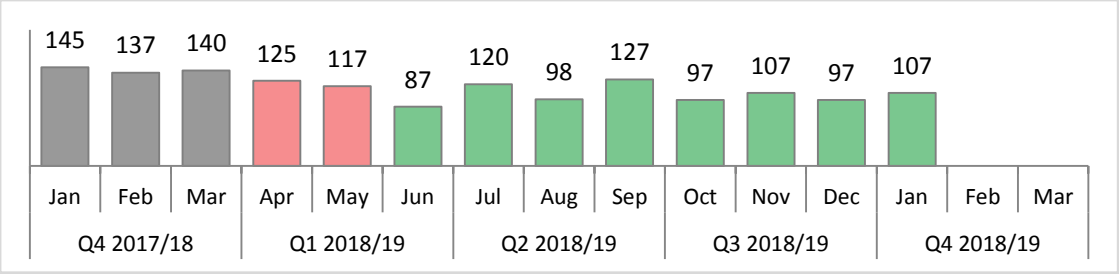
Dec-18	E.Coli Infection Count
7	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases
<=28 *	



Actions
This is monitored through the Infection prevention & control group

Indicator Detail

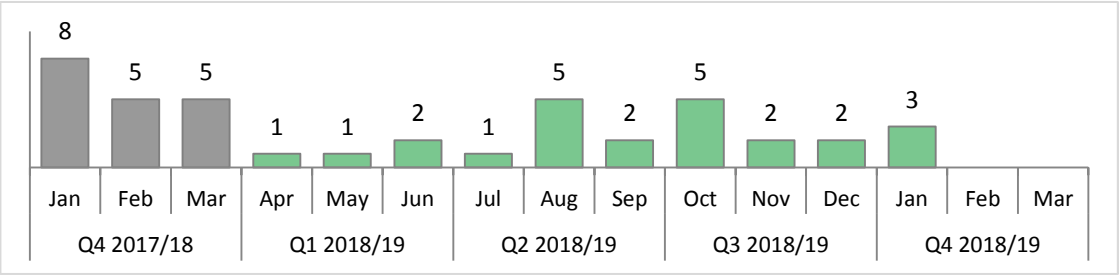
Jan-19	Falls: Total Incidence of Inpatient Falls
107	Total number of Inpatient falls
Target	The Trust has set a target of 10% reduction in in-patient falls for 2018/19 in comparison to the previous year. Currently this target is being exceeded
<=1148 *	



Actions

There has been a full review and cleanse of the data; some adjustments have been made following this review which is now reflective of the current position.
The Trust continues on track to exceed the 10% total reduction target set.
January 19 continues the trend noted in December 18 with a month on month reduction in comparative data from the previous year (Jan 18-130 falls; Jan 19- 107 falls).

Jan-19	Falls: Causing Moderate Harm and Above
3	Total number of falls causing moderate harm and above.
Target	The Trust has 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. Currently this target is on track
<=26 *	

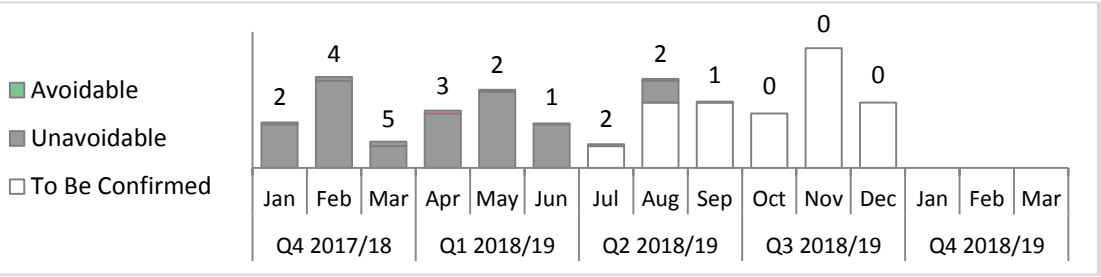


Actions

There has been a full review and cleanse of the data; some adjustments have been made following this review which is now reflective of the current position.
There have been 3 falls in month resulting in Moderate or above harm to the patient.
All 3 are in the process of being fully investigated; 2 are in Medicine and Clinical Support BG and 1 in in the Integrated care BG.

Indicator Detail

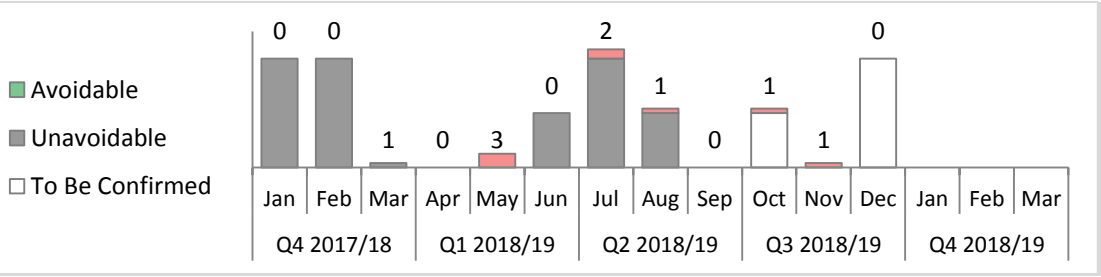
Dec-18	Pressure Ulcers: Hospital, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (December data) there has been a total of 10 category 2 pressure ulcers reported in the hospital Avoidable = 0, Unavoidable = 0, TBC = 6. YTD = There have been 11 avoidable category 2 pressure ulcers reported.
<= 10 *	



Actions

We have now reached the threshold for numbers of avoidable pressure ulcers (PU)for the hospital, with the outcome of 36 incidents still to be confirmed.
- A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well.
- Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members.
-Skin inspection mirror with prompts provided to nursing staff to support skin inspection
-A new categorisation resource and competency package has been distributed to all clinical areas.
Medical device tool box training has commenced.
-A presentation was given to the CCG following a ‘deep dive’ review of PU serious incident outcomes
-The first meeting of the Tissue Viability operational \group took place on the 14/1/19
-A critical care PU study day event took place on the 16/1/19

Dec-18	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 (December data) there has been a total of two category 3 pressure ulcers reported in the hospital.Avoidable = 0, Unavoidable = 0, TBC = 2. YTD = There have been 8 avoidable category 3 pressure ulcers reported.
<= 4 *	



Actions

We have now reached the threshold for numbers of avoidable pressure ulcers (PU)for the hospital, with the outcome of 36 incidents still to be confirmed.
- A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well.
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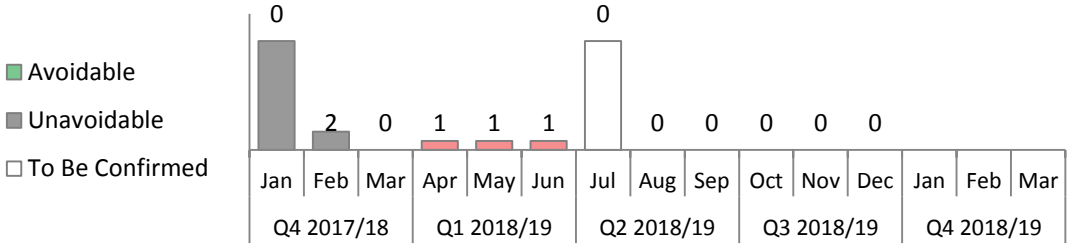
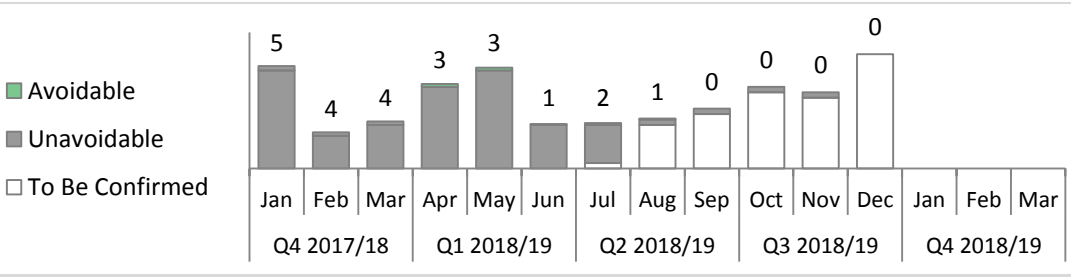
Indicator Detail

Dec-18	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 (December data) there have been no category 4 pressure ulcers reported in the Hospital. YTD = There have been 3 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 36 incidents still to be confirmed. - A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well. - Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. -Skin inspection mirror with prompts provided to nursing staff to support skin inspection -A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training has commenced. -A presentation was given to the CCG following a 'deep dive' review of PU serious incident outcomes -The first meeting of the Tissue Viability operational \group took place on the 14/1/19 -A critical care PU study day event took place on the 16/1/19

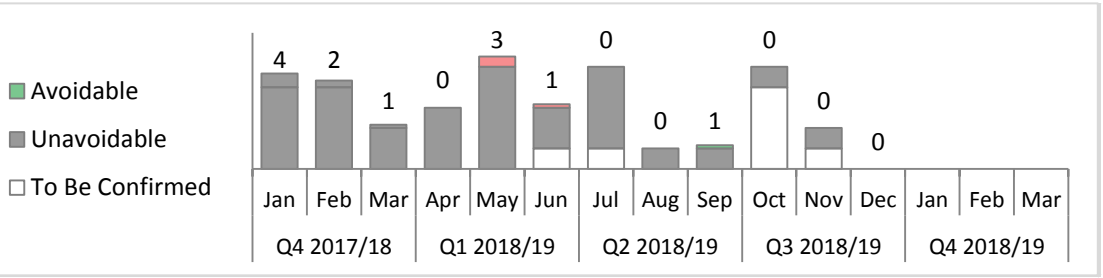
Dec-18	Pressure Ulcers: Community, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (December data) there has been a total of 21 category 2 pressure ulcers reported in the community Avoidable = 0, Unavoidable = 0, TBC = 21. YTD = There have been 10 avoidable category 2 pressure ulcers reported.
<= 30 *	



Actions
We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcers (PU) in the community - A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well. - Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. -Skin inspection mirror with prompts provided to nursing staff to support skin inspection -A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training has commenced. -A presentation was given to the CCG following a 'deep dive' review of PU serious incident outcomes -The first meeting of the Tissue Viability operational \group took place on the 14/1/19

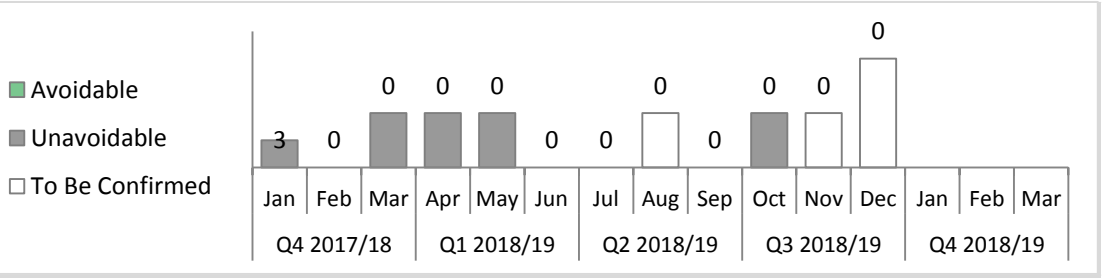
Indicator Detail

Dec-18	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 (December data) there has been no category 3 pressure ulcers reported in the Community. YTD = There have been 5 avoidable category 3 pressure ulcers reported.
<= 8 *	



Actions
We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcers (PU) in the community - A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well. - Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. -Skin inspection mirror with prompts provided to nursing staff to support skin inspection -A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training has commenced. -A presentation was given to the CCG following a 'deep dive' review of PU serious incident outcomes -The first meeting of the Tissue Viability operational \group took place on the 14/1/19

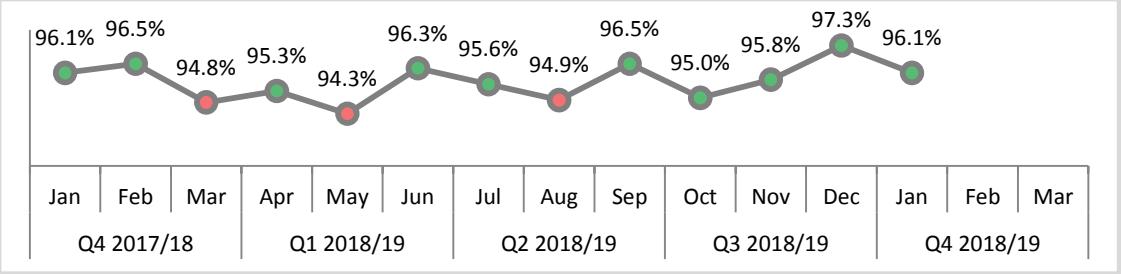
Dec-18	Pressure Ulcers: Community, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (December data) there has been a total of two category 4 pressure ulcers reported in the community. Avoidable = 0, Unavoidable = 0, TBC = 4. YTD = There have been 0 avoidable category 4 pressure ulcers reported in the community
<= 3 *	



Actions
We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcers (PU) in the community - A refreshed 3 hour pressure ulcer prevention update session is ongoing and is evaluating well. - Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. -Skin inspection mirror with prompts provided to nursing staff to support skin inspection -A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training has commenced. -A presentation was given to the CCG following a 'deep dive' review of PU serious incident outcomes -The first meeting of the Tissue Viability operational \group took place on the 14/1/19

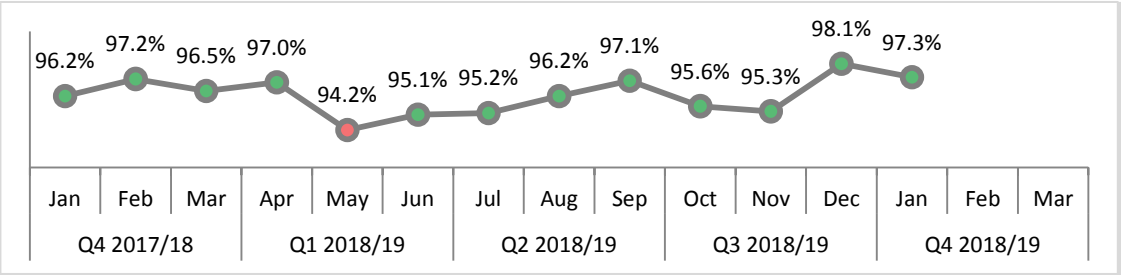
Indicator Detail

Jan-19	Safety Thermometer: Hospital
96.1%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for January show that we have achieved 96.1%
>= 95%	



Actions
Weekly validation meetings continue to be undertaken to improve the quality of the data. An update was provided at the Matron's Forum in January and dates have been set throughout February to deliver training to the ward managers within the business groups.

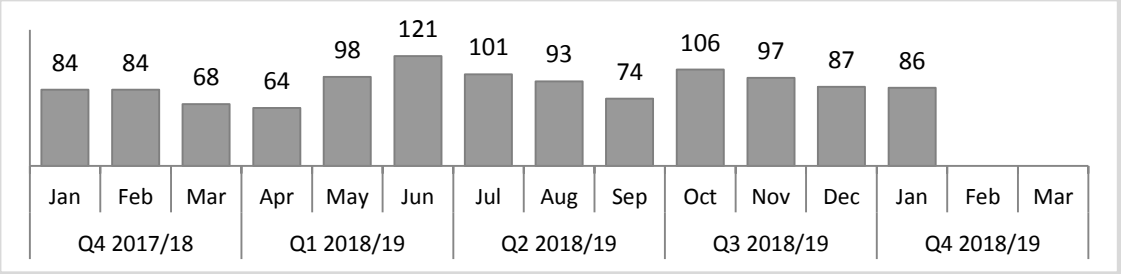
Jan-19	Safety Thermometer: Community
97.3%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for January show that we have achieved 97.3%.
>= 95%	



Actions
The target has been achieved in month.

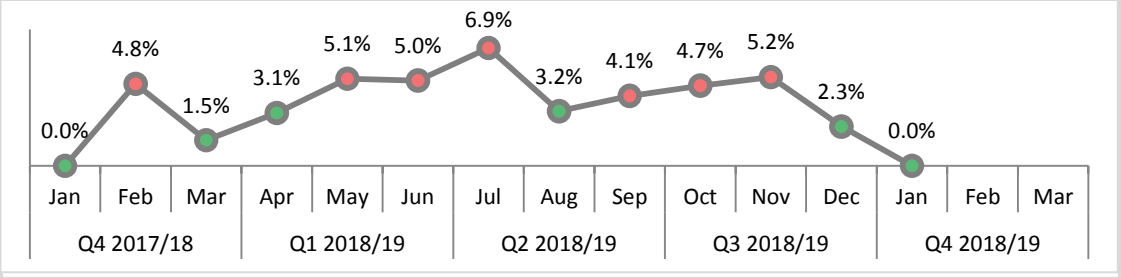
Indicator Detail

Jan-19	Medication Errors: Overall
86	Total number of Medication Errors.
Target	There were 86 medication incidents reported in January 2019.



Actions
All medication incidents are reviewed weekly by a trust executive at the patient safety summit. Medication issues continue to be highlighted in the weekly patient safety summit update, which is sent out to staff on a weekly basis. In January updates included A discharge check list for medication when a patient is transferred or discharged to another hospital. Checking that medications given at discharge match the discharge prescription.

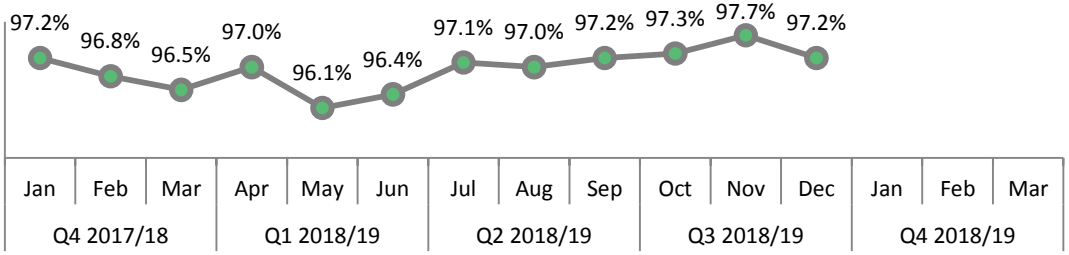
Jan-19	Medication Errors: Moderate Harm and Above
0.0%	The percentage of medication errors causing moderate harm and above.
Target	This month there have been no medication errors that have caused moderate harm or above.
<= 4%	



Actions
The trust is on track to meet the improvement trajectory set, to reduce the percentage of incidents causing moderate harm or above to below 4%.

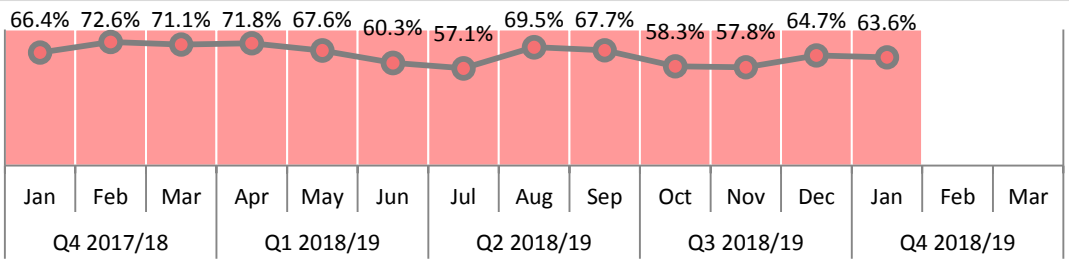
Indicator Detail

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



Actions
The target has been achieved in month

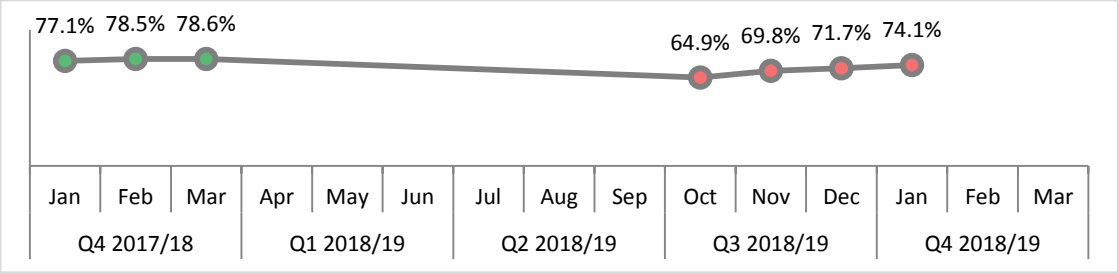
Jan-19	Clinical Correspondence
63.6%	The percentage of clinical correspondence typed within 7 days.
Target	The Trust achieved 63.6% against the 95% standard in January.
>= 95%	



Actions
The Trust-wide review will commence on the 18th February with the expectation that the options appraisal will be available by the beginning of March. The Trust has approved remedial action to outsource typing for Obs & Gynae and Paediatrics. Higher performing specialties have been targeted to support those with longer waits.

Indicator Detail

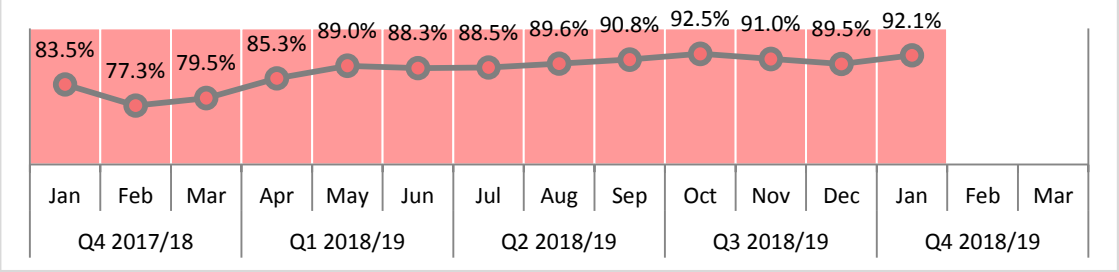
Jan-19	Flu Vacination Uptake
74.1%	The percentage of staff receiving the flu vaccination.
Target	74% (76% of frontline staff) of staff have been vaccinated as at end January 2019 , against a total target of 75% .
>= 75%	



Actions

Action continues to support staff to receive their influenza vaccination. Progress to achieve the target is on track and it is anticipated that this will be achieved.

Jan-19	Discharge Summaries
92.1%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Good pattern of improvement over the year.
>= 95%	

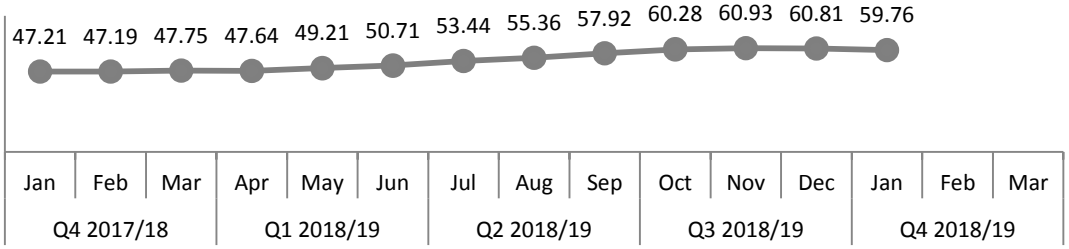


Actions

Continued focus upon the acute assessment areas continues.

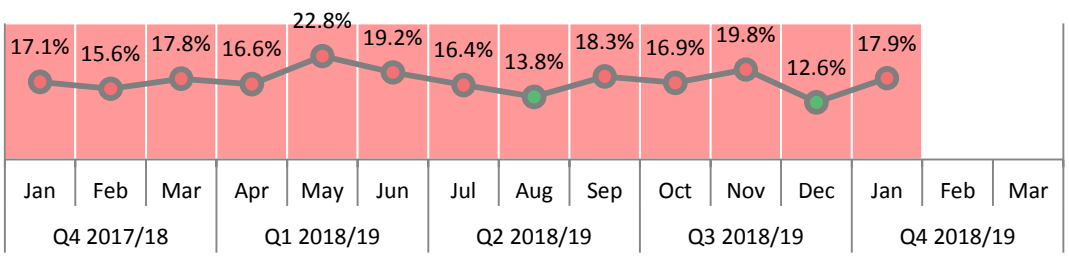
Indicator Detail

Jan-19	Patient Safety Incident Rate
59.76	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
Pressure ulcers are the highest number of reported incidents. There has been a slight drop in the number of staffing incidents reported in January. Staff continue to be encouraged to report staffing issues via the incident reporting system.

Jan-19	Emergency C-Section Rate
17.9%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	The emergency caesarean section target is <15.4%
<= 15.4%	

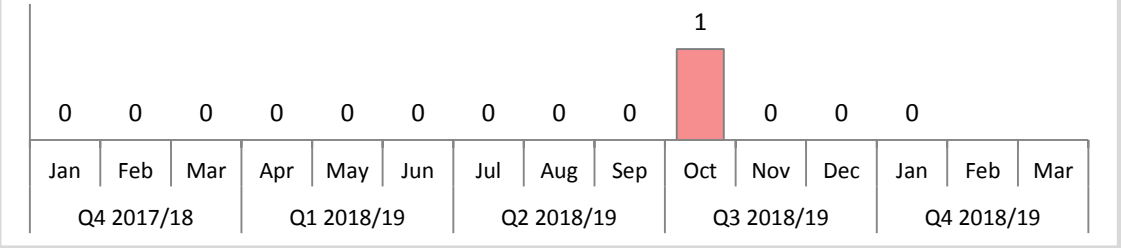


Actions
The emergency C-section rate needs to be taken into account alongside the number of ladies who had their labour induced. For the month of January the induction of labour rate was 42.5%. This is monitored through the maternity dashboard within the Business Group.

Indicator Detail

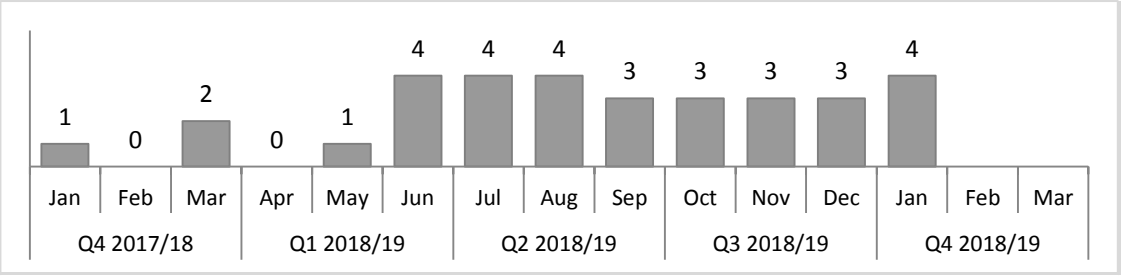
Jan-19	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	No never events were reported in January.
<= 0	

Actions
The last never event occurred in October 2018.



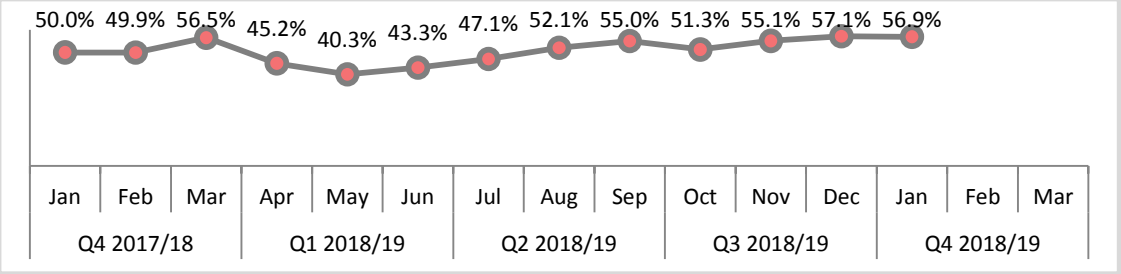
Jan-19	Duty of Candour Breaches
4	Total number of Duty of Candour breaches in month.
Target	In January 2019, there were 4 occasions where Duty of Candour was not opened within the 10 day timeframe, as detailed in our policy.

Actions
Duty of Candour breaches are monitored and sent to the business groups on a weekly basis. The Duty of Candour policy is in the process of being changed, to more accurately reflect Regulation 20.



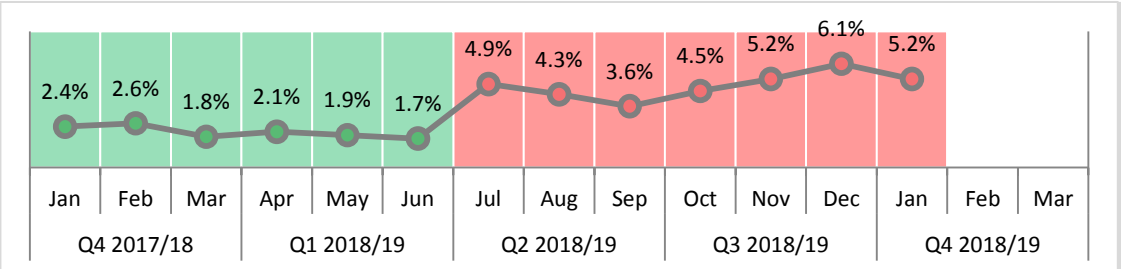
Indicator Detail

Jan-19	Stranded Patients
56.9%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The percentage of stranded patients remains significantly high.
<= 35%	



Actions
The Integrated Transfer Team review has now been completed and the report available. This will now be considered by the Executive Team and the Urgent Care Delivery Board. There continues to be a daily focus on the complex stranded patients. Twice weekly Red to Green ward meetings continue and an improvement in the coding has been noted. February to date is presenting more positively.

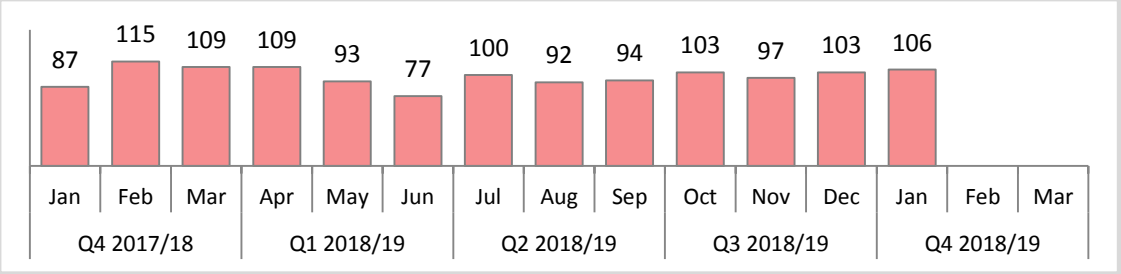
Jan-19	Delayed Transfers of Care (DTOC)
5.2%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	DTOC numbers remain high.
<= 3.3%	



Actions
Daily validation is undertaken of the DTOC patients. DTOC is on the agenda of the daily Executive teleconference, with actions resulting each day.

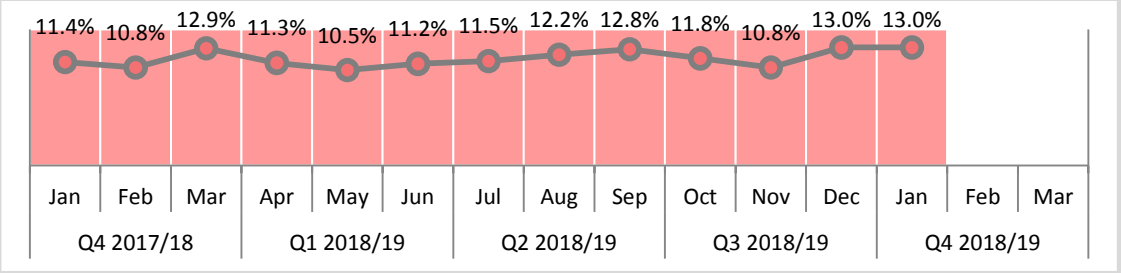
Indicator Detail

Jan-19	Medical Optimised Awaiting Transfer (MOAT)
106	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The number of patients classified as MOAT remains significantly above the Trusts target position.
<= 40	



Actions
Agreement has now been reached that a proportion of the MOAT patients can be transferred to Bluebell whilst awaiting final placement. This will reduce the number of MOAT patients and improve flow.

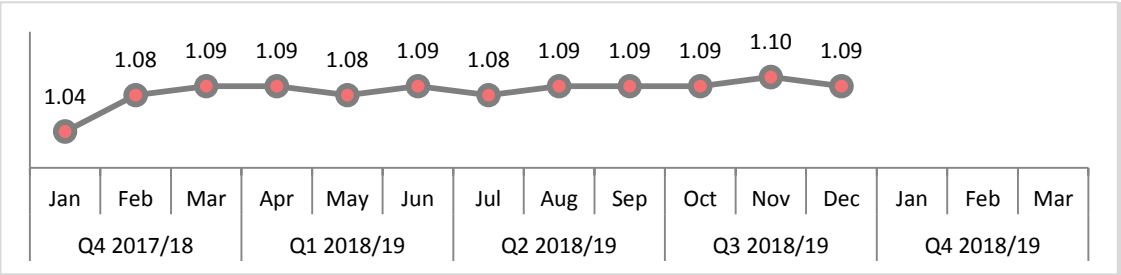
Jan-19	Bank & Agency Costs
13.0%	The total bank & agency cost as percentage of the total pay costs
Target	Total spend on bank staff in January 2019 was £1.54M, which is 8.32% of the total pay spend. Agency spend was 4.63% of total pay expenditure, a figure of £859K.
<= 5%	



Actions
The Medicine & CS Business Group bank and agency spend has decreased by £153K to £862K in January 2019, but continues to have the highest spend on bank and agency equating to 36% of the Trust overall bank and agency spend and 4.65% of the Trust total paybill.

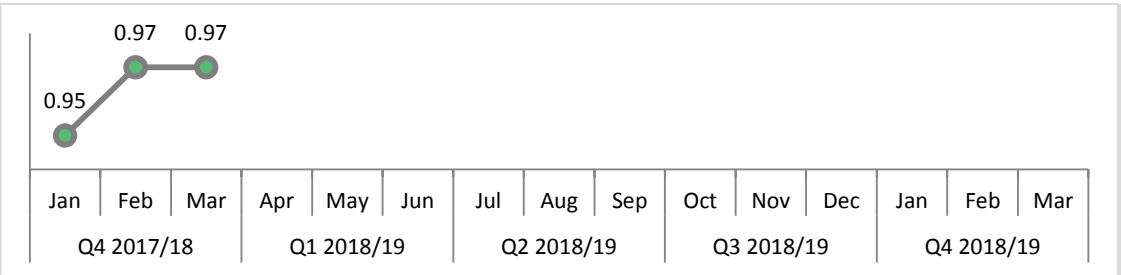
Indicator Detail

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.

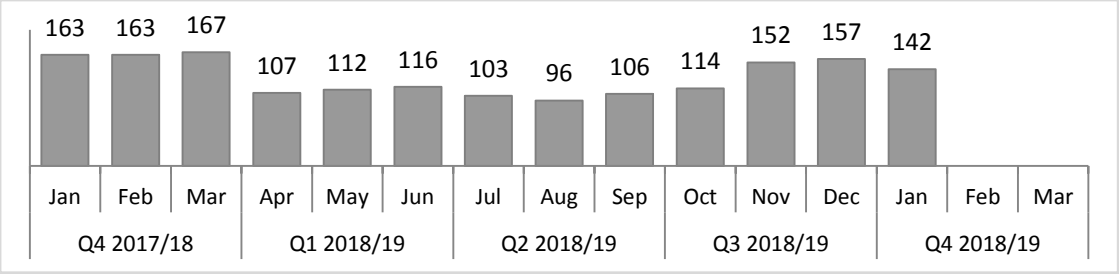
Mar-18	Mortality: SHMI
0.97	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	SHMI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



Actions
Actions as for HSMR

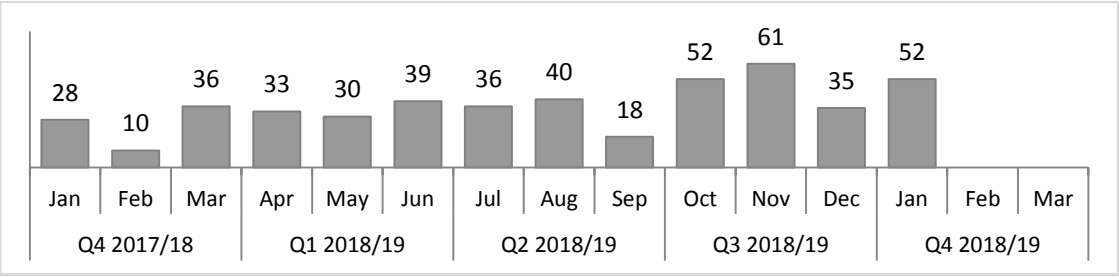
Indicator Detail

Jan-19	Mortality: Deaths in ED or as Inpatient
142	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	Seasonal increase in mortality in line with last year. There is no associated target.



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

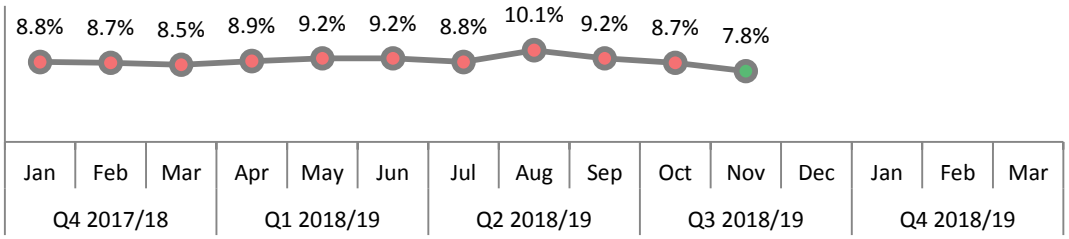
Jan-19	Mortality: Case Note Reviews
52	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	The number of case note reviews was increased last month with a percentage of 37% of deaths being reviewed, which is above our internal target of 30%.



Actions
The main focus this month is on development of an improved facilitation of feedback from bereaved next of kin.

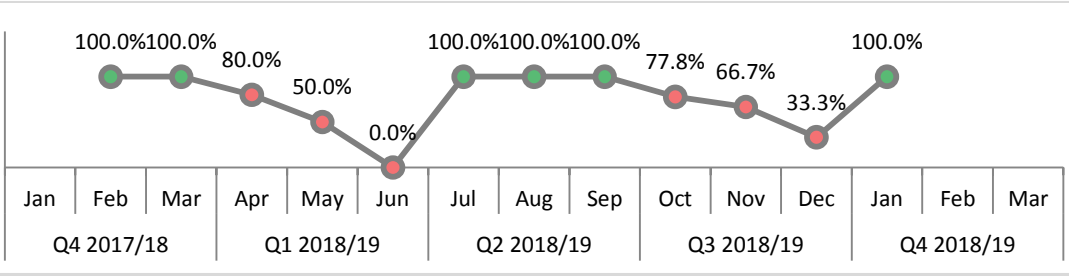
Indicator Detail

Nov-18	Emergency Readmission Rate
7.8%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	good direction of travel, but it remains too early to conclude that this is a sustained improvement.
<= 7.9%	



Actions
Stockport together initiatives, improved collaboration with general practice as well as investments in neighborhood support and crisis response.

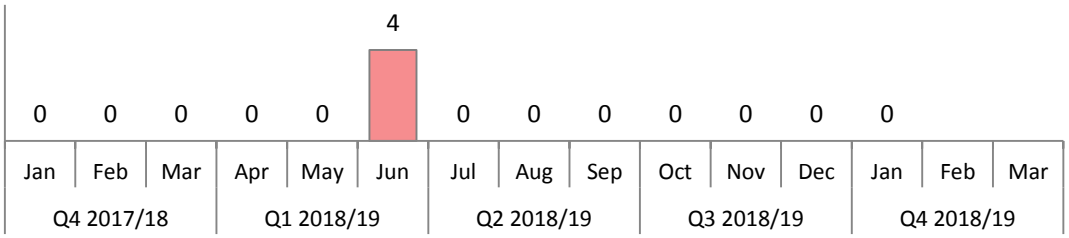
Jan-19	Patient Safety Alerts: Completion
100.0%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	There were 4 alerts due to be completed in January. All were completed within the deadline set.
>= 100%	



Actions
There are two alerts that remain outstanding from previous months Nasogastric tube misplacement- work continues through the hydration and nutrition group and compliance will be gained no later than March 2019 Risk of uncontrolled bolus of medication in certain enteral syringe pumps - a remediation team will be attending site in March 2019

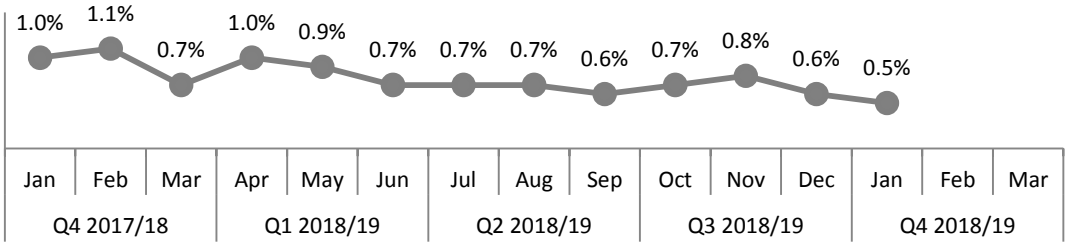
Indicator Detail

Jan-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
There were no patients affected by a mixed sex breach in the month of January.

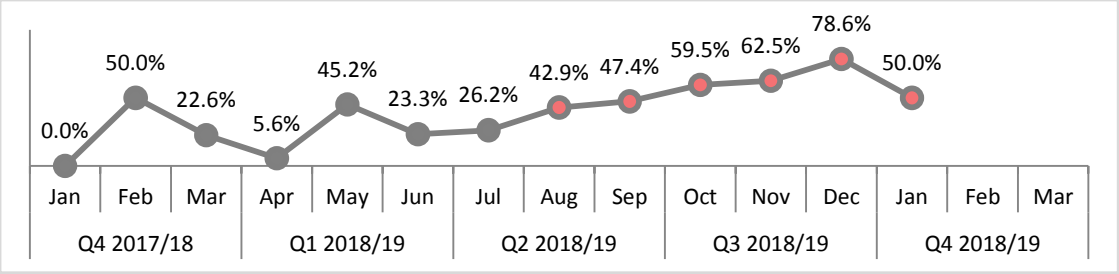
Jan-19	Complaints Rate
0.5%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	24 complaints were received in January 2019: Integrated Care = 4, Medicine = 5, Surgery = 8, WCDS = 6, Executive Team = 1



Actions
The patient and customer services team continue to focus on resolving concerns informally where appropriate in order to reduce the number of formal complaints.

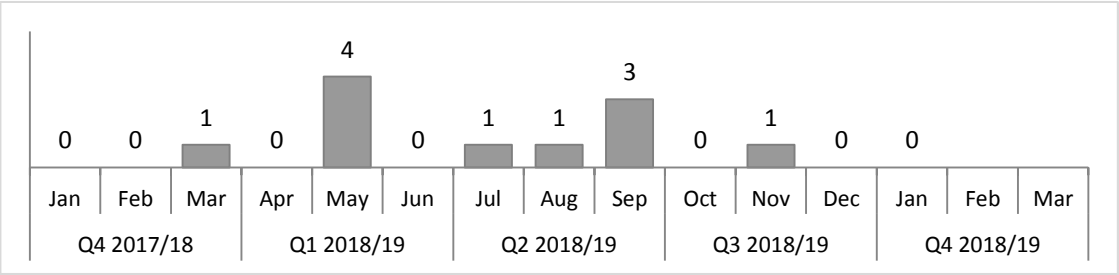
Indicator Detail

Jan-19	Complaints: Response Rate 45
50.0%	The percentage of formal complaints responded to within 45 days.
Target	In the month of January 2019, 39 responses were due out 15 of which were sent on time resulting in a 38.5% response rate. The business group response rate is as follows: Int Care: 80%, Surgery: 40%, Medicine: 30% and WCDS: 25%
>= 95%	



Actions
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 also kept informed of any delays that occur resulting in the Trust not being to respond in the agreed timeframe

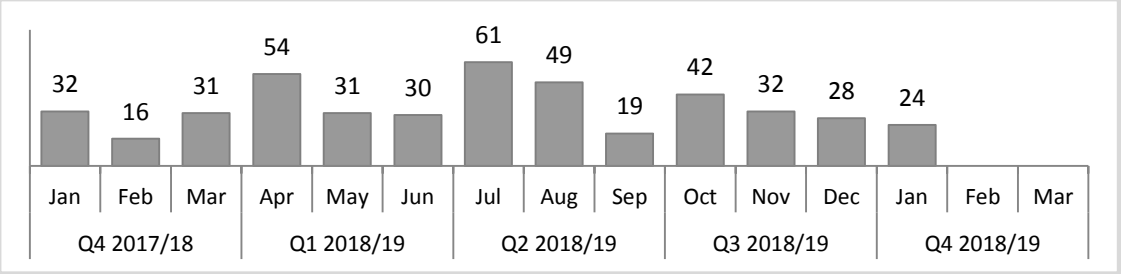
Jan-19	Complaints: Parliamentary & Health Service Ombudsman Cases
0	The total number of open Ombudsman cases.
Target	In January 2019, there were 0 referrals was received from the Parliamentary and Health Service Ombudsman and no final reports were received in month.



Actions
The PALS and Complaints Team Lead are 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.

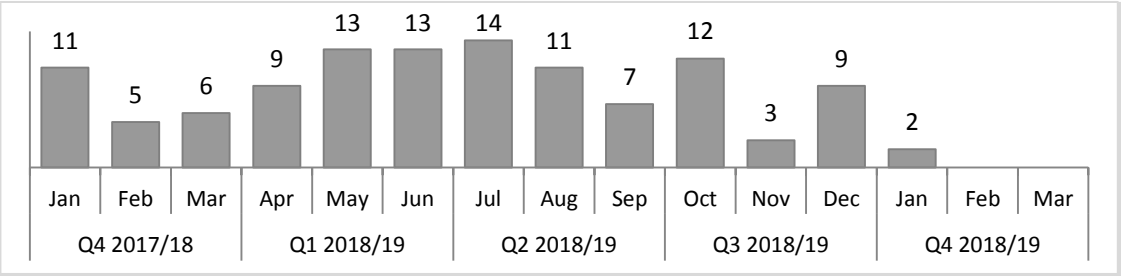
Indicator Detail

Jan-19	Complaints Closed: Overall
24	The total number of formal complaints that have been closed.
Target	In January 2019 24 cases were closed. Integrated care = 5, Medicine = 10, Surgery = 5, WCDS = 4



Actions
Work continues to ensure responses are sent in the timeframe initially agreed on the commencement of the investigation. Of the 24 closed in January, 4 were late as they were was due out in December, 16 were due out in January (although 7 of which were late) and 4 were sent early as they were not due until February.

Jan-19	Complaints Closed: Upheld
2	The total number of upheld formal complaints that have been closed.
Target	For January 2019, 2 cases were upheld out of the 24.

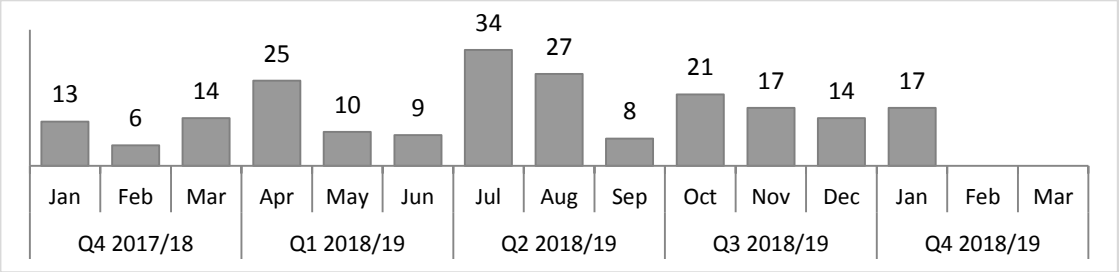


Actions
The chief nurse & director of quality governance continues to monitor the learning from complaints requests that this is always shared with the complainant.

Indicator Detail

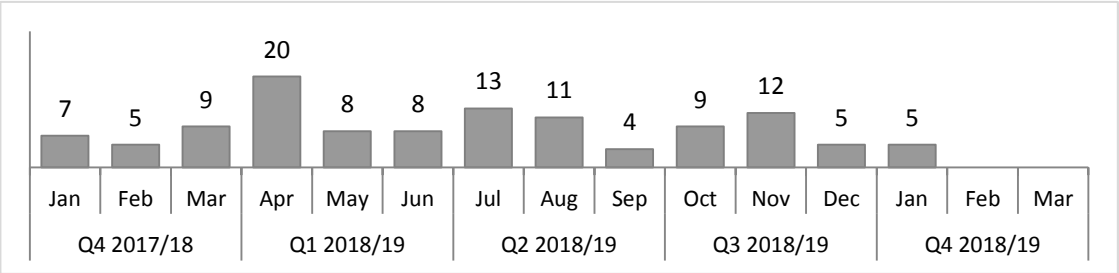
Jan-19	Complaints Closed: Partially Upheld
17	The total number of partially upheld formal complaints that have been closed.
Target	In January 2019, 5 of the cases were not upheld of the 24 closed.

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



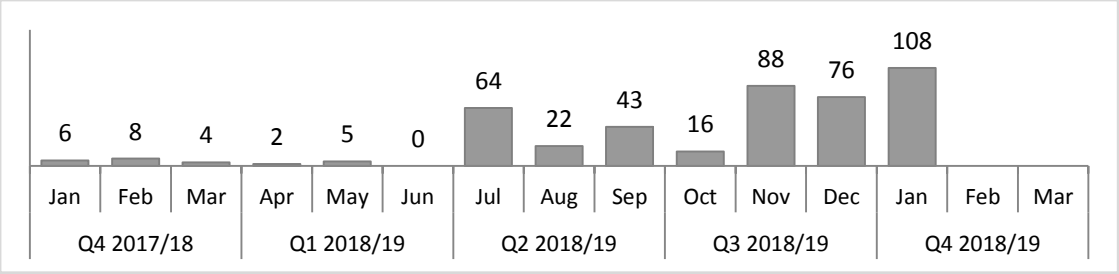
Jan-19	Complaints Closed: Not Upheld
5	The total number of not upheld formal complaints that have been closed.
Target	In January 2019, 5 of the cases were not upheld of the 24 closed.

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



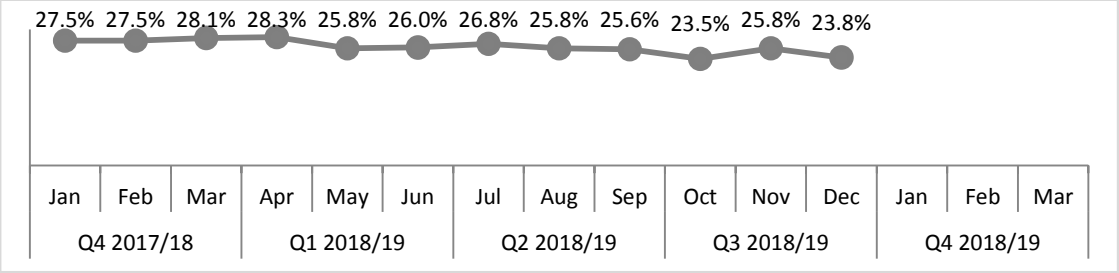
Indicator Detail

Jan-19	Compliments
108	Total number of compliments received.
Target	For January 2019, 108 compliments have been received by the Trust.



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

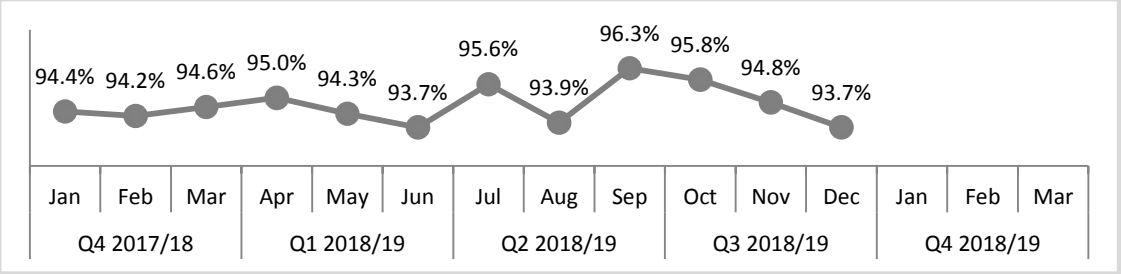
Dec-18	Friends & Family Test: Response Rate
23.8%	The percentage of eligible patients completing an FFT survey.
Target	The overall trust response rate for January 2018 for the Friends and Family test is 23.8%.



Actions
Although there is no national indicator for response rate business groups, wards and departments are encouraged to ensure as many patients as possible continue to provide feedback to enable us to triangulate the information with other patient feedback mechanisms. The patient experience group and the patient experience action group monitor the results and themes on a monthly basis.

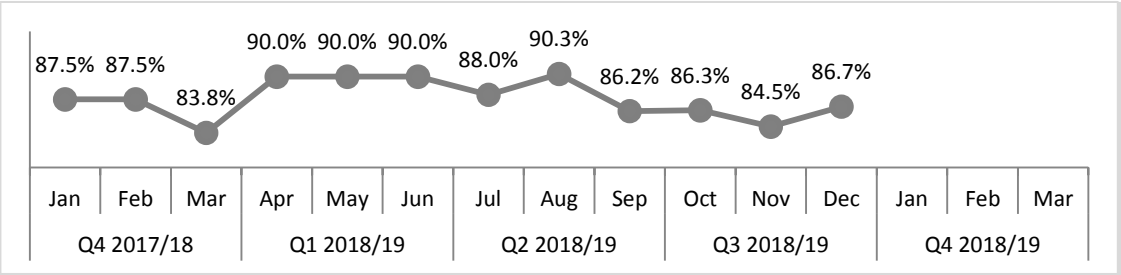
Indicator Detail

Dec-18	Friends & Family Test: Inpatient
93.7%	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 January are: Positive: Staff attitude (251), Care (122), Environment (76) Negative: Care (5), Staff attitude (5), Environment (4) The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

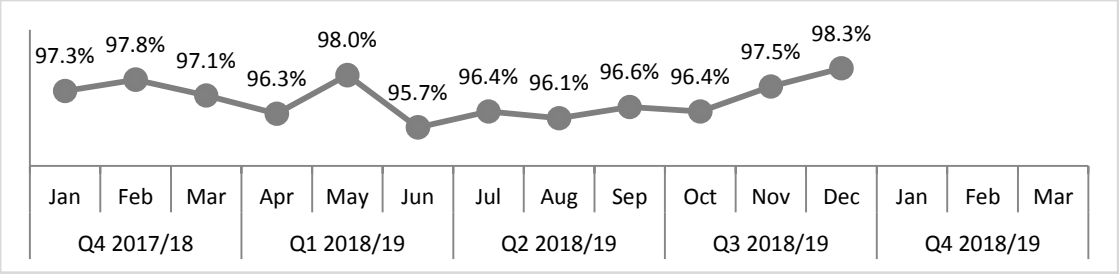
Dec-18	Friends & Family Test: A&E
86.7%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients in the Emergency Department who are extremely likely or likely to recommend the Trust for care.



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 Emergency Department for FFT in January are: Positive: Staff attitude (545), Care (204), Waiting Time (193) Negative: Waiting time (80), Staff attitude (66), Environment (51) The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

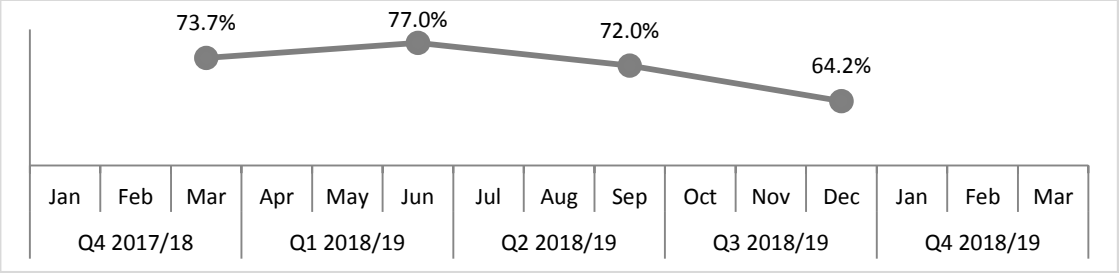
Indicator Detail

Dec-18	Friends & Family Test: Maternity
98.3%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients in the Maternity Department 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 Maternity(Birth Stage) for FFT in January are: Positive: Staff attitude (78), Care (51), Patient Mood (33) Negative: There were no negative comments. The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

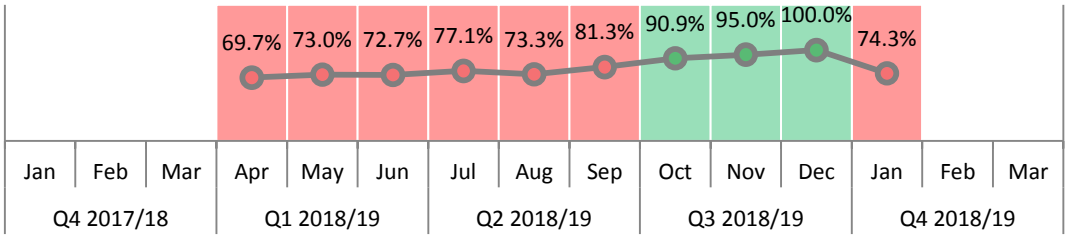
Dec-18	Staff Friends & Family Test
64.2%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The overall trust staff response rate for the Friends and Family test is 64.00%.This data was taken from the national staff survey for Qtr 3 where 598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

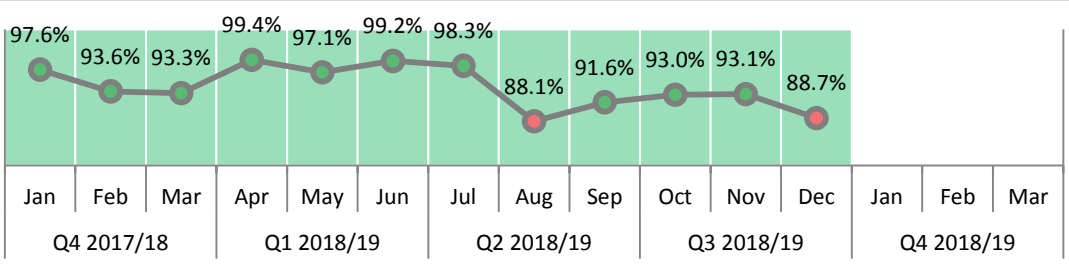
Indicator Detail

Jan-19	Diabetes Reviews
74.3%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	As anticipated there has been increased Diabetes nurse activity in January which is a seasonal variation we recognise.
>= 90%	



Actions
Given that there are continued national drivers to improve Glucose control, and rising Diabetes prevalence it is anticipated that inpatient diabetes complications will continue to increase. It is unlikely that, with current distribution of resource, the Trust will be able to consistently achieve the KPI by proactive searching for patients experiencing hypoglycaemia. A system-wide approach is required.

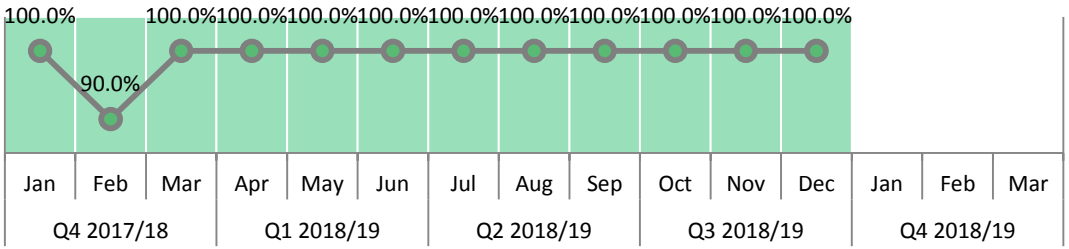
Dec-18	Dementia: Finding Question
88.7%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The Trust has a target of above 90% for the finding question within the FAIR process.
>= 90%	



Actions
In December 2018 the completion of the FAIRs was transferred to the newly appointed Matron for Dementia. There has been some transitional obstacles and a review of the systems to ensure that the FAIRs are completed with an improved percentage and on target.

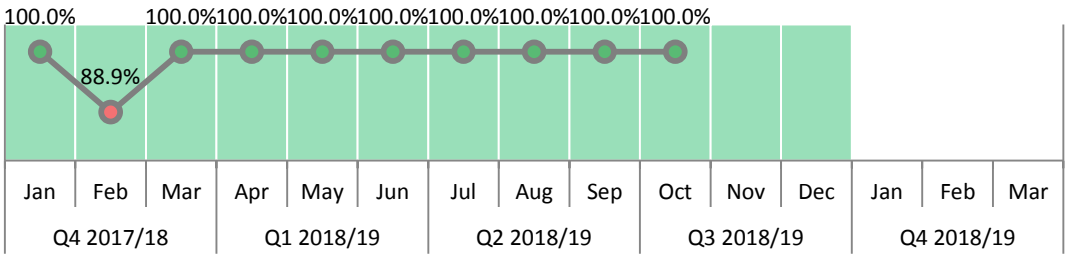
Indicator Detail

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



Actions
The target was achieved in month.

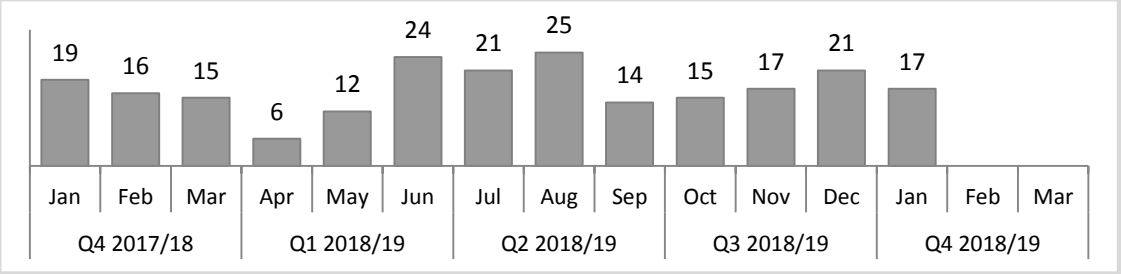
Dec-18	Dementia: Referral
	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target is >90%
>= 90%	



Actions
The target was achieved in month.

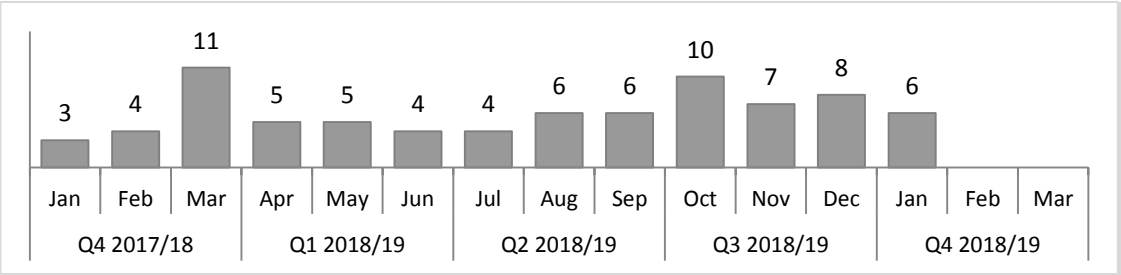
Indicator Detail

Jan-19	Serious Incidents: STEIS Reportable
17	The total number of STEIS reportable incidents.
Target	There have been 17 StEIS reportable incidents in the month of January. All serious incidents have been reviewed by the Chief Nurse & Director of Quality Governance and the Medical Director.



Actions
Investigations are underway in accordance with trust policy. 6 cases relating to pressure ulcers. There were 5 category 3 pressure ulcers and 1 category 4 pressure ulcer. 6 cases relating to patients waiting more than 12 hours in emergency department and meeting the criteria of a 12 hour breach. 2 cases relating to missed diagnosis 1 case relating to a deceased patient not being transferred in a timely manner to the mortuary. 1 case relating to a patient who fell and sustained a fractured hip. 1 case relating to a maternity divert due to increased activity and reduced staffing levels.

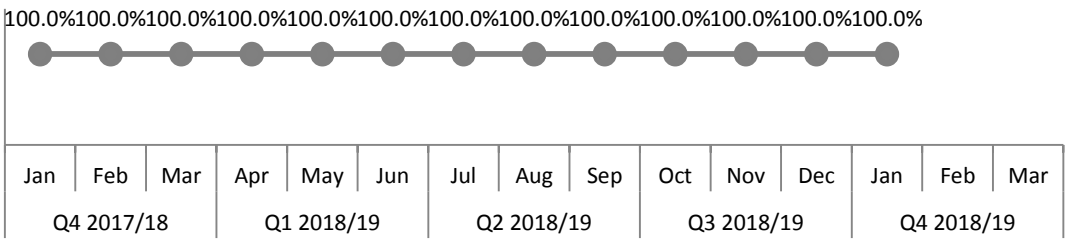
Jan-19	Litigation: Claims
6	Total number of claims opened in month.
Target	There were 6 medical negligence claims received last month. No employee liability claims were received. No public liability claims were received.



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

Indicator Detail

Jan-19	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	In January 2019, eleven claims were closed. Only one was successful against the trust.

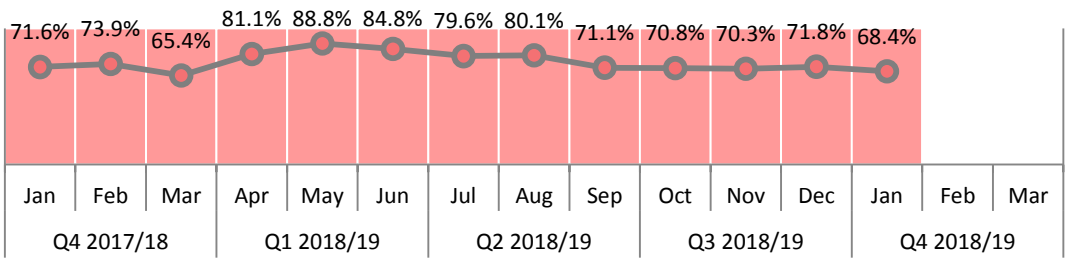


Actions

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

The claim settled this month, related to a failure to diagnose a significant complication following surgery.

Jan-19	A&E: 4hr Standard
68.4%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance against the 4hr standard remains significantly challenged.
>= 95%	



Actions

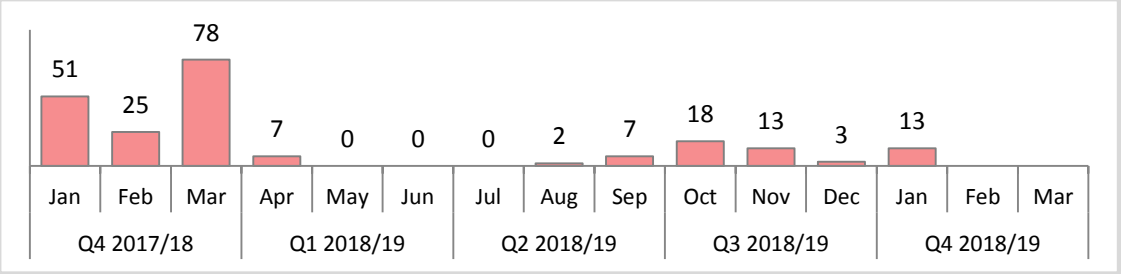
Focus continues on:-
- discharges before 12 noon
-'red rigour' within ED - focus on non-admitted and minor patients.
- increasing protocols going through RATs - which has maintained the wait to be seen
- the SOS protocol for resusitation response - this will ensure that only the medical staff rota'd for resus attend.

The capital build will be complete by the 25th February, with the exception of the 4 additional cubicles which are due to come on-line 30th March

The Urgent Care Delivery Board is monitoring progress against the 4 work streams; Stay well; Home first; Patient Flow & Discharge. The SROs for these work streams are being reviewed to strengthen delivery.

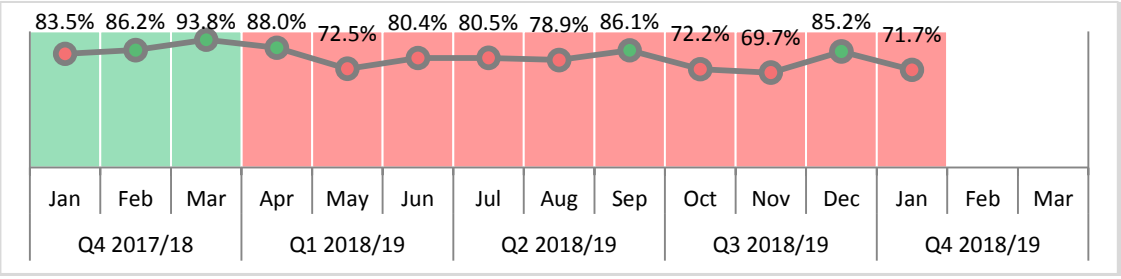
Indicator Detail

Jan-19	A&E: 12hr Trolley Wait
13	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	There were 13 reported breaches of the 12hr standard in month.
<= 0	A proportion of these were due to the requirement of side-rooms, primarily as a result of a high number of patients presenting with Flu.



Actions
A full Root Cause Analysis is undertaken immediately for each occurrence. The staff members involved attend a meeting with the Chief Operating Officer to explain the reason for the breach and to discuss how this may be avoided in the future,

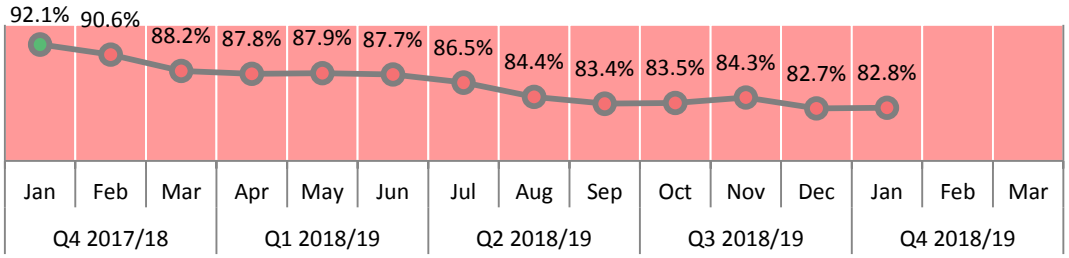
Jan-19	Cancer: 62 Day Standard
71.7%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	As predicted, the Trust achieved the 62 day standard in December with a performance of 85.2%.
>= 85%	The latest performance for January is 71%



Actions
As indicated in the cancer deep dive paper, recovery of the cancer standard is multi-factorial. At the meeting on the 4th March with GM Cancer representatives, it is the intention to share the analysis to date to establish any support that they may be able to offer.

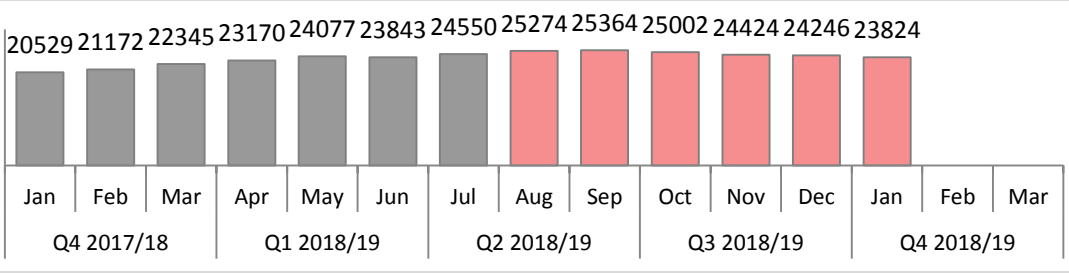
Indicator Detail

Jan-19	Referral to Treatment: Incomplete Pathways
82.8%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	The Trust achieved 82.8% against the 92% standard in January.
>= 92%	



Actions
There is a focus on the longest waiting patients each week at the Trust PTL meeting ensuring that each patient has an appropriate plan in place. Elective activity recovery plans continue to be enacted. The Trust-wide review of clinical correspondence processes and alternative provision of this service will help to support timely delivery of RTT pathways going forward.

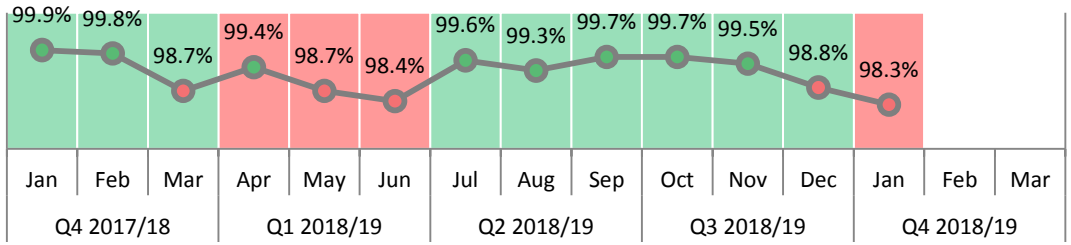
Jan-19	Referral to Treatment: Incomplete Waiting List Size
23824	The total number of patients on an open pathway.
Target	The Incomplete waiting list size continues to improve with a further reduction o f 422 pathways in month.
<= 22346	



Actions
Data quality checks continue to be systematically undertaken. Elective activity recovery plans continue to positively impact.

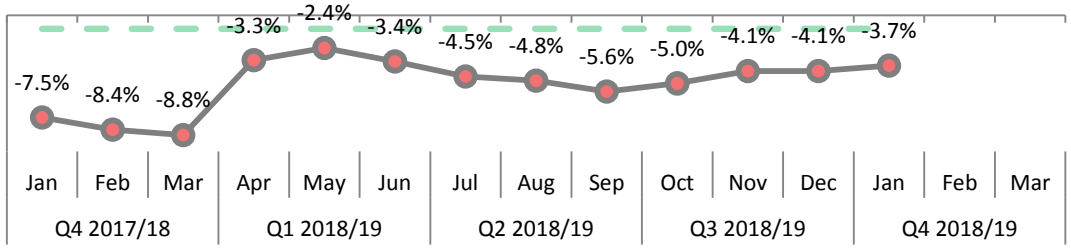
Indicator Detail

Jan-19	Diagnostics: 6 Week Standard
98.3%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust failed to achieve the diagnostic standard in January. In the main this was due to capacity constraints within Audiology following an unusually high level of acute sickness within the team. A residual number of MR breaches were incurred due to the continuing national shortage of contrast medium.
>= 99%	



Actions
Staffing numbers within Audiology are back to full compliment. Additional lists are being planned to address the waiting time. It is anticipated that this will have been fully addressed by the end of February. MR scans continue to be clinically prioritised.

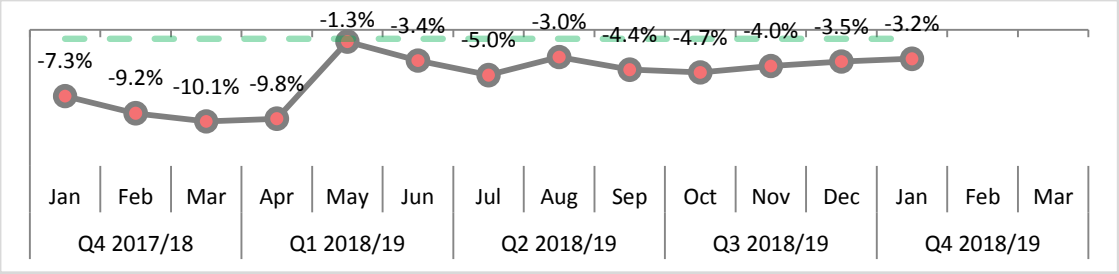
Jan-19	Elective Activity vs. Plan
-3.7%	The percentage variance between planned elective activity and actual elective activity.
Target	The elective variance to plan has improved to -3.7% in January. There has been a significant improvement in in-month performance over the last couple of months following stronger grip and control.
>= -1%	



Actions
Business Group recovery plans for elective activity are monitored via the Executive Performance Review meetings.

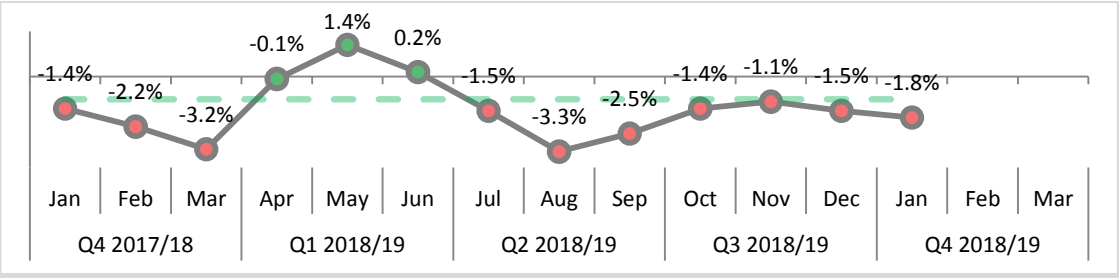
Indicator Detail

Jan-19	Elective Income vs. Plan
-3.2%	The percentage variance between planned elective income and the actual elective income.
Target	Elective income variance has improved in conjunction with the improved elective activity throughput.
>= -1%	



Actions
Business Group performance is closely monitored via the Executive Performance Review meetings.

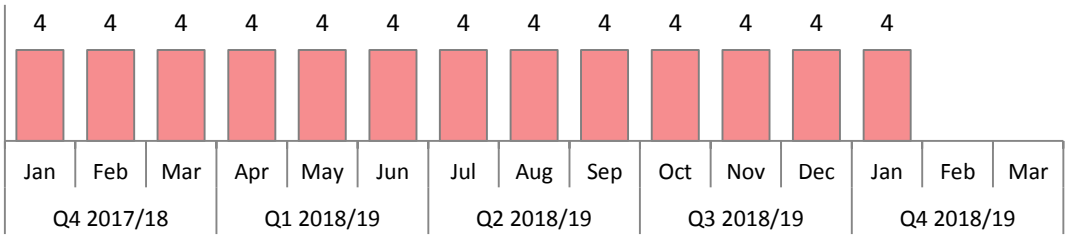
Jan-19	Outpatient Activity vs. Plan
-1.8%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Variance to Outpatient plan in month was mainly driven by under-performance in Ophthalmology, Physiotherapy and Anticoagulation.
>= -1%	



Actions
Ophthalmology clinical gaps have started to be filled with 2 clinicians in post in January and a further 2 clinical staff commencing in February. In month, physiotherapy spells are significantly behind plan, however the year to date performance remains positive. It should be noted that the plan includes inflated spells associated with the Anticoagulant pathway whose change has reduced the requirement for patient monitoring.

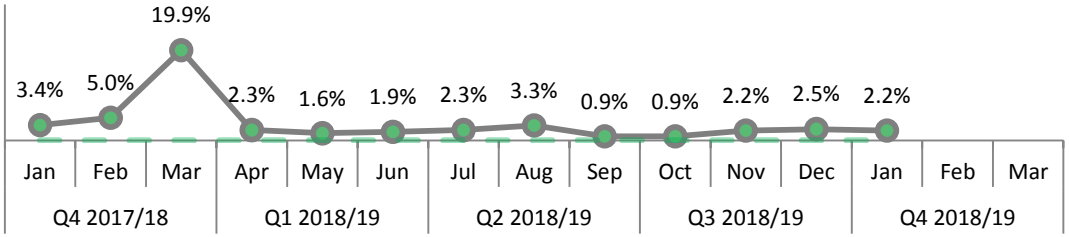
Indicator Detail

Jan-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 improve by circa £30m to a deficit of less than £3m (within 1% of planned operating income).
<= 2	



Actions
The financial outlook for the Trust remains difficult; in the twelve months to 31st March 2019 the Trust is planning a loss of £34m (£93,000 per day) even after the achievement of a £15.0m CIP. The Trust has delivered a deficit of £28.5m with two months to go in the 2018/19 financial year. This is slightly favourable to plan; however it does not represent a sustainable financial position for the Trust. The underlying position continues to be monitored by NHSI through the Enhanced Financial Oversight and Use of Resources processes, and is working closely with colleagues to improve the underlying run-rate. The Trust has accepted a control total offer for 2019/20 from NHS Improvement to support the journey to break even, and as part of planning for the year ahead.

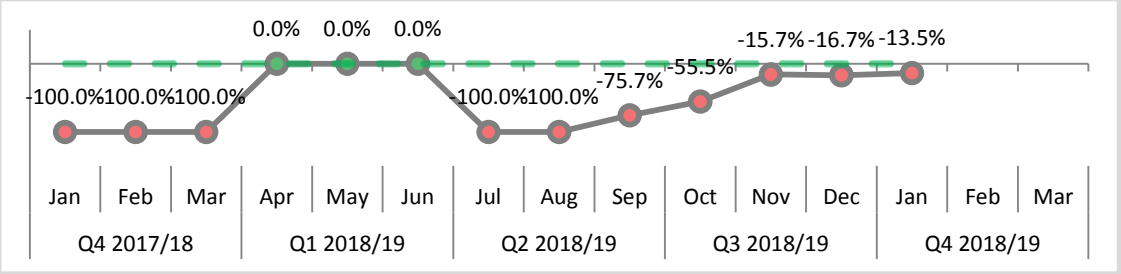
Jan-19	Financial Controls: I&E Position
2.2%	The percentage variance between planned financial position and the actual financial position.
Target	The Trust has lost of £28.5m with two months to go in the financial year, an average loss of £93,000 per day. The planned deficit was £29.2m so this is £0.6m 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. This is despite the elective income performance, winter demands, and risk of additional contract penalties due to operational performance. 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 final two months of the financial year.

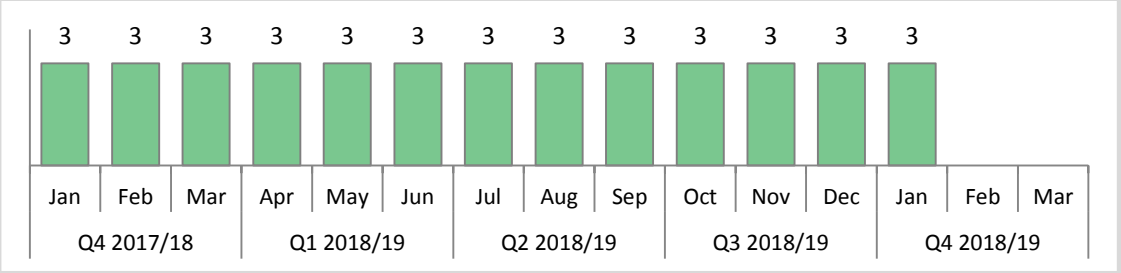
Indicator Detail

Jan-19	Cash
-13.5%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st January 2019 was £6.7m. 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 January was £6.7m, which is £0.9m 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 £2.2m in January, increasing the total borrowed to date to £15.6m. The requested cash for February is £3.3m and a further £5.5m for March, increasing total cash borrowing for the financial year to £24.4m. Cash borrowing is directly linked to the Trust's annual planned deficit, so from 1st April 2019 with acceptance of the control total for the new financial year cash will be significantly more constrained. Achievement of the financial plan from day one is vital to the cash position of the Trust.

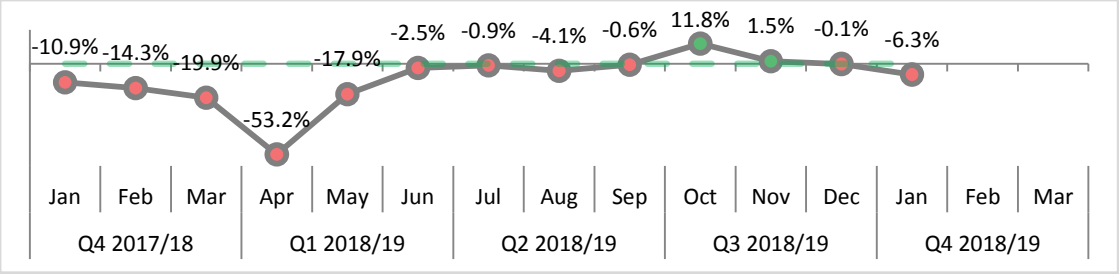
Jan-19	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's overall Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as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

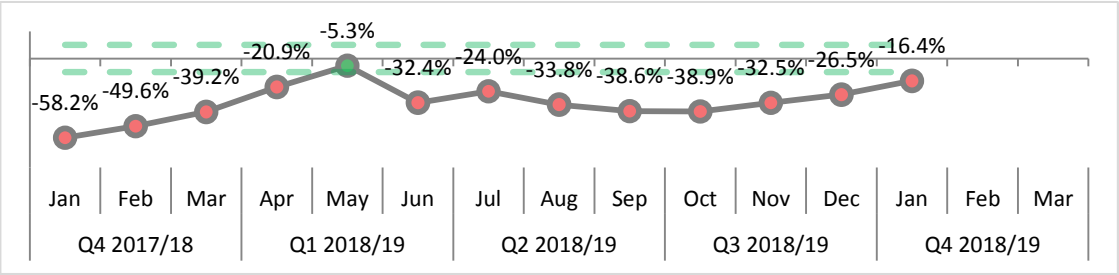
Indicator Detail

Jan-19	CIP Cumulative Achievement
-6.3%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is behind the profiled plan to date with £10.3m delivered to date. £11.7m of CIP has been delivered against the £15.0m in year target. The unidentified gap remains at £2.3m.
>= 0%	



Actions
Whilst the Trust is in line with its profiled CIP plan to date there is a significant risk to the delivery of the total CIP programme in 2018/19. The phasing of the CIP means that the level of savings required increases in the last quarter of the year. There is a further risk of delivery in 2019/20 as there is not the required level of recurrent savings delivered to date. Recurrently £8.1m of savings have been delivered against the £15m requirement. Even with potential mitigation the Trust can only provide moderate assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

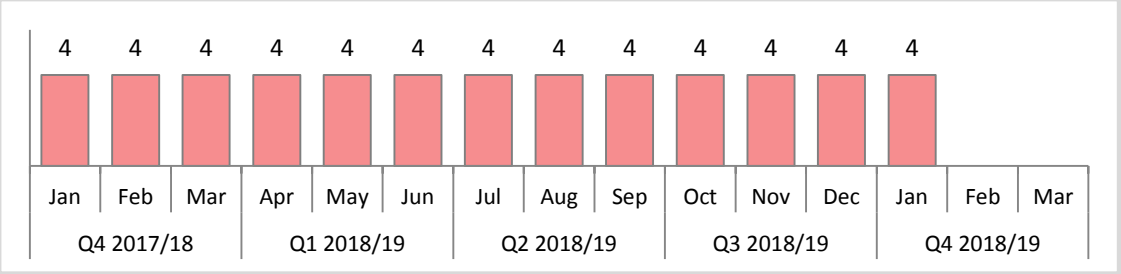
Jan-19	Capital Expenditure
-16.4%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £7.2m have been incurred to date against a plan of £8.6m so is £1.4m behind plan. This relates to equipment which is £0.8m behind plan and estates schemes which are £0.8m underspent.
+/- 10%	



Actions
The major variance for equipment is £0.7m for the gamma camera project which has been reforecast to complete in March 2019. Building work to modify the room for the equipment has commenced and the service has been temporarily diverted to other hospitals. Estates projects are also behind plan but the Trust is confident that these projects will deliver within £0.2m of plan by the end of the financial year. The full funding of Healthier Together schemes is fundamental to the delivery of the capital programme, but these will not be incurred in the current financial year, so as a result the Trust's capital plan will show a variance for the Healthier Together schemes later in the year. The Trust's overall capital plan will reduce to £10.1m for 2018/19.

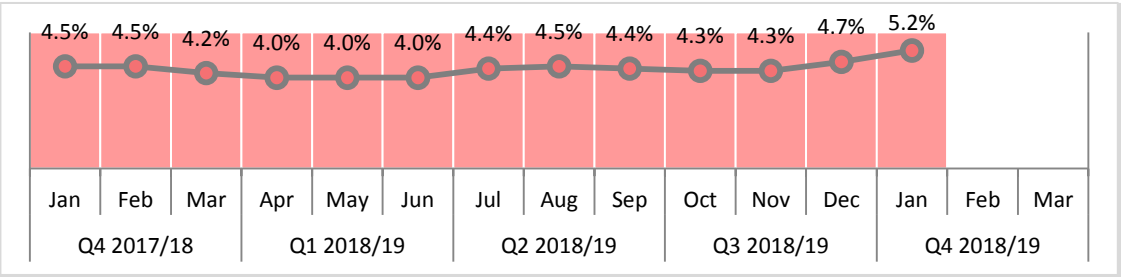
Indicator Detail

Jan-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

Jan-19	Sickness Absence Rate
5.2%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for January 2019 is 5.19%; an increase of 0.48% against the adjusted December 2018 figure of 4.71%. (January 2018 was 4.84%). The 12-month rolling sickness percentage for the period February 2018 to January 2019 is 4.36%.
<= 3.5%	



Actions

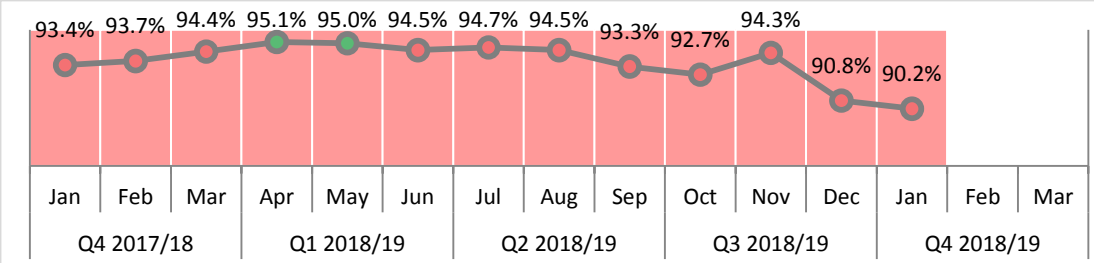
The top three reasons for absence in January 2019 are: Anxiety/Stress/Depression/Other Psychiatric at 28.17%; Back/ Musculoskeletal Problems including Injury/Fracture at 26.72%; and Cough/ Cold/ Flu/ Asthma/ Chest problems at 10.07%. The high sickness rate for January is mainly attributed to an increase of Anxiety/Stress related episodes which have increased by almost 650 WTE days since December 2018.

The unadjusted cost of sickness absence in January 2019 is £605,402; an increase of £44,343 from the adjusted figure of £561,059 in the previous month. This does not include the cost to cover the absence.

Further analysis of the increase in absence is underway, with a spotlight approach to be undertaken in hot spot areas.

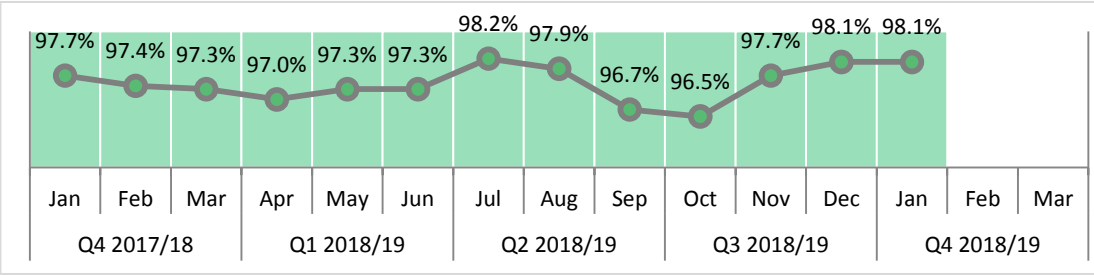
Indicator Detail

Jan-19	Appraisal Rate: Non-medical
90.2%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for January 2019 is 90.22%, which is significantly below the target of 95%.
>= 95%	



Actions
1. A review of the reporting processes has been undertaken in order to provide managers with a specific non-compliance list to support the targeting of efforts. 2. A task and finish group to improve the whole appraisal process and experience has commenced; this is attended by representatives from across the Trust clinical areas.

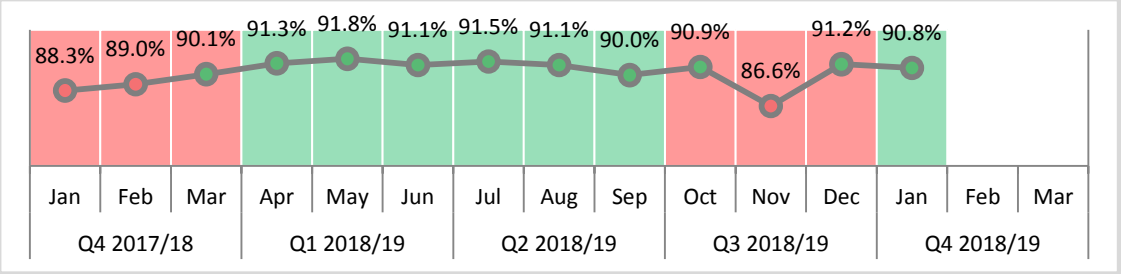
Jan-19	Appraisal Rate: Medical
98.1%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for January 2019 is 98.07% and above the Trust target of 95%.
>= 95%	



Actions
Maintain performance.

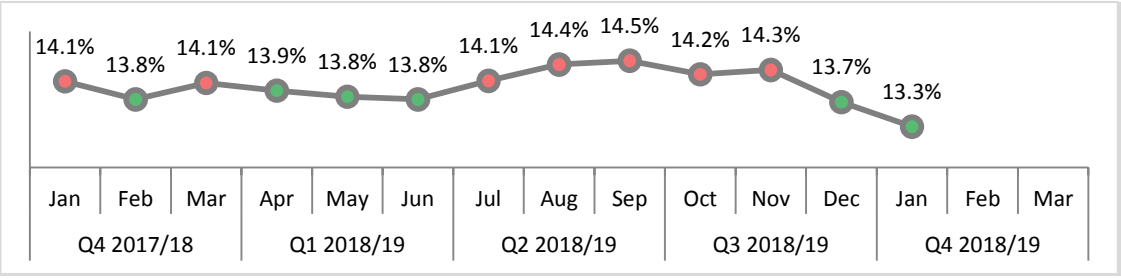
Indicator Detail

Jan-19	Statutory & Mandatory Training
90.8%	The percentage of statutory & mandatory training modules showing as compliant.
Jan-19	Statutory and Mandatory training has achieved the required level of compliance in January 2019 (90.79%).
>= 90%	



Actions
Monthly reports continue to be sent to managers to enable them to monitor staff compliance and encourage completion of e-learning updates.

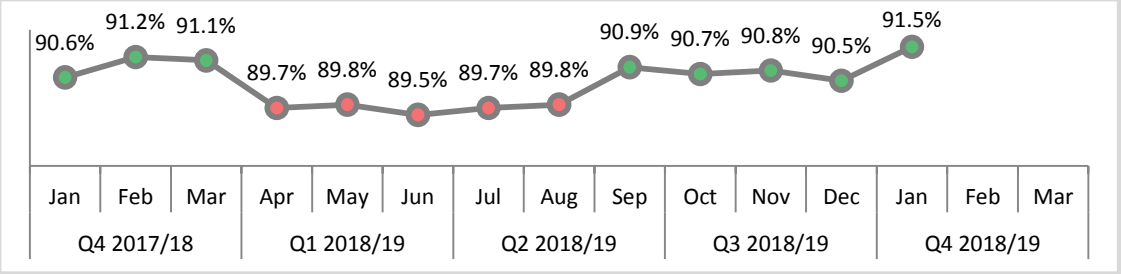
Jan-19	Workforce Turnover
13.3%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of January 2019 is 13.25%; the adjusted turnover figure for the period to January 2019 is 11.84%, both of which fall below the Trust target.
<= 13.94%	



Actions
The main reasons for leaving are: Relocation 16.43%, Work Life Balance/Dependents 14.99%, Retirement 14.83% & Promotion 14.51%. 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 doctors from overseas to our hard to fill vacancies and development of 'new roles'.

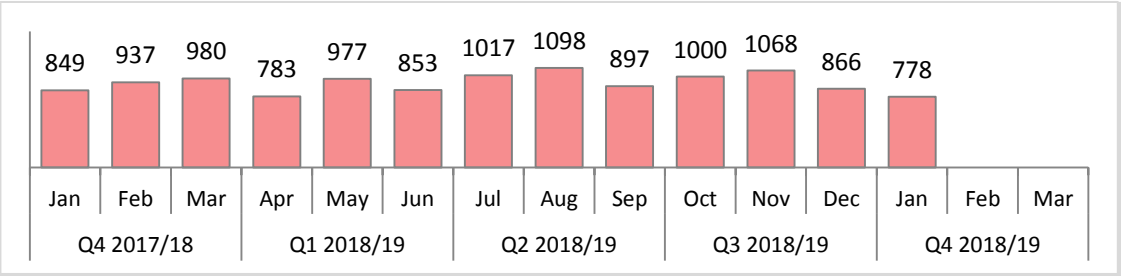
Indicator Detail

Jan-19	Staff in Post
91.5%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for January 2019 is 91.47% of the establishment, which is an increase of 0.95% from 90.52% the previous month.
>= 90%	



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

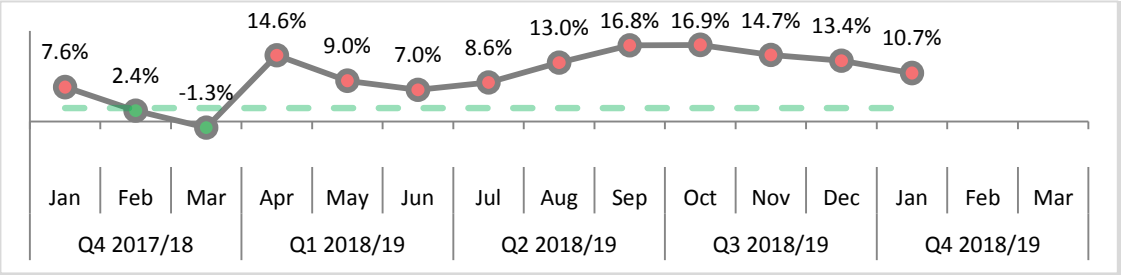
Jan-19	Agency Shifts Above Capped Rates
778	Number of agency shifts above above the provider spend cap.
Target	A total of 778 shifts were paid above the NHSI cap rate during the 4 week period from 31st December 2018 and 27th January 2019; equating to an average of 195 shifts per week. A decrease of 22 shifts per week compared to December's and a decrease of 17 shifts per week compared to January 2018 performance.
<= 0	



Actions
Medicine & Clinical Support had the highest number of agency cap breaches with an average of 95 shifts per week, followed by Integrated Care with an average of 59 per week. There were a total of 141 shifts paid at or above £100 per hour, which required Chief Executive approval, which is an average of 35 shifts per week, compared to 42 shifts per week in December. As part of the efforts to reduce agency spend, a revision of the locum rates bas been completed by ECP. Business Groups have been issued with the revised rates thresholds. A new agency request form and log has been developed. These changes will take effect from February 2019.

Indicator Detail

Jan-19	Agency Spend: Distance From Ceiling
10.7%	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 4.63% of total pay expenditure, a figure of £859K. In month 10 the Trust spent £859,000 (£435,000 on medical agency & £310,000 on non-medical, clinical agency). A significant reduction from last month's spend and falls under forecast.
<= 3%	



Actions
There has been a significant reduction in medical agency spend, particularly in Medicine and Clinical Support and Integrated Care; however, nursing spend has increased. Actions remain in place to reduce the level of spend and the current forecast for the end of the year is £11.5M, exceeding the agency ceiling of £10,534,000 for 2018/2019.

Safer Staffing Report

Jan-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	3,276	3,348	3,156	3,720	3,097	3,069	2,981	80.1%	94.3%	83.3%	97.1%	1707	3.7	3.6	7.3	0	0	0	0
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	192	3.7	3.7	7.4	0	0	0	0
D4	1,163	1,013	791	753	682	682	682	671	87.1%	95.3%	100.0%	98.4%	491	3.5	2.9	6.4	0	0	0	0
A3	1,442	1,225	977	909	1,023	759	682	638	84.9%	93.1%	74.2%	93.5%	721	2.8	2.1	4.9	1	0	0	0
A10	2,895	2,580	2,046	1,488	2,046	1,974	1,364	1,376	89.1%	72.7%	96.5%	100.9%	793	5.7	3.6	9.4	0	0	0	0
A11	1,581	1,413	1,628	1,470	682	473	682	671	89.4%	90.3%	69.4%	98.4%	806	2.3	2.7	5.0	1	0	0	0
A12	861	847	651	644	308	308	462	594	98.3%	98.9%	100.0%	128.6%	250	4.6	5.0	9.6	0	0	0	0
B4	1,209	1,245	713	835	682	682	682	1,008	102.9%	117.1%	100.0%	147.7%	511	3.8	3.6	7.4	0	0	0	1
B2	1,209	804	605	863	682	682	682	682	66.5%	142.7%	100.0%	100.0%	508	2.9	3.0	6.0	1	0	0	2
B6	1,442	1,299	1,302	1,302	682	726	1,023	1,177	90.1%	100.0%	106.5%	115.1%	663	3.1	3.7	6.8	0	0	0	0
Bluebell Ward	1,209	1,161	2,077	1,879	682	613	682	598	96.0%	90.5%	89.9%	87.7%	643	2.8	3.9	6.6	0	0	0	0
C3	918	903	476	551	374	374	374	561	98.4%	115.8%	100.0%	150.0%	240	5.3	4.6	10.0	0	0	0	0
C4	1,209	917	605	1,161	682	682	682	847	75.8%	192.0%	100.0%	124.2%	479	3.3	4.2	7.5	0	0	0	1
Coronary Care Unit	837	837	465	426	682	682	341	352	100.0%	91.6%	100.0%	103.2%	167	9.1	4.7	13.8	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,070	1,070	2,000	1,898	682	660	682	1,001	100.0%	94.9%	96.8%	146.8%	502	3.4	5.8	9.2	0	0	0	0
E1	1,952	1,359	2,310	2,295	1,023	836	1,364	1,584	69.6%	99.4%	81.7%	116.1%	970	2.3	4.0	6.3	0	0	0	0
E2	2,279	2,235	1,581	1,991	1,023	1,012	1,023	1,364	98.1%	125.9%	98.9%	133.3%	985	3.3	3.4	6.7	1	2	0	0
E3	2,279	2,230	1,581	1,596	1,023	1,012	1,023	1,353	97.8%	100.9%	98.9%	132.3%	1064	3.0	2.8	5.8	0	0	0	0

Safer Staffing Report

Jan-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	1,140	1,209	1,059	1,023	858	682	660	81.7%	87.6%	83.9%	96.8%	969	2.1	1.8	3.8	0	0	0	0
B3	942	950	837	936	682	660	682	847	100.8%	111.9%	96.8%	124.2%	482	3.3	3.7	7.0	0	0	0	2
C6	942	1,110	1,119	1,251	682	1,012	682	759	117.8%	111.8%	148.4%	111.3%	689	3.1	2.9	6.0	0	0	0	0
D1	1,686	1,349	1,349	1,265	682	682	1,023	990	80.0%	93.8%	100.0%	96.8%	728	2.8	3.1	5.9	0	0	0	0
D2	1,642	1,267	1,442	1,752	682	611	682	1,361	77.2%	121.5%	89.6%	199.6%	615	3.1	5.1	8.1	0	0	0	0
D6	1,314	1,243	1,044	855	682	661	682	682	94.6%	81.9%	96.8%	100.0%	650	2.9	2.4	5.3	0	0	0	0
M4	1,248	1,140	977	875	682	679	594	572	91.3%	89.6%	99.6%	96.3%	452	4.0	3.2	7.2	0	0	0	0
SAU	1,859	1,823	729	606	1,023	946	682	561	98.1%	83.2%	92.5%		446	6.2	2.6	8.8	0	0	0	0
Short Stay Surgical Unit	1,937	1,605	801	765	891	857	682	706	82.9%	95.5%	96.2%	103.5%	654	3.8	2.2	6.0	0	0	0	0
ICU & HDU	4,712	4,298	372	336	4,092	3,924	341	341	91.2%	90.3%	95.9%	100.0%	335	24.5	2.0	26.6	0	0	0	0
Birth Centre	930	758	465	458	620	560	310	280	81.5%	98.4%	90.3%	90.3%	15	87.8	49.2	137.0				
Delivery Suite	2,790	2,655	465	443	1,860	1,860	310	310	95.2%	95.2%	100.0%	100.0%	214	21.1	3.5	24.6				
Maternity 2	1,628	1,613	930	915	682	682	341	321	99.1%	98.4%	100.0%	94.1%	466	4.9	2.7	7.6				
Jasmine Ward	930	930	465	471	620	620	0	85	100.0%	101.3%	100.0%	na	246	6.3	2.3	8.6	0	1	0	0
Neonatal Unit	2,325	1,988	0	0	1,628	1,365	0	0	85.5%	na	83.9%	na	337	9.9	0.0	9.9	0	0	0	0
Tree House	3,255	3,068	465	465	2,170	2,186	0	0	94.2%	100.0%	100.7%	na	660	8.0	0.7	8.7	0	0	0	0
	57,548	51,714	36,192	36,037	35,720	33,757	23,533	26,274	89.9%	99.6%	94.5%	111.6%	19650	4.3	3.2	7.5	4	3	0	6

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : January 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	89.8% of expected Registered Nurse hours were achieved for day shifts. This is the 5th 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.	January 89.9% December 89.8% November 89.9%	The lowest RN staffing levels during the day were on Ward B4 at 66.5%. This has been supported by an increase in non-registered staff to 142.7%. There are never less than 2 RN on duty. The business group is reviewing the harm free care metrics that have been reported for this ward in month.
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	94.5% of expected Registered Nurse hours were achieved for night shifts.	January 94.5% December 93.4% November 93.4%	The lowest RN night staffing levels are reported on Ward A11 69.4%. Closely supported by business group Matron and Associate Nurse Director. Harm free care metrics alongside staffing levels are reviewed to assure safe care. Business group Matron and Associate Nurse Director are reviewing the staffing levels due to harm free care results in month.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	99.6% of expected Non-registered hours were achieved for day shifts.	January 99.6% December 99.9% November 104.0%	The lowest non registered staffing levels for day duty is on Ward A10 at 72.7%. The ward is closely monitored by business group Matrons; recruitment for non-registered staff is on-going. Harm free care metrics on A10 are optimal in month.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	111.6 % of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed & is predominately due to wards requiring 1:1 support for patients following a risk assessment or to support Registered Nurses staffing numbers when there are unfilled RN shifts.	January 111.6% December 106.8 % November 108.9%	The lowest levels of non-registered night duty staffing at 87.79% on Bluebell. The wards is closely monitored by the business group Matrons alongside harm free care metrics, which are optimal in month for Bluebell.

BOARD PAPERS – Quality, Safety & Experience Section : November 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered nurse safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	In January 2019 there were 213.9 WTE filled	Of the RN 213.9 WTE the fill rate overall is 71% of the shifts requested Of the 71% filled 46% are NHSP and agency 25% In month substantive vacancies are 157 WTE RN.
Non-registered safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	January WTE filled is 215.4	Of the non-registered 215.4 WTE the fill rate overall is 72% and agency is 0.1% Vacancies at band 2 non registered are 50 WTE however a small number of these vacancies are reserved for trainee nurse associates .

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/02/19		**Report of:** Quality Committee
Date of last meeting: 22/01/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Pressure Ulcer Presentation • Committee Work Plan • IPR – Quality Metrics • Safe, High Quality Care Improvement Plan • Seven Day Service – Board Assurance Submission • Learning from Experience Quarterly Report • Duty of Candour Policy • Sepsis Update Report • CQUIN Report • Quality Account • Medicines Management Group • Patient Experience Group • Trust Risk Register • Key Issues for Board of Directors
	Alert	• The Committee were alerted to the current position in relation to Sepsis Screening. - Sepsis screening and antibiotics within 1 hour have declined since September 2018. - New Sepsis screening tool has been implemented. - New process in place to facilitate more BG ownership with requirement for BG compliance data to be discussed at their quality boards with action plans. - Additional leadership support from AMD hospital care and Deputy Chief nurse has been provided to the sepsis steering committee from December 2018. - Sepsis steering committee and NEWS 2 group has agreed on changes on patient track to identify suspected sepsis streamlining data collection requirements and releasing clinical resource for education and ward level feedback. • The Committee heard that the Trust is in the process of responding to the CQC in relation to any potential breach of Duty of Candour Regulation. The committee heard that the Trust has been open and transparent with patients where harm has occurred, there have been delays in internal timescales to Duty

		of Candour and a necessary change in the Trust policy. The Trust is due to complete a review and respond to the CQC on 22nd February 2019
	Assurance	• The Committee received a presentation from the Matron for Tissue Viability in relation to pressure ulcers. The presentation highlighted the improvements relating to quality of care, patient experience and staff education and training that have supported regarding clinicians in pressure ulcer incidents, particularly in the Community. The Committee were assured that the Quality Improvement methodology approach taken by the safety collaboration had positively affected patient outcomes.
	Advise	• The Committee received an update to the Safe, High Quality Care Improvement Plan which will be agreed with the CQC team on 7th March 2019. • The Duty of Candour Policy has been updated and approved by the Committee. • The Committee noted that the emergency C Section rate had risen in month. The Committee discussed that triangulation of this measure with other metrics including complaints, claims and survey information was requested. The committee requested a broader report to be presented at the meeting in May 2019. • The Committee discussed the HSMR position at 1.07 noting that Quality Improvement Projects are in place to support improvement in this area. It was noted, however that the patients are seen by a senior doctor, unknown time frame. • The Committee received the 7 day services report and noted that in relation to the four priority areas, the Trust is fully compliant in standard 8. In standards 2, 5 and 6, the Trust assured that patients continue to receive care through the appropriate care pathways. Standard 2 – Patients should be seen by a consultant within 14 hours. More than 90% of the time, our current position is 85%. We are assured that the mitigation of patients being seen by a senior doctor (ST3 and above) is in place Standard 5 – MRI has limited availability for Stroke and spinal patients on bank holidays and weekends and also not available after 5:00 p.m. and overnight weekdays. Opportunities exists for the Trust to open up MR imaging over the weekend as largely the reporting is undertaken by external reporting arrangements and this will also support flow from acute admission settings. Echocardiography provision has been recognised as a national challenge given limited expertise in trained clinicians and the solutions needs to be sector based or with a network arrangement. The Northwest 7DS peer support network is aware of this challenge and is exploring solutions. Standard 6 – Interventional endoscopy is currently only provided during weekdays. There are agreed plans to implement the gastro rota in the weekday's nights as well once the gastroenterology consultant establishment has been fully recruited to eight consultants and this will ensure full compliance with endoscopy access

		standard		
2.	Risks Identified	Nil		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Company Secretary

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NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/02/2019		**Report of:** Finance & Performance Committee		
Date of last meeting: 20/02/2019		**Membership Numbers:** Quorate		
1.	**Agenda**	The Committee considered an agenda which included the following: • Operational Performance Report • Performance Review Meetings - Key Issues • Financial Performance Report • Agency Utilisation Report • CIP Progress Report • Registration Authority Annual Report • Financial & Performance Risks		
	Alert	• The Committee held a discussion surrounding the Trust's Breast services. It was agreed that the Breast services options paper will be discussed next month. • A discussion was held regarding the Stockport Together development and it was decided that the Committee will need to go through the finances of Stockport Together in detail at the next meeting.		
	Assurance	• There was a significant level of assurance provided on delivery of 18/19 financial plan. • Note position on key performance metrics		
	Advise	• Operating plan performance metrics to be agreed and presented to Board. Also agreed trajectories for drivers will be agreed and tracked by the Committee. • Received an update on 19/20 Clinical Services Efficiency Programme and agreed to monitor during the year.		
2.	Risks Identified	• Delivery of 19/20 Operating Plan		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Company Secretary

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Board of Directors' Key Issues Report

NHS Stockport NHS Foundation Trust

Report Date: 28/02/19		**Report of:** People Performance Committee
Date of last meeting: 21/02/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • End of Life Model (Presentation) • Committee Annual Report • NHS Plan & Workforce Implications • Equality, Diversity & Inclusion (Presentation) • Guardian of Safe Working Hours Report • 'The Health Care Workforce in England' Publication • Month 10 Agency Utilisation Report • Medical Revalidation Compliance • GMC Governance Handbook • Apprenticeship Update Report • Trust Risk Register • Key Issues Reports: - Joint Local Negotiating Committee - Educational Governance Group - Workforce Effectiveness Group • Consent Agenda: - Medical Education Update Report.
	Alert	• Dr S Rendell, Guardian of Safe Working, presented a report which highlighted concerns around a lack of engagement from Clinical Supervisors in acting upon exception reports. The Committee supported the recommendation to encourage engagement of Clinical Supervisors with their responsibilities and to reinforce the approach of timely action in response to exception reports, with the default position being time off in lieu to encourage safe working rather than payment for extra work.
	Assurance	• The Committee received an informative presentation on the work that is taking place around transforming palliative and end of life care, which will be monitored under the clinical services efficiency programme. The case for change position paper relating to the model redesign has been presented to Senior Management Team and will be shared with Executive Management Group in the near future. • The Committee received a presentation on the achievements pertaining to the promotion of Equality, Diversity and Inclusion (EDI) across the Trust over the past 12 months. It was noted that good progress had been made with clear

		evidence of improvements against data for Workforce Race and Equality Standards including the shortlisting, disciplinary and training indicators. A number of key priorities were highlighted to take forward and work will continue in encouraging staff members to embed EDI into day to day business.		
	Advise	• The Committee received and noted 'The health care workforce in England' publication alongside a report, presented by Ms H Brearley, Interim Director of Workforce & Organisational Development, relating to the NHS 10 year plan. Mrs L Robson, Chief Executive, advised that there are plans to work in partnership with the Local Authority around the long term workforce strategy in Stockport and the Trust will be taking the opportunity to feed into discussions around the wider workforce implementation plan. • Ms S Woolridge, Head of Workforce Delivery, presented a report which detailed agency utilisation as at 31 January 2019 and the Committee noted a significant reduction in medical agency spend during January 2019, particularly in Medicine and Clinical Support and Integrated Care. There are no plans to amend the forecast for agency spend in coming months, partly due to a marked increase in sickness absence across the nursing workforce at present. • The Committee received a report providing an update on the progress of the Trust's Apprenticeship Levy, the public sector target and the apprenticeship standards. There is work on-going around proactively developing roles for apprenticeships, whilst also continuing to discuss the potential of placing apprentices into any new roles that are presented for approval at the Establishment Control Panel meetings. • Mrs A Lynch, Chief Nurse & Director of Quality Governance, highlighted a key issue raised at the Workforce Efficiency Group meeting, relating to a review of the establishment position against staff in post. This review has identified examples of re-modelling, such as Allied Health Professionals and Trainee Nurse Associates, resulting in the reporting of a higher number of nurse vacancies than is currently being recruited for. Work is on-going to ensure that there is an improved understanding of the 'true' vacancy position.		
2.	Risks Identified	Nil		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	• Critical Incident Feedback Report to be reviewed at Board of Directors on Thursday 28 February 2019.		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Jane Butterworth, PA to Interim Director of Workforce & OD

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Report to:	Trust Board	**Date:**	28th February 2019
Subject:	Trust Strategy – Progress report		
Report of:	Director of Strategy, Planning & Partnerships	**Prepared by:**	Assistant Business Manager – Strategy and Planning

REPORT FOR INFORMATION

Corporate objective ref:	S1 & S2
Board Assurance Framework ref:	-----
CQC Registration Standards ref:	-----
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This paper provides an update on progress of the Trust strategy based on amendments made following staff consultations.

Attachments: Annex A – Consultation sessions complete

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 This paper provides an update on the progress of the Trust Strategy. Amendments have been made to the content of the Strategy based on feedback received from staff and partners throughout the consultation process.

2. BACKGROUND

2.1 The consultation process for the refreshed Trust Strategy began in October 2018. Sessions booked from 1st October 2018 to 19th February 2019 focused on staff and key partners/stakeholders. All sessions were presented by Hugh Mullen, Director of Strategy, Planning and Partnerships, Andy Bailey – Associate Director Strategy & Planning, Rebecca Simmons – Assistant Business Manager or Philippa Desborough – PMO Manager, with a member of the planning team to record attendance and document discussions. The majority have also been attended by Holly Cubitt, Head of Communications.

3. CURRENT SITUATION

3.1 As of Tuesday 19th February 2019, 40 sessions have taken place. A total number of 672 staff have received the briefing in person and had the opportunity for discussion and to give feedback. There are two sessions planned in March, with HealthWatch and GM Combined Authority.

3.2 **Feedback**

Comments and feedback at each session is captured and recorded by a member of the Strategy & Planning Team. Some of the key changes to the Strategy document are listed in the table below:

Feedback/Comments	Changes made to Strategy document
Those consulted stated that the 5 priorities of the Strategy should be in a different order placing financial resilience as the fifth priority	Narrative on the priorities has been changed and the graphic in figure 2 is being amended by the Communications team to reflect comments.
Those consulted wanted an introduction of the GM themes and their purpose adding into the strategy document	Narrative on GM themes have been added to 7.2 of the strategy explaining each GM theme
Those consulted stated need to include the new 10 year NHS plan to ensure the strategy aligns with this	Section 6.1 created in the Strategy
Those consulted felt that a summary document would be useful to share with staff to ensure communication around the Strategy is delivered across the Trust	Once the Strategy is approved, the Communications team will create a summary document to be launched with the Strategy
Those consulted felt End of Life services should be included in the document	Additions made to the strategy working with the End of Life team
Those consulted felt that Research and Innovation should be included within the Strategy	Section 9.7 created in the Strategy working with the Research and Innovation team
Those consulted felt many of the graphics in	The Communications team has reviewed

the document were difficult to read	graphics within the document and redesigned these with a consistent look and branding.

4. NEXT STEPS

4.1 The Communications team have reviewed all graphics included in the Trust Strategy. The front cover, design of the paper and each graphic has been changed to provide a consistent design throughout the document. The communications team have also designed a local services strategy document for use throughout the Trust.

4.2 As Louise highlights in her Chief Executive's report, in addition to feedback sessions with staff groups the next phase will be developing the vision for our clinical services, ensuring that it is clinically led and that our services align with the developing strategies of our partners.

5. CONCLUSION

5.1 The approach being taken has been received positively and provided the chance to engage with staff and key partners/stakeholders who otherwise may not have had this opportunity. Communications will be sent to all people who attended sessions to explain key changes to the document.

5.2 The briefing sessions have gathered useful intelligence about the effectiveness of methods of communication. There has been differing levels of awareness of the Strategy materials in circulation via All User email communications. It has also provided useful feedback to inform effective communication on the Strategy going forward.

6. RECOMMENDATIONS

6.1 The Trust Board are requested to note progress to date and to approve the feedback sessions to staff.

Sessions Complete

Meeting	Venue	Date/Time of Meeting	Number of Attendees
Strategy & Planning Team Session	Pinewood House	23.10.18 14.00 - 15.30	10
Trust Members Annual General Meeting	Edgeley Park	09.10.18 15.00 - 18.30	44
Council of Governors	Lecture Theatre Pinewood House	25.10.18 16.00 - 18.00	20
Information/IT/EPR (Session 1)	EPR Meeting Room	29.10.18 14.00 - 15.00	8
JLNC Meeting	Oak House	09.11.18 16.25	11
Information/IT/EPR (Session 2)	EPR Meeting Room	12.11.18 09.00 - 10.00	9
JCNC	Committee Room Oak House	12.11.18 13.45 - 14.45	10
Surgery, GI & CC BG Assurance Board	Committee Room Oak House	14.11.18 14.00 - 14.45	18
Women, Children & Diagnostics Quality Board	Education Room Maternity	14.11.18 15.00 - 16:00	15
Pharmacy Technical Staff Team Meeting	Pharmacy Tea Room	15.11.18 08:45 - 09:30	29
Palliative Care	David Waterman's Office	15.11.18 11:00 - 12:00	1
Pharmacy Manufacturing and Aseptics Teams	Pharmacy Loading Bay	19 Nov 13.00 - 14.00	32
All staff drop in	Maternity Education Room	20.11.18 12.00 - 13.30	2
Finance Team	Pinewood House	20.11.18 15.00 - 16.00	56
Estates & Facilities Finance & Performance Board	Estates Conference Room	21.11.18 10.00 - 10.45	13
Therapy Board	Pinewood House	21.11.18 11.00 - 12.00	17
Integrated Care Quality Board	Rowan Suite	22.11.18 11.00 - 12.00	14
Medicine Operational Planning Session	DMOP	22.11.18 14.00 – 15.00	18
Pharmacists Team Meeting	Pharmacy	28.11.18 08:45 - 09:30	22
East Cheshire CCG Management Meeting	New Alderley House	28.11.18 1.00pm	17
HR Directorate Dialogue	Lecture Theatre Pinewood	28.11.18 14.30 - 15.00	38
QCNW Team Strategy Specific Session	QCNC Main Office	29.11.18 13.00 - 14.00	9

Viaduct - Senior Management Team	Kingsgate House	29.11.18 16.00 - 17.00	4
All staff drop in	Pinewood G18	29.11.18 15.30 - 17.00	0
Community drop-in session	Hazel Grove Clinic Room 2	06.12.18 3.30-5pm	2
Community drop-in session	Kingsgate House	07.12.18 3.30-4.30	4
All staff drop in	G15 Pinewood House	10.12.18 09.00 - 10.30	3
Stockport CCG Wider Management Team	Stopford House	10.12.18 1pm - 2pm	12
Ward Managers Meeting (Surgery)	Lecture theatre A	12.12.18 09.00 - 10.00	9
NHSI	Hugh Mullen's Office	13.12.18 09.00 – 10.00	1
Estates & Facilities Staff drop-in 1	Lecture Theatre B	13.12.18 16.00 - 16.30	25
Theatres Team Meeting	Theatres	17.12.18 18.00	21
Estates & Facilities Staff drop-in 2	Lecture Theatre B	19.12.18 08.00 - 08.30	62
Children's Therapies Strategy Meeting	Beckwith House -	20.12.18 14.30 - 15.30	17
Estates & Facilities Staff drop-in 3	Lecture Theatre A	07.01.19 13.00 – 13.30	48
Ward Managers (Medicine)	DMOP Conference Room	09.01.19 11.00 – 11.30	19
Corporate Quality Board		22.01.19 09.00 – 11.30	10
Stockport Council Corporate Leadership Team	Town Hall	22.01.19 11.30 – 12.00	3
Pennine Care NHS Foundation Trust	Pennine Care	11.02.19 11.30 – 12.30	2
Active Recovery	Regent House	14.02.19 13.30 – 14.30	17
		Total	**672**

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Report to:	Trust Board	**Date:**	28 February 2019
Subject:	7 Day Board Assurance Report		
Report of:	AMD, Hospital care	**Prepared by:**	AMD , Hospital Care

REPORT FOR APPROVAL

Corporate objective ref:	2a,2b,3b,5d,
Board Assurance Framework ref:	SO2,SO7
CQC Registration Standards ref:	12,17,18,
Equality Impact Assessment:	☐ Completed ☒ Not required

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

This report outlines the new board level reporting requirements for progress against the 7 day National standards with particular reference to the 4 priority clinical standards (CS 2, 5 ,6 and 8)

The report provides the key narrative contained in the seven day self-assessment tool and has been elaborated upon where required to give the required context. This report has previously been presented to and approved by the Quality Committee. The Trust Board is asked to consider the level of detail and content of the report which is due for National submission on the 29th February 2019. Please note this is a trial submission and results will not be published Nationally on this return.

Attachments:	Appendix 1 – 7 day Board Assurance template Appendix 2 – NHS 7 day Board Assurance Introduction Appendix 3 – NHS 7 day Board Assurance Briefing

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

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1. INTRODUCTION

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

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

1.3 The guidance requested Trust to trial this process in February 2019 and put information collated through the appropriate Trust Board in their organisation. The purpose of this was to ascertain if Trust were satisfied with the detail provided as part of the self-assessment and the assurance that this provides. Guidance stated that audit information from the last National seven day survey could be utilised for the February trial self-assessment supported by any available local evidence and or triangulation with trust level data on consultant sessions, mortality data, LOS, readmission data, GMC and patient survey data etc. It is anticipated that the ongoing submission will be an iterative process feedback and more guidance nationally for the next submission in June 2019. The NHS England briefing on the guidance is included in the attachments section on page 1

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

2. CLINICAL STANDARD 2

2.1 This standard states 'All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'.

2.2 As shown in Appendix one the Trust is currently not compliant against standard 2.

Weekday	Weekend	Overall Score
Compliance score : 88.5 % No, the standard is not met for over 90% of patients admitted in an emergency	Compliance score : 76.0 % No, the standard is not met for over 90% of patients admitted in an emergency	Overall Compliance score of 85% Standard Not Met

2.3 **EVIDENCE SOURCE 1: Consultant sessions / cover for key admitting specialties**

Consultant cover / sessions out of hours was provided by Human resources from Allocate system and was as follows

Paediatrics - Weekday September to May is 9am-10pm and June to August 9am-5pm. Weekend is 9am-3pm

Acute Medicine - Until 9.30pm weekdays and 8am-5pm at the weekend. The hot week consultant is there 8am-12pm and 4pm-8 pm
General Surgery - Weekday cover until 6pm, plus 3 hours predictable until 9pm and then 14 hours predictable per weekend

Stroke - Weekdays until 8pm and until 12pm and 4-6 pm at weekends + Telemedicine

Obstetrics and Gynecology - Weekday non-perspective twilight cover. Residential nights have two obstetric consultants (non-perspective) alternate Mondays and every Thursday (8.30pm to 9am). Weekends 8.30am-11.30am prospective. 1 in 8 weekends three obstetric consultants do a prospective 12 hour shift Saturday and Sunday

G**astroenterology** - weekdays 9an-5pm COW and weekend is on call cover

Urology - Weekdays is on call cover and weekend has ward round then consultant finishes when ward round complete this is 10 hours per weekend

T&O - Weekdays until 6pm then on call and will return before 8am the next day to complete ward round. Weekends have on call orthopedic and spinal consultant will come in and do a ward round on a Sunday

High dependency areas - ICU has cover weekdays and weekends 8am-9.45pm

Radiology (supporting specialty) - Weekdays On call ROTA until 8pm with the consultant typically on site with a few reporting remotely. After 8pm work is outsourced. Weekends on call consultant is on site 9am-3pm, mainly delivering CT reporting, after 3pm all the oncall work is outsourced.

Going forward we can also evidence this data as sessions or PAs per specialty or consultants for weekends and compare with weekday provision.

2.4 **EVIDENCE SOURCE 2: Local Audit Data (149 pts)**

Weekday audit data shows that out of 104 patients 12 patients did not see a consultant within 14 hours ie 88.5% of patients were seen within 14 hours. Weekend audit data shows that out of 45 patients 11 did not see a consultant within 14 hours ie 76% of patients were seen within 14 hours. Overall compliance score with this standard was 85% against the target of 90%.

7DS Clinical lead review of audit data on <14 hr consultant review breaches (CS2) clearly demonstrated that target compliance was missed by 1-2 hours in 20 % of the breaches particularly in acute medicine admissions.

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

SHMI Mortality data for the period 1st July 17 - 30th June 18 is 0.93 for patients admitted on weekdays (Mon -Fri) compared to 1.09 for patients admitted at weekend indicating slightly increased mortality for patients admitted over the weekend. This is similar to the national trend and is one of the drivers for 7DS implementation and the causes are multifactorial including timely access to community services including palliative care over the weekend.

LENGTH OF STAY (LOS) Data of the same period (period 1st July 17 - 30th June 18) for mean Length of Stay was 2.36 days for patients admitted on weekdays and 3.93 for patients admitted at the weekend. This shows that LOS is increased for patients admitted over the weekend probably as a result of reduced consultant sessions and supporting MDT and social infrastructure over the weekend. Outline Business cases has been submitted and considered by the trust but presently there is no funding allocation to implement the full 7DS consultant requirements due to manpower and financial pressures and the aim is to adopt an incremental approach by ensuring all new Business cases for consultants and allied staff supports and improves on the 7day working standards.

READMISSION RATES for the same period (period 1st July 17 - 30th June 18) shows 8.2% of those admitted in the week compared to 10.9% of those admitted at the weekend. This increased in readmission rates for patients admitted over the weekend may reflect more complex admissions over the weekend but will need further interrogation. Maybe a better indicator would be to look at readmissions of patients discharged over the weekend vs weekday and can explore this data in the next submission

PATIENT EXPERIENCE: Friends and family test had over 90% positive rate January 2018-December 2018. One of the questions was “If someone close to the patient wanted to talk to a doctor whether they had enough opportunity”. In January 2018-December 2018 this answer received a 86.58% positive response. Another question asked was “if a patient had important questions to ask a doctor did they get answers they understood". In January 2018-December 2018 this answer received a 94.99% positive response. However it is important to acknowledge that the present patient satisfaction questionnaire does not distinguish between experiences for patients admitted over the weekend versus weekdays and the feasibility of this data being available for future reports is being explored through the Patient Experience Group.

GMC TRAINEE SURVEY is completed by the Trust on an annual basis. The last survey was completed in May 2018. This showed overall Trainee satisfaction rate of 76.60%. Clinical supervision response had an 89.70% satisfaction rate with 86.55% for out of hour’s supervision indicating no major concerns with regards to out of hour’s clinical supervision and the data is reassuring in this respect.

ED PERFORMANCE for the Trust shows weekday and weekend performance to be similar with averages for Q1 being 85% for weekday vs 85% weekend, Q2: 78% weekday vs 76% weekend and Q3 72% weekday vs 71% weekend. The results show no significant variation in ED performance between weekday’s vs weekends which is very surprising given that we have fewer discharges over the weekend. This may also suggest ED resource is broadly similar between weekdays and weekends.

ED ADMISSION CONVERSION RATES data shows average rates for Q1 33% weekday and 33% weekend, Q2 32% weekday and 32% weekend and Q3 33% weekday and 32% weekend. Again the results show no variation in performance between weekday’s vs weekends.

3. CLINICAL STANDARD 5

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

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

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

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

3.3 MRI has limited availability for Stroke and spinal patients on bank holidays and weekends and also not available after 5 pm and overnight weekdays. Opportunities exists for the trust to open up MR imaging over the weekend as largely the reporting is undertaken by external reporting arrangements and this will also support flow from acute admission settings.

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

4. CLINICAL STANDARD 6

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

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

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

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

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

4.5 For Interventional endoscopy at present gastro on call rota is only available over the weekend and in hour's weekdays. There are agreed plans to implement the gastro rota in the weekday's nights as well once the gastroenterology consultant establishment has been fully recruited to eight consultants and this will ensure full compliance with endoscopy access standard.

5. CLINICAL STANDARD 7

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

We believe that Pennine trust will be responding to this standard in their trust response as they provide this service for us.

6. CLINICAL STANDARD 8

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

6.2 EVIDENCE SOURCE 1: AUDIT DATA

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

Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met based on audit data
Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

Trust audit data shows that of 149 patients audited there are 10 instances where patients was not reviewed once daily .This was 4 in the week and 6 at the weekend. Compliance was 96% in the week and 97% at the weekend.

Trust audit data shows that from 149 patients 6 patients required twice daily review. 5 of these during the weekend and 1 at weekend all of these reviews were achieved showing 100% compliance for patients requiring twice daily reviews

Note:

Trust audit only reviewed 149 patients (we have submitted the same patient data that we have submitted for the last national audit) and not all admissions. The daily consultant review (CS8) was audited only for the first 5 days of admission and the national audit compliance figures is not a reflection of consistent delivery of this standard in all inpatients.

A significant number of admitted patients (up to 40%) get discharged from the assessment unit settings where there is 7 day consultant review and this has helped with the overall compliance figures. The better weekday performance also contributed to a better overall position with compliance.

For future assurance individual speciality audit data would better reflect compliance against this standard. We request the board to interpret this data with caution and if we were to audit all the patients in acute medical beds we would be noncompliant.

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

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

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

SURGERY: The ward manager undertakes the board round supported by the ST3+ senior decision makers or equivalent in surgical wards on behalf of the consultants.

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

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

PAEDIATRICS - 9am consultant led handover 7/7 of all paediatric & neonatal patients on Treehouse & Neonatal Unit plus babies under paediatric review on postnatal ward. All patients discussed & prioritised for order of review. Management & discharge plan discussed for all patients. Hot weeks are job planned for all paediatric consultants.
UROLOGY reviews all patients each day in a ward round therefore does not complete a white board round.

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

STROKE – All wards have a board round daily

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

At present the Trust do not have a clear auditable process to decide which patients do not need a daily consultant review however there are opportunities to embed this electronically as we have the Advantis ward infrastructure to support this implementation but will need dedicated IT resource support for the same.

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

NEWS2: The Trust have successfully implemented a new system of escalation for deteriorating patients based on agreed protocols and policy in Dec 2018 ie NEWS2 National Early Warning

Score tool ; one of the few trusts in the northwest to do so.

The number of triggers requiring medical review has increased significantly with NEWS2 as the tool is much more sensitive in recognizing deterioration and consequently the response times are longer at weekends than during the week as we have a much reduced workforce over the weekends.

The newly formed deteriorating patient group will be looking into this data with actions to support and mitigate and or reduce this delay out of hours.

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

7.1 STANDARD 1: PATIENT EXPERIENCE

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

The Trust does not collate patient experience data relating to consultant presence. Friends and family test had over 90% positive rate January 2018-December 2018. One of the question was " If someone close to the patient wanted to talk to a doctor whether they had enough opportunity" . In January 2018-December 2018 this answer received a 86.58% positive response. Another question asked was " if a patient had important questions to ask a doctor did they get answers they understood". In January 2018-December 2018 this answer received a 94.99% positive response.

However the present patient satisfaction questionnaires do not distinguish between experiences for patients admitted over the weekend versus weekdays. The feasibility of this data being available for future reports is being explored through the Patient Experience Group. .

7.2 STANDARD 3 MULTIDISIPLINARY REVIEWS:

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

The response from the business groups and specialities are as follows

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

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

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

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

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

7.3 **STANDARD 4 SHIFT HANDOVERS**

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

Paediatrics - Monday to Friday consultant led handover of all children/neonates under care of paediatrics takes place at 9am, 4.30pm & 9pm. Saturday & Sunday consultant led handover of the above takes place at 9am. Handover sheets are in use, stored on the paediatric I drive & updated prior to each handover.

HDU patients, patients required immediate review & new admissions are highlighted.

T&O complete shift handovers and pass any cases needed to the on call team. There is also a formal handover from day to night staff.

Obstetrics and Gynaecology - The department have a robust shift handover process at 8.30 and 20.30 where a multidisciplinary formal hand over takes place with a consultant in obstetrics and anaesthesia present at 8.30 and a registrar leading this at 20.30. Over the past year a formal written handover of patients admitted in Gynaecology ward has also been added to this.

Stroke ward A10 has a daily shift handover.

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

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

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

THERAPIES - The areas that are funded for 7 day working for therapies are: Stroke – Occupational Therapy, Physiotherapy and Speech and Language Therapy, Respiratory on call 24/7 – Physiotherapy, FRESH team in ED , T&O Saturday– Physiotherapy Sunday - Physiotherapy and Occupational Therapy, Community Neuro - rehabilitation Service – Saturday only. There is no funded establishment for the wards at weekend, MSK Out Patient Services or Adult Community Therapy Team. GM Partnership are now carrying out a therapy review, initially looking at the front end of the hospital.

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

DISCHARGE COORDINATORS - Discharge coordinators work a 7 day week, although there is a reduced service at the weekend. 7 day working is part of the new ITT review that is being completed, within this will be options appraisal for a new staffing model which will include increased support at weekends

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

PATIENT TRANSPORT

The Trust has a contract with NWAS across Greater Manchester 7 days a week but not 24 hours. There is also a contract with ST Johns for on the day discharges which is 7 days but hours on each day differ in hours. If there are discharges to some areas such as Macclesfield then there is no service at the weekend.

7.5 STANDARD 10 QUALITY IMPROVEMENT

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

Data relevant to this domain has already been evidenced and elaborated upon in section 2

8.0 7DS AND URGENT NETWORK CLINICAL SERVICES

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This standard looks at Hyper acute stroke patients. Other Urgent services are not applicable for the Trust.

The Trust is currently not compliant against standard 5, access to diagnostic services for stroke.

	Hyperacute Stroke
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	No, the standard is not met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency

For clinical standard 2 for stroke audit results show that out of 15 Stroke patients included in the audit 1 patient was not seen by a Consultant within 14 hours. This is 93% compliance

For clinical Standard 5 for stroke MRI has only limited availability for Stroke patients on bank holidays and weekends (2 slots in the morning only) and hence non-compliant with CS 5. To be compliant with this standard for Stroke Urgent clinical Network 7DS standard MR should be available during PSC opening hours 7/7 days.

For clinical standard 8 for stroke the audit results show that 26 once daily reviews were required and all of these reviews were performed by a consultant. 100% compliance for standard 8**.**

9. RECOMMENDATIONS

9.1 The Trust Board are asked to consider and approve the information and level of detail and assurance contained in this report and if this process is approved to continue for the next Board Assurance submission in June 2019.

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	EVIDENCE SOURCE 2: Weekday audit data shows that out of 104 patients 12 patients did not see a consultant within 14 hours ie 88.5% of patients were seen within 14 hours. Weekend audit data shows that out of 45 patients 11 did not see a consultant within 14 hours ie 76% of patients were seen within 14 hours. Overall compliance score with this standard was 85%. 7DS Clinical lead review of audit data on <14 hr consultant review breaches (CS2) clearly demonstrated that target compliance was missed by 1-2 hours in 20 % of the breaches particularly in acute medicine admissions. EVIDENCE SOURCE 3: SHMI MORTALITY RATES SHMI data for the period 1st July 17 - 30th June 18 is 0.93 for patients admitted on weekdays (Mon -Frid) compared to 1.09 for patients admitted at weekend indicating increased mortality for patients adnitted over the weekend. This is similar to the national trend and is one of the drivers for 7DS implementation and the causes are multifactorial. LENGTH OF STAY (LOS) Data of the same period (period 1st July 17 - 30th June 18) for mean Length of Stay is 2.36 days for patients admitted on weekdays and 3.93 for patients admitted at the weekend. This shows that LOS is increased for patients admitted over the weekend probabaly as a result of supporting MDT and social infrastructure over the weekend. READMISSION RATES Readmission rates for the same period (period 1st July 17 - 30th June 18) shows 8.2% of those admitted in the week compared to 10.9% of those admitted at the weekend. Again this may be a reflection of adequate community support provision over the weekend.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	MRI has only limited availability for Stroke and spinal patients on bank holidays and weekends and also not available after 5 pm and overninght weekdays. Oppurtunities exists for the trust to open up MR imaging over the weekend as largely it is externally reported and also will support flow. Echocardiography provision has been recognised as a national challenge given limited expertise in trained clinicians and the solutions needs to be sector based or with a network arrangement. The Northwest 7DS peer support network is aware of this challenge and is exploring solutions	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	No the test is not available	
		Upper GI endoscopy	Yes available on site	Yes available on site	

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

consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.		Interventional Endoscopy	No the intervention is only available on or off site via informal arrangement	Yes available on site	Standard Met
		Emergency Surgery	Yes available on site	Yes available on site	
	Interventional radiology is presently delivered with a network arrangement for vascular interventions, thrombectomy etc but is also a key requirement of healthier together local provision, and hence is being considered as part of this development as well for in-house provision . Cardiac pacing is provided by daytime consultant cardiology cover and requirements for weekend has been adhoc and cardiology consultant onsite sessional provision would cover this requirement in those rare infrequent circumstances. Dedicated weekend pacing will require development of a weekend service from our consultants including equipment and or technician availability, or development of an agreement from one of our neighbouring tertiary cardiac centre. The numbers are very small and	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	EVIDENCE SOURCE 2: We have trust agreed board round principles . ICU/HDU: In high dependency areas like ICU /HDU Twice daily review is undertaken by ICU/HDU consultants SURGERY: The ward manager undertakes the board round supported by the ST3+ senior decision makers or equivalent in surgical wards on behalf of the consultants. MEDICINE: Board round is undertaken by the consultant or ST3+ doctor and ward manager Mon-Frid. There is no white board round over the weekend except in AMU, SAU and stroke HASU. We do not have a clear auditable process to decide which patients do not need a daily consultant review however there are oppurtunities to embed this electronically as we have the advantis ward infrastructure to support this implementation but will need dedictaed IT support for the same. BOARD ROUNDS - Paediatrics - 9am consultant led handover 7/7 of all paediatric & neonatal patients on Treehouse & Neonatal Unit plus babies under paediatric review on postnatal ward. All patients discussed & prioritised for order of review. Management & discharge plan discussed for all patients. Hot weeks are job planned for all paediatric consultants. Urology reviews all patients each day in a ward round therefore does not complete a white board round. T&O have a Trauma daily ward round led by the consultant which will also review any inpatients identified. Orthopaedics inpatients are seen by a consultant daily with a fixed ward round each week. NEWS2: We have implemented a new system of escalation for deteriorating patients based on agreed protocols and policy in Dec 2018 ie NEWS2 National Early Warning Score EVIDENCE SOURCE 3: Trust audit data shows that of 149 patients audited there are 10 instances where patients	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
PATIENT EXPERIENCE - The Trust does not collate patient experience data relating to consutant presence. Friends and family test had over 90% positive rate January 2018-December 2018. One of the question was " If someone close to the patient wanted to talk to a doctor whether they had enough oppertunity" . In January 2018-December 2018 this answer recieved a 86.58% positive reponse. Another question asked was " if a patient had important questions to ask a doctor did they get answers they understood". In January 2018-December 2018 this answer recieved a 94.99% positive reponse. However the present patient staisfaction questionnaires does not distinguish between experiences for pateints admitted over the weekend versus weekdays. PAEDIATRICS

MULTIDISIPLINARY REVIEWS:
Neonatal unit – discharge checklist in place. Discharge planning meeting held prior to discharge of complex patients. 0.8WTE Discharge planning lead post to commence March 2019. Role to coordinate discharge, disseminate learning & produce guidelines. Learning to be shared across paediatrics
Paediatrics (Treehouse) – Vast majority of patients are short length of stay, discharge check list part of admissions booklet. All complex patients, likely to need discharge planning, are assigned named nurse on admission who will coordinate this process. No written guidance at present but will share learning from neonatal discharge planning lead and written guidance will be produced.
Medicines reconciliation – Department covered by trust medicines reconciliation policy. Neonatal unit, Acorn, Brambles, Rainforest & paeds HDU have pharmacist cover. Gap – Paediatric assessment unit, Mulberry, Paeds ED. T&O hold a daily meeting as a multidisiplinary team to review patient care planning. This meeting acts as an MDT and shift handover.
SHIFT HANDOVERS
Paediatrics - Monday to Friday consultant led handover of all children/neonates under care of paediatrics takes place at 9am, 4.30pm & 9pm. Saturday & Sunday consultant led handover of the above takes place at 9am. Anonymised handover sheets are in use, stored on the paediatric I drive & updated prior to each handover. HDU patients, patients required immediate review & new admissions are highlighted. T&O complete shift handovers and pass any cases needed to the oncall team. There is also a formal handover from day to night staff.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Hyperacute Stroke is the only clinical service of the Urgent Network Clinical Services commissioned for delivery by our organization For clinical standard 2 audit results show that out of 15 Stroke patients included in the audit 1 patient was not seen by a Consultant within 14 hours. This is 93% compliance For clinical standard 5: MRI has only limited availability for Stroke patients on bank holidays and weekends (2 slots in the morning only)and hence non compliant witrh CS 5. To be compliant with this standard for Stroke Urgent clinical Network 7DS standard MR should be availbale during PSC opening hours 7/7 days. For clinical Standard 6: we are fully complinat for stroke with network arrangement For standard 8 audit results show that 26 once daily reviews were required and all of these reviews were performed by a consultant. 100%

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

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NHS England
NHS Improvement

Board assurance framework for Seven Day Hospital Services: an introduction for providers of acute services

November 2018

The Seven Day Hospital Services Programme aims to deliver improvements for patients by supporting high quality care seven days a week

The Seven Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

This work is built on 10 clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013. With the support of the Academy of Medical Royal Colleges, four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week.

Priority 7DS clinical standards

- Standard 2: **Time to initial consultant review**
- Standard 5: **Access to diagnostics**
- Standard 6: **Access to consultant-led interventions**
- Standard 8: **Ongoing daily consultant-directed review**

We are changing the way we measure the improvements trusts make

- Providers of acute services have previously completed a bi-annual self-assessment survey.
- This measured progress against the four priority standards through a combination of case note reviews and self-assessment.
- Though useful in supporting implementation, this survey placed a significant administrative burden on trusts as it involved reviewing many patient case notes.
- To reduce this burden and to allow trust boards to provide direct oversight of 7DS progress, 7DS will be measured through a board assurance framework.
- This process consists of a standard template to assess progress in delivering 7DS, which is then assured by the trust board before submitting results to regional and national 7DS teams.

The new 7DS board assurance framework is based on principles that ensure continuity and robust, accurate assessment

The 7DS board assurance framework for trust self-assessment of 7DS performance follows a set of principles that ensure it is:

- consistent, both in terms of the product (a single template for all providers of acute services) and its contents (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory)
- robust and accurate, with assessments based on information directly related to 7DS, allowing for board-level scrutiny and external assurance if necessary
- less of an administrative burden than the 7DS survey
- completed bi-annually, with sign-off by the trust board before submission
- compatible with national-level measurement and reporting against the mandate and planning guidance 7DS ambitions.

The process for 7DS board assurance is consistent for all providers of acute services

- The new measurement system consists of a standard template that all trusts will complete with self-assessments of their performance against the 7DS clinical standards, supported by local evidence.
- This self-assessment will then be formally assured by the trust board. Boards can decide appropriate processes and details to include, based on local systems, governance structures and timetables.

XX NHS TRUST : 7 Day Hospital Services Self-Assessment - Autumn 2018

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Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Historical Compliance: Oct 2016: 63%, April 2017: 92% Oct 2017: 90% April: 91%. Whilst the data suggests sustained compliance across the Trust as a whole this masks inconsistent performance across directorates. For those admitted through the medical wards (60% of our total emergency admission) compliance is as high as 96%. Patients admitted through Paediatrics, Orthopaedics, Obs and Gynae, Head and Neck and Surgery have not consistently complied with achievement with results ranging from 78% compliance for Surgery to 43% compliance in Head and Neck. More latterly the evidence has shown that the results do not differ across the days of the week.		Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All diagnostics available across 7 days. CT Heads read by ED Consultants	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes, mix of on-site and off-site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Interventional Radiology available at weekends via shared arrangement with local Trusts. Other interventions available for urgent cases in Trust.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	No the intervention is only available on or off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Historical Compliance: Oct 2016: 73%, April 2017: 95% April: 86%. Compliance shows an historically mixed compliance rates across the Trust as a whole and an inconsistent performance across directorates. Acute Medicine performs highly. The evidence has shown that compliance is consistent across all days of the week.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

Board assurance implementation

The 7DS board assurance framework will be implemented gradually, with a trial run followed by full implementation

Trial run – Nov 2018 to Feb 2019

- In place of the proposed autumn 2018 7DS self-assessment survey, providers of acute services will undertake a trial run of the board assurance process.
- This trial run will take place from November 2018 to February 2019. All providers of acute services will complete the template and gain board assurance of the self-assessment.
- As this is a trial, providers of acute services are not required to complete any new audits to support these self-assessments. Data from the previous 7DS survey can be used as evidence.

Full implementation – Mar to Jun 2019

- Full implementation of the 7DS board assessment framework will take place in March to June 2019.
- This will follow the same process of completing the measurement template and subsequent board assurance of the self-assessment.
- This self-assessment will be based on local data, such as consultant job plans and local clinical audits, as outlined in the full 7DS board assurance framework guidance.

The four priority clinical standards are unchanged and remain the main focus of 7DS measurement

Clinical Standard 2 – First consultant review within 14 hours

- Assessment based on a triangulation of consultant job plans to deliver 7DS, local audits to provide evidence and reference to wider metrics.

Clinical Standard 5 – Access to consultant-directed diagnostics

- As previously, assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by a formal arrangement with another provider.

Clinical Standard 6 – Access to consultant-led interventions

- As previously, assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, either on site or by a formal arrangement with another provider.

Clinical Standard 8 – Ongoing consultant-directed review

- Assessment based on consultant job plans to deliver 7DS, robust MDT and escalation protocols, local audits and reference to wider metrics.

Full details of the measurement criteria for these standards can be found in the 7DS board assurance framework guidance.

The measurement template also captures detail on 7DS in urgent network specialist services and all of the 7DS clinical standards

7DS in urgent network specialist services

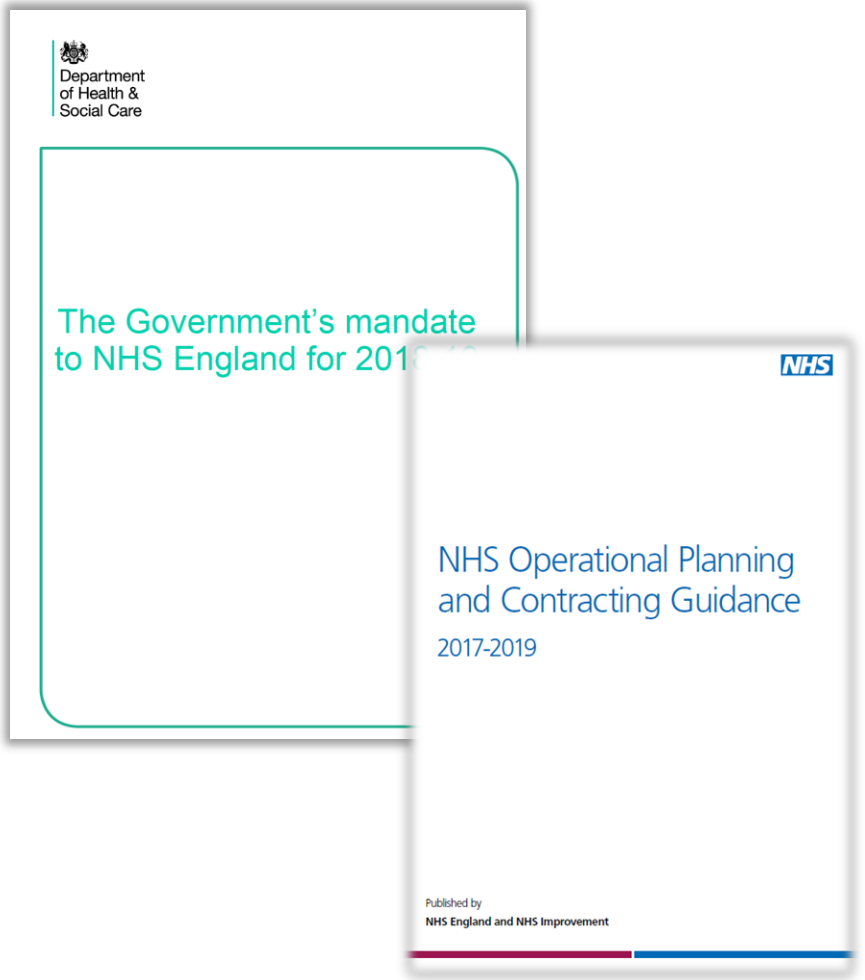
- Alongside the 7DS clinical standards for all patients admitted to hospital in an emergency, providers have been delivering the four priority clinical standards in five urgent network clinical services, namely:
  - hyperacute stroke
  - paediatric intensive care
  - STEMI heart attacks
  - major trauma
  - emergency vascular services.
- The measurement template asks providers of acute services for an updated assessment of progress against the four priority standards in the relevant specialist services on a seven day basis.

7DS standards for continuous improvement

- Delivering all 10 7DS clinical standards is vital to maintaining high quality care seven days a week.
- As well as measuring progress against the four priority 7DS standards, the measurement template asks providers of acute services to summarise progress against the six standards collectively known as the 7DS standards for continuous improvement.
- This summary is not a formal assessment of progress. Full details are in the 7DS board assurance framework guidance.

The board assured assessments of 7DS performance will be analysed to provide measurement against 7DS ambitions

- The government's mandate to NHS England and its remit letter to NHS Improvement set ambitions for delivering 7DS, which are reflected in the shared planning guidance.
- The 7DS board assurance framework will provide the data to support measurement against these ambitions.
- The board-assured measurement templates will be submitted to regional and national 7DS teams so they can analyse progress against the national ambitions.
- Data from the trial run will not be made public, but results from the subsequent full implementation will be published to demonstrate progress.



The board-assured assessments of 7DS delivery will feed into local and national accountability frameworks

The NHS Standard Contract will require providers to undertake the 7DS board assurance process bi-annually. The results from this will form a 7DS metric in the clinical commissioning group improvement and assessment framework to allow CCGs to assess local delivery of 7DS.

The CQC inspection regime assesses 7DS performance as part of its judgement on a trust's effectiveness. CQC will use providers' self-assessments of 7DS delivery as supporting evidence in its inspection processes covering 7DS.

NHS England
NHS Improvement

Briefing: Seven Day Hospital Services board assurance framework

November 2018

Trial period November 2018 to February 2019/transition to the new system

Do providers need to complete the Seven Day Self-Assessment Tool (7DSAT) survey this autumn?

No. The new board assurance framework for Seven Day Hospital Services (7DS) will be introduced in a trial form this autumn. This means the autumn 2018 national 7DS survey will not take place. Instead, we ask all providers to complete the 7DS self-assessment template and ask their boards to formally assure this assessment as an accurate and true reflection of delivery.

What audit data do providers need to produce to support the board assurance trial run?

Providers are not required to produce any new audit data for the trial run of the board assurance process this autumn. Providers can use their latest data from March/April 2018 as the basis for their self-assessments.

However, if a provider feels that their 7DS performance for clinical standards 2 and/or 8 has improved since the March 2018 survey, they are free to submit evidence to support any assessment of delivery in the form of a new local audit, in line with the guidance for completing the self-assessment template.

Can providers use the 7DSAT system for any new local audits during this trial period?

We are exploring the feasibility of amending the 7DSAT tool, so it can be used for bespoke local audits to support the self-assessment template and board assurance process. We will share further information shortly.

How will you support providers during the trial and the transition to a new measurement system?

Regional teams from NHS England and NHS Improvement will be available to directly support providers in completing the template and the process for their boards to provide assurance. We are planning events to discuss this process and will circulate supporting information on the new measurement system.

Will this trial period information be used for performance measurement?

No. We will assess the information on delivery in the completed templates submitted to regional and national teams to ensure the new system is producing consistent measurement. But we will not use the information to measure performance and will not make it publicly available.

Completing the self-assessment template

The template doesn't allow for lots of information to be added – how can providers report their delivery and activity in detail?

The self-assessment template should be used to provide a headline summary of provider delivery of the 7DS standards. This can be supported by more detailed information – for example, in a paper for the provider board – so board members have the details they need to give assurance. The completed self-assessment template could be added to this board paper as an annex.

How do providers report on 7DS delivery in urgent network specialist services?

Delivery of the four priority clinical standards in five urgent network specialist services was previously assessed separately from a provider's main 7DS results. This template brings these assessments into a single process.

To aid providers, their individual self-assessment templates will be pre-populated with the latest information on the specialist services they provide, so they can update this information through discussion with individual service leads.

What sort of assessment is needed of the six remaining 7DS clinical standards?

Progress against the six 7DS Standards for Continuous Improvement will not be measured through the collection of data or formal self-assessments, but we continue to recognise their importance both in their own terms and as an enabler for delivery of the four priority clinical standards.

To promote their implementation, we ask providers to include summary progress information about their delivery on the summary template. The guidance for completing the template outlines details for reporting on each of these six clinical standards.

Board assurance of the template

What sort of board assurance is required for the self-assessment?

Provider boards should be engaged with the 7DS programme as it directly relates to improvements in patient care and hospital flow. The board should give formal organisational assurance of the self-assessment of 7DS delivery contained in the completed template and any supporting paper before it is formally submitted to regional and national 7DS teams.

The exact method for achieving this board assurance is for providers to decide. This could be a specific item on a board meeting agenda, or the 7DS assessment could be reviewed by a board subcommittee and then form part of this subcommittee's report to the board – whatever method a provider decides is the best for them to gain formal board assurance of 7DS delivery.

Full implementation – March to June 2019

What will be the main difference between full implementation and the trial period?

We will fully implement the board assurance process from spring to summer next year. This will follow the same process as the trial period in terms of completing the summary template and gaining the provider board's assurance of this assessment before it is submitted to regional and national teams.

There will be two main differences from the trial period. The first is that the assessment of delivery recorded on the summary template will be evidenced by new local audit data. The second main difference is that the results from the spring to summer 2019 assessments will be publicly available in a similar format to previous national 7DS survey results.

What sort of audits are needed for the full implementation of 7DS board assurance?

The type and nature of an organisation's clinical audit should be guided by what its board feels is necessary for it to provide assurance of the assessment of delivery.

The guidance for completing the summary template outlines providers' options for audits. For example, a provider may wish to complete smaller, focused audits on specialties where it is concerned that the standards are not being met. Another option may be for a provider to focus on a time of day when it feels that patients may not receive care that meets the standards.

A further option would be for a provider to gather clinical information giving a snapshot of its overall emergency admissions. But note that with this approach, a provider must provide a statistically significant result – for example, by reviewing 70 case notes out of a sample of 500.

The only national requirement for clinical audits to support the 7DS board assurance process is that they measure delivery both on weekdays and at weekends, so it can be assessed separately.

Progress reporting and support

How will providers report their progress on 7DS to regional and national teams?

We will ask providers to submit their completed summary templates to regional and national 7DS teams once their boards have approved them.

What will this data be used for?

The assessments of delivery of the four priority clinical standards and the urgent network specialist services, from the spring to summer 2019 7DS board assurance process within the submitted templates, will be collated and analysed to produce a set of results for each provider, region and at a national level.

The provider-level results will show how each provider has performed for each of the four priority standards at weekends, on weekdays and over a seven-day period. The urgent network specialist services results will provide a single assessment for each of the four priority standards for each of a provider's services.

This data will be used to measure national-level performance against the mandate ambitions for 7DS and 7DS in urgent network specialist services.

What information will be publicly available?

We propose to publish online the overall assessment data from the spring to summer 2019 7DS board assurance templates, in a similar format to previous results from the 7DS self-assessment survey.

We will not make the completed 7DS measurement templates publicly available.

What sort of support will be available?

National and regional 7DS teams will be available to help providers embed the new measurement framework with the intention of making delivery of 7DS business as usual for providers, as agreed in local implementation plans.

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2019
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR APPROVAL

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

Summary of Report

The data for this report was collated on the 6 February 2019

This paper provides an overview of the current Trust Risk Register.

This report includes all current risks of 15 and above for the members to review that have been approved to go onto the trust risk register.

There are currently 363 live risks recorded on the Risk Register systems

There are 38 risks rated 15 or above on the Trust Risk Register with corporate approval. This is the same as last month.

Across the 38 risks rated 15 or higher that have been corporately approved;

- 16 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 934, 618, 686, 457, 869 and 825)
- 9 risks are associated with capacity issues or increase in demand (130, 400, 586, 183, 429, 407,576 872 and 355)
- 4 risks are associated with financial issues (469, 127, 461, 466)
- 4 risks are associated with equipment (46, 819, 765and 872)
- 3 risks associated with statutory or regulatory activity (513, 476, 499)
- 1 risk associated with delivery of a contract.
- 1 risk associated with the environment (816).

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

Attachments:

This subject has previously been reported to:

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

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1. Introduction

1.1 There are 363 live risks recorded on the risk register system. In addition there are 5 risks awaiting corporate approval

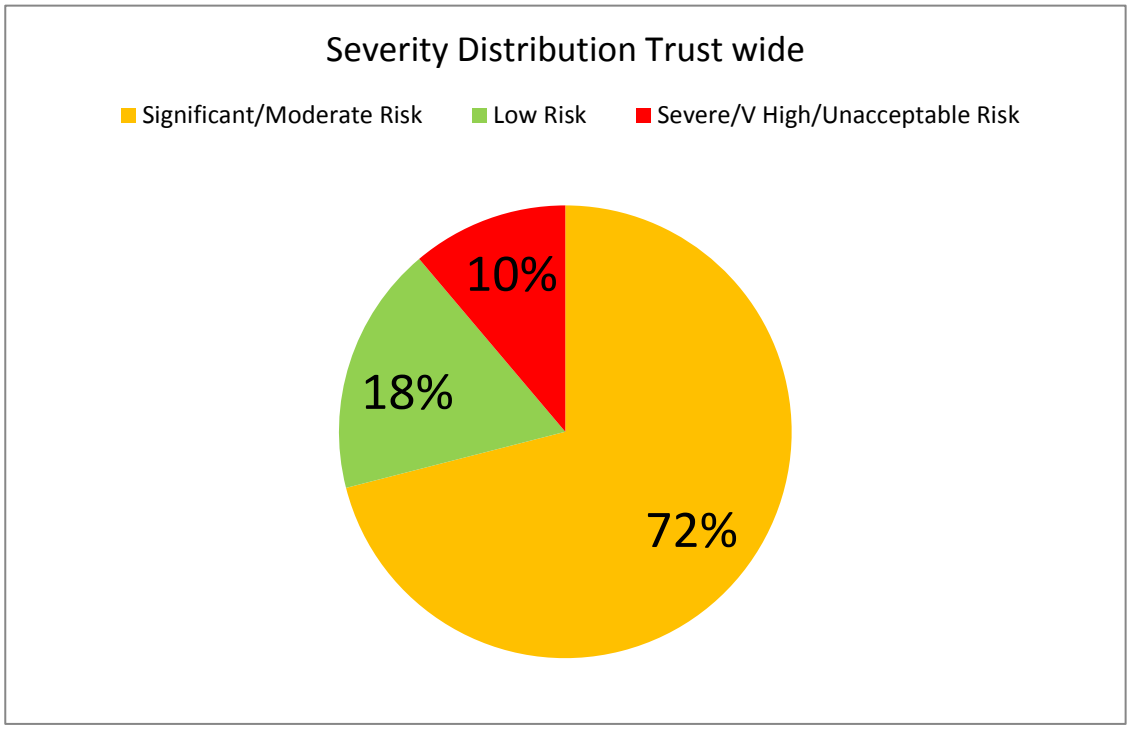
1.2 There are 68 risks awaiting business group approval. There are 66 general hazard inventory assessments awaiting approval.

2. Risk profile

2.1 The trust wide distribution of risks is shown below

	Low				Significant			High			Very High		Severe	Unacceptable
Rating	**1**	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
Number of risks	**2**	**4**	**11**	**47**	**2**	**46**	**44**	**57**	**20**	**95**	**11**	**15**	**8**	**0**

2.2 The severity distribution is shown below



2.3 The corporately approved risks that are on the trust risk register are distributed across the business groups as detailed below

Business Group	Risk Score 15	Risk Score 16	Risk Score 20	Risk Score 25	Total
Corporate	5	3	3	0	13
Integrated Care	0	3	1	0	4
Medicine and Clinical Support	4	3	0	0	7
Surgery, GI and Critical Care	2	3	0	0	5
Women's and Children and Diagnostic	0	6	3	0	9

2.4 The table below shows the movement of risks that are on the trust risk register

Risk number	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19		Mar 19
46	20	20	20	20	20	20	20	20	20	20	20	↔	
130	20	20	20	20	20	20	20	20	20	20	20	↔	
124							20	20	20	20	20	↔	
400						15	20	20	20	20	20	↔	
469			20	20	20	20	20	20	20	20	20	↔	
505						16	16	16	20	20	20	↔	
586							20	20	20	20	20	↔	
869										16	16	↔	
618									16	16	16	↔	
652									16	16	16	↔	
686									16	16	16	↔	
765									16	16	16	↔	
816										16	16	↔	
125						16	16	16	16	16	16	↔	
127	16	16	16	16	16	16	16	16	16	16	16	↔	
429		20	20	20	16	16	16	16	16	16	16	↔	
457									16	16	16	↔	
461		16	16	16	16	16	16	16	16	16	16	↔	
466			16	16	16	16	16	16	16	16	16	↔	
134	20	20	20	20	20	20	20	20	20	20	12	↓	
183	16	16	16	16	16	16	16	16	16	16	16	↔	
50					16	16	16	16	16	16	16	↔	
67			16	16	16	16	16	16	16	16	16	↔	
75	16	16	16	16	16	16	16	16	16	16	16	↔	
78	20	20	20	16	16	16	16	16	16	16	16	↔	
599											16	N	
872											16	N	
934											16	N	
231	20	20	20	20	20	20	20	20	20	20	15	↓	
355	15	15	12	12	12	12	12	12	15	15	15	↔	
407					15	15	15	15	15	15	15	↔	
408		15	15	15	15	15	15	15	15	15	15	↔	
819									15	15	15	↔	
825										15	15	↔	
513					15	15	15	15	15	15	15	↔	
576					15	15	15	15	15	15	15	↔	
476							15	15	15	15	15	↔	
499									15	15	15	↔	
587						15	15	15	15	15	15	↔	

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

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

Risk number	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
53	12											
76	16	16	16	4								
74	10											
87	C											
91	C											
96	16	16	16	16	16	16	16	16	16	12		
108	16	16	16	16	16	8						
109	16	1										
101	20	20	20	20	20	20	10					
126	16	16	16	12								
134	20	20	20	20	20	20	20	20	20	20	12	
135	20	20	20	20	20	20	20	20	20	20	12	
137	16											
145	C											
159	20	16	12									
160	15	8										
162	15	15	15	15	15	15	15	15	15	12		
177	12											
261	16	16	16	16	16	C						
282	15	12										
286	15	15	15	15	15	15	C					
288	15	9										
296	15											
305			15	15	10							
318	6											
319	3											
354	16	16	16	16	C							
362	15	15	9									
399	15	15	15	C								
458			16	16	16	16	16	C				
506					16	16	16	16	16	C		
624								16	16	12		
627								16	16	12		
638							15	15	15	15	12	

3. Risk Movement

3.1 There are 38 risks on the trust risk register, the same as last month.

3.2 Three risks were approve at the Safety & Risk Group this month (599,872 and 934). One risk has reduced in score but remains on the trust risk register (231)

3.3 Three risks were reduced to a risk rating of 12 and therefore removed from the register (638, 134 and 135).

3.4 Please note that risk 652 is commercially sensitive and will not appear on the paper registers.

4. Trends

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

4.2 Across the 38 risks rated 15 or higher that have been corporately approved;

- 16 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 934, 618, 686, 457, 869 and 825)
- 9 risks are associated with capacity issues or increase in demand (130, 400, 586, 183, 429, 407,576 872 and 355)
- 4 risks are associated with financial issues (469, 127, 461, 466)
- 4 risks are associated with equipment (46, 819, 765and 872)
- 3 risks associated with statutory or regulatory activity (513, 476, 499)
- 1 risk associated with delivery of a contract.
- 1 risk associated with the environment (816).

5. Summary

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

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

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

The risk factor = severity x likelihood

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

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

QUALITATIVE MEASURE OF CONSEQUENCE

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

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Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	46	Smethurst, Mr Richard	Women Children and Diagnostics	There is a risk that the Telepath Server will Fail	16	To have contingency plans in place and documented. To put in place a new system that would mitigate the risk of the system failing and not being retrievable.	5	4	20	Replacement Telepath Server	20/02/2019	5
Trust Risk	130		Integrated Care	There is a risk that the ED 4 Hour Target will not be met	20	Combined oversight of PGD into UCDB looking at full system solutions to poor flow and other root causes of poor performance	4	5	20	Please refer to actions of the Programme Delivery Group (PGD)	01/04/2019	10
Strategic Risk	124	Stimpson, Emma	Human Resources	This is a risk of increased use of Temporary Staffing and failure to achieve the agency ceiling	25	Further actions in place include recruitment at international and national events to attract doctors to join teams where we have hard to fill vacancies. Reduced internal rates for medical bank shifts. Exercise with procurement team to agree reduced commission rates with agencies on a tiering system. Significant challenge on all agency requests to ensure doctors are only booked when absolutely essential and that rates are negotiated to within an acceptable range.	4	5	20	Internal rates (bank) for medical staff	28/02/2019	12
										Challenge of Rates and Improved Negotiations	31/03/2019	
Trust Risk	400	Sperring, Mrs Carol	Women Children and Diagnostics Business Group	There is a risk to 18 week targets and compliance with NICE guidance.	15	1) Local offer defines the limitations on the provision for different parts of the service 2) The service has requested a review by the CCG to re-define priorities and re-define the local offer to aim to increase capacity and improve access times for assessment. AS part of this each area of service is listing the capacity required to meet the need.	4	5	20	LOCAL OFFER DEFINED FOR 2018	02/09/2019	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	469	Wiss, Kay	Finance	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	There are a number of meetings in place to manage the overall financial performance of the organization led by the executive management team.	5	4	20	Ensure that the Business Groups are held to account on the delivery of their respective operational plans	29/03/2019	10
										Develop a demand and capacity model	31/03/2019	
										Preparation of a workforce plan	01/03/2019	
										To regularly report the key issues facing the Trust as part of the Stockport Together Programme	29/03/2019	
										Grip and Control Meetings	31/03/2019	
Trust Risk	505	May, Mr David	Women Children and	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	16	Escalation spreadsheet on shared drive to monitor progress of urgent cancer cases. Met with Salford Dermatology team to	4	5	20	Recruit to vacant histopathologist posts	28/02/2019	4
Trust Risk	586	Statham, Mr David	Estates and Facilities	There is a risk due to the significant Estate Backlog Maintenance Increase	20	Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised. Planned Preventative Maintenance (PPM) schedule of works. Regular walkrounds/visual checks undertaken by Estates Staff. Estates Helpdesk: Facility to report jobs. On-going review & monitoring of DATIX Incidents & appropriate remedial action.	4	5	20	Prioritise Identified High Risks	01/07/2019	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Risk Assessment	869	Heal, Dr Carrie	Women Children and Diagnostics Business Group	There is a risk of harm to patients with current medical staffing levels and threat to sustainability of Neonatal Unit	20	Review of rota and informal support at Consultant level	4	4	16	Business Case to be developed	29/03/2019	8
Trust Risk	618	Glynn, Marie	Corporate Nursing	This is a risk of a failure to recognise and adequately treat sepsis within our organisation	12	sepsis screening tool and rolling audit. Introduction of NEWS 2 and quality improvement project	4	4	16	Following a none compliance of the sepsis screening tool, an email will be sent to the clinical director of that business group for an investigation	29/03/2019	8
										To produce a guidance document for sepsis triggers and completion of screening tool	28/02/2019	
										To review patient track questions for patients triggering 5 or above	28/02/2019	
Trust Risk	686	Hancock, Susan	Integrated Care Business Group	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	20	NHSP working to fill shifts through bank and agencies via the trust agreed agency cascade. AMU currently has an agreed uplift on rate, RN04 rate. Continued recruitment to vacancies Cancellation of non-clinical shifts Cancellation of training	4	4	16	Commencement of recruited staff	29/03/2019	9

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Business Group Risk	765	Jones, Mr David	Women Children and Diagnostics Business Group	There is a risk to the delivery of the CT service and patient safety due to a delay in installing 3rd CT scanner	16	Mobile CT scanner being used to maintain the service at present and extra sessions booked to backfill our CT breakdowns. Mobile MR scanner will be used during down time for install of replacement MR Estates and procurement involved along with Radiology and the capital team in planning this large project	4	4	16	CT/MR Repacement Programme	29/03/2019	4
Business Group Risk	816	Lee, Mr James	Estates and Facilities	There is a risk of injury/death due to loose cladding on DMOP building	20	Survey of cladding condition. Repairs/Remedial works to be undertaken (pending outcome of survey) Estates Team undertaking regular monitoring of cladding condition. Harris fencing in situ around DMOP building.	4	4	16	Monitoring of cladding condition	28/02/2019	8
Trust Risk	125	MR1	Integrated Care Business Group	Reduced Emergency Department Medical Staffing	12	Dependant on internal cover and locum bookings	4	4	16	Review of Consultant rota for March 2019	28/02/2019	8
										Pursue international recruitment with Edge Hill Masters	28/02/2019	
										Tracking of temporary staffing use	12/02/2019	
Trust Risk	127	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the M&CS BG overspends due to agency costs	16	Monthly reporting of finance and performance Weekly agency meeting with medical staffing, finance and operational team Regular reviews of nurse eroster rota Ward monthly finance and HR reviews Monthly budget reviews with directorate budget holders Tier 2 authorization of nursing shifts ECP process to approve all agency spend Nursing workforce plan led by corporate nursing team	4	4	16	Introduction of medical e-rostering	08/03/2019	12
										Junior Ward Staffing Standard	29/03/2019	
										Review SCF Rota	29/03/2019	
										Review JCF Rota	29/03/2019	
										CD escalation process for locums above cap	28/02/2019	
st Risk	429	's Kelly	en and Group	Inadequate capacity to meet demand in Paediatric	20	Capacity deficit raised with Stockport Commissioner	4	4	16	Advertise additional consultant PA's to provide	29/03/2019	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Tru		Curtis, Mr	Women Childre Diagnostics Business	ADHD Services		Additional OWL lists monthly (not covering current demand)				ADHD Service		
										Additional Consultant PA's in post to provide ADHD service	29/03/2019	
										Review pathway for ADHD service	29/03/2019	
										Representation of Business Case	28/02/2019	
Trust Risk	457	Zaman, Ms. Raisa	Women Children and Diagnostics Business Group	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	12	In the process to get trained staff in post ASAP. BMS currently in post to join out of hours rota. 1 locum obtained 06/08/18 T295A however he left due to stress in the middle of October and new locum obtained on 01/11/18 thus we had to again train another member of new staff which still is not sufficient to cover shifts. 2nd locum post for out of hours shift cover advert placed on Tempre-T2P1S and appointed in Aug 2018 . They have been trained in Blood bank in Oct 2018 however due to lack of staff he has not been signed off in Haematology to work OOH so we are still short.Still recruiting via NHS jobs.	4	4	16	recruitment of BMS posts	14/02/2019	8
										Recruitment for Training Lead Bank Post	14/02/2019	
Trust Risk	461	Hatchell, Karen	Surgery GI and Critical Care	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19 including CIP	16	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment eg, physician associates, ANP's etc Validation of all activity with a view to alternativer modes of delivery eg., virtual clinics Robust financial controls in place across the	4	4	16	Management of Elective Plan	28/02/2019	12
										Support patient flow to ensure surgical admissions are not compromised	28/02/2019	
										Review all the spend across budgets to stop the run rate of spend	28/02/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
						Robust financial controls in place across the Business Group				Review agency locums and implement 3rd sign off models where necessary	28/02/2019	
										Review of coding to ensure the trust are receiving appropriate income	28/02/2019	
										Business Manager to attend budget scrutiny meetings on a bi-weekly basis	29/03/2019	
										Ensure BG representation at weekly CIP executive meeting	29/03/2019	
Trust Risk	466	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the BG will fail to deliver the CIP Target	16	Financial monitoring within BG occurs monthly Financial reports to monitor CIP schemes Tactical CIP schemes developed for the BG Improving patient flow work stream with metrics and governance arrangements Reporting of CIP savings, progress and escalation via Finance Improvement Group	4	4	16	Establish exception reporting for ward budget meetings	08/03/2019	8
										Introduce new WLI process in BG	29/03/2019	
										Identify first tranche of CIP schemes for 19/20	08/03/2019	
										Establish escalation process for budget holders	28/02/2019	
Strategic Risk	183	KEH	Executive teams	Failure to meet the 62 day Cancer target standards	12	Monthly Cancer Board. Tracking team review all patients on pathway. Cancer Services Manager reviews patients using "Predictor" tool. Patients discussed at weekly tumour specific PTL meetings, Business Group meetings and Trust-wide PTL. Escalation policy in use	4	4	16	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	01/04/2019	8
										Action plan being created with input from Business Groups to ensure sustained performance	01/03/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
										Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	01/04/2019	
Trust Risk	50	Cotton, Mrs Janet	Women Children and Diagnostics Business Group	Risk to maternity service continuity and safety due to midwifery staffing levels	16	- Birth Rate Plus staffing review undertaken June 2017 - Business case collated and submitted August 2017 - additional staff recruited. - Midwife to Birth Ratio reviewed on a monthly basis and reported on dashboard - Evaluation of maternity service diverts undertaken June 2018 - Escalation of concern reports formally submitted to Quality Board, Quality Governance Committee and People and Performance Committee as appropriate (see documents) - Ongoing recruitment taking place to	4	4	16	Resubmit outline business case	29/04/2019	8
Trust Risk	67	Drury, Mrs Margaret	Women Children and Diagnostics Business	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	20	Recruitment processes being followed Temporary staffing processes in place which is not sustainable and requiring substantial management to engage. OH support to staff where necessary. Laboratory and pharmacy support	4	4	16	Continuity for locum cover	11/02/2019	8
Trust Risk	75	Waterman, David	rated Care Business Group	There is a risk that there could be management of palliative atients due to lack of Specialist Palliative Care Medical Cover	20	During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. Clinical Nurse Specialists attend some cancer MDT's if they have capacity	4	4	16	There is a risk that Macmillan will not fund ongoing costs of new recruitment in palliative care	28/02/2019	9

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
			Integ			Current Consultant is available for telephone advise in own personal time						
Trust Risk	78	Ingleby, Mrs Sarah	Medicine and Clinical Support	There is a risk to patient safety and BG finances due to the excessive registered nursing staffing deficit within Medicine & CS	20	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment	4	4	16	Reference to the Minimum safe staffing escalation policy	12/04/2019	8
Trust Risk	231	Glynn, Marie	Corporate Nursing	lack of medical and nursing staff resulting in mandatory work only being undertaken resulting in an inefficient IP service.	20	To review all options for an interim and long term solution	3	5	15	review long term option for IV service	28/02/2019	8
										review BG for wider IP team	29/03/2019	
										review links with sepsis agenda	28/02/2019	
										Current work load undertaken by the IP service team	29/03/2019	
										To produce a gap analysis against the Health & Social Care Act	29/03/2019	
										present compliance data against the H&SC act	28/02/2019	
up Risk	355	Karen	al Care	There is a risk of cancelling elective activity due to bed	15	Start the day meetings to assess the position and prioritise patients. In response	3	5	15	Medical involvement in decision making	29/03/2019	6

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Business Grou		Hatchell,	Surgery GI and Critica	and patient flow pressures, particularly during the winter months		to NHSI guidance, cease operating on routine procedures. Screened trauma patients to enable the elective orthopaedic units to admit these patients. Elective programme to re-commence on 9th April. Plan in place to de-escalate B3 (discharge or repatriate patients into Medical wards) and deep clean ward, repatriate patients from D2 to B3 and deep clean D2 in preparation for 9th April. Plan in place to maximise opportunity to undertake				Use decision matrix to determine which elective surgery cases are appropriate to cancel during periods of extreme bed capacity and patient flow pressures	29/03/2019	
										Monitor impact of lost activity	29/03/2019	
Trust Risk	407	Barrett, Mrs Angela	Medicine and Clinical	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed	12	- Urgent OWL codes used to identify patients who need to be prioritised for urgent Follow Up. - Consultants doing some validation of longest waiting patients to see if may be	3	5	15	Locum (Resp Medicine) to perform WLI	22/02/2019	6
Trust Risk	408	damant, Mrs gillian	Medicine and Clinical Support	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	Staff resources allocated to prioritise patient needs however this can impact on staff wellbeing and cause delays for other work commitments.	3	5	15	electronic prescribing system	01/04/2019	3
Business Group Risk	819	Ryan, Mr Joseph	Estates and Facilities	There is a risk of patients absconding undetected via Ripley Ave due to broken CCTV equipment.	15	View CCTV footage of other areas to ascertain patient location (process of elimination). Security routine search of Ripley Ave when notified of patient absconding.	3	5	15	Arrange Replace CCTV Equipment	28/02/2019	9
										Replacement of CCTV equipment	28/02/2019	
Risk Assessm	825	Hatchell, Karen	Surgery GI and	There is a risk to loss of activity due to staffing levels in theatre	15	Sporadic cover depending on who can volunteer for the shifts. Short term sickness and childcare issues	3	5	15	Full workforce action plan to be drafted to mitigate the risk	29/03/2019	6
Trust Risk	513	Statham, Mr David	states and Facilities	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards.	15	Survey Specification	3	5	15	Review cleaning programme for Ward Kitchens	30/04/2019	9
										Programme of Food Safety Training for Ward Based Staff	22/02/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
			E									
Trust Risk	576	Barrett, Mrs Angela	Medicine and Clinical Support	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	- - ring-fenced capacity for 2ww and Cancer upgrade patients - clinical triage of all referrals - patients booked into clinic by clinical urgency / longest wait - monitoring of wait times in Trust performance meetings. - Capacity and Demand work completed. - Consultants offering WLI's where able but	3	5	15	Business Case for expansion to be developed	22/02/2019	6
										Service Review	22/02/2019	
										Additional Clinics	22/02/2019	
										Review of Lung function provision	22/02/2019	
Trust Risk	476	damant, Mrs gillian	Medicine and Clinical	There is a risk of not achieving the empiric review of antibiotic prescriptions &reduction in	15	Guidelines on reviewing antibiotics exist and should be embedded in practice already. Antibiotic stewardship ward rounds and education sessions are carried out when	3	5	15	Consider additional antibiotic pharmacist post	07/01/2019	6
Trust Risk	499	Buckley, Lisa	Corporate Nursing	There is a risk that complaints responses are not being completed within Trust timescales	15	Action Plan Reports	3	5	15	weekly monitoring of complaints that are overdue	31/03/2019	4
Trust Risk	587	Fox, Mrs Paddy	Information and IT	There is a risk to the operation of the Trust electronic syst/ntwrk due to the need to recruit Senior IT Technical Support	15	Advertising 2 key post; in interim attempting to recruit agency to be in place until substantive recruitment successful.	5	3	15	Recruit to 2 senior IT posts	30/04/2019	10

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	872	Culverwell, Mrs Caroline	Surgery GI and Critical Care	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	16	The capacity and demand business case demonstrates that there is a need for more capacity compared to the demand. Therefore we are proposing a 4th room build which will reduce the cost associated with the insourced Alliance Lists and WLI sessions.	4	4	16	Schedule patients into additional insourced lists with Alliance	28/02/2019	1
										Updating of Endoscopy Business Case for presentation and consideration by Exec board	15/02/2019	
										Presentation of Endoscopy Business Case to SMT & EMG	28/02/2019	
										Create additional insourced lists with Alliance until end of financial year	31/03/2019	
Risk Assessment	934	Marshall, Ms Fran	Surgery GI and Critical Care	There is a risk of reduced critical care capacity due to staffing shortages	20	Additional staffing request in advance Block booking from NHSP Crit Care staff in other areas been asked to help Moving staff from night to days to balance days Escalated appropriately	4	4	16	Recruitment	29/03/2019	4
										Enticement	28/02/2019	
Trust Risk	599	Fox, Mrs Paddy	Information and IT	There is a risk to the timely delivery of ECDS (new contract data set for A&E)	20	Negotiations with Stockport CCG Plan for Intersystems to deliver in the new EPR.	4	4	16	Implement series of PAS upgrades and test eCDS in Patient Centre	01/04/2019	8

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2019
Subject:	Registration Authority Annual Report		
Report of:	Deputy Chief Executive	**Prepared by:**	I.G. Co-ordinator

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The Registration Authority Annual Report is required to be reviewed by the Trust Board. The report is presented to the Trust Board, having been approved by the Finance & Performance Committee.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	Registration Authority Annual Report – 2018/2019

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

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Report to:	Board of Directors	**Date:**	Jan 2019
Subject:	Registration Authority Annual Report 2018/2019		
Report of:	Hugh Mullen Director of Support Services/Deputy Chief Executive/SIRO	**Prepared by:**	S. Raisbeck Registration Authority Manager

REPORT FOR BOARD APPROVAL

Corporate objective ref:	N/A	**Summary of Report** Contents of this report demonstrate compliance with the requirements against the Data Security and Protection Toolkit (DSPT) and National Registration Authority (RA) Policy. National Registration Authority Policy states: "The Board/EMT individual must report to the Board annually on RA activity and must sign off on RA DSP Toolkit submissions." Trust compliance is submitted in March as part of the DSP Toolkit. Stockport FT is required to complete the Registration Authority DSPT Requirements for RA and Smartcards. These requirements ensure that organisational processes and procedures are in place to meet an organisation's responsibility to be a Registration Authority and to ensure that NHS Smartcard users comply with the Terms and Conditions of use. Board members are requested to; • Note the content of this report for reporting year 2018 to 2019.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	Appendix A – Access Positions Appendix B – RA Sponsor Log Appendix C – Summary of Sponsor Audit 2018 Appendix D– Summary of Individual User Audit 2018

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
		☐ Joint Negotiating Council
	☐ FSI Committee	☒ Other

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Registration Authority Annual Report 2018/2019

1. INTRODUCTION

The Registration Authority (RA) manages Smartcards and the registration and access control processes. The role of the RA is to ensure all users of National Programme applications are provided with the appropriate levels of access through the Smartcard system and have their identity rigorously checked.

2. BACKGROUND

The registration process applies nationally and must meet the current Government requirements.

The Executive Director of Support Services is the Board level individual who has overall accountability in Stockport NHS Foundation Trust for RA activity; and in line with national policy must report annually to the organisation on this activity. This report has been submitted to also meet evidence requirements of the DSP toolkit.

3. CURRENT SITUATION

3.1 NHS Digital published a revised National Registration Authority (RA) Policy 02/09/2014 in preparation for the new Smartcard registration system in 2015, Care Identity Service (CIS). Stockport NHS Foundation Trust's local policy has subsequently been reviewed and updated in line with the National RA Policy and is available on the Intranet.

3.2 The Registration Authority comprises of the RA Manager, Agents, ID checkers and Sponsors.

3.3 This Trust operates under Position Based Access Control (PBAC). PBAC simplifies how access rights are granted to a user and builds on the existing Role Based Access Control (RBAC) security model. This provides access to NHS CRS (Care Records Service) compliant systems appropriate to the job that staff have been employed to do.

3.4 Access positions are under constant review and any changes are agreed with Caldicott Guardian, Information Governance lead and RA Manager with sign off at board/ET level in this report. There are currently 46 Access positions in the Trust and details are shown in Appendix A. The inclusion of this appendix is a requirement of the DSP Toolkit.

3.5 There are currently 192 registered sponsors in the Trust and it is mandatory that they all **must** complete RA Sponsor training when registered. Sponsors are set at a senior level to authorise correct access to systems. The Training for Sponsors is via the Registration Authority Manager in accordance with National Policy requirements. Sponsor details are shown In Appendix B. The inclusion of this appendix is a requirement of the DSP Toolkit.

In Summary, currently Trust Sponsors are Split across the Business Groups as follows:

- 52 in Integrated care
- 41 in Surgical GI and Critical Care
- 18 in Corporate Services
- 37 in Women Children & Diagnostic Services
- 44 in Medicine & Clinical Support

3.6 Integration with HR **–** There is a robust, assured process in place within HR to ensure all new starters are RA ID checked and registered when they present their documents to the recruitment team. All HR ID Checkers are trained and complete RA e-learning.

3.7 Introduction of new systems and applications:

Hospital EPR – TrakCare. The RA team are continuing to Identify, register and train appropriate Sponsors who in turn authorise staffs access to TrakCare. All staff needing access to the system require a smartcard. The RA Team are working with Sponsors to ensure staff have cards and access ready for roll out.

3.8 Two annual audits have been conducted. The first was sent to a selection of individuals and the second was the Sponsor Audit. Summary details are shown in Appendix C & D. The inclusion of these Appendices is a requirement of the DSP Toolkit.

3.9 Statistics:

Currently maintain smartcards and access for 4861 users.

559 new registrations to *e-GIF level 3 in last 12 months (this includes HR registrations for some staff that have yet to have cards printed)

2006 smartcards issued in the last 12 months (includes re-issues)

1042 smartcards erased and refreshed in last 12 months

2195 users registered for self-service unlocking (smartcard passcodes lock after 3 incorrect code attempts).

- ***e-GIF stands for e-government interoperability framework. It is a set of policies and standards to enable information to flow seamlessly across the public sector. As part of the framework, four confidentiality levels were set (zero to three) representing degrees of impact of disclosure of private information. The levels are layered according to the severity of consequences that might arise. Level 3 which imposes the most stringent security requirements around confidentiality has been adopted for the NHS CRS.***

4. RISK & ASSURANCE

The Board can be assured that our existing processes and procedures are comprehensive and robust. Our detailed approach to the management of RA meets the requirements of national standards surrounding registration and ID checking to the government standard e-GIF level 3.

5. CONCLUSION

The Hospitals EPR project requires approximately 4200 staff to be issued with NHS Smartcards and detailed access control, the continued support of RA by the Trust Board and all registered sponsors is intrinsically important. Some changes to local processes may be required but always within the set boundaries required by the DSP toolkit and National Policy.

6. RECOMMENDATIONS

That the content of this report be noted.

APPENDIX A

Position name	Position description
1. Acceptance of Terms and Conditions	Temporary Job Role to allow smartcard user to accept terms and conditions before sponsor approval of required PBAC.
Caldicott Guardian	Restricted access for Caldicott Guardian only
Child Protection Information Sharing (CP-IS) in SCRa	Allows staff in unscheduled care, Summary Care Records access - can check if a Child Protection Plan is in place or are classed as Looked After by Local Authorities. Used to check the status of children and pregnant mothers due to give birth
CSC Cluster System Administrator	Access for CSC to support upgrades and deal with service calls.
Data Management Team	Restricted Specialist Role allowing access to SCR (Summary Care Record) and PDS
Emergency Department Sponsor	Sponsor with access to CP-IS in SCRa - can check if a Child Protection Plan is in place or are classed as Looked After by Local Authorities. Used to check the status of children and pregnant mothers due to give birth.
EMIS Web Admin Authorised To Manage Appointment Slots - Restricted	Restricted access authorised by the Information Team to manage appointment slots - includes the standard EMIS Web Administrator access
EMIS Web Administrator	Emis Web access for Community Admin staff including NHS e-referral codes
EMIS Web Call Handler	Limited access for Mastercall call handlers to add referrals and activate inactive patients.
EMIS Web Clinician	Emis Web access for Community Clinicians
EMIS Web Service Lead	Emis Web access for Community Clinician Managers with reporting rights.
Emis Web System Admin - Restricted	Restricted position for EMIS Web System Admin only
e-RS Admin	NHS e-Referral Service access for Call Centre Staff
e-RS Admin Manager	NHS e-Referral Service access for e-RS Admin Managers
e-RS Consultant	Choose and Book access enabling Consultants to receive referrals
e-RS Information Analyst	Restricted Access for Business Information Team retrieving the A&G data from e-RS
e-RS Medical Records	NHS e-Referral Service access for Medical Records staff
e-RS Referring Clinician	Access for referring clinicians allowing triage of referrals and to read directly in e-RS
General User	Allows the user to access ESR, MOM, E-Learning, ORMIS and SSO (the user also requires a profile to be created on the appropriate system).
Local Smartcard Administrator	General user access with the ability to unlock smartcards and renew certificates for non RA staff.
Midwife Sponsor	Access to PDS Birth Notifications Application (Maternity) with rights to Sponsor staff
Operational RA Manager	RA Manager access including predecessor access to 5F7 to enable position management for community staff

Ormis Admin	Administrator access in the ORMIS system with the right to unlock users cards
Overseas Visitor Management	Restricted access to verify the surcharge status of overseas visitors in SCRa used by the overseas visitor management team only.
Patient Demographics view only access (PDS)	User with access to Personal Demographic Service can view patient demographic information and check patients NHS numbers and registered GP.
PDS Birth Notification Application - Restricted	Access to PDS Birth Notifications Application (Maternity)
RA Agent	This is a standard position for RA Agents. Able to assign R8008 for acceptance of T's and C's only.
RA Agent ID Checker	HR staff able to check ID, upload photos and register details for smartcards. No other RA activities included cannot grant access or issue cards.
RA Manager & Privacy Officer	Restricted to RA Manager and authorised Privacy Officer.
RA Sponsor	Allows the user to access & Sponsor staff for ESR, MOM, E-Learning, ORMIS and SSO (the user also requires a profile on the appropriate system & must be authorised to use the system).
Senior Information Analyst SUS access	Restricted Specialist role allowing access to SUS and SCR/PDS
Sponsor with access to SCRa	View only access in Summary Care Record application (SCRa) with rights to Sponsor staff.
Summary Care Record application view only access	View only access in Summary Care Record application (SCRa)
TrakCare AHP	Access to perform non clinical functions move and discharge a patient; request case notes; request a bed in case of admitted patients; view clinics and book appointments. Additionally add nursing details.
TrakCare Back Office	Access contains functions related to back office for PDS. Users can create new patient records, decease patients, merge patient records, check the requires attention list (e.g. for records that have been uncoupled).
TrakCare Clerical Access	Non clinical functions including registration of patient; request case notes; search for beds and perform bed requests; Move, transfer and discharge patients; view ward lists; view individual patient episode details.
TrakCare Coding	Access for clinical coders
TrakCare Doctors Access	Access for all doctors to emergency assessment and ambulatory care patients, request for beds; discharge the patient; view/ add discharge summaries; access the EPR.
TrakCare Medical Secretary	Access to perform the waiting list functions and enquiries for OP wait list and IP wait list ; request case notes; view the RTT Workbench; book appointments ;book and cancel TCIs.Allowed to book past guarantee dates.
TrakCare Midwife	Access to perform all the Maternity related functions: add to wl; book first appointment; view EPR; use active clinical notes; view pregnancies; admit patient; perform delivery and early loss functions.

TrakCare Nurse Independent Prescriber	Access for qualified Independent Nurse Prescribers to emergency assessment and ambulatory care patients, request for beds; discharge the patient; view/ add discharge summaries; access the EPR
TrakCare Nurses Access	Nurses and HCA's access to perform non clinical functions move and discharge a patient; request case notes request a bed in case of admitted patients; View clinics and book appointments. Additionally add nursing details .
TrakCare Pharmacist Independent Prescriber	Access for qualified Independent Pharmacist Prescribers to emergency assessment and ambulatory care patients, request for beds; discharge the patient; view/ add discharge summaries; access the EPR
TrakCare Super Med Records	Allows med records managers & PAS back office to perform all medical records functions: create new records an volumes, request case notes, move the case notes, bulk request & move and additionally merge patients, move episodes, view an EPR.
TrakCare Systems Support	Access to all menus for support and investigation purposes. Allows overbooking, booking past guarantee dates and amendments to RTT pathways and stages.
TrakCare Ward View	Access for a display only view of patients in a ward. it should be assigned to a user with logged in location for that ward.

APPENDIX B

Trust Sponsors

Staff Group	Job Title	Area of Sponsorship	Business Group
SFT	Clinical Director	Anaesthetics and Critical Care	Surgery GI & Critical Care
SFT	Medical Day Case Unit (MDCU) Manager & Specialist Nurse	MDCU C5	Medicine & Clinical Support
SFT	Senior Sister	A1	Medicine & Clinical Support
SFT	Ward Manager	A11	Medicine & Clinical Support
SFT	Acting Ward Manager	A11	Medicine & Clinical Support
SFT	Lead Nurse	A12	Medicine & Clinical Support
SFT	Ward Manager	A12 (was A11)	Medicine & Clinical Support
SFT	Matron	A12,A3,CCU,B6,Cath Lab, ECG/EEG, Cardiology Nurse Consultants	Medicine & Clinical Support
SFT	Ward Manager	A3 & Coronary Care (CCU)	Medicine & Clinical Support
CHS	Team Leader	Adult Community Therapy	Integrated Care
CHS&SFT	Active Recovery Team manager	Active Recovery (Community Therapies)	Integrated Care
SFT	Ward Manager	ACU	Integrated Care
SFT	Ward Manager	Acute Medical Unit (AMU)	Medicine & Clinical Support
SFT	Clinical Director & Consultant	Acute Medicine Doctors	Integrated Care
SFT	Business Manager - Theatres and Critical Care	Admin/Rota team in Critical Care	Surgery GI & Critical Care
SFT	Senior Sister	B3	Surgery GI & Critical Care
SFT	Acting Ward Manager	B4	Medicine & Clinical Support
SFT	Ward Manager	B5	Medicine & Clinical Support
SFT	Ward Manager	B6	Medicine & Clinical Support
SFT	Senior Sister	Bluebell	Medicine & Clinical Support
SFT	Assistant Business Manager	Booking/Health Records, Clinical Cancer Services/Haem	Medicine & Clinical Support
CHS	Head of Performance and Business Development	Business Unit and Community Admin	Integrated Care
SFT	Ward Manager	C4	Medicine & Clinical Support
SFT	Ward Manager	C6	Surgery GI & Critical Care
SFT	Cancer Services Manager	Business Manager	Women, Children & Diagnostics
SFT	Cancer Services Manager	Cancer Services	Women, Children & Diagnostics
SFT	Cardiac rehab Team Lead	Cardiac rehab team	Medicine & Clinical Support

SFT	Clinical Director & Consultant	Cardiology	Medicine & Clinical Support
SFT	Business Manager	Child & Family Services	Women, Children & Diagnostics
SFT	Associate Nursing Director	Children's Nursing (inc Community, Neonatal, Therapies & Safeguarding)	Women, Children & Diagnostics
CHS	Children's Occupational Therapy Team Lead	Children's Occupational Therapy	Integrated Care
CHS	Physiotherapy Team Lead	Children's Physio	Integrated Care
CHS	Specialist SALT	Children's Speech And Language Therapy	Integrated Care
CHS	Children's Therapy Manager	Children's therapies + Early attachment service	Integrated Care
CHS	Children's Speech & Language Therapist TL	Children's Therapy services	Integrated Care
CHS	Speech & Language Therapist TL	Children's Therapy services	Integrated Care
SFT	Head of Outcomes and Assurance	Clinical Audit	Corporate Services
SFT	Clinical Coding Manager	Clinical Coding Team	Corporate Services
SFT	Associate Medical Director & Consultant	Clinical Directors	Women, Children & Diagnostics
SFT	Associate Medical Director	Clinical Directors	Medicine & Clinical Support
CHS	Business Support Manager	Community admin staff	Integrated Care
CHS	Nutrition and Dietetics Service Lead	Community Dietetics	Integrated Care
SFT	Clinical Director	Complex Care & LTC	Medicine & Clinical Support
CHS	Continence Service Lead	Continence Service	Integrated Care
CHS	COPD Specialist Nursing Service Lead	COPD & HF teams	Integrated Care
SFT	EPR clinical Project Lead-Nursing	Corporate Nursing	Corporate Services
SFT	Assistant Director of Nursing	Corporate Nursing	Corporate Services
CHS	Crisis Response Team Lead	Crisis Response Team	Integrated Care
SFT	Ward Manager	D1	Surgery GI & Critical Care
SFT	Ward Manager	D2	Surgery GI & Critical Care
SFT	Ward Manager	D4	Surgery GI & Critical Care
SFT	Ward Manager	D5	Surgery GI & Critical Care
SFT	Ward Manager	D6	surgery GI & Critical Care
SFT	data Manager	Data Management Team	Corporate Services
SFT	Ward Manager	Devonshire Suite	Medicine & Clinical Support
SFT	Acting Ward Manager	Devonshire Suite	Medicine & Clinical Support
CHS	Diabetes Specialist Nursing Service Lead	Diabetes	Integrated Care
CHS	Diabetes Specialist Nurse	Diabetes Team	Integrated Care
SFT	Gov & Quality Manager	Diagnostic and Clinical Support	Women, Children & Diagnostics
CHS	Pathway Lead Community Nursing DN's	District Nursing	Integrated Care

CHS	Locality Lead for District Nursing	District Nursing	Integrated Care
CHS	District Nurse Team Lead (Cheadle Gately Heald Green)	District Nursing	Integrated Care
CHS	Locality Lead for District Nursing	District Nursing	Integrated Care
CHS	District Nurse Team Lead (Heaton's)	District Nursing	Integrated Care
CHS	Locality Lead for District Nursing	District Nursing	Integrated Care
CHS	District Nurse Team Lead Marple & Treatment Rooms	District Nursing	Integrated Care
CHS	Pathway Lead Community Nursing DN's	District Nursing	Integrated Care
CHS	Locality Lead for District Nursing	District Nursing	Integrated Care
CHS	District Nurse Team Lead (Heaton's)	District Nursing	Integrated Care
CHS	District Nurse Team Lead (Victoria)	District Nursing	Integrated Care
CHS	Locality Lead Marple/Werneth DN's	District Nursing Werneth	Integrated Care
SFT	Clinical Director & Consultant	Doctors, DMOP, Rheumatology, Rehab medicine	Medicine & Clinical Support
SFT	Clinical Director & Consultant	Doctors- Head & Neck	Surgery GI & Critical Care
SFT	Clinical Director & Consultant	Doctors Ophthalmology & Dental	Medicine & Clinical Support
SFT	Ward Manager	E1	Medicine & Clinical Support
SFT	Ward Manager	E2	Medicine & Clinical Support
SFT	Ward Manager	E3	Medicine & Clinical Support
CHS	Early Years team Leader	Early Years team/HV's	Integrated Care
SFT	Associate Medical Director & Consultant	ED/Acute Medicine	Integrated Care
SFT	Clinical Director & Consultant	Emergency Dept	Medicine & Clinical Support
SFT	Clinical Director & Consultant	Endocrinology, Respiratory, Haematology Doctors	Medicine & Clinical Support
SFT	Endoscopy Sister	Endoscopy Unit	Women, Children & Diagnostics
SFT	Endoscopy Manager	Endoscopy Unit	Women, Children & Diagnostics
SFT	EPR clinical Project Lead-Nursing	EPR Project team	Corporate Services
SFT	Head of EPR Technical Deployment	EPR Project team	Corporate Services
SFT	Head of EPR Clinical Deployment	EPR Project team	Corporate Services
CHS	Family Nurse Supervisor	Family Nurse partnership	Integrated Care
SFT	Business Accountant	Finance	Corporate Services
SFT	Clinical Director & Consultant	Gastro	Surgery GI & Critical Care
SFT	Clinical Director & Consultant	General Surgery	Surgery GI & Critical Care
SFT	Assistant Business Manager - SCC business group	General Surgery Medical Secs, Waiting list teams	Surgery GI & Critical Care
CHS	Advanced Physiotherapist and Physiotherapy Team Leader	GP Direct Access Physiotherapy	Integrated Care
CHS	Advanced Physiotherapist and Physiotherapy Team Leader	GP Direct Access Physiotherapy	Integrated Care

SFT	Ward Manager	HASU-Ward B2 & C2 - now moved to A10	Medicine & Clinical Support
CHS	Health Visiting Team Lead	Health Visiting Stepping Hill & Victoria	Integrated Care
CHS	Integrated Children's Services Manager	Health Visiting, School Nursing	Integrated Care
CHS	Service Manager	Health Visiting, School Nursing	Integrated Care
CHS	QA & Governance Lead	Health Visiting, School Nursing	Integrated Care
SFT	Recruitment Manager	HR	Corporate Services
SFT	Workforce Team Leader	HR	Corporate Services
CHS	Health Visitor Team Lead	HV Service	Integrated Care
CHS	Early Years Team Leader	HV's Cheadle , Bramhall & Marple	Integrated Care
CHS	Early Years Team Leader	HV's Gately & Werneth	Integrated Care
CHS	Integrated Children's Services -Team leader	HV's Heaton's and Tame Valley Locality	Integrated Care
SFT	Nursing Manager	ICU	Surgery GI & Critical Care
SFT	Ward Manager	ICU	Surgery GI & Critical Care
SFT	Clinical Director & Consultant	ICU	Surgery GI & Critical Care
SFT	Matron - ICU	ICU	Surgery GI & Critical Care
SFT	Matron for Surgery & Critical Care	ICU & Trauma & Ortho	Surgery GI & Critical Care
SFT	Nurse Team Manager	ICU/HDU/Critical care	Surgery GI & Critical Care
SFT	Senior Infection Prevention Nurse	Infection Prevention Team	Corporate Services
SFT	AD of information	Information	Corporate Services
SFT	Assistant Director of Information Governance & Security	Information Governance	Corporate Services
CHS	Information and Performance Manager	Information Team	Integrated Care
SFT	Team Leader	In-Patient Therapies	Women, Children & Diagnostics
SFT	Therapy Manager	In-patient Therapies	Women, Children & Diagnostics
SFT	Physiotherapist Team lead	In-Patient Therapies T & O Team	Women, Children & Diagnostics
SFT	Assistant Business Manager	Integrated Care BG	Medicine & Clinical Support
SFT	Acting Assistant Director of IM&T	IT	Corporate Services
SFT	Service Manager	IT	Corporate Services
SFT	Macmillan Lead cancer nurse	Laurel Suite & Haematology	Medicine & Clinical Support
SFT	Ward Manager	M4	Surgery GI & Critical Care
SFT	Senior Sister Anaesthetics & Recovery	Main Theatres	Surgery GI & Critical Care
SFT	Unit Manager	Marjory Warren Unit	Medicine & Clinical Support
CHS	HV Team Lead	Marple HV team	Integrated Care
SFT	Practice Educator Facilitator (Maternity)	Maternity	Women, Children & Diagnostics

SFT	Clinical Midwifery Manager	Maternity	Women, Children & Diagnostics
SFT	In Patient Matron	Maternity	Women, Children & Diagnostics
SFT	Assistant Business Manager	Medicine	Medicine & Clinical Support
SFT	Acute Services Manager	Medicine	Medicine & Clinical Support
SFT	Assistant Business Manager	General Surgery, Gastroenterology and Endoscopy	Medicine & Clinical Support
SFT	CCIO	Medicine BG Consultants	Medicine & Clinical Support
SFT	Assistant Business Manager	Gastroenterology, Diabetes & Endocrinology	Medicine & Clinical Support
SFT	EPR Clinical Lead AHP	Medicine for Older People Therapy Team	Women, Children & Diagnostics
SFT	EPR Clinical Lead AHP	Medicine for Older People Therapy Team	Women, Children & Diagnostics
SFT	Senior Occupational Therapist	Neuro Rehab team - In-patient Therapies	Women, Children & Diagnostics
SFT	Associate Nursing Director	Nursing - Surgery GI & Critical Care	Surgery GI & Critical Care
SFT	Clinical Director & Consultant	Obs & Gynae	Women, Children & Diagnostics
SFT	Business Manager	Occupational Health	Women, Children & Diagnostics
SFT	Senior Clinical Research Nurse	Oncology Research	Women, Children & Diagnostics
SFT	Research & Innovation Manager	Oncology Research	Women, Children & Diagnostics
SFT	Sister	Ophthalmology	Surgery GI & Critical Care
SFT	Eye Centre Manager	Ophthalmology	Surgery GI & Critical Care
SFT	Head Orthoptist	Orthoptics	Surgery GI & Critical Care
SFT	MSK Outpatients Team Lead	outpatient Therapies	Women, Children & Diagnostics
SFT	Physiotherapist Team Lead	outpatient Therapies	Women, Children & Diagnostics
SFT	Outpatients Manager	Outpatients Department	Women, Children & Diagnostics
SFT	Clinical Director	Paediatric Doctors	Women, Children & Diagnostics
SFT	Advanced Nurse Practitioner	Paediatrics - Tree House	Women, Children & Diagnostics
CHS	Head of Palliative Care	Palliative Care Team	Integrated Care
CHS	Parenting Team Leader	Parenting Team	Integrated Care
SFT	Technical Head of Blood Sciences	Path Lab/haematology including Laurel Suite	Women, Children & Diagnostics
SFT	Consultant Histopathologist & Clinical Director	Pathology	Women, Children & Diagnostics
SFT	Pharmacist	Pharmacy	Medicine & Clinical Support
SFT	Pharmacist	Pharmacy	Medicine & Clinical Support
SFT	Chief Technician	Pharmacy	Women, Children & Diagnostics
CHS	Podiatry Team Lead	Podiatry	Integrated Care
SFT	Pre-op Service Manager	Pre-op (Magnolia Suite)	Surgery GI & Critical Care
SFT	Radiology Systems Manager	Radiology	Women, Children & Diagnostics

SFT	Acting AMD & Consultant	Radiology & Lab Med CD"s and doctors	Medicine & Clinical Support
SFT	Clinical Director	Radiology Doctors	Women, Children & Diagnostics
SFT	Clinical Director	Radiology Doctors	Women, Children & Diagnostics
SFT	Assistant Business Manager	Respiratory, Rheumatology, Oral/Max Fax,Outpatients	Medicine & Clinical Support
SFT	Associate Nursing Director/Head of Quality Governance	Risk & Customer Services	Corporate Services
CHS	Name Nurse LAC	Safeguarding children Stockport	Integrated Care
SFT	Ward Manager	Short stay Older People (SSOP) - B3	Medicine & Clinical Support
SFT	Acting Ward Manager	Short stay Older People (SSOP) - D4	Medicine & Clinical Support
SFT	Ward Manager	SSSU	Surgery GI & Critical Care
CHS	District Nurse Team Leader	Stepping Hill, Victoria and Eve DN service	Integrated Care
SFT	Assistant Business Manager	Strategic planning Admin	Trust planning
SFT	Clinical Director & Consultant	Stroke Medicine	Medicine & Clinical Support
SFT	Stroke Therapy Team Lead	Stroke Therapy Team	Women, Children & Diagnostics
SFT	Associate Medical Director & Consultant	Surgery	Surgery GI & Critical Care
SFT	Ward Manager - Matron	Surgery and Urology (SAU) C3	Surgery GI & Critical Care
SFT	Matron	Surgery GI & Critical Care	Surgery GI & Critical Care
SFT	Matron	Surgery GI & Critical Care	Surgery GI & Critical Care
SFT	Medical Director/Consultant	Surgery GI & Critical Care	Surgery GI & Critical Care
SFT	Senior Sister	Surgical Assessment Unit (SAU)	Surgery GI & Critical Care
SFT	Children's Complex Needs Co-Ordinator	Swanbourne Gardens	Women, Children & Diagnostics
SFT	Nurse Manager	Swanbourne Gardens	Women, Children & Diagnostics
SFT	Matron Operating Theatres	Theatres	Surgery GI & Critical Care
SFT	Senior Sister T&O Theatres	Theatres	Surgery GI & Critical Care
CHS	AD of Nursing	Tissue Viability	Integrated Care
CHS	Integrated Tissue Viability Lead	Tissue Viability Service	Integrated Care
SFT	Clinical Director & Consultant	Trauma and Orthopaedic Services	Surgery GI & Critical Care
SFT	Business Manager	Trauma and Orthopaedic Services	Surgery GI & Critical Care
SFT	Matron - Paediatrics	Tree House	Women, Children & Diagnostics
SFT	Ward Manager	Tree House	Women, Children & Diagnostics
SFT	Senior Sister	Urology	Surgery GI & Critical Care
SFT	Sister	Urology	Surgery GI & Critical Care
SFT	Assistant Business Manager - SCC business group	Urology	Surgery GI & Critical Care
SFT	Clinical Director, Urology	Urology doctors	Surgery GI & Critical Care

Appendix C **SUMMARY of Sponsor Audit 2018**

Registration Authority Smartcard Usage Monitoring

The Data Security and Protection Toolkit (DSPT) requires the Trust to put monitoring and enforcement procedures in place to ensure that NHS Smartcard users comply with the terms and conditions of use.

This form is to be completed by the Registration Authority Manager, Sponsors or Agents to document that checks have been carried out on the appropriate use of Smartcards and associated applications.

Where non-compliance with the Terms & Conditions or other Stockport NHS Foundation Trust polices is identified a formal incident report should be completed on the Datix Risk Management System. The results of any spot checks undertaken should also be submitted to the Information Governance Team.

Action must be taken in line with the Trust's disciplinary procedures where any re-occurring issues are identified; where serious breaches are identified criminal prosecution may also be taken against the individual concerned.

Completed by:

Name:	Sue Raisbeck

UUID:	61574076030

Date:	30/11/2018

Location details:

Directorate / Business Group	Information Governance
Department:	Registration Authority
Location:	Cedar House
Area Uses Smartcards? Yes/No	Yes

Checklist (Part One):

Physical Security Checks				
Question		**No. of users / pc's checked (min 5)**	**Yes**	**No**
1. Are there any Smartcards left unattended in the readers?	Normal Working Hours	580	1	579
	Out of Normal Working Hours	314	0	314
2. Are there any Smartcards left unattended elsewhere?	Normal Working Hours	591	0	591
	Out of Normal Working Hours	318	0	318
3. Ask the user to show you their Smartcard to confirm that it has not been lost / stolen.		569	568	1
4. Ask the user to confirm that when not in use their Smartcard is stored securely i.e. kept in a locked		568	567	1

draw / handled like bank/credit cards.			
5. Ask the user if their name remains the same as that printed on the card?	568	568	0
6. Is the user using their own Smartcard?	568	568	0
7. Are there any notes/stickers on the Smartcard or surrounding work station that show the users passcode?	565	0	565
8. Has the Smartcard been altered, defaced, tampered with or otherwise manipulated?	572	0	572

Issues and Actions:

These details must be recorded for any issues identified:

Name	UUID	Question Number	Datix Incident Reference	Action Taken
D*** R****	5610******08	3	w-14625	"Reported to HR and smartcard. Identity card found since reported lost"
Not Named	Unknown	4	N/A	"One member of the team admitted not always locking away or taking card home. When challenged it came to light when not put into their draw that it was left in card reader. Advice given and team lead to continue random audit over next month to ensure lesson learned and policy adhered to".
A*** F******	4612******16	N/A	N/A	Card is worn and sometimes takes time to read. Advised this staff member to contact Smart Card team to get the card renewed.
J**** L***	5562******05	N/A	Was not recorded on datix, as I didn't realise I had to record it.	12/7/18 Staff member went out on health visits leaving the smart card in her keyboard by accident. I removed the card and put in an envelope and secured in a locked drawer. On her return I explained that the card should be treated like a bank card and not left unattended. I also discussed this with other staff who were present at the time for their learning and development.
Not Named	Unknown	1	Sponsor/Line Manager (JP) addressed issue	Reinforced with staff that smart cards should never be left in devices when unattended

Additional Comments / Observations:
"No issues when audit completed this morning. All checks satisfactory and good compliance noted"

"Pleased with results in Occupational Health Department. Everyone aware of compliance requirements."

"All being used and stored appropriately"

"Highlighted some new starters without smartcards this has been actioned today to arrange getting a smartcard"

"All 5 staff audited were managing their smartcards in line with the expected standards. No issues of concern noted from this audit"

"All staff checked were compliant. Some staff have cards coming to need security renewing and I have brought up with smartcard team and IT that many ward computers do not have appropriate software. I understand this is being addressed."

Summary

In summary, this was a positive annual audit which demonstrated general good practice across the Trust.

Any/All issues addressed and/or resolved – checked completed by S. Raisbeck, RA Manager.

Appendix D

SUMMARY Individual User Audit 2018

Registration Authority Smartcard Usage Monitoring

The Data Security and Protection Toolkit (DSPT) requires the Trust to put monitoring and enforcement procedures in place to ensure that NHS Smartcard users comply with the terms and conditions of use.

This form is to be completed by the Smartcard User to document that checks have been carried out on the appropriate use of Smartcards and associated applications.

Where noncompliance with the Terms & Conditions or other Stockport NHS Foundation Trust polices is identified a formal incident report should be completed on the Datix Risk Management System. The results of any spot checks undertaken should also be submitted to the Information Governance Team.

Action must be taken in line with the Trust's disciplinary procedures where any re-occurring issues are identified; where serious breaches are identified criminal prosecution may also be taken against the individual concerned.

Name:	Sue Raisbeck, RA Manager

UUID:	615744076030

Date:	Oct 2018

Location details:

Directorate / Business Group	Corporate, Medicine & Clinical Support, Child & Family, Integrated Care, Women, Children and Diagnostics, Surgery GI & Critical Care, Boroughwide Services
Departments:	Information, EPR Dept, Clinical Coding, Health Records, Community, Diabetes and Endocrinology, COPD, Corporate Nursing, Health Visiting, Children's Therapy, Orthopaedic, Crisis response Team, Evening Nursing Service, T & O, Pain Clinic, General Surgery, Podiatry, Active Recovery, Outpatients, Community Nursing, Research & Innovation, District Nursing, Pharmacy, General Medicine, Maternity, Orthoptics, Neurological Rehabilitation, ANP Neighbourhood, Children's Therapy Services, Speech & Language, safeguarding Children VCT, Out of hours team/ Night Sister, Pre-Op Assessment, Pain Clinic, Newborn Hearing Screening, Outpatient Therapies, Patient Education, Audiology, Directors PA Office, OP Bookings, Elective Orthopaedic Surgery, Radiology, Chest Clinic, Infection Prevention, Risk,
Locations:	Cedar House, OPB, Ash House, Centralised Library, Cheadle Hulme Clinic, Maple suite, Woodley HC, Shaw Heath HC, Treehouse, Birch House, OPA, Heaton Moor MC, Kingsgate House, Aspen House, Regent House, OPB, Marple Clinic, Ward C2, Stopford House, Hazel Grove Clinic, Pharmacy, Ward B6, Buxton Community Maternity Team, Devonshire Centre, Ward A11, DMOP, Continence Team, Rainforest, Beckwith House, Community Treatment Rooms , Control and command suite, Magnolia Suite, MAT 3, Ward D1, Audiology dept. Antenatal Clinic, ward M4, X-Ray B,Chest Clinic
System accessed with smartcards	ESR, EMIS Web, e-Learning, e-RS, ORMIS, SCR

Checklist

Question	
1. Where do you keep your smartcard when it's not in use?	• With my ID badge • Tunic Pocket • At home • In a locked drawer • Work bag/Purse
2. Do you leave your smartcard unattended at any time?	• No/Never
3. Do you use another person's smartcard?	• No
4. What must you do if your smartcard is lost or stolen?	• Report to my Line manager • Report it to Information Governance • Report it to the Registration Authority (Smartcard) Team and complete DATIX • Inform manager/ report it - Apply for new smartcard/datix • Report it to IT
5. Do you allow anyone to share your smartcard?	• No
6. What must you do if your name changes?	• Inform the Registration Authority/Smartcard Team • Notify HR • Report it to IT
7. Are there any notes/stickers on your Smartcard or surrounding work station that show the passcode?	• No
8. Has the Smartcard been altered, defaced, tampered with or otherwise manipulated?	• No
9. Can smartcards be used for ID?	• No • No. I have a Stockport NHS Trust • Identity card which I use as ID within the Hospital only • Yes/Possibly (8%) • No, your official identification badge should be used as it has the Trust logo, your Professional title, and area of work. None of these details are on the Smart Card. • Not outside the trust.
10. Does the photo on the smartcard clearly bear a true likeness to you and is the smartcard number clear?	• Yes • Number is clear. Likeness is clearly identifiable as me • Part of the 10th & 11th numbers have rubbed off (User asked to come in for a new card)

Additional Comments:

One Person made a comment *"Not all computer keyboards or smart card access points can use the newer smartcards and these have to be updated. Some still do not work when they have been updated by the IT Dept, this can be frustrating but tend not to use these when using Smart Card".*

SUMMARY

There is currently a workaround being investigated and implemented via the IT department due to an NHS Digital known issue with Obethur middleware. This should resolve the problem experienced by some users when updating or using the series 08 smartcards.

8% of users were either unsure or thought the smartcards can be used for ID. All of those users were advised by email that the cards are not to be used for ID. The Red rules were also posted on the intranet as a reminder to all users.

Overall the 2018 audit has shown a good increase in user awareness across the Trust.

----------**END**----------

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