Stockport NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

28 SEPTEMBER 2017

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 28 September 2017 - final

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Stockport NHS
NHS Foundation Trust

September 2017

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 28 September 2017 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.**

An agenda for the meeting is detailed below.

Yours sincerely

ADRIAN BELTON
CHAIR

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AGENDA ITEM	TIME
1. Apologies for Absence.	1.15pm – 1.20pm
2. Opening Remarks by the Chair.	"
3. Declaration of Amendments to the Register of Interests.	"
4. Patient Story	1.20pm – 1.35pm
5. **OPENING MATTERS:**	
5.1 To approve the minutes of the previous meeting of the Board of Directors held on 27 July 2017 (attached).	1.35pm – 1.40pm
5.2 Report of the Chair (attached).	1.40pm – 1.50pm
5.3 Report of the Chief Executive (verbal).	1.50pm – 2.00pm
5.4 Key Issues Reports from Assurance Committees: 5.4.1 Audit Committee (attached and Mr J Sandford to report) 5.4.2 Quality Assurance Committee (attached and Dr M Cheshire to report) 5.4.3 Finance & Performance Committee (attached and Mr M Sugden to report) 5.4.4 People Performance Committee (attached and Ms A Smith to report)	2.00pm – 2.20pm
6. **ASSURANCE AND GOVERNANCE:**	
6.1 Performance Report (Report of Chief Operating Officer attached).	2.20pm – 2.40pm

AGENDA ITEM	TIME
6.2 CQC Report (Report of Interim Director of Nursing attached)	2.40pm – 3.10pm
6.3 Maintaining Safe Staffing Levels (Report of Interim Director of Nursing to follow).	3.10pm – 3.20pm
6.4 Strategic Risk Register (Report of Interim Director of Nursing attached).	3.20pm – 3.30pm
6.5 Alliance Provider Agreement (Report of Interim Managing Director SNC attached).	3.30pm – 3.40pm
6.6 Use of Resources Assessment (Report of Director of Finance attached).	3.40pm – 3.50pm
6.7 Annual Fire Safety Report (Report of Director of Support Services attached).	3.50pm – 3.55pm
6.8 Terms of Reference Report (Report of Director of Corporate Affairs attached).	3.55pm – 4.00pm
7 **CLOSING MATTERS:**	
7.1 Date of next meeting: • Thursday 26 October 2017, 1.15pm, in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.	4.00pm

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public on Thursday 27 July 2017 1.15pm in Lecture Theatre B, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr J Sandford	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Mrs A Barnes	Chief Executive
Mr P Buckingham	Director of Corporate Affairs
Ms R Holt	Interim Director of Nursing
Mr H Mullen	Director of Support Services
Mr F Patel	Director of Finance
Mrs J Shaw	Director of Workforce & OD
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

In attendance:

Mrs S Curtis	Membership Services Manager
Mr D Johnson	Consultant Orthopaedic Surgeon
Mr K Spencer	Interim Provider Director

191/17 Apologies for Absence

Apologies for absence had been received from Mrs C Anderson and Mr A Webb.

192/17 Opening Remarks by the Chairman

The Chair welcomed members of the Board to the meeting and made specific reference to Ms R Holt, Interim Director of Nursing, who was attending her first Board meeting.

193/17 Getting to grips with national data: Improving outcomes in Trauma & Orthopaedics

Mr D Johnson, Consultant Orthopaedic Surgeon, delivered a presentation on current national and regional developments with regard to Trauma & Orthopaedic processes. The presentation covered the following subject areas:

- Bristol and beyond
- 3M Capital Hip – National Joint Registry
- Introduction
- The patient journey
- Outcome measures

- Data flows
- Getting the plot
- 'Getting it Right First Time' (GIRFT)
- GIRFT presentation
- Greater Manchester Elective Orthopaedic Alliance (GMEOA) development
- GMOA goal
- GMOA Dashboard
- TKR – highlight of outliers
- TKR – goal setting
- Fracture Neck of Femur – 2014 data
- Stockport NHS Foundation Trust
- National Hip Fracture Database (NHFD)
- Fracture Neck of Femur – NHFD
- GIRFT Report 2016
- The future
- Clinical lead opportunities with GIRFT.

Mr D Johnson sought support from the Board of Directors with regard to enabling consultants to participate in the Getting it Right First Time (GIRFT) programme. The Director of Corporate Affairs thanked Mr D Johnson for the informative presentation and queried the barriers which had prevented development in the area of length of stay. Mr D Johnson noted that improvement was required regarding streamlining and having an enhanced recovery philosophy; waiting for social care and getting patients fit for safe discharge and arranging further treatment as outpatient appointments if required.

The Medical Director thanked Mr D Johnson for the presentation and queried how the Trust would facilitate implementation of benefits and ensuring an improved process for business cases. Mr D Johnson noted that in addition to the GIRFT programme, the purpose of the Greater Manchester dashboard was to feed specific issues to individual Boards of Directors for consideration. He reiterated his earlier request for Board support to ensure successful delivery of the projects. In response to a question from Dr M Cheshire, Mr D Johnson advised that it was possible for GIRFT to be successfully implemented in Medicine.

The Director of Finance advised that the Trust would use the cost saving information detailed in the presentation in its service reviews to help with the Cost Improvement Programme. Mrs C Barber-Brown thanked Mr D Johnson for the presentation and noted that it had been refreshing for the Board to hear about such a positive and clinically led project. In response to a question from the Director of Finance, Mr D Johnson advised that he had compiled the Orthopaedic Alliance data but that it was anticipated that the process for data collection would improve in future. In response to a question from the Chair, the Chief Executive advised that the Board would receive information with regard to the GIRFT programme via service review updates.

Mr D Johnson left the meeting.

194/17 Declaration of Amendments to the Register of Interests

There were no interests declared.

195/17 Minutes of the previous meeting

The Board of Directors considered the minutes of the previous meeting held on 26 June 2017 and Mrs C Barber Brown referred the Board to minute number 170/17 'Stockport Together – Outline Business Cases', third paragraph on page 5. She requested a formal response outside of the meeting with regard to resource implications associated with implementing cost reductions in the Trust. Subject to this action, the minutes were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

196/17 Report of the Chair

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events. He wished to formally record the appreciation of the Board to Mrs J Morris, Director of Nursing & Midwifery, who had been asked to work as Nurse Advisor on the National Enhanced Care Programme at NHS Improvement until her planned retirement at the end of this year. The Chair paid tribute to Mrs J Morris' impressive 37-year career in the NHS. He also advised that interviews for the substantive Director of Nursing post had been held on 20 July 2017 and was pleased to announce the successful appointment of Ms Alison Lynch. The Chair noted that it was anticipated that Ms A Lynch, who was currently Director of Nursing at Mid Cheshire, would commence in her new role on 1 December 2017.

The Chair also made reference to the considerable and increasing agenda facing the Trust and wished to record the appreciation of the Board to the Executive Team and their individual teams for working extraordinarily hard in areas such as Accident & Emergency, CQC findings, Finance, Stockport Together and other Greater Manchester initiatives and seasonal challenges. The Chair concluded his report by advising the Board that the Council of Governors had approved a proposal to extend the term of office of Mr J Sandford for a further 12-month period at a meeting held on 24 July 2017. He wished to thank Mr J Sandford for agreeing to the extension.

The Board of Directors:

- Received and noted the Report of the Chair.

197/17 Report of the Chief Executive

The Chief Executive presented a report which informed the Board of national and local strategic and operational developments. She briefed the Board on a 12-hour breach and noted with regret that whilst the breach had occurred in February 2017, it had only recently been identified during the course of a serious incident review. The Chief Executive assured the Board that the relevant reporting protocols had been observed as soon as practicable following identification. She also advised that a review had been commissioned to identify any system or process weaknesses that might have contributed to the delay in identification and noted that there had been no patient harm as a result of the breach.

The Chief Executive advised that the Chief Operating Officer and the business group were leading on associated mitigating actions. With regard to clinical care, it was noted that the extended wait had been as a result of clinical decision making by the Intensive Care Team in the interest of patient safety. The Chief Executive advised that the incident had been reported to the Quality Assurance Committee and noted that the Board would be informed of any subsequent actions via the Committee's key issues reports.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

198/17 Key Issues Reports

Quality Assurance Committee

Dr M Cheshire briefed the Board on matters considered at a meeting of the Quality Assurance Committee held on 18 July 2017 and advised that the principle focus of the meeting had been on the CQC Action Plan. Dr M Cheshire reported that the Committee had noted the vast amount of work undertaken in this area, particularly with regard to ensuring that progress against the Action Plan was being implemented. The Chair noted that the CQC Action Plan would be considered under a separate item on the Board meeting agenda. Dr M Cheshire advised that the Committee had also considered the 12-hour breach which the Board had already been briefed upon earlier at the meeting.

People Performance Committee

Ms A Smith briefed the Board on matters considered at a meeting of the People Performance Committee. She advised that the Committee had undertaken an annual review of its Terms of Reference and had completed a Committee self-assessment, outcomes of which would be presented for approval at the next Board meeting. Ms A Smith noted that the Committee had also considered a Workforce Plan update and identified the need to incorporate the workforce implications of strategic change programmes, such as Stockport Together and Healthier Together, in order to provide a complete forward-looking plan.

Ms A Smith advised the Board that the Committee had also considered actions taken in response to the 2016 Staff Survey outcomes and had noted that the specific areas which would help to 'turn the dial' included quality of appraisals, e-learning provision and recognition initiatives. She noted, however, that feedback from the Listening Events suggested a lack of awareness, understanding and clarity amongst staff of the Trust's overarching Strategy with implications for assessing priorities and alignment of objectives. In response to a question from the Chief Executive, the Director of Corporate Affairs noted that the issue related to the quality of appraisals and a lack of clarity with regard to the Trust's priorities rather than objective setting itself.

Ms A Smith advised the Board that the Committee had considered an Agency Utilisation report and noted that the Month 3 position suggested that there was a significant risk to achievement of the agency ceiling for 2017/18. She reported that the risk also included a potential overspend against the £0.5m previously approved by

the Board of Directors to manage the transitional arrangements associated with IR35 regulations and noted that an associated report would be considered at a future Board meeting.

In response to a question from Mr M Sugden who queried whether business group representatives attended meetings of the People Performance Committee to update on recruitment and retention issues, the Director of Workforce & OD advised that the report presented to the Committee was the corporate workforce plan which was prepared with business groups. The Director of Finance added that overall workforce planning was a corporate process but that business groups were responsible for their individual recruitment processes, with support provided by the Finance and Workforce departments. The Director of Workforce & OD advised that associated issues were also considered at the Workforce Engagement & Efficiency Forum which reported to the People Performance Committee. The Chief Operating Officer noted the need to track workforce planning in the monthly business group performance reviews.

Mrs C Barber-Brown noted the link between the Quality Assurance Committee and the People Performance Committee with regard to successful service delivery. Ms A Smith advised that the three Committee Chairs were in the process of considering the triangulation of the Committees' functions and the identification of associated key metrics. It was noted that outcomes of the review would be reported to the Board of Directors.

Finance & Performance Committee

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Performance Committee held on 19 July 2017. He advised that in consideration of the forecast outturn position, the Committee had noted a financial risk relating to a contract for Health Visitors and School Nurses held with SMBC and was advised that the contract for 2017/18 had yet to be completed. Mr M Sugden reported that the Committee had also noted an element of risk relating to the recurrent nature of associated income and advised that the Committee had requested assurance on contract intentions for 2018/19.

With regard to operational performance, Mr M Sugden advised that whilst the Committee had noted positive recovery of performance against the Cancer 62-day standard, achievement of the standard for Quarter 1 was at risk as a result of the May 2017 performance. He noted that the Committee had also considered a downturn in performance against the A&E standard during the first few weeks of Quarter 2 and was advised that a root cause analysis (RCA) had been undertaken to identify factors causing this downturn. Mr M Sugden advised that the Committee had requested that results of the RCA be shared with Committee and Board members. He noted that delayed transfers of care and numbers of patients medically fit for discharge were likely to be a factor and advised that the Committee had agreed that the nature of relationships with local health economy partners in this area should be referred to the Board for consideration.

Mr M Sugden advised that the Committee had considered a report on the 2017/18 Cost Improvement Programme and noted a considerable gap of circa £2.7m against the £15m target for the year. He noted, however, that when the high-risk element of identified schemes was taken into account, the size of gap potentially increased to

circa £4.5m and advised that the Committee was currently only able to report low assurance on delivery of the 2017/18 Cost Improvement Programme. Mr M Sugden then advised the Board that representatives from the Medicine business group had presented reports on business group performance and financial recovery. The Committee had noted that a series of actions were being implemented to address the financial position but had requested that a further assurance report be presented at the next meeting to quantify the expected financial benefits from these actions.

Mr M Sugden concluded the report by advising the Board that the Committee had received reports on Electronic Patient Record (EPR) Benefits Realisation and Project Progress. He noted that the Committee had requested further clarity on the level of expected financial benefits and timescales for delivery and had noted an overall amber-rated status with regard to progress. The Chief Operating Officer then briefed the Board on latest developments with regard to delayed transfers of care (DTOC). In response to a question from the Chair, she advised that the Trust was awaiting a response regarding social care funding. The Chief Operating Officer also reported an issue regarding recruitment to the Integrated Care Teams and noted the need for an Exit Strategy. The Chief Executive commented on the large multiplicity of care home providers in Stockport and advised the Board of an intention of the local authority to contract further hours from those organisations. She noted that the whole system would take time to mature and that Stockport Together new models of care would assist in this area.

The Interim Provider Director noted that with regard to sense of scale, there would be three times more support workers in the system and advised that significant progress had been made in this area. He advised that a more flexible approach was being applied when deciding who would be employing the support workers and noted the aim to get them in post as soon as possible. Mrs C Barber-Brown commented on a recent ward visit and advised that the support staff she had spoken to had noted reduced external support at weekends to facilitate discharges. In response to Mrs C Barber-Brown, the Chief Operating Officer advised that system-wide consideration was being given to 7-day working and requirement for cultural change. The Interim Provider Director advised that a 7-day service consultation had recently been launched for community and adult social care staff. The Chief Executive noted the considerable work being done in the area of care homes and that it was anticipated that the additional social care funding would improve the position of care homes at weekends.

The Board of Directors:

- Received and noted the Key Issues Reports.

199/17 CQC Inspection – June 2017

The Chair introduced the agenda item and advised that the Chief Executive had delivered a presentation on the Care Quality Commission (CQC) inspections at the meeting of the Council of Governors on 24 July 2017. He noted that this was an area which the Board of Directors viewed with utmost seriousness. The Chief Executive presented a report which provided an update on the response of the Trust to the CQC unannounced inspection on 22 and 23 June 2017. She noted that the CQC had visited the Emergency Department, Ward A11 (Diabetes / General Medicine), Ward C2 (Acute Stroke) and the Coronary Care Unit. The Chief Executive advised that following verbal

feedback received from the CQC on the evening of 23 June 2017, an immediate alert on issues raised had been hand delivered and explained to each ward, Emergency Department and Critical Care that evening. She noted that the Trust had received a letter detailing the concerns on 26 June 2017 and the Trust had subsequently submitted an action plan by the deadline of 30 June 2017.

The Chief Executive reported that the concerns raised by the CQC included staffing levels, medicines management, stock management of clinical products, diabetes patient management , recording, risk escalation and training and Mental Capacity Act and Deprivation of Liberty Safeguard knowledge, training and application. She advised that the staffing and mental capacity issues were similar to the issues raised during the March inspection but noted that the other concerns were new. The Chief Executive advised that the action plan produced on 30 June 2017 had been accepted without amendment by the CQC. She wished to thank Mr P Weller, NHSI GM Head of Governance, and Ms A Rolfe, Executive Nurse, Stockport CCG, who had worked with the Director of Nursing and the nursing team to produce the action plan.

The Chief Executive advised that the initial phase of implementation of the plan had been completed and noted that the embedding phase had commenced on 24 July 2017. She advised that the challenge of the embedding phase was to focus on addressing the standards rather than treat the action plan as a 'tick box' exercise. The Chief Executive noted that with regard to quality improvement, the Board's focus would be on the Improvement Plan. In response to a question from Dr M Cheshire who queried the background to the workforce and training issues which had been raised by the CQC, the Chief Executive noted that a number of factors had contributed to the position, including recruitment issues and consequent high number of locums, as well as cultural issues. She noted that it was important to ensure that staff adhered to policies and procedures and that consequence for non-adherence was understood. In response to follow up questions from Dr M Cheshire, the Chief Executive noted that this applied to all staff and that the triangulation between finance, quality and workforce would need to be articulated in the Improvement Plan.

Mr J Sandford noted that he had reviewed the Board reports with a view to understanding whether the reports, in particular the Integrated Performance Report (IPR) and the Strategic Risk Register, would alert the Board to significant safety issues such as those raised by the CQC. He advised that he had not found anything in the reports that would have alerted him to the issues and subsequently queried whether reporting methods required review to facilitate better triangulation. The Medical Director noted that the first phase of the action plan delivery was micromanagement of specific issues but that the long term solution needed to be more transformational to ensure that issues such as the ones raised by the CQC would not be identified for the first time by external assessors and ensuring that transformational changes were everybody's responsibility. He agreed that currently neither the IPR nor the Strategic Risk Register would easily identify such issues and made reference to the 'three legged stool' analogy to ensure a correct balance of performance, finance and quality. The Interim Director of Nursing noted that the next stage of the process would be the embedding of the actions and building the changes into the business units.

With regard to triangulation, Mrs C Barber-Brown noted her involvement in ward audits which supported the direction of travel with regard to planned ward visits. The Chief Executive noted the importance of peer challenge and advised that in the short

term, “disruptive communication” was part of the communications plan to make staff think things from a different point of view and with fresh pairs of eyes. The Interim Director of Nursing commented on the importance of being clear about standard setting. Ms A Smith made reference to the staff survey results and noted the link between listening events and walkabouts in the context of culture and leadership. The Interim Director of Nursing noted that she would shortly be contacting Board members with regard to arrangements for safety walkabouts.

The Chair referred the Board to recommendation 4.1 in the report and noted that triangulation of the Quality Assurance Committee, People Performance Committee and Finance & Performance Committee was key in providing the necessary assurance to the Board. In response to a comment from the Medical Director, the Chief Executive noted that the Improvement Plan would include information with regard to bigger transformational work. She advised that the Improvement Plan would be considered by the Board of Directors at the meeting on 29 September 2017 but noted that the plan might not be the final version at that stage. Dr M Cheshire noted that quality improvement work could be undertaken by all levels of staff across the organisation.

The Chair noted that Governors would receive an update on the CQC inspection at the Patient Safety & Quality Standards Committee meeting on 3 August 2017. With regard to recommendation 4.2, it was noted that Board members would be asked to be involved in audits and safety walkabouts on wards to get first hand assurance on the processes and to demonstrate commitment and leadership to staff. The Medical Director noted that outcomes of the audits and walkabouts would be reported via the Quality Governance Committee to the Quality Assurance Committee and the Board would subsequently receive assurance via the Committee’s key issues report.

In response to a question from Mrs C Barber-Brown who queried the measurement of cultural change, the Director of Workforce & OD and the Chief Executive noted that this would be covered in the Quality Improvement Plan and advised that the £200k funding allocated by NHSI would be focused on the organisational development aspect. The Interim Provider Director reiterated earlier comments with regard to reporting arrangements and noted that this area required review to ensure the Board was better sighted on issues. It was noted that the Board would be provided with the outcomes of the March inspections report which would be published with the June inspection report and ratings.

The Board of Directors:

- Received and noted the CQC Inspection Report.

200/17 Trust Performance Report – Month 3

The Chief Operating Officer presented the Performance Report which summarised the Trust’s performance against the NHSI Single Oversight Framework for the month of June 2017, including the key issues and risks to delivery. She advised that the report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. The Chief Operating Officer noted that much of the report content had been covered earlier as part of the Finance & Performance Committee key issues report. She advised that there were two areas of non-compliance in month which were the non-achievement of the Accident &

Emergency (A&E) 4-hour target and the Cancer 62-day standard. It was noted that the Referral to Treatment (RTT) standard performance was compliant with the national standard for the eighth consecutive month.

With regard to the Emergency Department (ED) performance, the Chief Operating Officer noted the June position of 85.3% and advised that the quarter position of 85.8% was in line with the NHSI improvement trajectory of 85%. She advised that work to deliver the Health Economy-wide trajectory continued and noted that the Urgent Care Plan focused on the following key themes:

- Improvements to front end processes
- Reduction of inappropriate attendances
- Reduction of Delayed Transfers of Care (DTOC)
- Improvements to discharge processes.

The Chief Operating Officer reported that delivery of the NHSI improvement trajectory of 90% for Quarter 2 was significantly under threat. She advised that currently the system was not able to cope with increased ED attendances which had a direct adverse effect on the DTOC position. The Chief Operating Officer advised that a system-wide 'plan on a page' would be completed by the end of July 2017 and noted that the plan would be shared with the Board virtually. The Medical Director noted that at the time when the Trust had achieved the 95% 4-hour target, the number of ED attendances had decreased. He noted that improved staffing levels would be the sustainable answer to the issue rather than increasing the number of wards. The Chief Operating Officer endorsed these comments and added that the Trust had been able to cope with peaks in attendance and recover quickly at that time.

In response to a question from Mrs C Barber-Brown, the Chief Operating Officer advised that drop-in centres merely increased demand and noted that the essence of Stockport Together was around new ways of working. The Interim Provider Director commented on the need to improve out of hospital services and noted that ultimately Stockport Together was the sustainable winter plan. In response to a comment from the Chair, Mr M Sugden noted that forward looking reporting would be helpful as well as an increased level of granularity to give Board a better sight of issues. In response to a question from Dr M Cheshire, the Interim Provider Director advised that recruitment to the Neighbourhood Teams was currently underway and was hoped to be completed by September 2017.

With regard to the Cancer 62-day standard, the Chief Operating Officer advised that the latest position for June was 83.8%. She noted that due to the significant number of breaches incurred in May 2017, and the less than average number of treatments in April and June 2017, it was unlikely that the 85% target would be achieved in Quarter 1. The Chief Operating Officer reported that a diagnostic of the Cancer 62-day processes and pathways was currently underway to ensure any issues were addressed and improvements identified and implemented. She briefed the Board of a number of factors which had contributed to the position, including a surge of 2-week referrals in March 2017 and the impact of Urology Cancer referrals. In response to a question from Mr J Sandford, the Chief Executive and the Chief Operating Officer confirmed that the Trust was not over-performing in RTT to the detriment of its financial performance.

The Director of Finance briefed the Board on the Finance section of the report and highlighted the Cost Improvement Programme (CIP) performance, workforce and cash position as the three main risks. He noted that the ongoing urgent actions following the CQC inspection had diverted attention from CIP. With regard to workforce, the Director of Finance noted issues regarding shortage of theatre nursing and a high level of vacancies of ward nurses and medical staff. With regard to the cash position, he advised that the Trust would be required to draw from the working capital facility in Quarter 3.

Mrs C Barber-Brown queried whether there would be opportunities to bring care together within the hospital to realise quality and financial benefits. The Chief Executive noted the constraint with regard to the physical layout of the hospital which included a number of old, smaller wards. She advised that the Estates department was undertaking work in this area to establish business group requirements and noted that the Estates Strategy would be brought to the Board of Directors in November 2017. The Chief Operating Officer advised that this work formed part of the Optimising Capacity workstream. Mr J Sandford made reference to Chart 5 of the Integrated Performance Report and noted a decline in performance regarding one of the Dementia standards. The Chief Executive confirmed that performance against the standard had improved in June 2017 and noted that the position had been reported at the Corporate Team Brief the previous day.

The Director of Workforce & OD briefed the Board on the Workforce section of the report and provided an update on metrics relating to essentials training, appraisals, turnover and efficiency. She noted an improved position with regard to medicine workforce vacancies and advised that further consideration would be given to the Trust's approach to nursing vacancies. The Director of Workforce & OD advised that the Trust might need to consider incentives offered by other organisations and noted that the People Performance Committee would receive updates in this area.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 3 compliance standards
- Noted the future risks to compliance and corresponding actions to mitigate
- Noted the key risk areas from the Integrated Performance Report.

201/17 Maintaining Safe Staffing Levels

The Interim Director of Nursing presented a report which provided an overview, by exception, of actual versus planned staffing levels of the month of June 2017. She briefed the Board on the content of the report and noted that average fill rates for Registered Nurses (RN) were 92.5% on day duty and 95.1% on night duty in month. She further noted that average care staff rates remained above 100% to support RN rates. The Interim Director of Nursing highlighted six areas in Medicine with sub-optimal RN staffing levels, two areas in Surgery & Critical Care and one in Child & Family. She noted a concern with regard to staffing at night which would require review. The Interim Director of Nursing advised that the three key areas for consideration were an acuity review, a review of the Recruitment & Retention Plan and agency usage.

In response to a question from the Director of Workforce & OD, the Interim Director of Nursing acknowledged the need to review the impact of 12-hour shifts on workforce. In response to a question from Ms A Smith who made reference to s3.6 of the report (Care hours per patient day), the Interim Director of Nursing agreed to include comparative information in future reports. In response to a comment from Mrs C Barber-Brown, the Interim Director of Nursing agreed to consider inclusion of exception reporting and the consequence of the specific exceptions in future reports. She noted that a report on the six-monthly acuity review would be brought to the Board of Directors in September 2017.

The Board of Directors:

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

202/17 Strategic Risk Register

The Interim Director of Nursing presented the Strategic Risk Register and advised that there was currently one strategic risk with a score of 25, eight new strategic risks and one strategic risk had been closed or mitigated to below a risk score of 15. She invited comments from the Board on the content of the Risk Register and consequently agreed to consider the following issues with the Head of Risk & Customer Services:

- Risks 2806 and 2640 had been on the risk register since January 2016, what had been done to mitigate these risks?
- Consider the level of risk rating for training and quality of training for medical trainees and relationship with the Deanery.
- Need to ensure regular updating of risks as many of the risks did not appear to have been updated for a number of months.

In response to a comment from Mr J Sandford, the Chief Executive noted that the Datix training needed to incorporate guidance with regard to the accountability for updating risks.

The Board of Directors:

- Received the Strategic Risk Register and noted the content.

203/17 Annual Report on Emergency Preparedness, Resilience and Response

The Director of Support Services presented a report which provided the Board of Directors with an overview of the management of Emergency Preparedness, Resilience and Response (EPRR) within the Trust during 2016/17, in particular for the period 1 January 2016 to 30 June 2017. It was noted that EPRR was a statutory responsibility under the Civil Contingencies Act 2004 and was integral to the Care Quality Commission's Safety Domain. The Director of Support Services advised the Board of significant changes in personnel within the EPRR / Resilience Team during 2016 and noted that following interim arrangements, Ms J Kilheeney had taken up the position of Emergency Preparedness & Resilience Manager in November 2016.

The Director of Support Services advised that in September 2016, the Trust had undertaken a self-assessment against required areas of NHS England Core Standards for EPRR and had subsequently deemed to be 'substantially' compliant against the standards. He noted that this meant that 'EPRR arrangements were in place, however they did not appropriately address one to five of the core standards that the organisation was expected to achieve'. The Director of Support Services advised that an action plan detailing these areas was appended to the report and in response to a question from Mrs C Barber-Brown, confirmed positive completion of the actions. The Director of Support Services made reference to the Trust's involvement in 'Exercise Socrates' in March 2017 which, he noted, had positively influenced the Trust's response to the Manchester Arena attack in May 2017.

In response to a question from the Interim Director of Nursing, the Director of Support Services advised that the Trust was well placed regarding cyber security due to investment in this area 18 months ago. Mr J Sandford noted that the Audit Committee had spent considerable time reviewing cyber security.

The Board of Directors:

- Received and noted the Emergency Preparedness, Resilience & Response Annual Report.

204/17 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that an additional meeting of the Board of Directors was anticipated to be held in August 2017, with a provisional date of Thursday 31 August 2017 to be confirmed. The Chief Executive noted that the meeting would not be a 'normal' Board meeting but would be useful in maintaining momentum of urgent items of business, such as Stockport Together.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
9/16	24 Nov 16	340/16	Strategic Risk Register	Mrs J Morris advised that all risks would be transferred to the new Datix system by the end of December 2016 and suggested that once implemented, Ms C Marsland would provide a presentation to the Board with regard to the new system. **Update on 27 Jan 2017** – A presentation would be provided to the Board in April 2017. **Update 27 Apr 17** – The Board noted a delay to implementation of the Datix system and agreed that the presentation would be provided on 29 June 2017. **Update 26 Jun 17** – Mrs J Morris advised that due to the revised Board meeting date, Ms C Marsland had been unable to attend the meeting as she was at an inquest. It was noted that the presentation would be deferred to the July Board meeting. **Update 27 Jul 17** – The Chief Executive advised the Board that the Trust was looking to procure an external trainer to provide training on the new Datix system. It was noted that the presentation to the Board would be arranged as soon as practicable.	J Morris
09/17	27 Apr 17	108/17	Trust Performance Report – Month 12	Further to a comment made by Dr C Wasson, it was agreed to invite ED representatives to deliver a presentation on the department's strategy and vision at the June Board meeting. **Update 25 May 17** – It was noted that the presentation would be delivered at the July Board meeting. **Update 27 Jul 17** – The Board noted delivery of a presentation by Mr D Johnson and agreed to reschedule the ED presentation to 28 September 2017.	C Wasson
10/17	27 Apr 17	108/17	Trust Performance Report – Month 12	The Chief Executive suggested that Prof P Turner and Mr D Johnson, Orthopaedic Consultants, be invited to a future Board meeting to present on a piece of work they were leading on in Greater Manchester. She noted that the work related to Orthopaedics and the use of data to reduce variability to standardise care and maximise outcomes.	C Wasson

				Update 26 Jun 17 – Dr C Wasson advised that Prof P Turner and Mr D Johnson would deliver the presentation at the Board meeting in September 2017. **Update 27 Jul 17** – On the agenda. Action complete.	
11/17	26 Jun 17	167/17	Patient Story	In response to a comment from the Chair, it was suggested that consideration be given to inviting patient and ward representatives to meetings of the Board to share learning with regard to issues raised in patient stories.	J Morris / J Shaw
12/17	26 Jun 17	170/17	Stockport Together – Outline Business Cases	In response to questions from Mr M Sugden, Board members agreed that the Operational Delivery Plan referenced at s5.7 of the report should be considered by the Board on 27 July 2017. **Update 27 Jul 17** – The Board had considered the Operational Delivery Plan at the private meeting earlier that day. Action complete.	S Toal / K Hatchell
13/17	26 Jun 17	170/17	Stockport Together – Outline Business Cases	Board members agreed to receive presentations on key enablers at the Board of Directors meetings in August / September 2017: • Workforce – August • IM&T and Information Governance – September	J Shaw H Mullen
14/17	26 Jun 17	170/17	Stockport Together – Outline Business Cases	The Director of Corporate Affairs noted the intention that a draft Alliance Provider Agreement would be presented to the Board for formal consideration on 27 July 2017. **Update 27 Jul 17** – The Board had considered the draft Alliance Provider Agreement at the private meeting earlier that day. Action complete.	K Spencer
15/17	26 Jun 17	173/17	Strategic Risk Register	The Director of Corporate Affairs and Mr J Sandford agreed to review the Audit Committee terms of reference with a view to incorporating risk in its functions and consider content for a risk workshop. **Update 27 Jul 17** – The Director of Corporate Affairs advised that outcomes of the review would be considered at the next Audit Committee meeting on 12 September 2017.	P Buckingham / J Sandford
16/17	27 Jul 17	199/19	CQC Inspection –	The Chief Executive advised that the Improvement Plan would be	

			June 2017	considered by the Board of Directors at the meeting on 29 September 2017 but noted that the plan might not be the final version at that stage.	A Barnes

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
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:	Annex A – Board of Directors Role Description Annex B - Chair & Chief Executive Responsibilities

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

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1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 The Chair and Chief Executive attended a national conference on the subject of Urgent Care and winter preparedness held in London on Monday, 18 September 2017. Key note speeches were delivered by the Secretary of State for Health, Mr J Mackey, NHS Improvement, and Mr S Stephens, NHS England. The expectations on both trusts and commissioners were made clear and this will be the subject of a separate report from the Chief Executive.

3. BOARD DEVELOPMENT

3.1 I am pleased to welcome Mrs Caroline Griffiths, Improvement Director, NHS Improvement who commenced work with the Trust on 21 September 2017. She will support our governance, strategy and planning work as we continue with our efforts to develop and improve services. Caroline is employed as an Improvement Director by NHS Improvement (Medical Directorate) and has a wealth of experience in developing clinical strategy, service improvement and integrated governance, from both the public and private sectors. Most recently, Caroline was Programme Director for the West Yorkshire Association of Acute Trusts and, before this, held Board-level strategic planning and governance posts at Mid-Yorkshire Hospital NHS Trust and North Cumbria University Hospital NHS Trust. Caroline will divide her week between our Trust, and another Trust in the North West where she will have a similar role. She will work as part of our executive team and we will provide more information about the specific areas of Caroline's work shortly.

3.2 Work is currently in progress on arrangements to recruit a replacement for the Chief Executive who is due to retire in December 2017. The Remuneration Committee met on 20 September 2017 to consider these arrangements with a particular emphasis on ensuring that there is an appropriate handover period.

4. CHAIR ENGAGEMENTS

4.1 A summary of the Chair's activities during September 2017 is as follows:

23 August 2017	Attended a Regional Chairs event facilitated by NHS Providers Visited the Christie Hospital NHS Foundation Trust
29 August 2017	Patient Safety Walkround (M4)
5 September 2017	Patient Safety Walkround (SSOP)
7 September 2017	Patient Safety Walkround (A11)
11 September 2017	Attended a Financial Oversight Meeting with NHS Improvement
11 & 12 September 2017	Attended the Health Expo in Manchester, which included a closed Chairs session with Mr S Stevens.
14 September 2017	Attended a Northern Chairs event facilitated by NHS Improvement
18 September 2017	Attended a national Urgent Care conference with the Chief Executive
19 September 2017	Attended the Quality Assurance Committee and met with the Lead Governor
20 September 2017	Attended the Finance & Performance Committee Chaired a Remuneration Committee meeting Attended and spoke at the Stockport Healthwatch AGM
21 September 2017	NHS Providers Chairs Conference

5. REGULATORY DEVELOPMENTS

5.1 We still await publication of the CQC Reports on the re-inspections carried out in the Trust in March 2017 and June 2017. A report from the Interim Director of Nursing which summarises the current position is included elsewhere on the agenda.

6. FORWARD LOOK

6.1 Work has been completed on preparation of a Role Description for the Board of Directors, which is recognised good practice. In addition a document which details the separation of responsibilities between the Chair and Chief Executive has been reviewed and agreed by both post holders. Both documents are included at Annex A and Annex B of the report for formal adoption by the Board of Directors.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.
- Approve adoption of the documents included at Annex A and Annex B of the report.

BOARD OF DIRECTORS

BOARD OF DIRECTORS – ROLE DESCRIPTION

1. THIS DOCUMENT

1.1 This document describes the role and working of the Board and is for the guidance of the Board, for the information of the Trust as a whole and serves as the basis of the Terms of Reference for the Board's own Committees.

2. ROLE AND PURPOSE

2.1 The principal purpose of the Trust is to "provide goods and services for the purposes of the health service in England". It may provide goods and services for any purposes relating to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health. More than half of the Trust's income must come from fulfilling its principal purpose.

2.2 The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of Directors or to an Executive Director. In addition, certain decisions are made by the Council of Governors, and certain Board of Director decisions require the approval of the Council of Governors.

2.3 The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Chair. The Board leads the Trust by undertaking three key roles:

i. formulating strategy;

ii. ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; and

iii. shaping a positive culture for the Board and the organisation.

2.4 The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

2.5 Each Director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

2.6 The practice and procedure of the meetings of the Board are not set out here but are described in the Trust's Constitution (Annex 8 refers).

3. RESPONSIBILITIES

3.1 General Responsibilities

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible and well-governed services for patients and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the Trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner; and
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Board will work in a way that makes the best use of the skills and experience of the Non-Executive Directors and Executive Directors.

3.2 Leadership

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is an excellent employer by the development of a Workforce Strategy and its appropriate implementation and operation; and
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

3.3 **Quality**

The Board:

- ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- promotes an environment of excellence and sets expectations of required standards;
- has an intolerance of poor standards, and fosters a culture which puts patients first; and
- ensures that it engages with all its stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with.

3.4 **Strategy**

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the Trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual Operational Plan, with due regard to the views of the Council of Governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that local and regional developments, such as the Greater Manchester Health & Social Care Partnership, inform strategic planning and that the Trust fully participates in such developments; and
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

3.5 **Culture, Ethics and Integrity**

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;

- ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- establishes appeal panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings; and
- ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time; and
- establishes policies and practice to achieve the above.

3.6 **Governance / Compliance**

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to NHS trusts;
- ensures that compliance arrangements relate to all areas of the Trust's responsibilities as a public body;
- ensures that all sections of the NHS Provider Licence relating to the Trust's governance arrangements are complied with;
- ensures that the Trust has comprehensive governance arrangements in place to promote effective use of available resources, ensure that key risks are identified and effectively managed and ensure that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services, taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the relevant regulators;
- formulates, implements and reviews standing financial instructions as a means of regulating the conduct and transactions of Trust business;
- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged; and
- acts as corporate trustee for the Trust's Charitable Funds.

3.7 **Risk Management**

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;

- ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement in the development of care plans, the review of quality of services provided and the development of new services; and
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to Executive Directors.

3.8 **Committees**

The Board is responsible for maintaining Committees of the Board with delegated powers as prescribed in the respective Terms of Reference and/or by the Board from time to time.

3.9 **Communication**

The Board:

- ensures that a timely and effective communication channel exists between the Trust, its governors, members, staff and the local community;
- meets its engagement obligations in respect of the Council of Governors and members and ensures that the governors are equipped with the skills and knowledge they need to undertake their role;
- holds its meetings in public except where the public is excluded 'for special reasons';
- shares the agenda and minutes of Board meetings with the Council of Governors;
- holds an annual meeting of its members which is open to the public;
- ensures the effective dissemination of information on service strategies and plans, and also provides a mechanism for feedback; and
- publishes an annual report and annual accounts.

3.10 **Finance**

The Board:

- ensures that the Trust operates effectively, efficiently and economically;
- ensures the continuing financial viability of the organisation;
- ensures the proper management of resources and that financial responsibilities are fulfilled;
- ensures that the Trust achieves the targets and requirements of stakeholders within the available resources; and
- reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

4. ROLE OF THE CHAIR

4.1 The Chair is responsible for leading and presiding over the Board of Directors and the Council of Governors and for ensuring that they successfully discharge their responsibilities.

4.2 The Chair is responsible for the effective running of the Board of Directors and the Council of Governors and ensuring they work well together.

4.3 The Chair is responsible for ensuring that the Board of Directors and the Council of Governors play their part in the development and determination of the Trust's strategy.

4.4 The Chair is the guardian of the Board of Directors and the Council of Governors decision-making processes and provides general leadership of the Board of Directors and the Council of Governors.

5. ROLE OF THE CHIEF EXECUTIVE

5.1 The Chief Executive reports to the Chair and to the Board of Directors directly. All members of the management structure report either directly or indirectly to the Chief Executive.

5.2 The Chief Executive is responsible to the Board of Directors for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for consideration and approval by the Board.

5.3 The Chief Executive is responsible for implementing the decisions of the Board of Directors and its Committees and providing information and support to the Board of Directors and Council of Governors.

6. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS

6.1 The Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To exercise this accountability effectively the Non-Executive Directors will need the support of their Executive Director colleagues.

6.2 A properly functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance, to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship.

7. OTHER MATTERS

7.1 The Board of Directors shall be supported by the Company Secretary whose duties in this respect will include:

- agreement of the agenda for Board of Directors meetings with the Chair in consultation with the Chief Executive;
- collation of reports and papers for Board of Directors meetings and Board Committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring the Board procedures are complied with;
- supporting the Chair in ensuring good information flows within and between the Board, its Committees, the Council of Governors and senior management;
- advising the Board of Directors and Board Committees on governance matters; and
- supporting the Chair on matters relating to induction, development and training for Directors.

7.2 A full set of papers comprising the agenda, minutes and associated reports will be sent to all Directors five calendar days before meetings. A copy of the papers for meetings held in public will also be posted on the Trust's internet site.

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ROLES AND RESPONSIBILITIES – CHAIR AND CHIEF EXECUTIVE

Introduction

Article A.2.1 of the NHS Foundation Trust Code of Governance states that: *"The roles of chairman and chief executive should not be undertaken by the same individual. The division of responsibilities between the chairman and chief executive should be clearly established, set out in writing and agreed by the board of directors".* This document sets out the relevant roles and responsibilities for the Chair and Chief Executive in compliance with Article A.2.1.

Leadership & Management

Chair	Chief Executive
Reports to the Board of Directors and is accountable to the Council of Governors for performance of the Board	Reports to the Chair and to the Board of Directors.
Other than the Chief Executive, no Executive Directors report to the Chair	All members of the management structure report either directly or indirectly, to the Chief Executive
Ensures effective operation of Board of Directors and Council of Governors	Responsible for day-to-day running of the Trust's business
Ensures that the Board of Directors as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives, having regards to the views of the Council of Governors	Responsible for proposing and developing, in consultation with the Board, the Trust's strategy and overall objectives. Once agreed, responsible for their implementation, putting appropriate resources and risk management systems in place.
Acts as the guardian of the Board of Directors' decision-making processes	Implements the decisions of the Board of Directors and its Committees
Leads the Board of Directors and the Council of Governors	Ensures the provision of information and support to the Board of Directors and Council of Governors.
Presides over the Council of Governors in holding the Non-Executive Directors to account.	Supports the Chair in delivering an effective accountability process.

Ensures that the Board of Directors and Council of Governors work together effectively	Facilitating and supporting effective joint working between the Board of Directors and Council of Governors.

Board of Directors and Council of Governors Meetings

Chair	Chief Executive
Oversees the operation of the Board of Directors and sets its agenda	Providing input to the Board of Directors' agenda on behalf of the executive team.
Ensures that the Board of Directors' and Council of Governors' agendas take full account of the important issues facing the Trust.	Ensures that the Chair is aware of the important issues facing the Trust and proposing agenda items accordingly.
Ensures that the Board of Directors and Council of Governors receive accurate, timely and clear information	Ensures the provision of reports to the Board of Directors and Council of Governors which contain accurate, timely and clear information
Ensures compliance with the Board of Directors' approved procedures	Ensures the compliance of the executive team with the Board of Directors' approved procedures
Proposes a schedule of matters reserved to the Board of Directors, terms of reference for each Board Committee and other Board policies and procedures.	Provides input as appropriate on changes to the schedule of matters reserved to the Board of Directors and Committee terms of reference.

Committee Responsibilities

Chair	Chief Executive
Chairs the Remuneration and Nomination Committees.	If so appointed by the Board of Directors, serve on any Committee.
Initiates succession planning measures at Board level with the Nomination Committee to ensure appropriate Board composition and refreshment.	Provides information and advice on succession planning and Board skill mix to the Chair and relevant Board Committees in accordance with Accountable Officer responsibilities set out in the Provider Licence.

Proposes the membership and the Chairs of Board Committees	Assists the Chairman in formulating proposals for the membership and the Chairs of Board Committees.

Skills, Knowledge & Development

Chair	Chief
Leads the provision of a properly constructed induction programme for new directors.	Contributes to induction programmes for new directors and ensures that appropriate management time is made available for the process.
Leads in updating the skills and knowledge and in meeting the development needs both of individual directors and of the Board of Directors as a whole.	Ensures that the development needs of the executive directors and other senior management staff are identified and met.
Ensures that members of the Council of Governors have the skills, knowledge and familiarity with the Trust to fulfil their role.	Supports the provision of appropriate development, training and information for the Council of Governors.
Ensures that the performance of the Board of Directors and Council of Governors as a whole, their Committees, and individual members of both are periodically assessed. This will include an external assessment against the Well Led Framework at least once in every three years.	Ensures that performance reviews are carried out at least once a year for each of the executive directors. Provides input to the wider Board of Directors and Council of Governors' evaluation process.
Ensures that the Non-Executive Directors understand their accountability, individually and collectively, to the Council of Governors for the performance of the Board.	Provides, with the executive team, support to the Non-Executive Directors in order to facilitate the accountability relationship.

Culture & Communication

Chair	Chief Executive
Sets clear expectations concerning the Trust's culture, values and behaviours, including setting the style and tone of discussions at Board meetings.	Communicates the expectations of the Board concerning culture, values and behaviours to all employees.

Facilitating the effective contribution of all members of the Board of Directors and the Council of Governors to ensure that constructive relations exist between executive and non-executive members of the Board of Directors, elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors.	Supporting the Chair in facilitating effective contributions and sustaining constructive relations between executive and non-executive members of the Board of Directors; elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors.
Ensures that there is effective communication by the foundation trust with patients, members, clients, staff and other stakeholders	Leads the communication programme with members and stakeholders.
Promoting the highest standards of integrity, probity, reputation and corporate governance throughout the organisation and particularly at Board of Directors level	Conducts the affairs of the Trust in compliance with the highest standards of integrity, probity, reputation and corporate governance. Promotes continuing compliance across the organisation.
Responsibility for ensuring compliance with Fit and Proper Persons (FPP) Requirements.	Ensures that robust management arrangements are in place to facilitate compliance with FPP requirements.
Responsible for arranging informal meetings of the directors, to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues	Ensures that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust
Ensures a good flow of information each way between the Board of Directors, Committees, Council of Governors and members of both and between senior management and non-executive directors.	Provides effective information and communication systems.

Signed:

A Belton **A Barnes**

Chair **Chief Executive**

Source: The Foundations of Good Governance – A Compendium of Best Practice.

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/09/17		**Report Of:** Audit Committee
Date of last meeting: 12/09/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Internal Audit Progress Report ▪ Follow-Up on Audit Recommendations ▪ Anti-Fraud Annual Report 2016/17 ▪ Anti-Fraud Progress Report ▪ External Audit Sector Report ▪ Patient Property Briefing ▪ Evolve Project - Lessons Learned Report ▪ Job Planning Review ▪ RTT Progress Report ▪ Clinical Audit Annual Report ▪ Compliance with FT Code of Governance ▪ Submission of Annual Report & Accounts 2016/17 With regard to matters to bring to the attention of the Board, the Committee considered a Progress Report from Internal Audit which detailed outcomes of audit reviews as follows: ▪ IT Service Continuity Review - Limited Assurance ▪ Quality Spot Checks: Ward Review - Limited Assurance ▪ Nurse Revalidation Review - Significant Assurance ▪ Ward Stocks Review - Significant Assurance With regard to the IT Service Continuity Review, while the Committee acknowledged that the timing of the review, in the context of a planned change of systems, in some part contributed to the outcome, members expressed their disappointment at the findings and both the apparent absence of routine documentation and the level of cooperation from the IT Team. The Director of Support Services was present at the meeting and so heard first-hand the Committee's concerns and provided assurance that shortcomings would be addressed as a matter of urgency. The Committee has requested that an assurance report relating to both progress with audit recommendations and the availability of general service continuity arrangements for Trust systems be presented at the next meeting on 14 November 2017. Timing was also a factor in relation to the Quality Spot Checks Review which resulted in an assessment of Limited Assurance. The findings of the review relating to MCA / DOLS arrangements were consistent with outcomes of the CQC

		inspection in June 2017 and the Committee acknowledged that these shortcomings were being addressed as key elements of the CQC Action & Assurance Plan. The Committee also noted that an action plan to address weaknesses identified in relation to management of Sickness Absence is being progressed by the senior Heads of Nursing. A general theme of the audit findings related to non-compliance with policies and procedures and the Committee felt that this in particular should be brought to the attention of the Board. Again, this is consistent with findings from the CQC inspection and emphasises the need for the Trust to implement behavioural changes and address a culture of non-compliance. On a more positive note, the Committee noted positive outcomes from the Nurse Revalidation Review and the Ward Stocks Review, each of which resulted in an assessment of Significant Assurance. With regard to Follow-Up on Audit Recommendations, the Committee took positive assurance that a robust system is in place to track progress with completion of audit recommendations. However, the Committee considered that the timescales for completion of a number of outstanding actions was unacceptable and the Chair of the Audit Committee is writing to the relevant management leads to set out the Committee's expectations that completion of these actions will be expedited. The Trust's Anti-Fraud Specialist (AFS) presented an Annual Report on the Anti-Fraud Service during 2016/17 together with a Progress Report on work undertaken to date during 2017/18. The Committee noted positive assurance in terms of a 'Green' rating on compliance with the Standards for Providers issued by NHS Protect. These standards cover the Anti-Fraud domains of; Strategic Governance, Inform & Involve, Prevent & Deter and Hold to Account. The Assistant Director for EPR Programme Delivery and the Chief Clinical Information Officer attended the meeting and presented a report which detailed Lessons Learned from Evolve Project and explained how these lessons had been applied to delivery of the EPR programme. The Committee noted positive assurance in terms of the confirmation provided that all lessons had informed arrangements for EPR planning delivery. The Director of Support Services agreed to report back to the Committee on the adoption of standard practice across the wider range of Trust programmes with particular emphasis on the adoption of standard project methodology. The Head of Outcomes joined the meeting to present the Clinical Audit Annual Report 2016/17. The Committee acknowledged that significant progress had been made in this area over the previous 2-3 years and was assured that a robust process is in place for the management of clinical audits. The Director of Support Services presented a report which detailed the current status of actions being taken to address outcomes of an Internal Audit Patient Property Review. The Committee welcomed the focus on resolution being provided by Mr H Mullen but agreed that, at present, there was insufficient assurance that all actions had been fully addressed. The Committee requested that a joint Estates / Nursing assurance report be provided at the next meeting on 14 November 2017. The Committee then considered a report on Job Planning which detailed the aim to achieve 95% compliance by 31 December 2017. The Committee took positive assurance on the momentum behind this initiative and requested an update on progress towards the compliance target at its next meeting. The Chief Operating Officer attended the meeting and presented a report which detailed outcomes of an RTT Data Quality Audit together with progress on implementation of an RTT e-learning programme. The Committee expressed its

		disappointment that outcomes of the audit did not demonstrate significant improvement and noted that advances in this area were not helped by slow progress with training delivery and a relatively low pass-rate where training had been completed. The Chief Operating Officer assured the Committee that this matter was now a subject for focus in Performance Review meetings with Business Groups in order to drive training compliance. The Committee noted, however, that audit outcomes suggested a risk of a further qualified audit opinion should this subject be included as a mandated indicator for audit work on the 2017/18 Annual Quality Report. Finally, the Committee considered two reports from the Director of Corporate Affairs the first of which provided assurance on the submission of Annual Report & Accounts documentation in compliance with relevant submission deadlines. The second report detailed outcomes of a 6-monthly review of compliance against the NHS Foundation Trust Code of Governance and the Committee took positive assurance from the high compliance rate detailed in the report.		
2.	Summary of Assurance	1. Internal Audit Reviews: ▪ IT Service Continuity Review - Limited Assurance ▪ Quality Spot Checks: Ward Review - Limited Assurance ▪ Nurse Revalidation Review - Significant Assurance ▪ Ward Stocks Review - Significant Assurance 2. Follow-Up on Audit Recommendations - positive assurance on process 3. Anti-Fraud Services - positive assurance on compliance with the Standards for Providers issued by NHS Protect. 4. Evolve Project - positive assurance that lessons learned had informed arrangements for EPR planning delivery. 5. Clinical Audit - assurance that a robust process is in place for the management of clinical audits. 6. Patient Property Review - Insufficient assurance that all actions had been fully addressed. 7. RTT Data Quality Audit - low assurance on data quality performance and training delivery. 8. Code of Governance - positive assurance on compliance with Code requirements		
3.	Risks Identified	Qualified opinion on mandated audit of the RTT indicator		
4.	Report Compiled by	John Sandford, Chair	Minutes available from:	Company Secretary

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/09/17		**Report of:** Quality Assurance Committee
Date of last meeting: 19/09/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Datix Risk Management Module • Quality Governance Committee - Key Issues Reports • CQC Action & Assurance Plan • Seven Day Services Report • Review of Hypoglycaemia • Monthly Clinical Governance Report • Research & Innovation 2016/17 With regard to matters to bring to the attention of the Board, the Committee received a demonstration of a new Datix Risk Management Module. While the demonstration indicated the enhanced management and risk monitoring capability which will be provided by the new system, the Committee was frustrated to learn of issues resulting in further delays to transition from the training system to a 'live' system. Committee members were informed post-meeting that the reported issue had been successfully resolved. However, transition to, and implementation of, the new system must be expedited in order to address the current low assurance on the ability to produce timely and accurate risk management information. The main focus of the meeting was on the CQC Assurance & Action Plan. The Committee considered a report from the Medical Director and Interim Director of Nursing which detailed the Plan itself together with an overview of forward-looking developments. In terms of progress against a total of 195 actions, the Committee noted the following: • Blue (complete) – 121 • Green (on track but incomplete) – 72 • Amber (off track but recoverable) – 2 • Red (off track, not recoverable) – 0 The progress made to date indicates the effectiveness of the Silver Command arrangements, which were implemented to direct and monitor the completion of actions. The Committee was advised in particular of the role carried out by Mr C Hudsmith in effectively leading these arrangements. The Committee noted that the Silver Command arrangements have now been disestablished and that responsibility for continuing progress with actions has transferred to Business Groups. The Committee was assured that monitoring of both progress with

		implementing actions and the embedding of practice will be achieved by means of a weekly Leadership Meeting jointly chaired by the Medical Director and Interim Director of Nursing. The Committee was briefed on associated current developments which included; preparation of a forward-looking Quality Plan, production of a Consolidated Improvement Plan, introduction of a Ward Accreditation Scheme and an enhanced focus on quality reviews as part of Performance Review meetings with Business Groups. Clearly, this subject area is a key issue for the Trust and the Committee will continue to seek assurance on progress at future meetings. The Committee noted the range of plans and developments currently in progress and the associated need for clarity on assurance reporting arrangements through relevant Committees to the Board. The Committee considered Key Issues Reports from the Quality Governance Committee and noted the range of business being conducted by the Committee. Discussion on the reports identified a development need for Non-Executive Directors on the subject of Safeguarding and arrangements will be made for delivery of appropriate training. The Committee considered the effectiveness of the reports, in terms of both an assurance focus and clarity of any issues for escalation, and the Medical Director agreed to review the format and style of future reports. The Medical Director presented reports on 7-Day Working and Hypoglycaemia and the Committee noted work being carried out respectively by a Seven Day Implementation Team and a Diabetes Care Task & Finish Group. With regard to the latter, the Committee noted concerns raised by the CQC relating to the incidence and management of hypoglycaemic episodes and acknowledged that the data included in the report provided assurance that the current incidence of hypoglycaemia is in line with that experienced in other organisations. The Committee also noted that the Task & Finish Group would be undertaking a review of all relevant policies and procedures, to provide clarity on the management of such episodes, and commented on the importance of training and education for all relevant staff given that Diabetes is one of the most common co-morbidities across all specialties. Finally, the Committee considered a Clinical Governance Report and agreed that the format of future reports should be revised in order to provide a greater emphasis on assurance reporting. The Committee also received a report for information which provided a comprehensive overview of Research & Innovation work carried out in the Trust during 2016/17.		
2.	Risks Identified	Availability of Risk Management information.		
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

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/09/17		**Report of:** Finance & Performance Committee
Date of last meeting: 20/09/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Terms of Reference - Annual Review ▪ Month 5 Finance Report ▪ Month 5 Operational Performance Report ▪ Month 5 Agency Utilisation Report ▪ Surgical & Critical Care Business Group – Performance Report ▪ Analysis of Locum Usage ▪ 2017/18 CIP Report ▪ Operational Plan 2018/19 – Timetable ▪ Post-Implementation Review – Medical & Surgical Centre ▪ EPR Progress Report ▪ Alternative Site Valuation Report ▪ Reference Costs Submission 2016/17 ▪ Validation of Policies With regard to matters to bring to the attention of the Board, the Committee completed an annual review of its Terms of Reference together with a self-assessment of Committee effectiveness. The outcomes of this review are reported separately elsewhere on the agenda. The Committee considered the Month 5 Finance Report and noted a deficit position of £14.1m at 31 August 2017, compared to a planned deficit of £15m, which resulted in a favourable variance of £0.9m. The Director of Finance provided the Committee with an overview of the following key issues: ▪ Cost Improvement Programme ▪ Application of Financial Penalties ▪ Theatre Utilisation and associated CIP / year-end forecast implications ▪ A deteriorating position against the Agency Ceiling ▪ Winter planning The Committee considered the Trust's cash position and noted the likelihood that the Trust would require additional cash investment in December 2017. Board members should note that relevant approval documentation will be prepared for consideration by the Board of Directors in November 2017. The Committee considered a separate report on the 2017/18 Cost Improvement

		Programme (CIP) and noted a gap of circa £3m against the £15m target for the year. However, when the high-risk element of identified schemes is taken into account, the size of gap potentially increases to circa £5.6m. In addition, of the efficiencies transacted to date, the proportion of recurrent savings is less than 50% which, if maintained, will result in an additional pressure in 2018/19. The Committee was briefed by the Director of Finance on preparation of a Financial Recovery Plan and noted the importance of planned service reviews in terms of both in-year and future year efficiencies. The Committee again emphasised the need to expedite these reviews and assess the anticipated benefits in order to inform the need for additional mitigating actions. On the basis of the report, the Committee is currently only able to report low assurance on delivery of the 2017/18 Cost Improvement Programme. The Committee also noted the importance of service reviews during consideration of a report which provided analysis of current locum usage. The Committee noted that circa 90% of locum use is related to cover for vacancies or training gaps and was assured that locum use is subject to formal approval by the Executive-led Establishment Control Panel with decisions informed by risk assessments which cover; RTT, Cancer, Out of Hours cover, Ward cover, the elective plan and the outpatients plan. The Committee acknowledged that the potential to reduce locum demand would need to be informed by relevant service reviews as opposed to a case-by-case basis. The cost implications of locum use were explicit in the Agency Utilisation Report considered by the Committee although the Board should note that the overall level of expenditure was reduced in July 2017 and again in August 2017 as a result of both recruitment to substantive positions and development of bank arrangements. However, the level of expenditure during the year to date, and the high likelihood of continuing high levels across the winter period, presents a real risk to achievement of the 2017/18 Agency Ceiling. The Committee has requested a forecast of expenditure for the remainder of the year to better understand the extent of the risk. The triumvirate from the Surgical & Critical Care Business Group attended the meeting to present a comprehensive report on Business Group performance. The Committee noted the impact of theatre staffing on elective activity and the consequential impact on the Business Group's financial performance with an adverse position at Month 5 of circa £1.3m. While the Committee noted that clinical income was expected to improve as a result of recruitment action to address staffing levels from September 2017, achieving the planned position will be a significant challenge. The Director of Finance briefed the Committee on actions initiated by the Executive Team through Performance Review meetings and the Committee requested a follow-up assurance report detailing the Business Group's recovery plan to include timescales for delivery and metrics used to track performance. The report will also need to demonstrate linkage to relevant programmes in the Optimising Capacity work stream. With regard to Operational Performance, the Committee noted that performance against the A&E 4-hour standard in August 2017 had improved in comparison with the July 2017 position but the performance level remained significantly short of the trajectory position. The Chief Operating Officer advised the Committee that the position had deteriorated in the first two weeks of September 2017 and noted the impact of an increase in the numbers of medically optimised patients and a consequent effect on patient flow. The Committee noted the attendance of the Chair and Chief Executive at a national conference on Urgent Care held on 18 September 2017 and outcomes in terms of the expectations on trusts in relation to

		the A&E 4-hour standard will be the subject of a report to the Board from the Chief Executive on 28 September 2017. The Committee was assured of continued compliance with the national standard for RTT and achievement of the Cancer: 62 Day standard in both July and August 2017. The Committee was advised of a 52-week RTT breach in August 2017 and was assured by the Chief Operating Officer that no patient harm had resulted from the breach. The Associate Director of Strategy Planning attended the meeting and presented a report which detailed arrangements for preparation and production of the Operational Plan for 2018/19. The Committee endorsed the proposed arrangements and agreed that the timetable set out in the report, which results in Board approval of the Plan in December 2017, should be adopted as presented despite the potential for a change in planning guidance. The Associate Director of Strategy & Planning also presented a report which detailed outcomes of a Post-Implementation Review of the Surgical & Medical Centre development. The Committee noted successful delivery of the project and recommended that the report be presented to the Board of Directors given the value of this major capital development. In considering the report, the Committee identified the need for wider consideration and standardisation of the project management and change management methodologies used by the Trust. Finally, the Committee received and noted reports relating to progress with the EPR Project, Alternative Site Valuation and the Reference Costs Submission 2016/17. The Committee also validated a number of Information Governance-related policies.		
2.	Risks Identified	Delivery of 2017/18 Cost Improvement Programme Operational Risk associated with Q2 A&E 4-hour standard trajectory		
3.	Actions to be considered at the	Nil		
4.	Report Compiled by	Malcolm Sugden, Chair	Minutes available from:	Company Secretary

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/09/17		**Report of:** People Performance Committee
Date of last meeting: 21/09/2017		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Staff Story – International Clinical Fellows • Leadership Strategy • Recruitment & Retention Strategy Update • WRES Report • Freedom to Speak Up Guardian Report • Guardian of Safe Working Report • Staff Friends & Family Survey Results – Update Report • Trust Agency Utilisation Update • Vacancy Position & Winter Preparedness • Review of Workforce Key Performance Indicators • Corporate Risk Register • Nursing & Midwifery Council Revalidation Report • Confidential Staff Matters • Key Issues Reports: - LNC - Workforce Engagement & Efficiency Forum • Policies for validation: - Dress Code & Uniform Policy - Flexible Working Policy - Grievance Policy - Disciplinary Policy & Procedure - Harassment & Bullying Policy With regard to matters to bring to the attention of the Board, the Committee received a presentation from Dr M Shashidhara (SAS Tutor & Associate Specialist in Anaesthetics) and Dr R Adappa (International Training Fellow, Anaesthesia & Pain) regarding International Clinical Fellowship. The Committee noted the positive developments in this area and noted that Dr M Shashidhara would undertake a further visit to India in November 2017. The Head of Learning & OD agreed to liaise with Dr M Shashidhara with regard to issues relating to the availability of appropriate accommodation, internet and telephone access for the international fellows. The Head of Learning & OD presented a report on the Leadership Development Plan 2017-20. The Committee noted the need for a fit for purpose, robust leadership programme as well as an associated Talent Management Strategy and Succession Plan. It was noted that all Trust staff on salary bands 7 and above would be included in the leadership programme and that a gap analysis

		would be considered at a future meeting of the Committee. The Committee then considered a draft Recruitment & Retention Strategy and members were requested to provide comments on the content of the draft strategy to the Deputy Director of Workforce & OD in advance of approval of the final strategy at the Committee meeting in October 2017. The Committee emphasised the importance of triangulating recruitment statistics with other intelligence, such as staff survey results and exist interviews. The Committee also considered a report which outlined headline data from the Workforce Race Equality Standard (WRES) 2016 data analysis report for NHS Trusts and highlighted areas of good practice for consideration. The Committee noted its disappointment with a number of the survey results and was advised that the Trust had appointed a new Equality, Diversity & Inclusion manager who would produce an associated action plan and would progress work in this area. The Deputy Director of Workforce & OD presented a report which provided details of the Trust's vacancy levels and hotspots as at August 2017. The Committee noted that the highest vacancy levels were within the registered nursing & midwifery (38%) and medical & dental (35%) staff groups and was advised of associated mitigation plans. The Committee commented on the need for earlier preparation with regard to winter planning. It was noted that the Committee would receive workforce performance flash reports in future meetings which would include vacancy information. The Committee received an update report from the Freedom to Speak Up Guardian (FTSUG) and noted positive assurance that the Trust was working in positive collaboration with the FTSUG to improve its culture and processes around raising and dealing with concerns. Committee members commented, however, that timely processing of issues appeared to be a concern which would be considered as part of cultural and leadership work. The Committee then considered a Quarter 1 update report from the Guardian of Safe Working which provided information on exception reports, details of any fines levied against departments with safety issues and data on rota gaps, staff vacancies and locum usage. The Committee noted a concern with regard to the lack of engagement by educational and clinical supervisors in the process and agreed to support the Guardian of Safe Working in this area. It was noted that a wider discussion was also required with regard to cultural issues and the lack of accountability for poor performance. The Head of Learning & OD presented a report which detailed the outcome of the Quarter 1 Staff Friends & Family Test and also provided benchmark comparison with other Greater Manchester trusts. The Committee noted that of the staff who had responded to the survey, 81% would recommend the Trust to friends and family if they needed care or treatment and noted with disappointment that only 58% would recommend the Trust to friends and family as a place to work. As an average across other Greater Manchester trusts, the results were 84% and 66% respectively. The Committee noted its concern with regard to the results and was advised of proposed mitigating actions which included more frequent pulse surveys, 'thank you' initiatives and the offer of bespoke support to disengaged staff groups. The Committee considered an Agency Utilisation report which identified a reduction in expenditure on agency / locum staff in July and August 2017 as a result of both recruitment to substantive positions and development of bank arrangements. The Deputy Director of Nursing provided an update with regard to nurse staffing and noted that the use of off-framework agencies remained a significant issue. The Committee noted that the current forecast for Month 6 agency expenditure was £600k which, if achieved, would a positive development. It was noted, however,

		that winter pressures presented a risk to achievement of the 2017/18 Agency Ceiling. The Head of Learning & OD presented a report on Workforce Key Performance Indicators (KPIs). The Committee noted that the report followed a review by the Workforce & Efficiency Forum to ensure the Workforce KPIs remained realistic whilst providing sufficient stretch to deliver continued improved performance. The Committee suggested that further consideration should be given to the actual KPIs as well as the proposed targets to ensure they remain fit for purpose. Finally, the Committee noted its disappointment that due to issues with the Datix Risk Management System, the Committee was unable to review the Corporate Risk Register.		
2.	Risks Identified	• Failure to achieve the 2017/18 Agency Ceiling • Availability of Risk Management information • Culture / lack of accountability.		
3.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

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Report to:	Board of Directors	**Date:**	28th September 2017
Subject:	Trust Performance Report (reporting period : Month 5 2017/18)		
Report of:	Chief Operating Officer	**Prepared by:**	Joanne Pemrick Head of Performance

REPORT FOR APPROVAL

Corporate objective ref: N/A	Summary of Report In relation to month 4 performance, the following are the main areas of concern for the Boards attention: • ED was non-compliant against the Single Oversight Framework metric and against the 90% trajectory plan. However, performance in August showed an improvement from July. The Trust breached the 12 hour trolley standard on 4 occasions in Month • The Trust financial position is favourable to plan to the end of August by £0.9m, but this is still an £14.1m loss equal to £92,000 per day. • CIP is £1.0m ahead the profiled plan to date, but this favourable variance will not continue after October 2017 when the profile of expected saving each month increases significantly. Only £2.6m (18%) of the recurrent target has been achieved. • Elective income has deteriorated again in month. Scheduled sessions taking place are being run more efficiently and in list utilisation is high, but fewer lists are going ahead than planned so income is low. • Agency Shifts above cap. There were a total of 1,446 for the 5 week period from 31st July to 3rd September. • Staff in post: 92.25% of the establishment, an increase of 0.31% since July. E&F are the only BG below the 90% target (87.25%) and has the highest vacancy rate with 9.30%, which equates to 112.54 FTE posts. The staff group with the highest vacancy rate is N&M = 12.29% / 195.10 FTE posts. The summary of all the key issues to note are detailed in section 1.1 of the report.
Board Assurance Framework ref: N/A	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed ☒ X Not required	

Attachments

Appendix 1

Monitor score card

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

1. Introduction

This report provides a summary of performance against the NHSI Single Oversight Framework for the month of July 2017, including the key issues and risks to delivery. It also provides, in section 4, a summary of the key risk areas from the Trust Integrated Performance Report which is attached in full in Annex A.

1.1 Key issues to note:

Operational Performance

- ED was non-compliant against the Single Oversight Framework metric and 90% trajectory plan.
- RTT performance remains compliant with the National standard. However, continued compliance will be at risk as resources become redirected away from elective care to support the urgent care pathway during winter pressures.
- The Cancer 62 day performance was achieved for June and July. August is also predicted to achieve against the 85% standard.
- Chest and Cardiology OWL show slight improvement in month, however the longer term forecast remains fairly static.

Workforce

- August's appraisal rate is 92%. Highest BG is WC&D (93.22%), lowest BG is SGI&CC (89.3%). Medical appraisals have increased by 0.79% to 93.4%.
- Turnover has decreased by 0.17% since July and August's figure is 13.12%. The 12 month turnover rate is 15.47%, an increase of 3.14% compared to the previous 12 months. Integrated Care has the highest rate with 19.74%, however, this is due to TUPE transfers. Without these, their rate is in line with the rest of the Trust.
- Total pay spend has decreased by £12K to £16.2M. This is £396K under the total pay budget for August. Bank spend equated to 5.49% of total spend, agency was 6.08% of total spend.
- Agency Shifts above cap. There were a total of 1,446 for the 5 week period from 31st July to 3rd September. Medicine had the biggest decrease of 29 shifts per week (predominantly medical shifts). Recruitment is underway for medical bank applicants.
- Staff in post: 92.25% of the establishment, an increase of 0.31% since July. E&F are the only BG below the 90% target (87.25%) and has the highest vacancy rate with 9.30%, which equates to 112.54 FTE posts. The staff group with the highest vacancy rate is N&M = 12.29% / 195.10 FTE posts.
- Sickness was 4.25% in August, an increase of 0.39% since July. All BGs are above the target, E&F are highest with 5.87%. The highest reasons for sickness were Back/Other Musculoskeletal Problems (inc Injury/Fracture); Stress related illnesses; Cough, Cold, Flu (inc Asthma & chest problems). The 12 month short term sickness figure was 1.14%, long term was 2.82%.
- Essentials Training compliance was 83.6% in August, which is below the 95% target. E-learning clinics are offered on a weekly basis. A new training matrix will be launched in November, inclusive of all statutory, mandatory and essential role training.

Finance

- The Trust financial position is favourable to plan to the end of August by £0.9m, but this is still an £14.1m loss equal to £92,000 per day.
- CIP is £1.0m ahead of plan the profiled plan to date, but this favourable variance will not continue after October 2017 when the profile of expected saving each month increases significantly. Only £2.6m (18%) of the recurrent target has been achieved.
- Elective income has deteriorated again in month. Scheduled sessions taking place are being run more efficiently and in list utilisation is high, but fewer lists are going ahead than planned so income is low.
- In month the Trust has accounted for the financial penalties which could be sanctioned against the Trust for failure to deliver national access targets. If penalties were levied in full then this will impact adversely on the forecast out-turn for the Trust.

2. Compliance against Single Oversight Framework

The table below shows performance against the indicators in the Single Oversight Framework that came into effect 1st October 2016. The forecast position for September is also indicated by a red (non-compliant) or green (compliant) box.

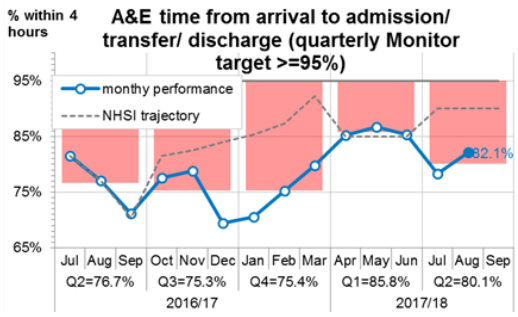
	Standard	Monitoring Period	Oct-16	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17	Q4	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sept-17 (f/cast)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate: Patients on an incomplete pathway	92%	Monthly	91.5%	92.4%	92.1%	92.0%	92.1%	92.5%	92.6%	92.4%	92.5%	93.3%	92.7%	92.8%	92.7%	92.1%	
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	Monthly	77.6%	78.9%	69.4%	75.3%	70.5%	75.2%	79.8%	75.4%	85.3%	86.7%	85.3%	85.8%	78.3%	82.1%	
All cancers: Maximum 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	Monthly	81.4%	85.1%	89.1%	86.0%	85.4%	87.3%	91.2%	88.1%	91.3%	74.5%	85.0%	83.7%	85.70%	90.6%	
All cancers: maximum 62-day wait for first treatment from: NHS Cancer Screening Service referral	90%		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Maximum 6-week wait for diagnostic procedures	99%	Monthly	99.7%	99.8%	99.6%	99.7%	99.8%	99.7%	99.8%	99.8%	99.6%	99.8%	99.8%	99.7%	99.4%	99.3%	

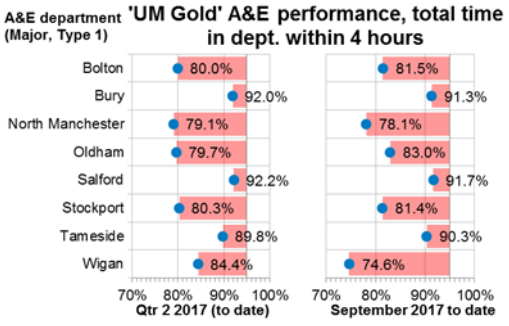
3. Month 5 2017/18: Performance against Single Oversight Framework

There was one area of non-compliance against the regulatory framework in month 5:

i) A&E 4hr target

A) 4hr standard



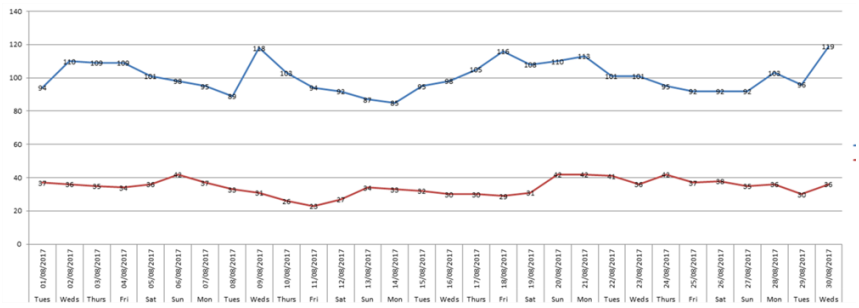


Performance in August was 82.1%, which is below the improvement trajectory of 90%.

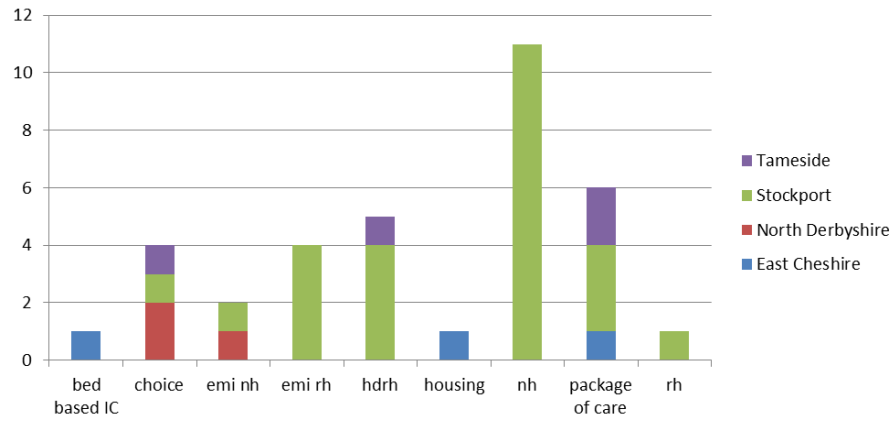
Although ED attendances were lower than July, there was a sustained increase in the number of Delayed Transfers of Care, coupled with a reduced daily discharge rate from the Medical wards.

<u>Delayed Transfers of Care (DToC)</u>

The graph below represents the number of patients each day in August who were medically optimised (blue line) and of those which were Delayed Transfers of Care (red line). The number of medically optimized patients peaked at 119 on the last day of August.



At the time of writing, there are a total of 35 Delayed Transfers of Care (25 Stockport). The distribution of delay reason is illustrated below:

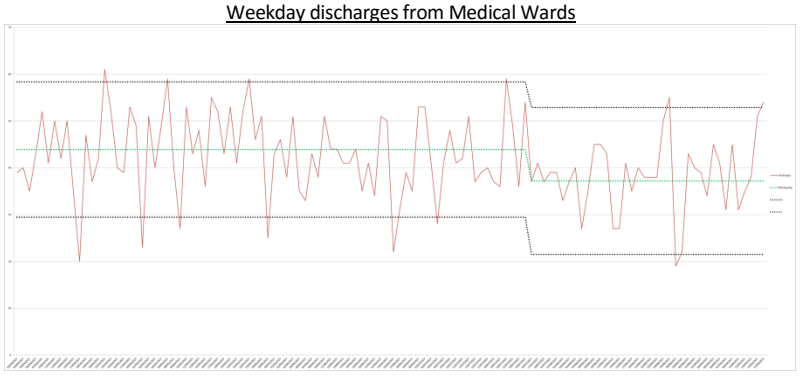


The most common reason for delay is a wait for a Nursing Home placement or a package of care.

Discharges from Medical wards

There has been a notable step change reduction in the average daily discharges from the end of July. The graph below details the number of daily discharges on a weekday (excludes weekends) across the Medical wards between April and August 2017:

Weekday discharges from Medical Wards



Short term actions

The Trust has identified the following 4 key areas as those which, once addressed, will make a significant difference in the short term. The collective impact should enable ED performance to reach trajectory:

1. **Staffing and Overnight performance**
   Currently overnight performance is 74%, this is significantly different from day performance which is currently at 86%, therefore there is a reduction in performance overnight currently of 12%.

   The staffing rota will be reviewed to ensure appropriate senior decision making overnight in ED. If we reduce overnight breaches (due to long wait to be seen) by approx. 200 per month (50 per week) we will increase performance by 3%.

2. **7 day working to increase weekend discharges and reduce bed occupancy.**
   The average number of weekend discharges (from medical wards) is 40 in total per weekend (which is below weekday average).

   The plan is to increase weekend discharges to approx. 50 per full weekend through more effective criteria led discharge processes- This in conjunction with the SAFER work will reduce bed occupancy to around 90% from its current level of 93%. Research suggests this should support a 1% increase in ED performance.

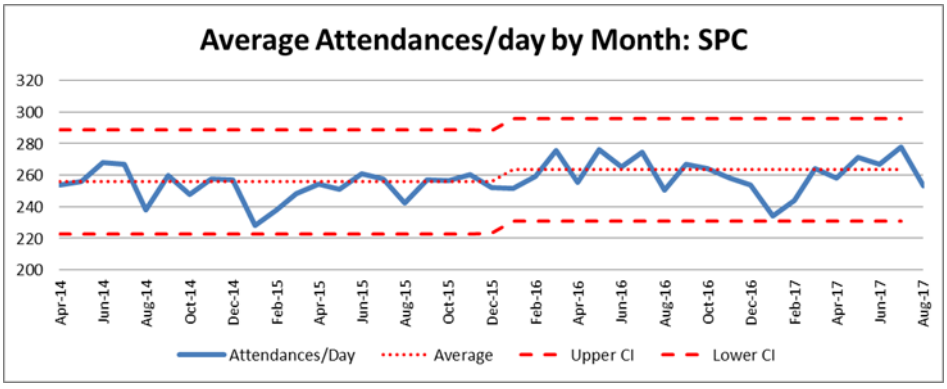
3. **Community capacity**
   The main reason for delayed discharge of patients is access to care homes and domiciliary care.

   The plan is to increase community capacity by enabling an extra care package per day, an extra care home placement a day and an extra discharge from intermediate care per day totalling an extra 21 discharges per week. This will positively impact Length of Stay and increase flow to wards. It is suggested that this will realise an increase in ED performance by 2%.

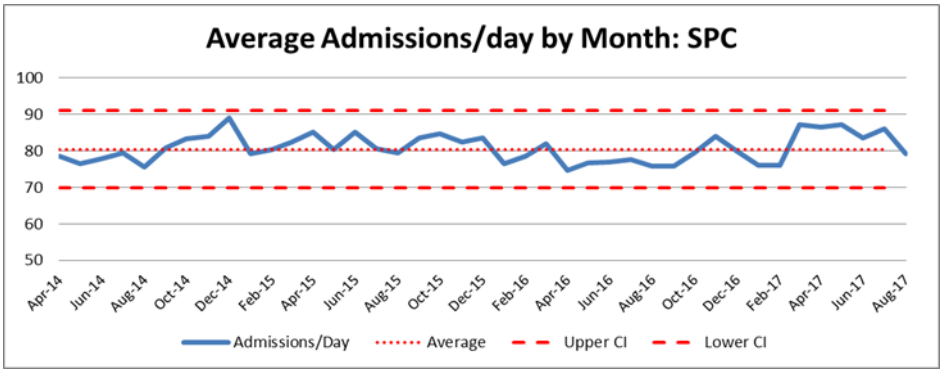
4. **Ward level leadership and improved flow- SAFER and LOS (bed occupancy)**
   The SAFER programme is not fully embedded across all Medical wards and our current Length of Stay (LOS) is above target at 10 days for August. In addition access to AMU due to flow issues on the Medicine Speacialty wards directly impact performance with the majority of patients waiting for a AMU bed breaching the 4 hour target.

   The plan is to implement SAFER effectively across all SAFER medical wards in order to reduce LOS by approx. 2.7 days. This will have a benefit of bed occupancy on the medical wards and in turn will increase flow through ED and assessment wards.

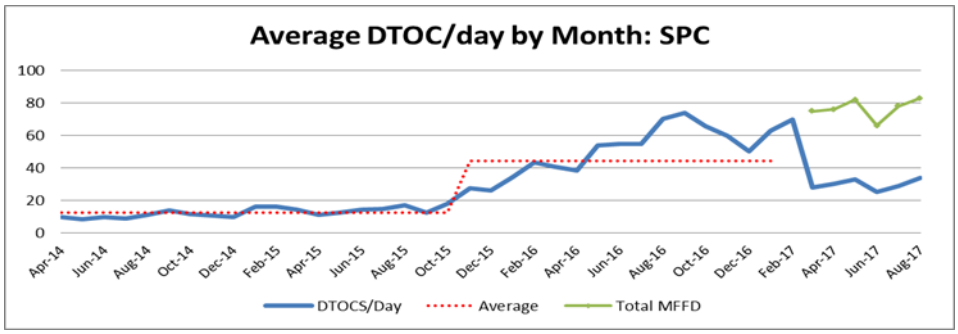
B) Average attendances: 253 per day in August



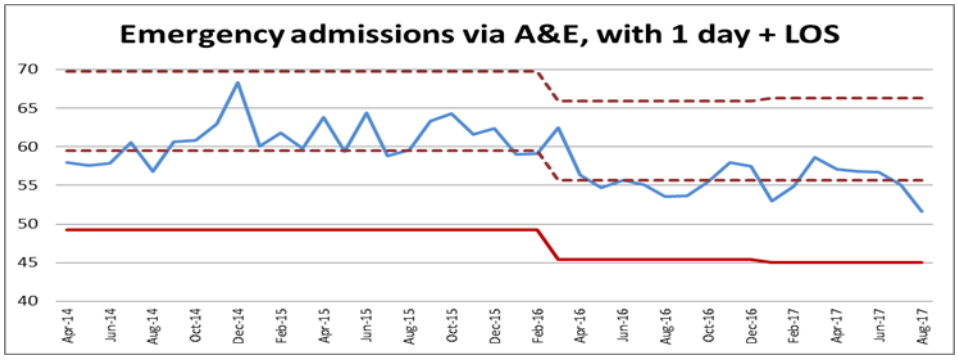
C) Admission rates of patients: 79 per day in August



D) DTOC levels were an average of 34 per day in August. However, the average number of patients medically fit for discharge was 83.



E) Emergency admissions via A&E > 1day LOS: average 51/day in August



Future risks to compliance against the new Single Oversight Framework
Future risks to compliance with the new framework are:

- ED
  - Recruitment and retention of medical and nursing staff
  - Speed and pace required to deliver cultural change associated with large scale transformation
  - Sustained increase in demand
  - Weekend and early in the day discharges from Medical Wards

- RTT
  - Redirection of Clinical resource away from elective activity to support the urgent care pathway, will affect the ability to maintain RTT performance over the winter period.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**
  The percentage of discharge summaries published within 48 hours was 86.3% in August.

  A comprehensive look at each specialty by ward location has been undertaken and a number of reasons have been identified to explain the reasons for static performance. Solutions are being investigated and the renewed focus on HCRs will continue as part of the Trust Performance meetings.

- **Clinical Correspondence**
  The overall Trust performance for clinical correspondence typed within 7 days showed a slight improvement in month.

  Resources within each Business Group have been directed to take a pooled approach to transcribing correspondence.

At the time of writing there are 466 letters waiting beyond 14 days, Cardiology and % Rheumatology account for of these. The Medicine and Clinical Support Business Group is looking to implement a more formal pooled approach for transcription of letters from the 9th October.

- **Patient Experience**
  Overall in August, the trust scored 93% extremely likely or likely to recommend. The ED score was 88.5%

4.2 Performance

- **Cancelled operations**
  There were 32 cancelations on the day due to non-clinical reasons. 10 were due surgeon sickness on the day, 8 due to lack of theatre time and 5 due to more urgent cases taking priority.

- **Outpatient Waiting Lists:**
  Progress with the OWL is monitored through the contract KPI's now that the contract notice has been removed.

  Gastroenterology and Ophthalmology remain ahead of their recovery trajectory.

  Chest and Cardiology showed a slight improvement in month,however the longer term forecast remains fairly static for both of these specialties. This is mainly due to current and future vacancies, the ability to attract to current posts, and the reliance on locum staff.

4.3 Finance

- **CIP**
  To the end of August £3.1m of CIP has been actioned towards the year-to date target of £2.1m, so is £1.0m ahead of plan. £6.0m (40%) of the £15.0m annual saving has been achieved, but the recurrent savings identified in 2018/19 have increased in month to £2.6m (18%).

  This chart shows the RAG rating of planned CIP for the year ahead and recurrently, showing there are £6.6m of high risk and unidentified plans in 2017/18, and the significant pressure building on next year's financial plan.

  Overall delivery of full year CIP savings of £15.0m is required to achieve the planned deficit of £27.4m but at present recurrent delivery is low. This is a significant concern as it does not support the Trust's drive to return to financial balance in the medium term, as a further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.

- **Financial sustainability**
  In five months the Trust has made a £14.1m loss. The planned deficit was £15.0m so this is £0.9m favourable to plan. The Trust has made an average daily loss of £92,000 to the end of August.

  The adverse movement in month is because the Trust has accounted for the financial penalties which could be sanctioned against the Trust for failure to deliver national access targets. This has not shifted the overall financial position adverse to plan as the CIP favourable variance to profiled plan continues to date, in addition to the extra Sustainability and Transformation Fund (STF) received in relation to 2016/17.

- **Agency Ceiling**
  Agency costs to date are £5.9m, which represents 7% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £1.0m.

Agency costs for medical staffing are £4.4m to August 2017, which is 74% of all agency costs and highlights that the Medicine business group's reliance on agency medical staff is a key driver for breaching the NHSI ceiling to date. A deep dive session into medical ward nursing spend to analyse the financial performance of the wards and review progress against the recovery plan began in early September 2017.

Recruitment to key medical specialty vacancies and successful international campaigns means that the Trust forecast agency spend is now within the annual ceiling.

- **Elective Income**

  Elective income has deteriorated by a further £0.1m in month, and is £0.9m behind plan. Scheduled sessions taking place are being run more efficiently and in list utilisation is high, but fewer lists are going ahead than planned so income is low.

  Elective activity is 492 cases below the profiled plan but day case activity is 182 cases ahead; tariff pricing means that the loss of elective income is only marginally offset by the additional day case work when theatre running costs are mainly fixed.

  Inpatient income is currently behind plan by £1.0m, but day case activity is £0.1m favourable. The Trust has spent £1.0m on waiting list initiatives and £0.7m on out-sourcing in five months, but this is not solely on elective work and includes out-sourced radiology reporting.

  Elective in-patient activity is 492 spells behind plan. Urology is the main specialty adverse to plan to date and is 242 spells below target, with orthopaedics a further 112 cases below plan. Day case activity is 182 spells above plan; driven by 120 ophthalmology cases above plan and oral surgery 90. Endoscopy have increased their planned level of activity as a efficiency CIP scheme, but remain 119 cases above the new higher target to the end of August.

  Running the requisite number of theatre sessions to deliver the plan continues to be a challenge and on-going theatre staffing pressures impact on the delivery of the elective activity plan. However, this is expected to improve from September due to a combination of further new starters and the completion of induction programmes for recent recruits. Reliance on premium rate initiatives continues in a number of specialties and the overall premium rate activity remains at 6% of total elective activity. A foreseeable risk is a national directive to cancel lists and free up surgical beds due to winter activity and this would inhibit financial recovery.

4.4 Workforce

- **Essentials training**

  In August 2017, compliance is 83.6% against the 95% target; All Business Groups are below the target and have prepared improvement plans to address the issued with key subjects. The OD and Learning team are producing weekly reports to target areas that are consistently non-compliant.

  The Mandatory Training review meeting took place on the 8th September with all disciplines to ensure that training topics are accurately reflected against staff profiles. The new training matrix will be launched in November alongside a training brochure inclusive of all Statutory, Mandatory and Essential to role training.

- **Appraisals**

  The Trust's total appraisal compliance for August 2017 is 92%, there has been continuous improvement during Q1 and the following are in place to support full compliance:

  - Hotspot reports to areas below the 90%
  - Continuing to promote the benefits of Appraisal through the holding to account

workshops.

- Prioritising Appraisal inputting for accurate data reporting
- Preparing improvements plans with the red areas (below 90%) and monitoring through WEEF & PPC

- **Turnover**
  The Trust's turnover figure is reported and compared nationally as an unadjusted figure, meaning that the data includes retire and return employees and TUPE transfers out of the organisation. The Trust target of 13.94% is based on the national average turnover rate for medium size Foundation Trusts in 2016/17.

- **Efficiency**
  Bank & Agency costs
  Bank and agency costs in month (August 2017) account for 11.57% (£2.12M) of the £18.32m total pay costs. This is an increase of 0.76% from the position reported in July (£1.96m).

  The Medicine Business Group bank and agency spend has reduced from £1.2m in July 2017 to £773,000 in August 2017, but continues to have the highest spend on bank and agency equating to 36.46% of the Trust overall bank and agency spend and 4.22% of the Trust total pay bill.

- **Sickness Absence**
  The in-month unadjusted sickness absence figure for August 2017 is 4.25%; an increase of 0.39% compared to the previous month. The sickness rate for comparison in August 2016 was 3.65%.

  The top three reasons for absence in August 2017 are: Back Problems and Other Musculoskeletal Problems including injury/fracture at 27.73% (a 1.04% decrease from July 2017), Stress related illnesses at 27.03% (a 1.39% increase from July 2017), and Cough, Cold, Influenza including Asthma and Chest Problems at 9.9.52% (a 0.33% decrease compared to July 2017).

5. Recommendations

The Board is asked to:

- Note the current position for month 5 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report.

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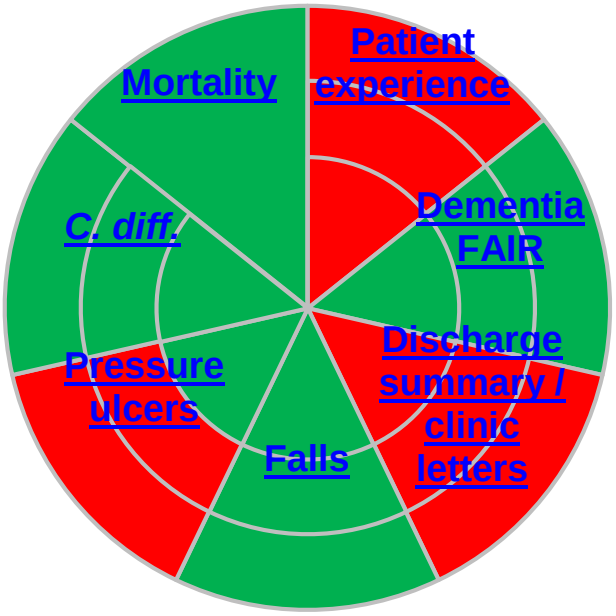
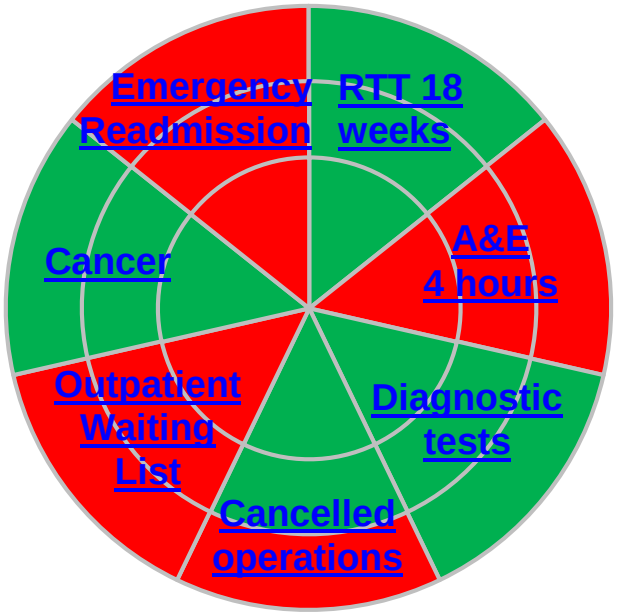
Integrated Performance Report August 2017

Stockport NHS Foundation Trust

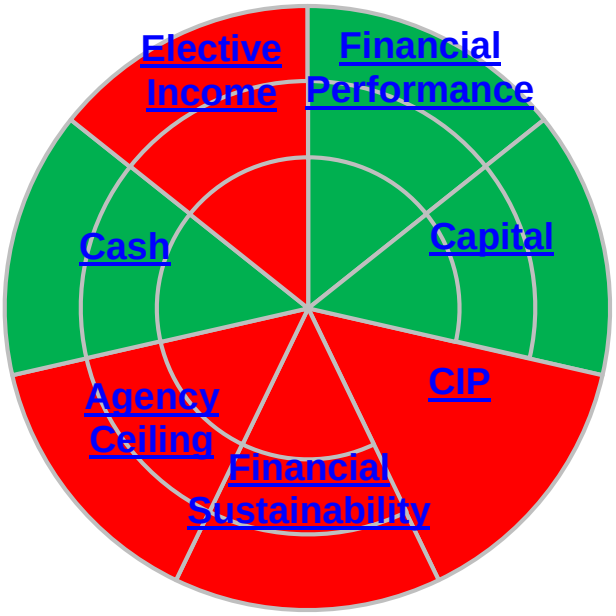
1. Quality



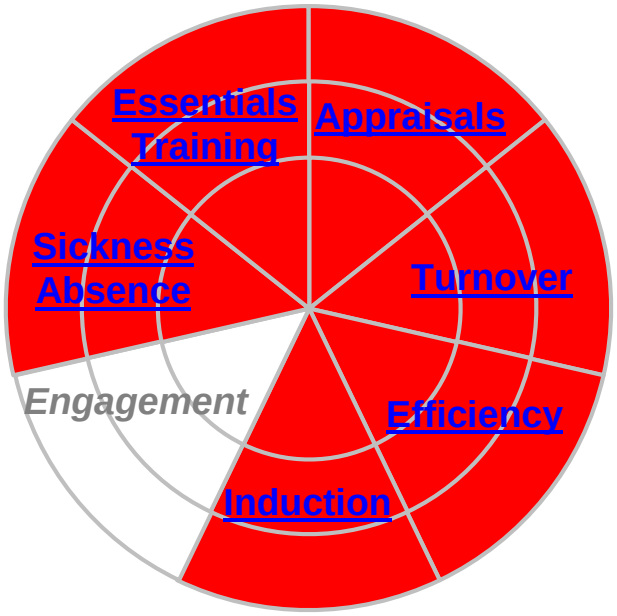
2. Performance



3. Finance



4. Workforce



Key to wheels:

Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month.

Mortality is assessed on the latest 12 months, CIP (Cost Improvement Programme) on the year-to-date.

Your Health. Our Priority.

Integrated Performance Report

Changes to this month's report August 2017:

- No changes to report.

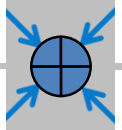
Key to indicators:

Monitor indicators (in Risk Assessment Framework): M
Monitor indicators for which we have made forward declaration: M

Corporate Strategic Risk Register rating (current or residual): 15
Risks rated on severity of consequence multiplied by likelihood, both based on a scale from 1 to 5. Ratings could range from 1 (low consequence and rare) to 25 (catastrophic and almost certain), but are only shown for significant risks which have an impact on the stated aims of the Trust, with an initial rating of 15+.

Data Quality: Kite Marking given to each indicator in this report 
This scoring allows the reader to understand the source of each indicator, the time frame represented, and the way it is calculated and if the data has been subject to validation. The diagram below explains how the marking works.

Filled Trust Data	**Blank** National Data	**Filled** Validated	**Blank** Unvalidated
Filled Automated	**Blank** Not Automated	**Filled** Current Month	**Blank** Not Current Month



Patient Experience

Chart 1

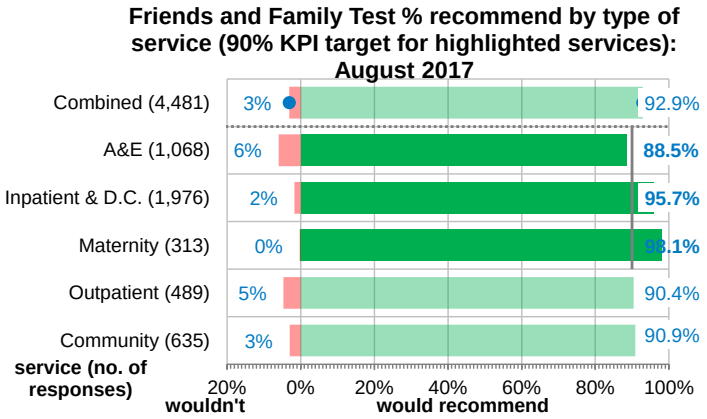


Chart 2

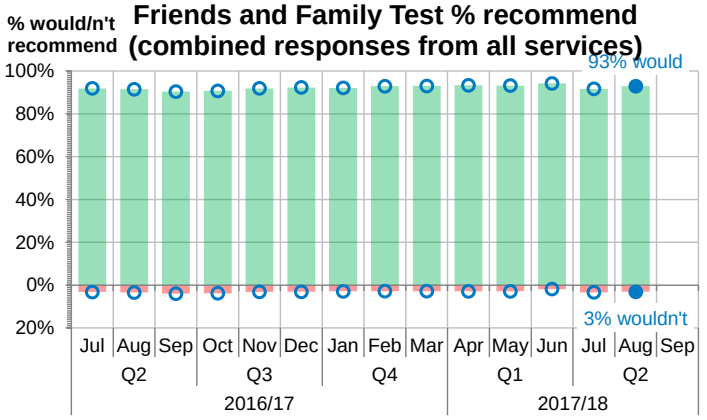
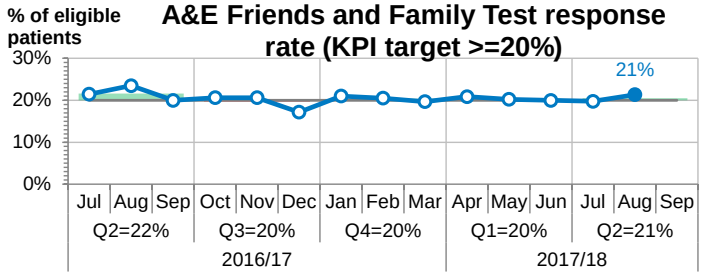


Chart 3



Overall in August the Trust scored 93% extremely likely or likely to recommend, this is an increase from July of 1.3%. We have had a total of 4481 responses in the month of August. Broken down:

AREA	Response rate	Variance on previous month (RR)	% extremely likely / likely to recommend	Variance on previous month (% Rec)
ED inc children's ED	21%	1%	88%	same
Inpatients	35%	same	96%	3%
Maternity (Birth)	37%	-7%	98%	2%
Outpatients	33%	-6%	90%	-1%
Daycase	34%	same	96%	2%
Community	26%	2%	91%	3%

Feedback Themes (acute):

ED (adult) Positive comments received related to the excellent quality of care and attitude provided by staff at all levels. There were also positive comments relating to caring and professional staff who listened efficiently and effectively. Negative comments continue to be related to long waiting times.

Inpatients (adults) Positive comments continue to be related to kind, caring and friendly staff. There were also many comments relating to the high standard of food. There were very few negative comments however there were some comments made relating to poor communication.

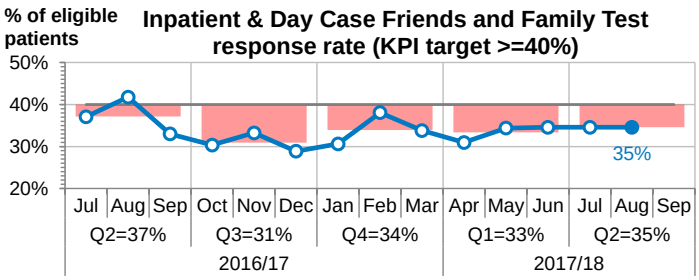
Maternity All comments received were positive and related to excellent, friendly and caring staff. The theme continues relating to the high standard of care provided and the positive experiences patients have had.

Paediatrics (inpatients) All comments received were positive relating to professional, caring staff who provide family centered care and good facilities.

Daycase: Positive comments related to the fantastic care provided by the staff who were caring and compassionate. There were very few negative comments, these related patients waiting and not being kept informed, there were also a few comments relating to surgery being cancelled at the last minute.

Outpatients: Positive comments related to extremely friendly and helpful staff, and there were numerous comments relating to how quickly patients were seen in

Chart 4



clinic. However there were many negative comments relating to long waiting times.

IPad Inpatient Surveys

In August 237 inpatient iPad surveys were undertaken, which is an increase of 32 compared to the number completed in July. Overall, the trust scored 86% positive responses in August which is a decrease of 1% from July.

As part of the CQC action plan there were two additional questions added to the survey asking patients if their call bell were within reach and did a member of staff complete a patient property list on admission. In August 96% of patients felt their call bell was within reach which is a decrease of 1% from July, and 59% of patients reported having had a property form completed with a member of staff on admission to the ward which was a decrease of 7% from July.

Results in August have shown improvements where patients feel they have been given enough privacy when discussing their condition or treatment with an increase of 2%. There have been further improvements where patients feel that staff have done everything they can to relieve pain with an increase of 2%.

Less positively results have deteriorated where patients felt they had not been involved in decisions about their care with a decrease of 4%, the overall rating of care with a decrease of 4%, a 3% decrease where patients felt there were not enough nurses on duty, a 6% decrease with assistance with opening sachets or packets, or cutting up food, a decrease of 35 where call bells were answered within a timely manner.

The night sisters are continuing to remind the ward staff about the noise at night standards and results continue to be shared with the Business groups to action accordingly, and with relevant departments as results remain poor and there has been a 3% decrease where patients feel they have been disturbed by staff.

The patient satisfaction results relating to the quality of the hospital food remain poor at 49%. The Catering Manager is currently reviewing this question with a view to adding some more specific questions to help identify areas for improvement.

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Dementia

Chart 5

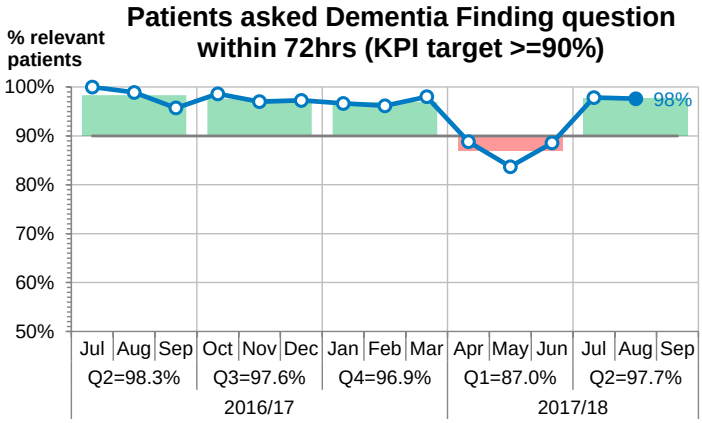


Chart 6

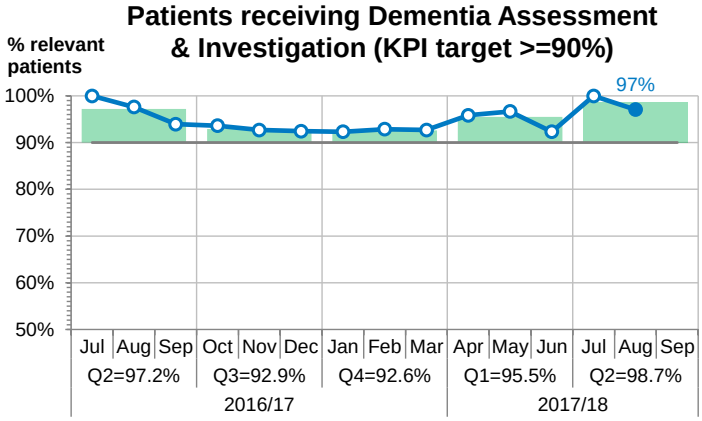
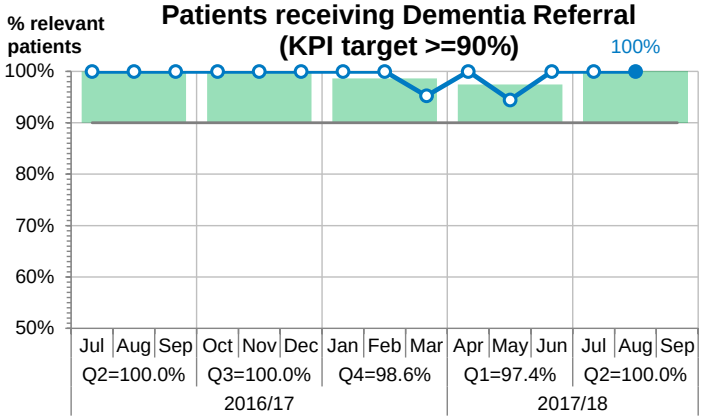


Chart 7



Charts 5 to 7 show performance against the dementia standards.

Compliance against the standard has been achieved for August.

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Discharge Summary

Chart 8

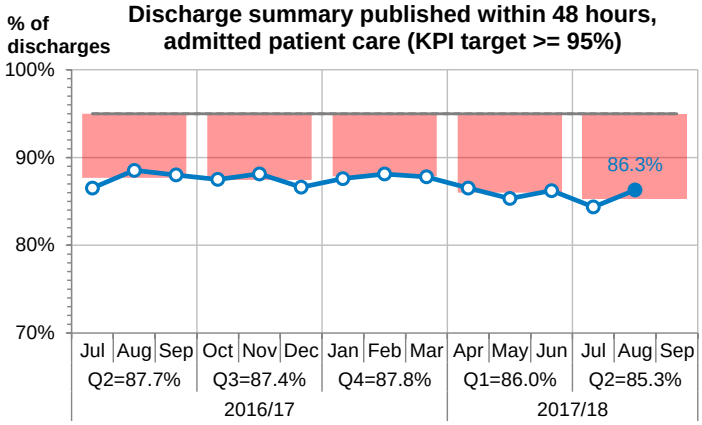

Chart 8 shows compliance with discharge summary completion within 48hrs.

The percentage of discharge summaries published within 48 hours was 86.3% in August.

A comprehensive look at each specialty by ward location has been undertaken and a number of reasons have been identified to explain the reasons for static performance. Solutions are being investigated and the renewed focus on HCRs will continue as part of the Trust Performance meetings.

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Clinical correspondence (typing backlog)

Chart 9

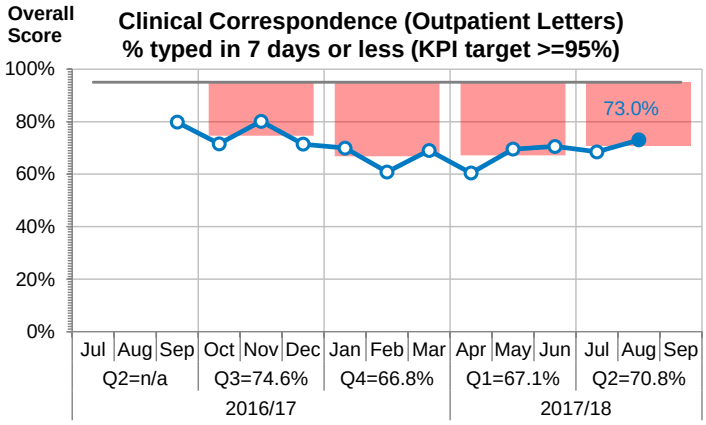

Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 7 days.

The overall Trust performance for clinical correspondence typed within 7 days showed a slight improvement in month.

Resources within each Business Group have been directed to take a pooled approach to transcribing correspondence.

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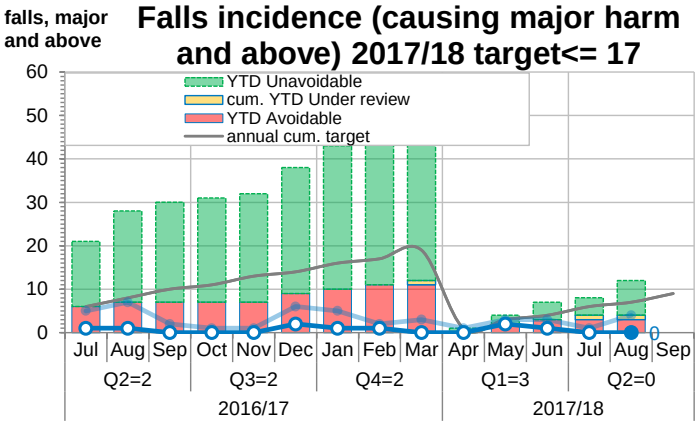
Falls 16

Chart 10



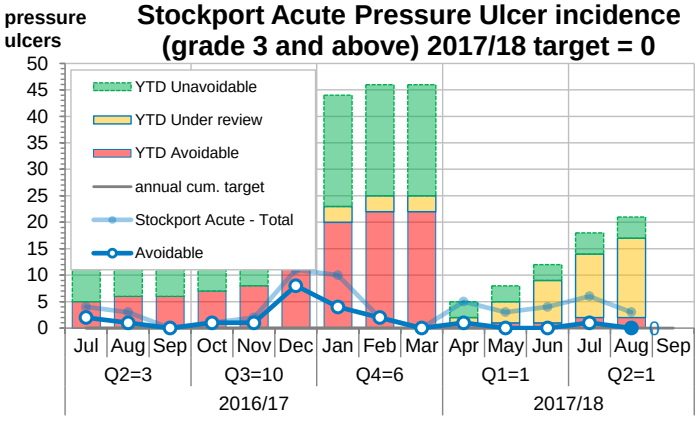
This year's target is 17 or below avoidable falls. In August 4 falls were reported all of which were unavoidable. To date there has been 3 avoidable falls.

Work continues to identify patients at risk of falls and ensure the falls bundle is implemented.

A Ward Sister was designated to co-ordinate work on falls in medicine but due to staffing vacancies this has been withdrawn. An alternate solution is being looked at for the next 6 months.
Work continues to identify patients at risk of falling in the community and a presentation was given at the Falls Steering group re "Steady in Stockport". Recruitment to these posts has commenced. An osteoporosis workshop will also be held on 3rd October people over 50 with osteoporosis.

Pressure Ulcers 16

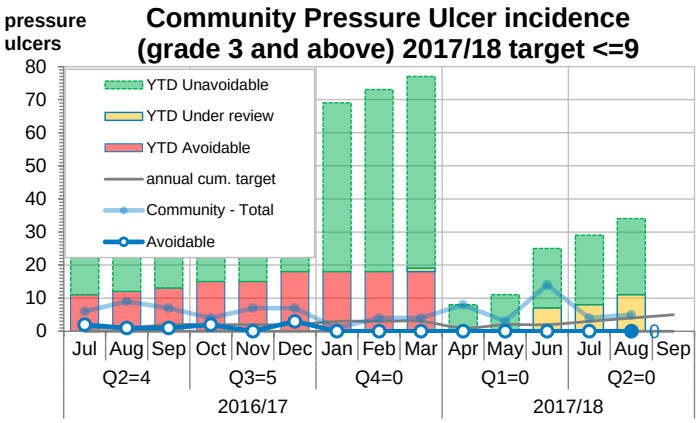
Chart 11



The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017/18. In August, there have been three, category 3 and above pressure ulcers reported in the hospital, all are currently under review.

The stretch target for Stockport Community is a 50% reduction in grade 3 and 4 avoidable pressure ulcers by the end of 2017/18. The target is 9 avoidable pressure ulcers for the year. In August there have been 5 new grade 3 or 4 pressure ulcers reported, 3 of which are still under review, and 2 have been deemed unavoidable.

Chart 12



In August a new Sofcare cushion was introduced into the Community Loans Equipment contract, negating the need for step up or step down in equipment provision, as now one level of cushion meets all levels of pressure ulcer risk, be it either at risk or elevated risk. This has the added advantage that pressure relieving cushions can now also be ordered by ward staff prior to patient discharge; previously patients had to wait until they were at home before they could be assessed for an appropriate cushion which meant there was a delay in the required equipment being provided.

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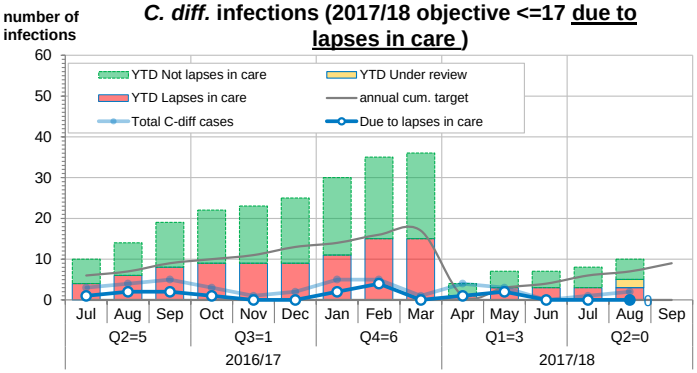
Clostridium difficile (C. diff.) infections M

Chart 13



There has been 2 cases of Clostridium difficile in August; the total number YTD is 10. Of these 10 cases 8 have been reviewed with the other 2 cases still under review.

We have been advised by the CCG that 5 cases reviewed by them do not have significant lapses in care and do not reach the threshold for reporting; however 3 cases do have significant lapses in care and do reach the threshold for reporting. Therefore 5 cases would not count towards the trajectory of 17 significant lapses in care but 3 cases will.

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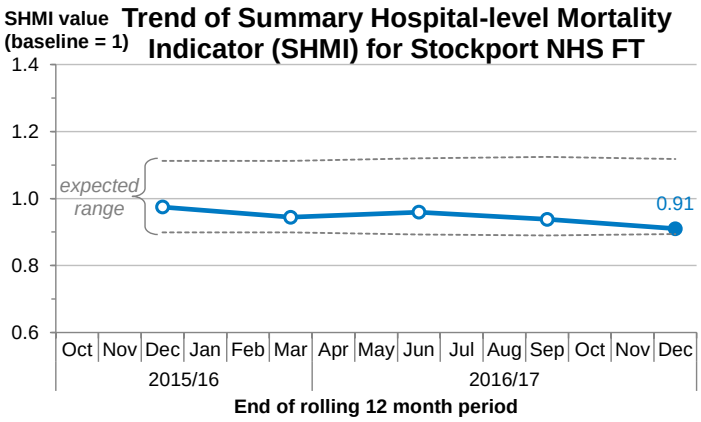
Mortality

Summary Hospital-level Mortality Indicator (SHMI)

This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
Data source: Health and Social Care Information Centre

Chart 14



Mortality analysis now includes 3 measures, SHMI, RAMI, and HSMR (not Dr Foster HSMR but a proxy provided by the CHKS software). Where possible data is shown to represent performance over time, against peers and with weekend/week comparisons.

Whilst overall mortality profile is good and reported as Green, investigation is needed into the varying mortality at the weekend compared to the week. This would be in tandem with the Trust 7 day services action plan

Chart 15

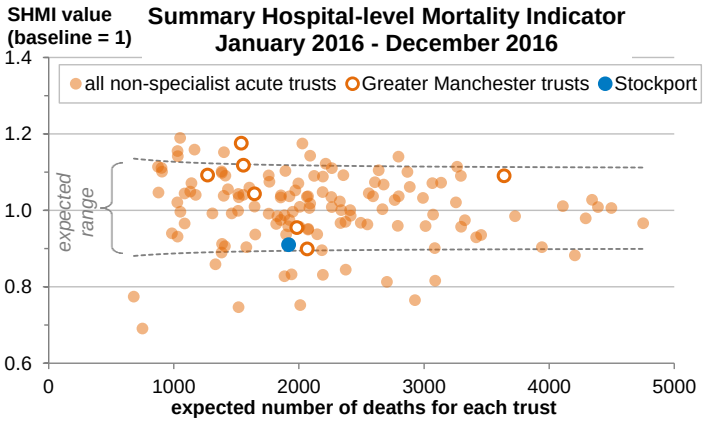
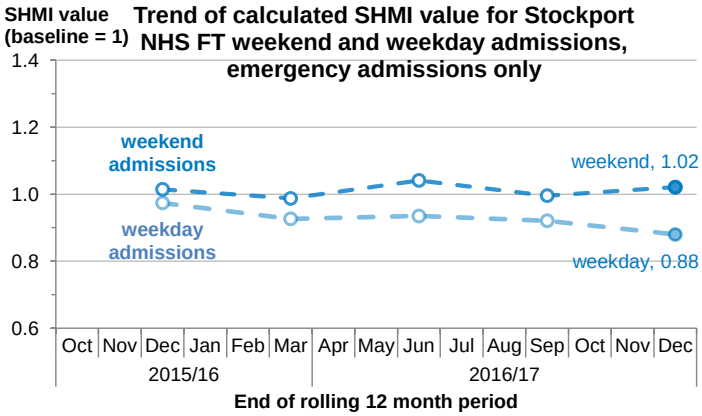


Chart 16



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Risk Adjusted Mortality Index (RAMI)

The main differences in calculation from SHMI are: RAMI only includes in-hospital deaths; it excludes patients admitted as emergencies with a zero length of stay discharged alive, and patients coded with receiving palliative care; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest 2016 benchmarks; RAMI includes data from the whole patient spell rather than just the first two admitting consultant episodes.

Data source: CHKS

Chart 17

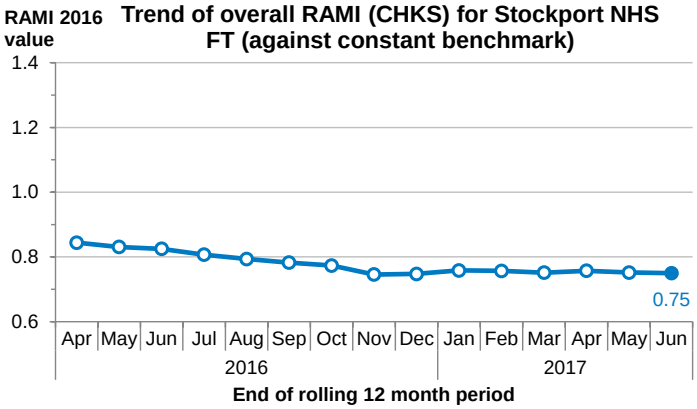


Chart 18

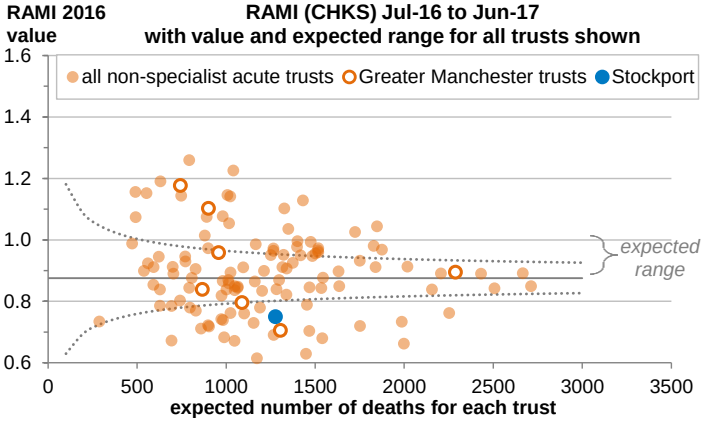
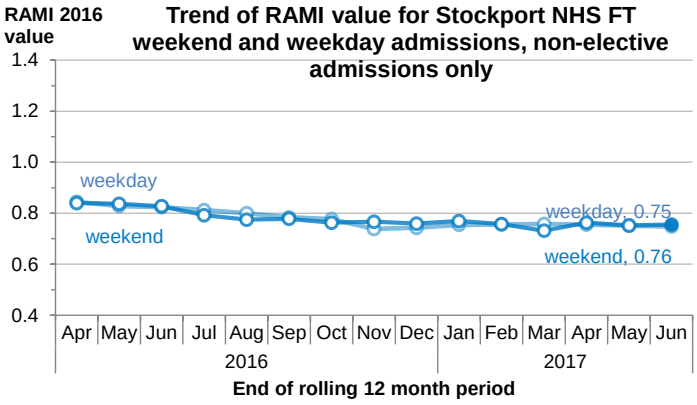


Chart 19



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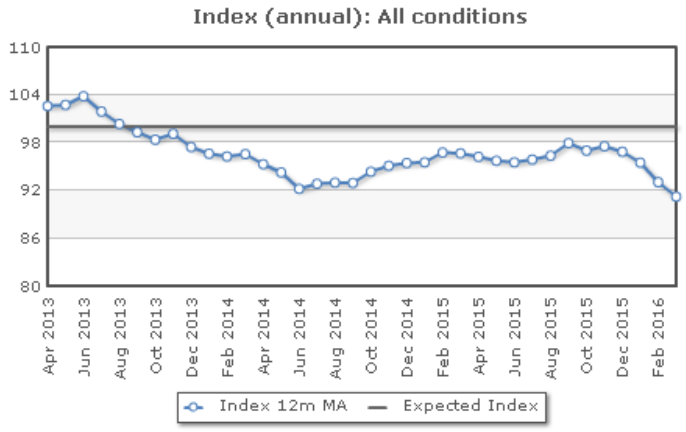
Hospital Standardised Mortality Data (HMSR)

The main differences in calculation from SHMI are: HSMR only includes in-hospital deaths; the factors used in estimating the number of patients that would be expected to die includes whether patients are coded with receiving palliative care, and socio-economic deprivation; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest benchmarks.

Data source: CHKS (using Dr Foster Intelligence methodology)

Chart 20



Referral to Treatment (RTT) waiting times

Chart 21

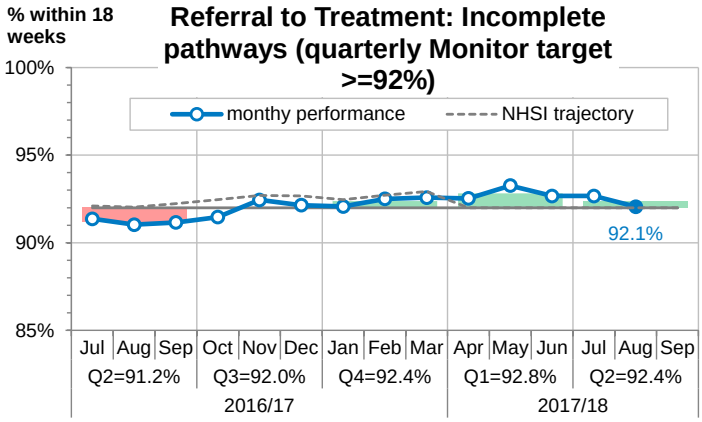
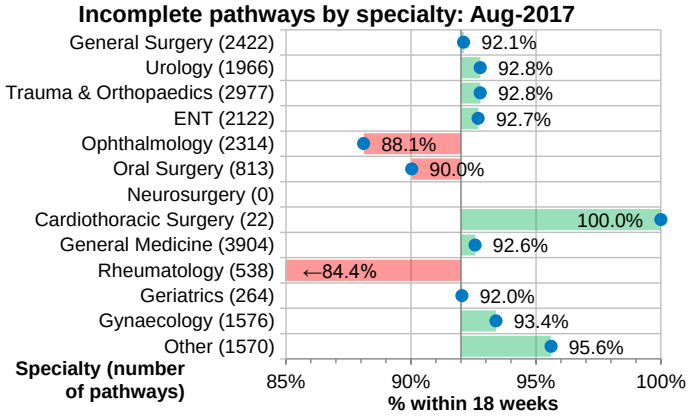


Chart 21 shows performance against the RTT Incomplete standard.

The Trust achieved 92.1% against the National standard in August.

Chart 22

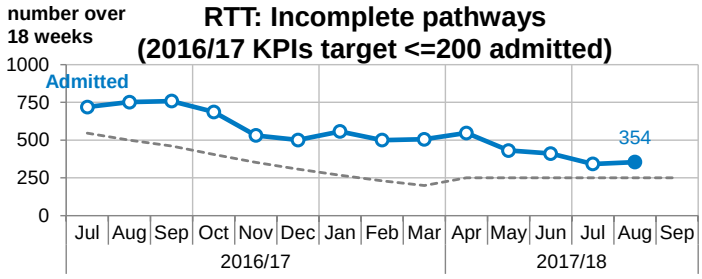


Ophthalmology, Oral Surgery and Rheumatology did not achieve standard at specialty level.

Rheumatology performance has been impacted by increased referrals outside of the Stockport area.

Ophthalmology and Oral surgery activity was affected by staffing pressures during the month.

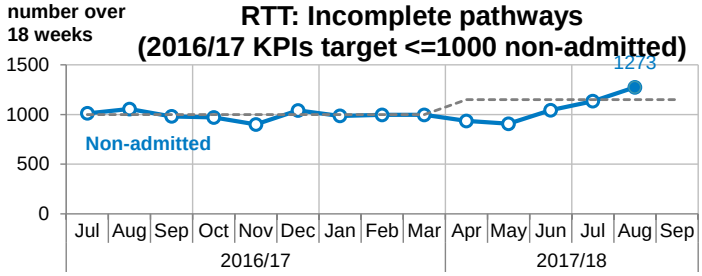
Chart 23



Charts 23 and 24 show the number of patients waiting beyond 18 weeks split by admitted and non-admitted pathways.

The admitted backlog rose slightly from 342 to 355 at month end.

Chart 24



The non-admitted backlog has risen above plan in month, mainly due to pressures within the Ophthalmology and Rheumatology services.

Accident & Emergency, Urgent Care & Flow

Chart 25

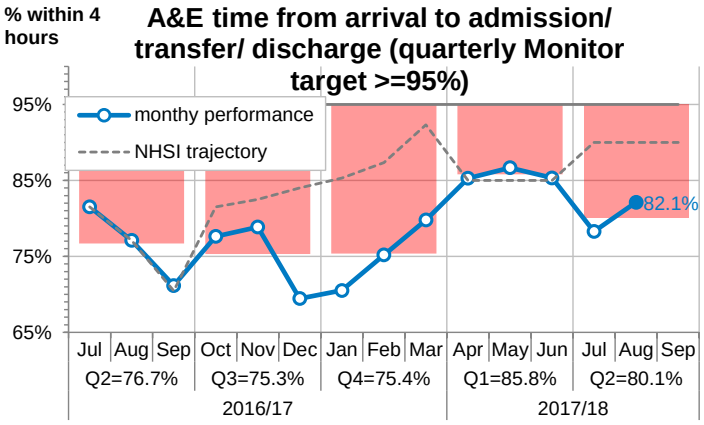


Chart 26

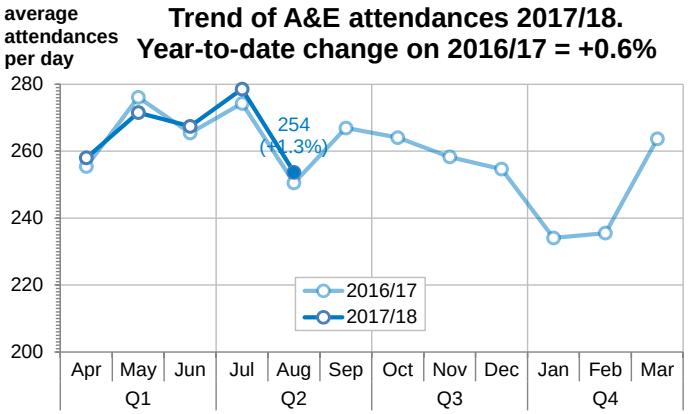


Chart *25* shows compliance against the 4hr A&E standard.

Performance in August was 82.1% an improvement on the July position of 78.3%, but below the improvement trajectory of 90%. The Trust breached the 12 hour trolley standard on 4 occasions in Month.

Although ED attendances were lower July, there was a sustained increase in the number of Delayed Transfers of Care, coupled with a reduced daily discharge rate from the Medical wards.

The Trust has identified the following 4 key areas as those which, once addressed, will make a significant difference in the short term. The collective impact should enable ED performance to reach trajectory:

1. Staffing and Overnight performance

Currently overnight performance is 74%, this is significantly different from day performance which is currently at 86%, therefore there is a reduction in performance overnight currently of 12%.

The staffing rota will be reviewed to ensure appropriate senior decision making overnight in ED. If we reduce overnight breaches (due to long wait to be seen) by approx. 200 per month (50 per week) we will increase performance by 3%.

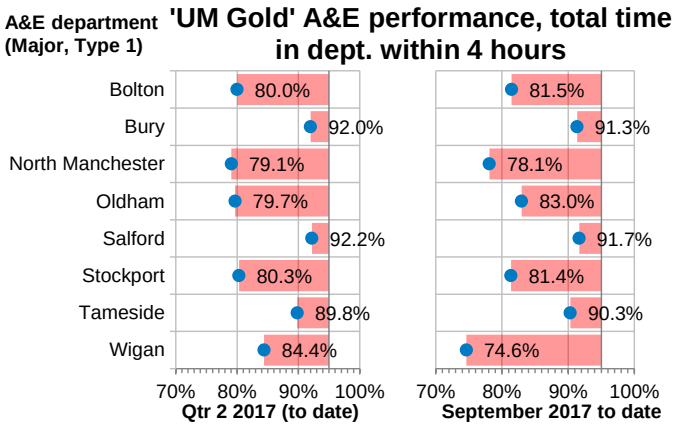
2. 7 day working to increase weekend discharges and reduce bed occupancy.

The average number of weekend discharges (from medical wards) is 40 in total per weekend (which is below weekday average).

The plan is to increase weekend discharges to approx. 50 per full weekend through more effective criteria led discharge processes- This in conjunction with the SAFER work will reduce bed occupancy to around 90% from its current level of 93%. Research suggests this should support a 1% increase in ED performance.

3. **Community capacity**

Chart 27



Source: Greater Manchester Academic Health Science Network.

The main reason for delayed discharge of patients is access to care homes and domiciliary care.

The plan is to increase community capacity by enabling an extra care package per day, an extra care home placement a day and an extra discharge from intermediate care per day totalling an extra 21 discharges per week. This will positively impact Length of Stay and increase flow to wards. It is suggested that this will realise an increase in ED performance by 2%.

4. **Ward level leadership and improved flow- SAFER and LOS (bed occupancy)**

The SAFER programme is not fully embedded across all Medical wards and our current Length of Stay (LOS) is above target at 10 days for August. In addition access to AMU due to flow issues on the Medicine Specialty wards directly impact performance with the majority of patients waiting for a AMU bed breaching the 4 hour target.

The plan is to implement SAFER effectively across all SAFER medical wards in order to reduce LOS by approx. 2.7 days. This will have a benefit of bed occupancy on the medical wards and in turn will increase flow through ED and assessment wards.

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Chart 28

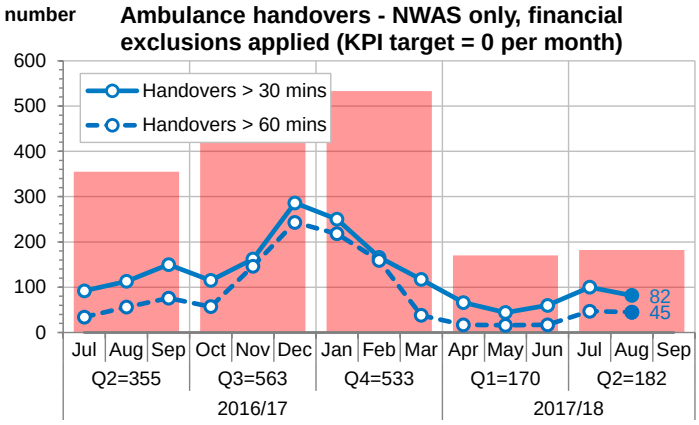


Chart 29

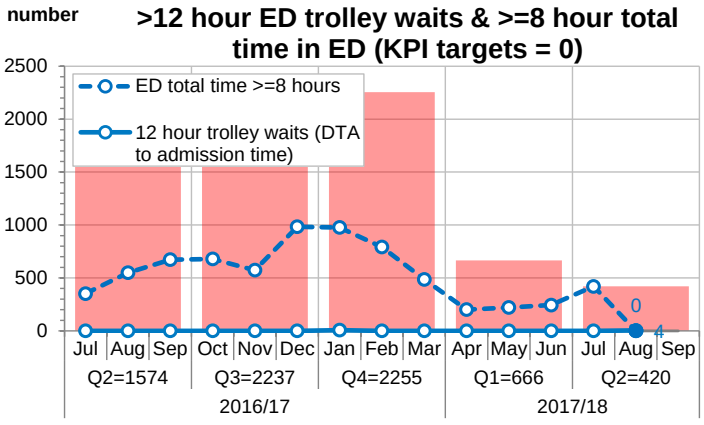


Chart 30

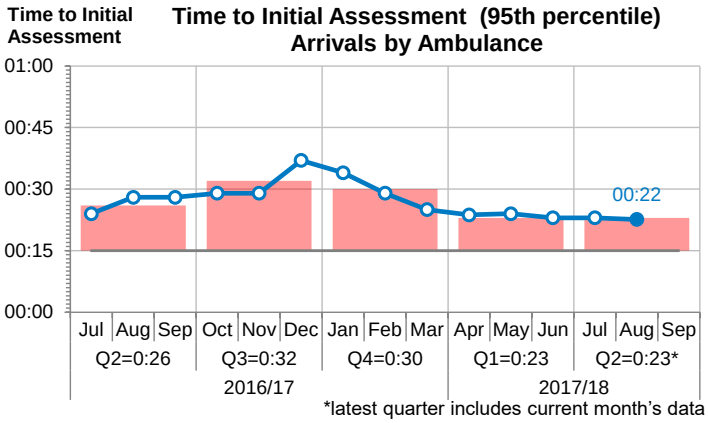


Chart 31

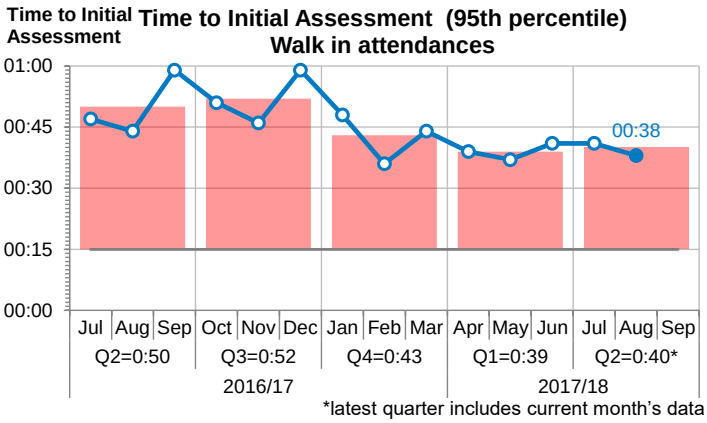


Chart 32

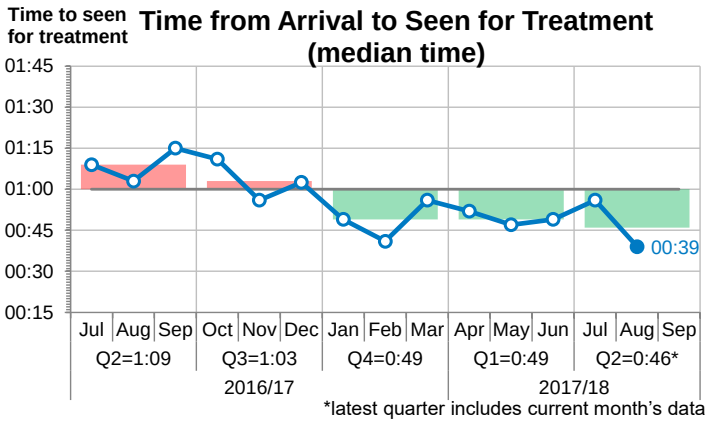


Chart 33

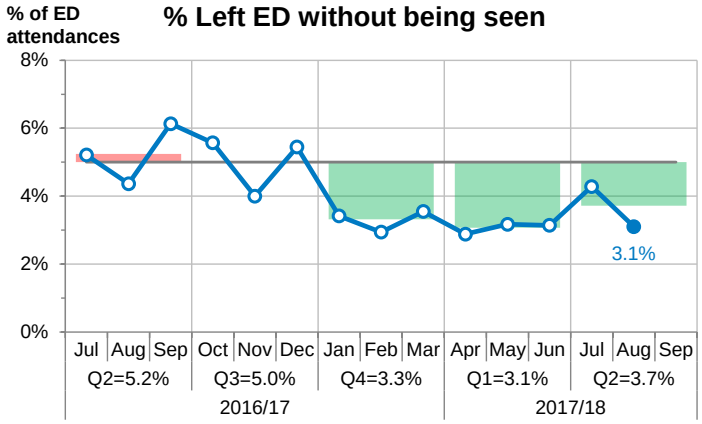


Chart 34

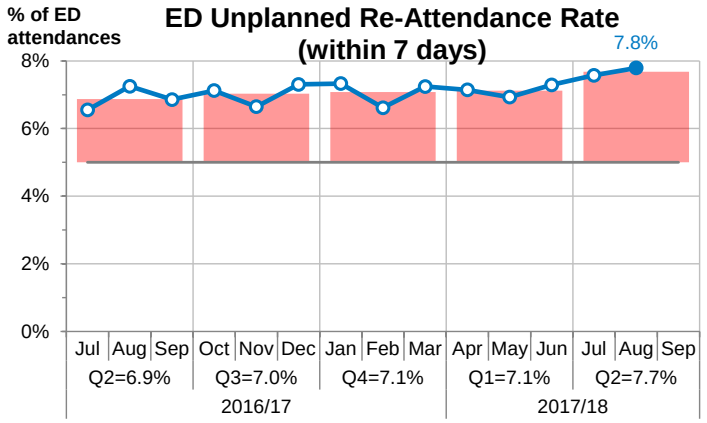
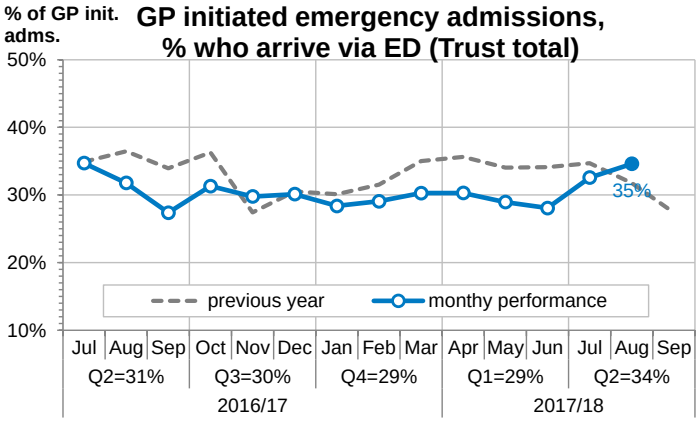


Chart 35



The following charts (35 to 43) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

Chart 36

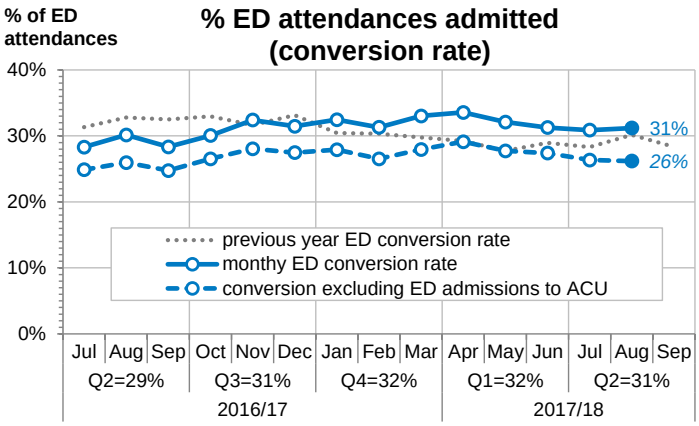


Chart 37

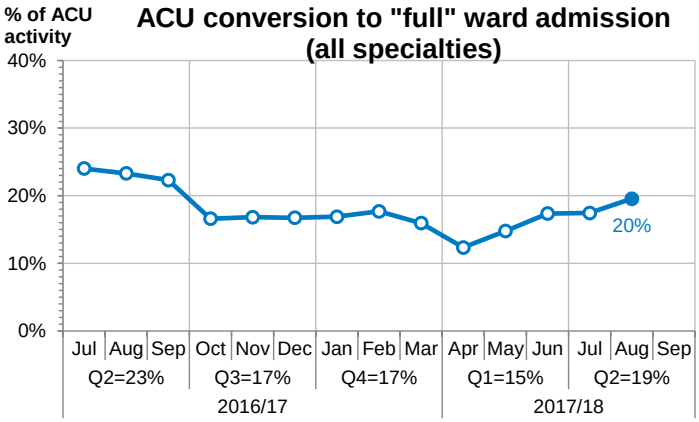


Chart 38

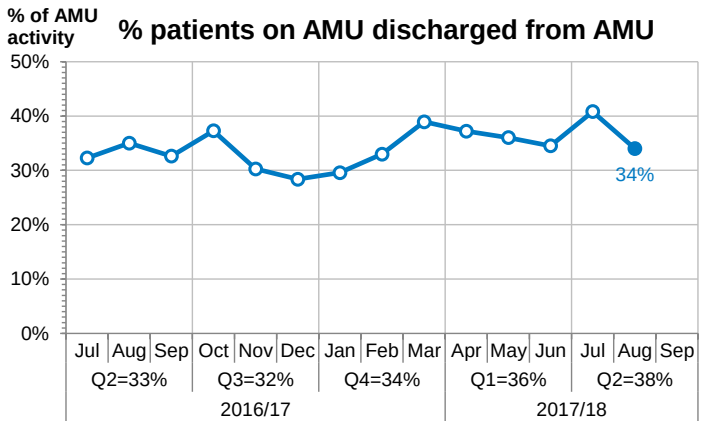


Chart 39

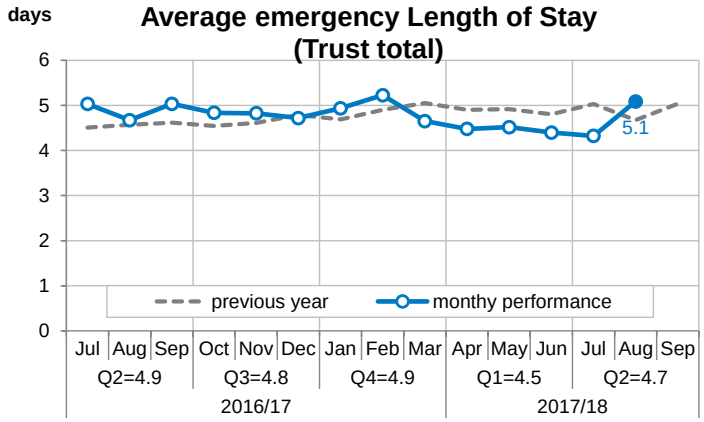
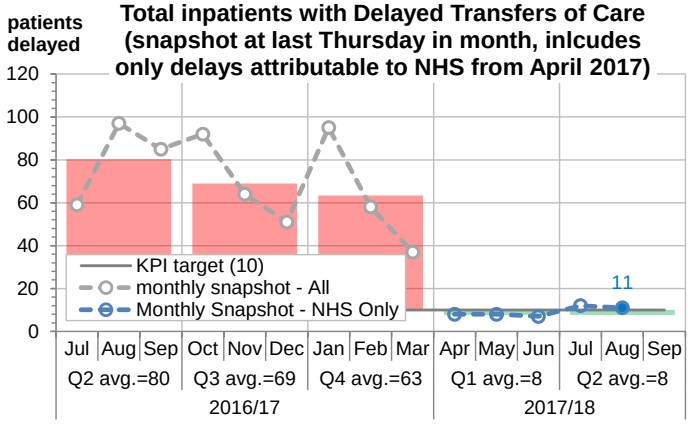


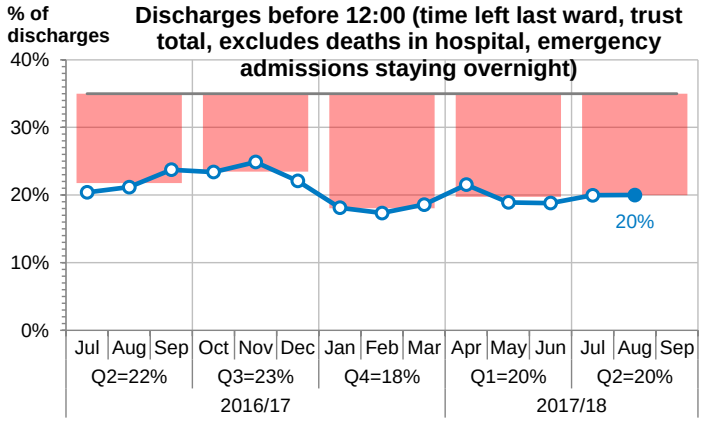
Chart 40



SAFER - is intended to improve the patient journey by ensuring an efficient pathway from admission to discharge by delivering timely appropriate care at the right time in the right place.

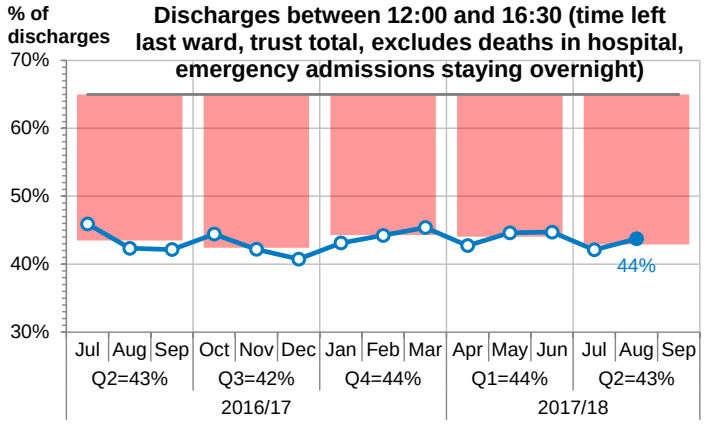
Key metrics have been agreed to measure SAFER performance which includes discharges before 12md and 16:30hrs as shown in chart 33 and 34. All wards are invited to attend monthly performance meetings to report compliance against these key metrics and actions plans developed as appropriate.

Chart 41



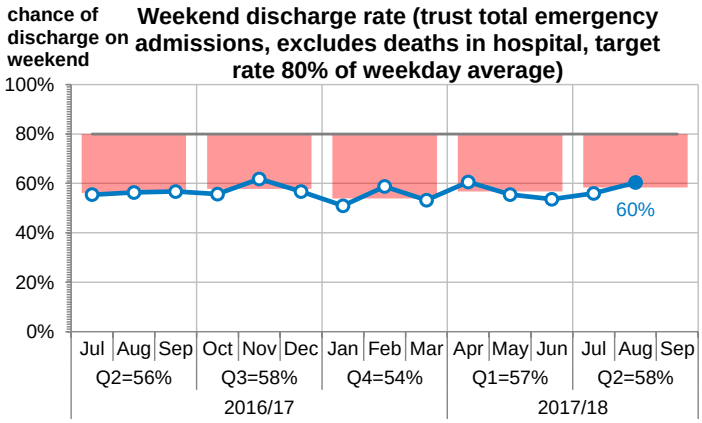
A team from the Emergency Care Improvement Programme (ECIP) is supporting further implementation of SAFER. Work has commenced on three wards, namely: A1, A11 and E2 for an 8 week period until the end of Jan 2017.

Chart 42



Identifying patients for discharge at the weekend is just as important as weekday discharges to continue flow and create capacity. An action plan has been developed to strengthen roles and responsibilities' of the on call team at weekend in order to ensure robust plans are in place and adhered to.

Chart 43



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Diagnostic tests (6 week wait) 16

Chart 44

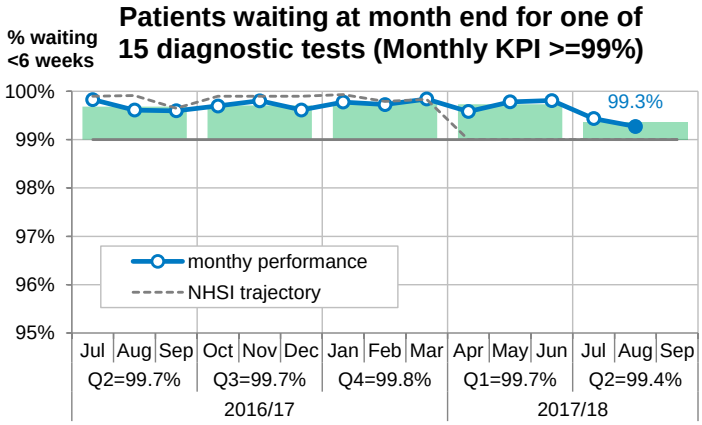

Chart 45 shows performance against the diagnostic standard.

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Cancelled Operations 20

Chart 45

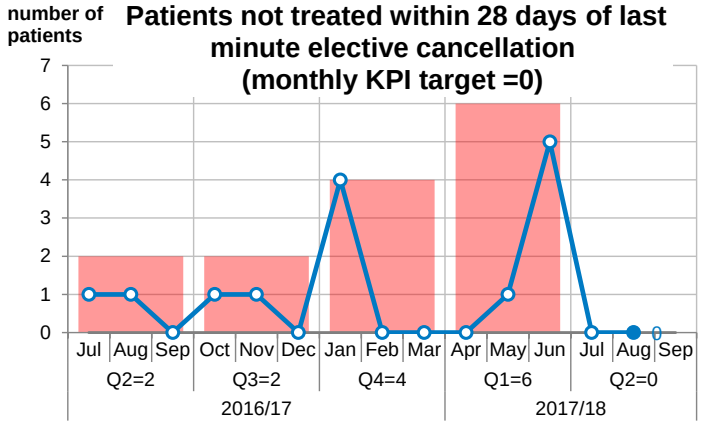

Chart 45 shows 0 breaches of standard in month.

Chart 46

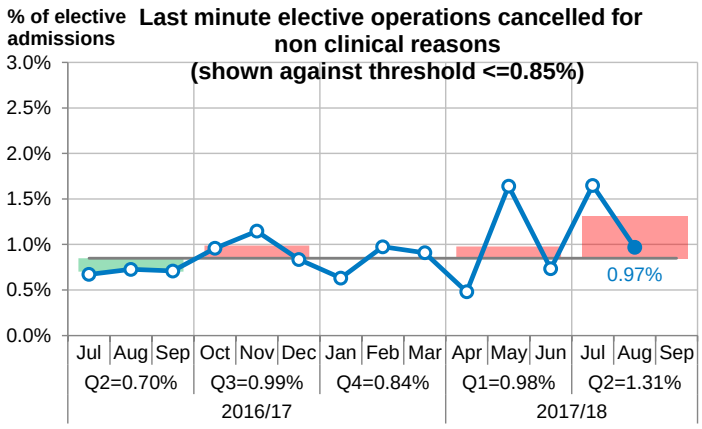

Chart 46 shows performance for last minute elective operations for non-clinical reasons.

In August, 32 cancellations were reported on the day for non-clinical reasons.

The top reasons for cancellation were:

- 10 due to surgeon sickness
- 8 due to lack of theatre time
- 5 due to urgent cases taking priority

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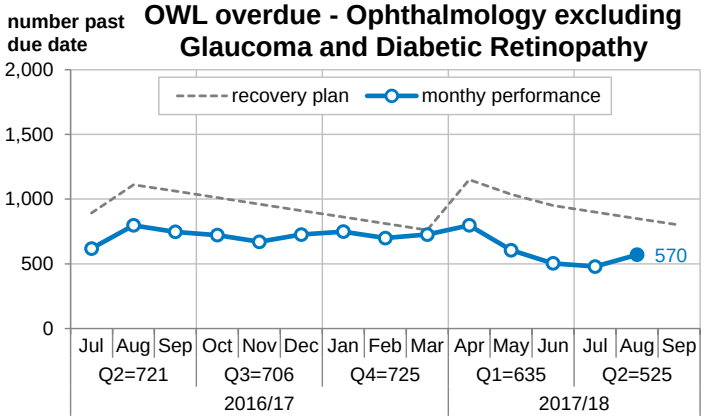
Outpatient Waiting List (OWL) 20

The Outpatient Waiting List (OWL) is where patients are placed when awaiting a future follow up appointment. When capacity and demand are mismatched, the numbers of patients who are overdue their follow up by a certain date will increase and delay these patients.

There are four specialties within the Trust where this is a current problem. This situation is being monitored by the Quality Assurance Committee (a sub-committee of the Board of Directors). This committee requested that the data should be shared with the Board through the Integrated Performance Report.

Chart 47 Ophthalmology OWLs past due date

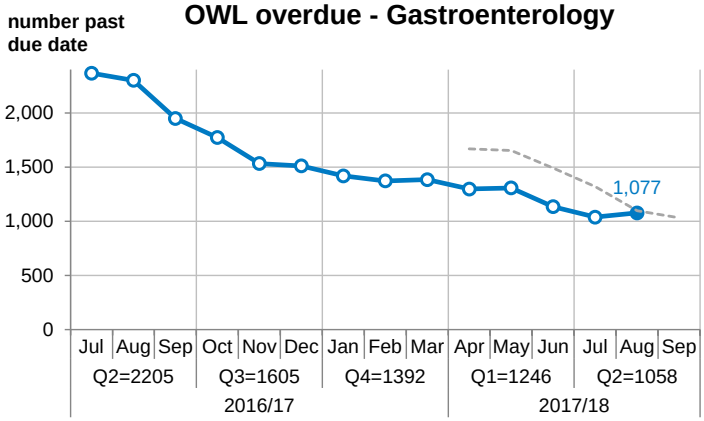


Ophthalmology

Chart 47 shows the number of Ophthalmology patients on the Outpatient waiting list beyond their due date.

Ophthalmology remains ahead of its recovery trajectory. A new Glaucoma practitioner commence in October providing further clinic capacity.

Chart 48 Gastroenterology OWLs past due date

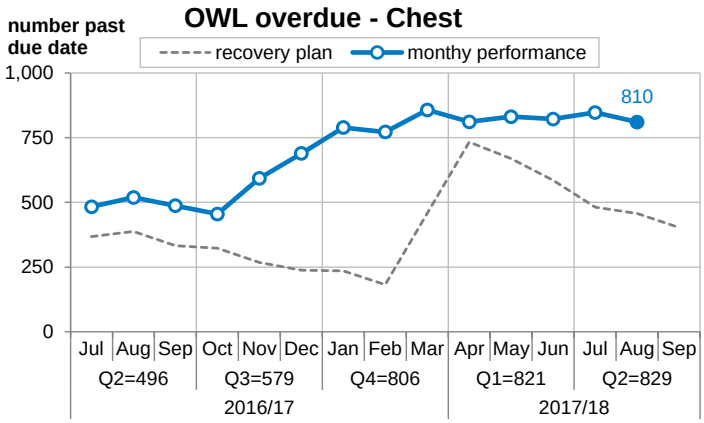


Gastroenterology

Chart 48 shows the number of Gastroenterology patients on the Outpatient waiting list beyond their due date.

Gastroenterology remains just ahead of its recovery trajectory. A Senior Clinical Fellow commences in October providing additional clinic capacity.

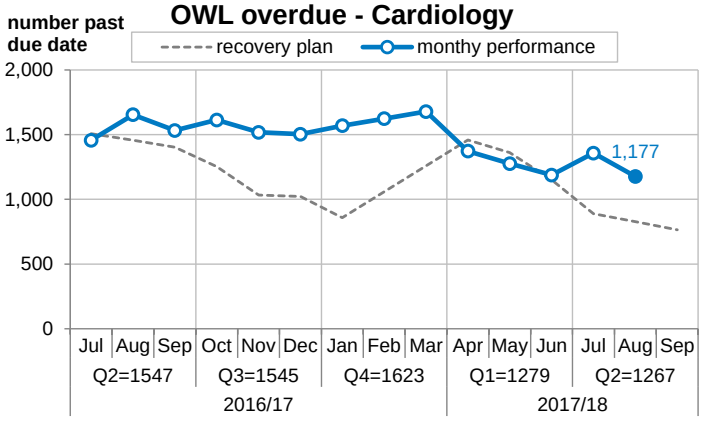
Chart 49 Respiratory Medicine OWLs past due date



Respiratory Medicine

The 2 substantive Consultant posts were unable to be recruited to in August due to candidates withdrawing their applications. The Trust intends to engage with partner Organisations to create a more attractive joint post arrangement in order to secure a robust workforce model.

Chart 50 Cardiology OWLs past due date



Cardiology

One substantive Consultant post has been recruited to and the post-holder will commence in September. This replaces a locum position so although an overall reduction in clinic capacity will be realised, there will be an increase in clinical quality with a forecast reduction in future follow-up demand. The second Consultant post will be re-advertised.

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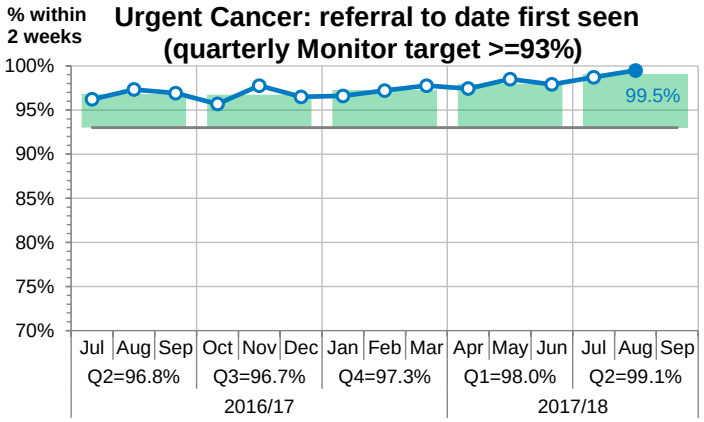
Cancer waiting times M 16

Chart 51



Compliance with the urgent referral standard continues.

Chart 52

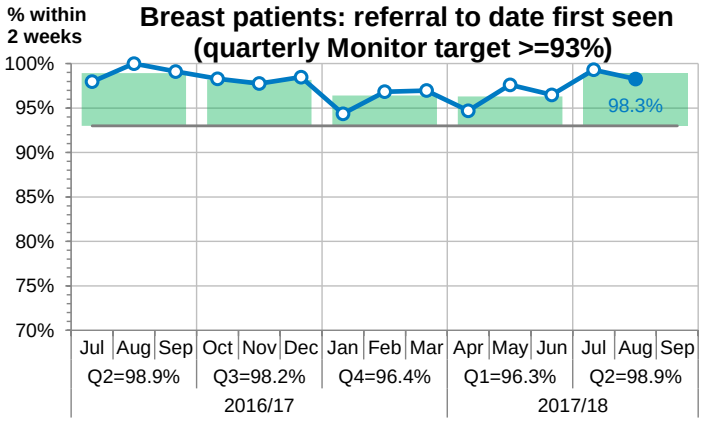


Chart 53

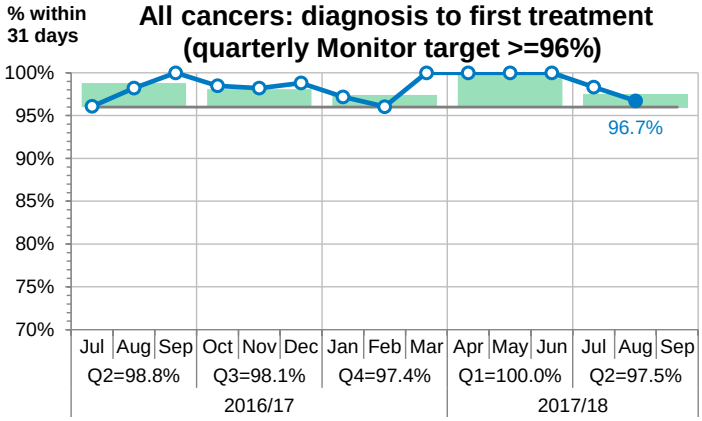


Chart 54

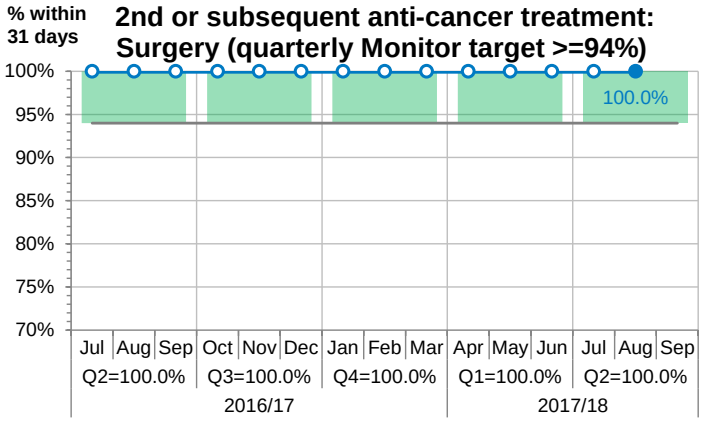


Chart 55

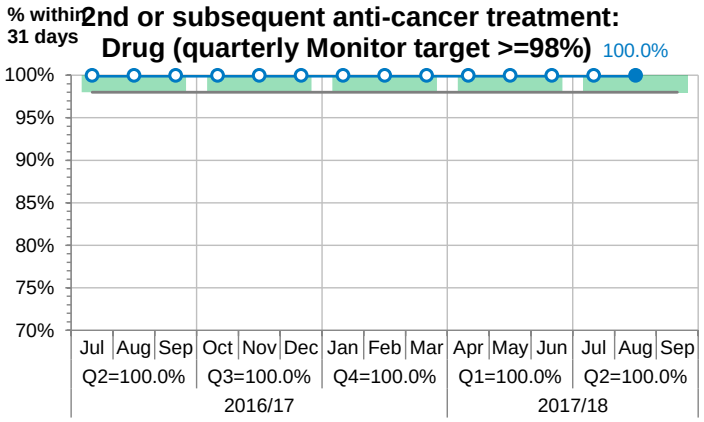


Chart 56

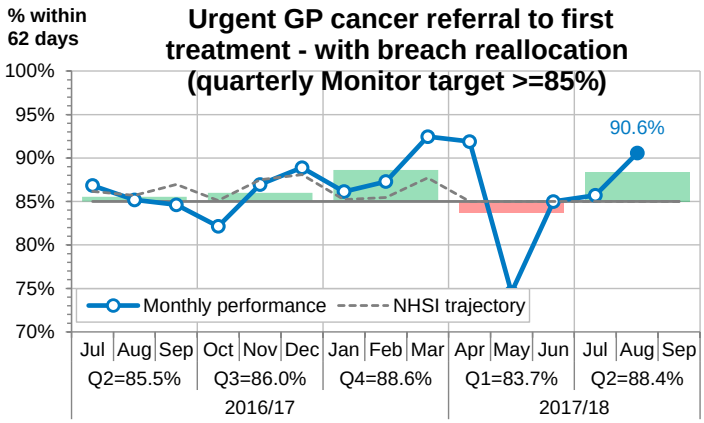


Chart 56 shows performance against the 62 day cancer standard.

The Trust achieved standard in June and July.
The latest position for August is 90.6%.

September is experiencing a higher number of patients than usual awaiting treatment on an Upper GI pathway.

Greater Manchester cancer data shows that this is a pressure across the region, with upper GI being the tumour group accounting for the highest cohort of breaches per month due to the complexity of its nature. We are in discussions with Central Manchester regarding the better management of patients on this particular pathway.

In terms of other pathway redesign, the colorectal service is looking to introduce a straight to test (Endoscopy) model, whilst Lung have successfully trialed a one stop model for upgrade patients.

Discussions are ongoing regarding providing lung diagnostics in a more efficient way across the Greater Manchester sector

Chart 57 GP referral to first treatment with breach reallocation, by tumour group.

Tumour Group (Aug-17 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Urology	1 / 10.5	90%	
Upper GI	1 / 7.5	87%	
Lung	1 / 2	50%	
Breast	0 / 17	100%	
Colorectal	0 / 7.5	100%	
Haematology	0 / 2.5	100%	
Gynaecology	0 / 2	100%	
Head & Neck	0 / 1.5	100%	

Chart 57 shows performance against the 62 day standard by tumour group.

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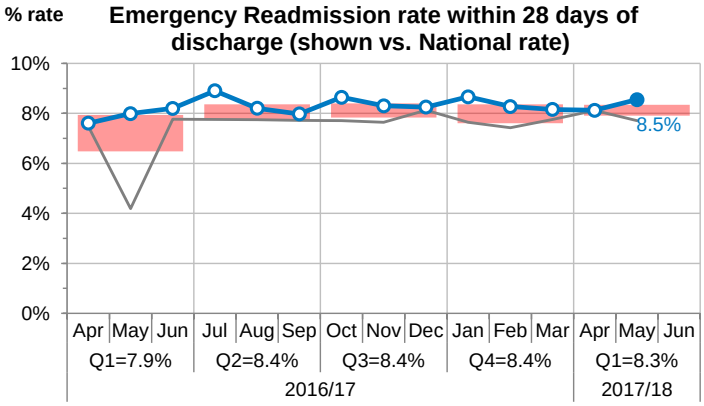
Emergency Readmissions

Chart 58



Data source: CHKS / Health and Social Care Information Centre

Chart 58 shows the Emergency Readmission rate within 28 days of discharge.

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Financial Performance

Chart 59

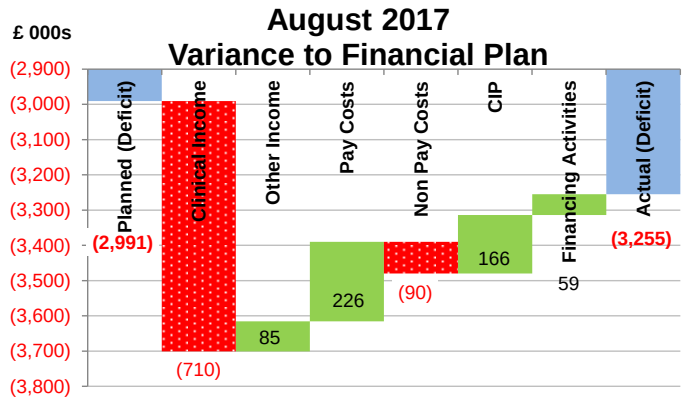


Chart 60

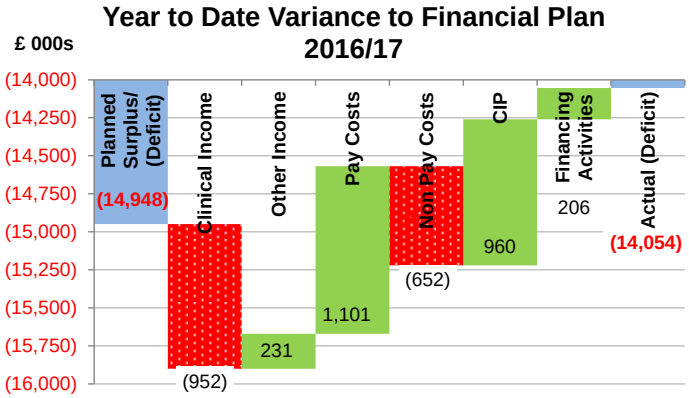
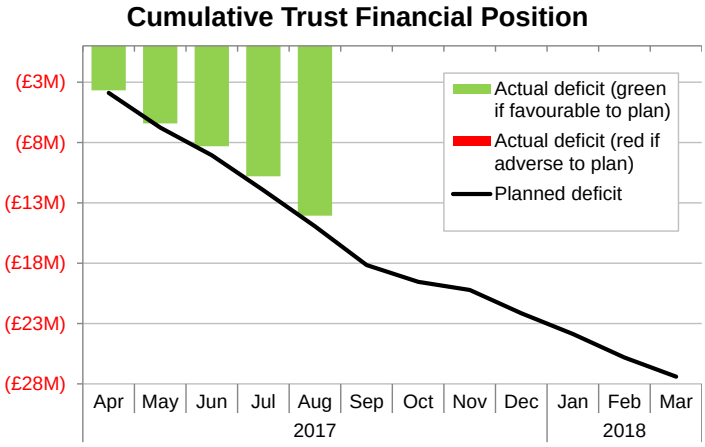


Chart 61



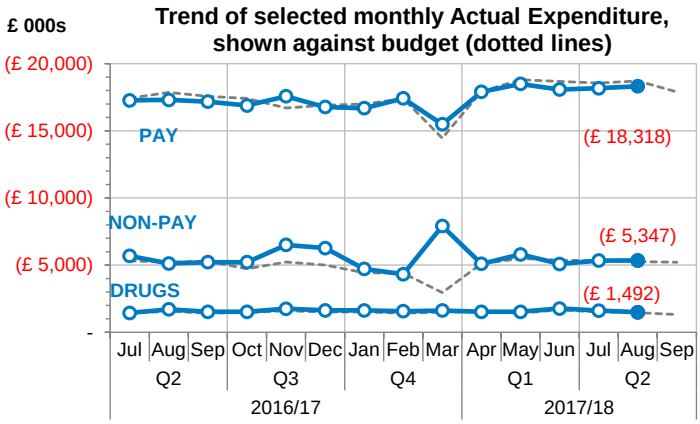
In five months the Trust has made a £14.1m loss. The planned deficit was £15.0m so this is £0.9m favourable to plan. The Trust has made an average daily loss of £92,000 to the end of August.

The adverse movement in month is because the Trust has accounted for the financial penalties which could be sanctioned against the Trust for failure to deliver national access targets. This has not shifted the overall financial position adverse to plan as the CIP favourable variance to profiled plan continues to date, in addition to the extra Sustainability and Transformation Fund (STF) received in relation to 2016/17.

Elective income has deteriorated again in month, and is £0.9m behind plan. Scheduled sessions taking place are being run more efficiently and in list utilisation is high, but fewer lists are going ahead than planned so income is low. The Surgery business group continues to focus on theatre efficiency and increasing throughput, but recouping under-performance over the winter months has proved challenging in previous years with system wide bed pressures, nationally mandated elective cancellations and outsourcing at premium rates.

CIP is £1.0m ahead of plan; £2.1m (15%) was expected by this stage in the year when £3.1m (21%) has been transacted. £6.0m (40%) of the £15.0m annual saving has been achieved. The CIP favourable variance will not continue after October 2017 when the profile of expected savings increases significantly. **Recurrent CIP has increased in month to £2.6m, but this is still only 18% of the required savings and this impacts on the medium term financial plans of the Trust.**

Chart 62



Pay budgets are underspent to date excluding CIP by £1.1m, as the Trust level of vacancies remains high. Agency costs to date are £5.9m and above the planned agency ceiling by 20%, but this is offset by vacancies not covered mainly in the non-clinical areas of the Trust. Bank and agency expenditure including NHS Professionals and waiting list initiative payments total £10.7m and represent 12% of overall pay expenditure.

Non-pay is overspent by £0.3m excluding CIP, which includes £0.7m of out-sourcing costs for surgical specialties and outsourced radiology reporting. The areas where outsourcing is used is part of efficiency CIP plans and therefore has a double impact as CIP is not being delivered. In radiology this is linked to shortfalls in recruitment.

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Capital Programme

Chart 63

Description	Plan 2017/18 Year £'000	Month 5 - YTD August 2017/18 Plan £'000	Actual £'000	Variance £'000
Healthier Together Schemes				
ED Resus Expansion	2,400	1,075	104	971
Ward Refurbishments	1,200	70	29	41
Endoscopy Building	250	250	-	250
Equipment - Critical Care & IT	280	140	-	140
	4,130	1,535	133	1,402
Internally Funded Schemes				
Equipment				
Endoscopy	250	250	-	250
Diagnostics	1,139	221	417	(196)
Surgery and Critical Care	848	108	242	(134)
Other Medical Equipment	812	86	41	45
Estates and Facilities Equipment	610	110	11	99
	3,659	775	710	65
Information Management & Technology				
Wireless Network	650	325	97	228
Hardware for Electronic Patient Records (EPR)	380	245	151	94
Software for EPR - Interfaces & Voice Recognition	590	142	7	135
Other Hardware	910	651	317	334
Other Software	120	-	26	(26)
Aspen House Server Room	-	-	2	(2)
	2,650	1,363	602	761
Estates				
Backlog Maintenance	335	120	42	78
Non Backlog Maintenance	500	150	451	(301)
Other Projects	863	220	95	125
	1,698	490	588	(98)
Revenue to Capital	-	-	39	(39)
Capital Expenditure Plan (excluding finance leases)	**12,137**	**4,163**	**2,072**	**2,091**
Specific Finance Leases				
Acute EPR - Intersystems - Capital repayments	1,422	719	718	1
Community EPR - EMIS- Capital repayments	68	29	29	0
	1,490	748	747	1
Capital Expenditure Plan (including finance leases)	**13,627**	**4,911**	**2,820**	**2,091**
Funded				
Depreciation	9,982	4,138	3,574	564
QCNW & Stockport Pharmaceudicals Surpluses			31	(31)
Externally Funded			6	(6)
Loan Repayment	(1,551)	(776)	(636)	(140)
Cash Resources	5,196	1,549	(156)	1,705
	13,627	**4,911**	**2,820**	**2,091**

Capital costs of £2.8m have been incurred to date against a plan of £4.9m so is £2.1m behind plan. This is due to a delay in the commencement of schemes linked to Healthier Together of £1.4m and planned spend for 2017/18 being brought forward at the end of 2016/17, mainly in IT which is £0.8m behind plan.

The full funding of Healthier Together schemes is crucial to the delivery of the capital programme but is reliant on external parties and their approval processes and are currently being validated at a detailed level by the Greater Manchester Devolution Team (GM Devo). The process has taken much longer than envisaged as Central Government approvals were only recently granted. The Trust is presently waiting for GM clearances to commence work once funding is confirmed.

The capital forecast has now been updated to include the expected delay in Healthier Together spend, and shows a forecast underspend of £2.8m at the year end. When confirmation of funding is received the lead time for project commencement and the project time plan for these major capital investments means that they are highly unlikely to be completed in year before 31st March 2018. A review of the corporate risk is being undertaken in light of these delays as orders need to be placed in the next two weeks to achieve the indicative project timelines. This does not impact on the cash position for the Trust as the planned cash levels included external funding for these works.

Cost Improvement Programme 20 M

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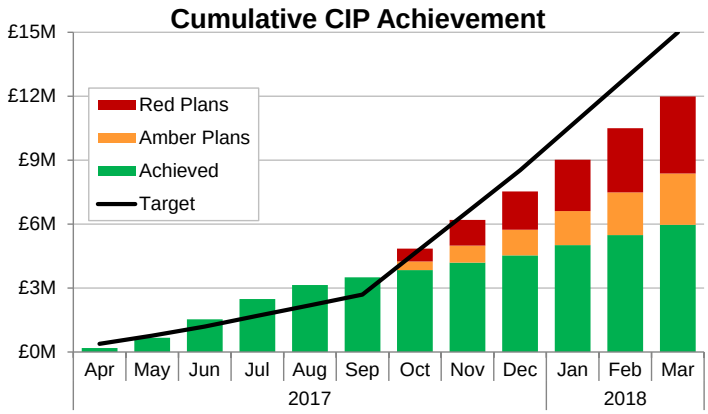
Chart 64



To the end of August £3.1m of CIP has been actioned towards the year-to date target of £2.1m, so is £1.0m ahead of plan. £6.0m (40%) of the £15.0m annual saving has been achieved, but the recurrent savings identified in 2018/19 have increased in month to £2.6m (18%).

This chart shows the RAG rating of planned CIP for the year ahead and recurrently, showing there are £6.6m of high risk and unidentified plans in 2017/18, and the significant pressure building on next year's financial plan.

Overall delivery of full year CIP savings of £15.0m is required to achieve the planned deficit of £27.4m but at present recurrent delivery is low. **This is a significant concern as it does not support the Trust's drive to return to financial balance in the medium term, as a further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.**

Financial Use of Resources Rating

Chart 65

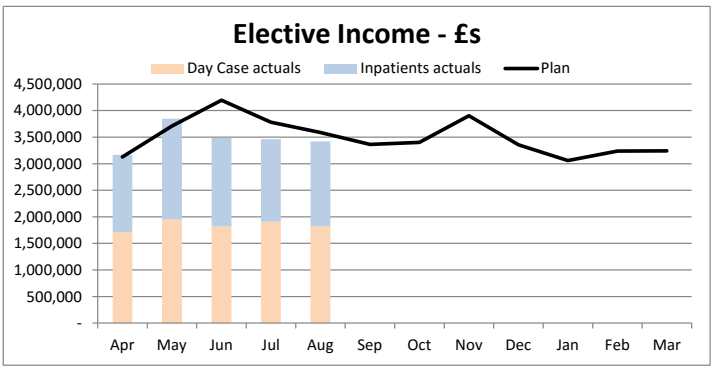
Finance & Use of Resources Metrics		Rating	Trigger Override	Excellent 1	2	3	Poor 4	Weight	Weighted score
Financial sustainability	Capital service cover	4	Yes	2.50	1.75	1.25	< 1.25	20%	0.8
Financial sustainability	Liquidity (days)	3	No	0	-7	-14	< -14	20%	0.4
Financial efficiency	I&E margin (%)	4	Yes	1.0%	0.0%	-1.0%	<-1.0%	20%	0.8
Financial controls	Distance from financial plan (%)	1	No	0.0%	-1.0%	-2.0%	<-2.0%	20%	0.2
Financial controls	Agency spend	2	No	< 0%	0%	25%	50%	20%	0.4
Finance Use of Resource Metric (UOR) - Calculated									**3**
OVERRIDE TRIGGERED?			Yes						Yes
Finance Use of Resource Metric (UOR) - Final Reportable									**3**

The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for August 2017 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

Elective Income vs. Plan

Chart 66

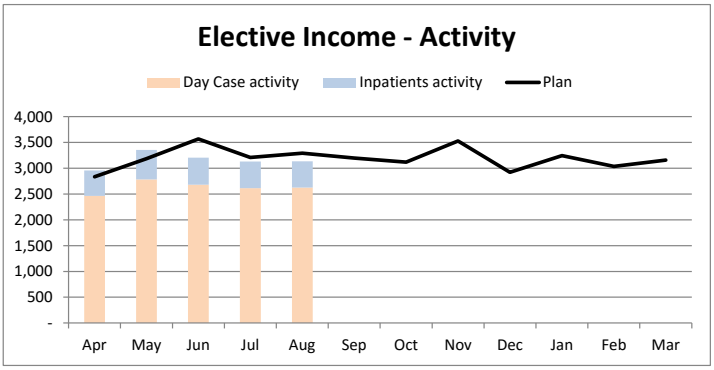


Elective income has deteriorated by a further £0.1m in month, and is £0.9m behind plan. Scheduled sessions taking place are being run more efficiently and in list utilisation is high, but fewer lists are going ahead than planned so income is low.

Elective activity is 492 cases below the profiled plan but day case activity is 182 cases ahead; tariff pricing means that the loss of elective income is only marginally offset by the additional day case work when theatre running costs are mainly fixed.

Inpatient income is currently behind plan by £1.0m, but day case activity is £0.1m favourable. The Trust has spent £1.0m on waiting list initiatives and £0.7m on out-sourcing in five months, but this is not solely on elective work and includes out-sourced radiology reporting.

Chart 67

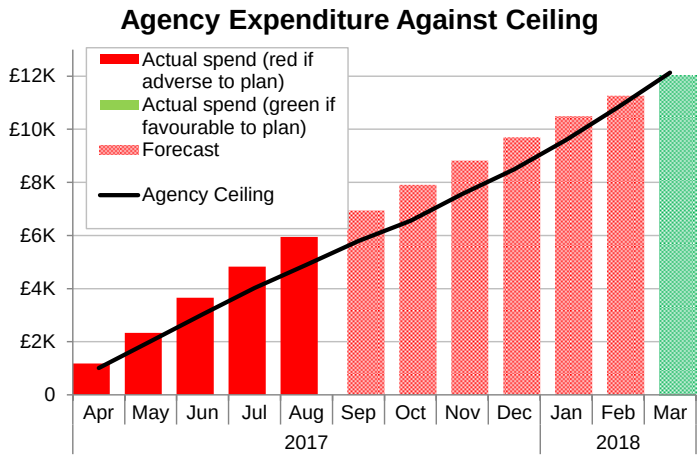


Elective in-patient activity is 492 spells behind plan. Urology is the main specialty adverse to plan to date and is 242 spells below target, with orthopaedics a further 112 cases below plan. Day case activity is 182 spells above plan; driven by 120 ophthalmology cases above plan and oral surgery 90. Endoscopy have increased their planned level of activity as a efficiency CIP scheme, but remain 119 cases above the new higher target to the end of August.

Running the requisite number of theatre sessions to deliver the plan continues to be a challenge and on-going theatre staffing pressures impact on the delivery of the elective activity plan. However, this is expected to improve from September due to a combination of further new starters and the completion of induction programmes for recent recruits. Reliance on premium rate initiatives continues in a number of specialties and the overall premium rate activity remains at 6% of total elective activity. A foreseeable risk is a national directive to cancel lists and free up surgical beds due to winter activity and this would inhibit financial recovery.

Agency Ceiling

Chart 68



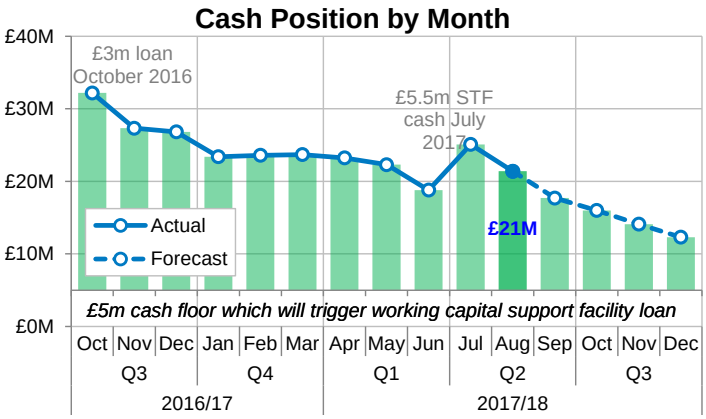
Agency costs to date are £5.9m, which represents 7% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £1.0m.

Agency costs for medical staffing are £4.4m to August 2017, which is 74% of all agency costs and highlights that the Medicine business group's reliance on agency medical staff is a key driver for breaching the NHSI ceiling to date. A deep dive session into medical ward nursing spend to analyse the financial performance of the wards and review progress against the recovery plan began in early September 2017.

Recruitment to key medical specialty vacancies and successful international campaigns means that the Trust forecast agency spend is now within the annual ceiling.

Cash

Chart 69

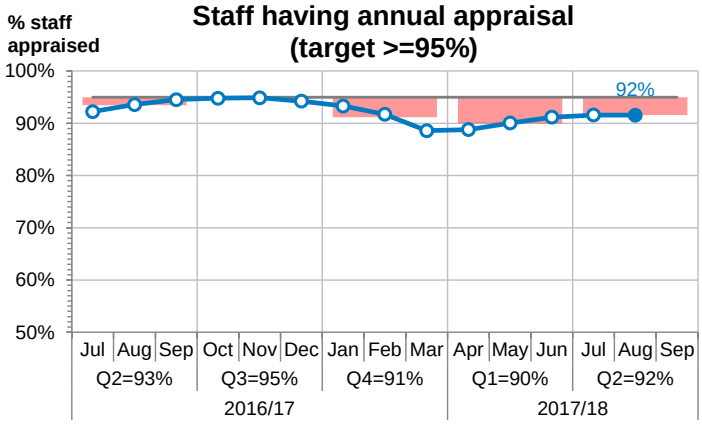


Cash in the bank on 31st August 2017 was £21.4m, which is £3.7m less than last month and £9.2m better than planned. Receipt of additional bonus, incentive and post-accounts STF relating to 2016/17 is £6.2m higher than included in the submitted plan for this year, so is a key driver for the higher than expected cash balance.

The cash position is carefully managed and the requirement for a working capital support facility loan will likely now fall into Q4. This is contingent on CIP plans being delivered and the business groups spending in line with or less than agreed budgets, as well as the Trust's ability to contain the potential winter pressures ahead.

Workforce Appraisals

Chart 70



The Trust's total appraisal compliance for August 2017 is 92%, there has been continuous improvement during Q1 and the following are in place to support full compliance:

- Hotspot reports to areas below the 90%
- Continuing to promote the benefits of Appraisal through the holding to account workshops
- Prioritising Appraisal inputting for accurate data reporting
- Preparing improvements plans with the red areas (below 90%) and monitoring through WEEF & PPC

Chart 71

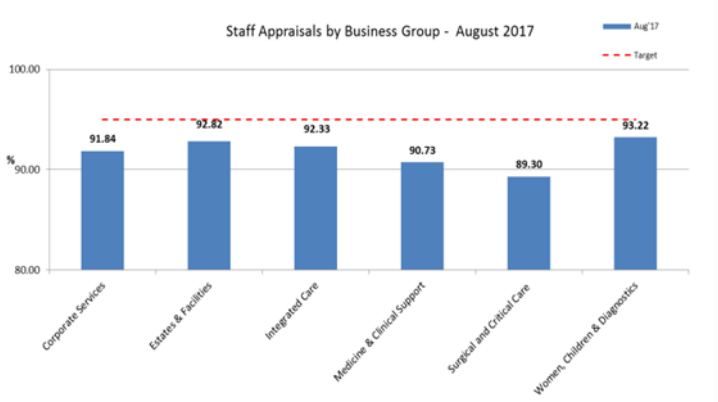


Chart 72

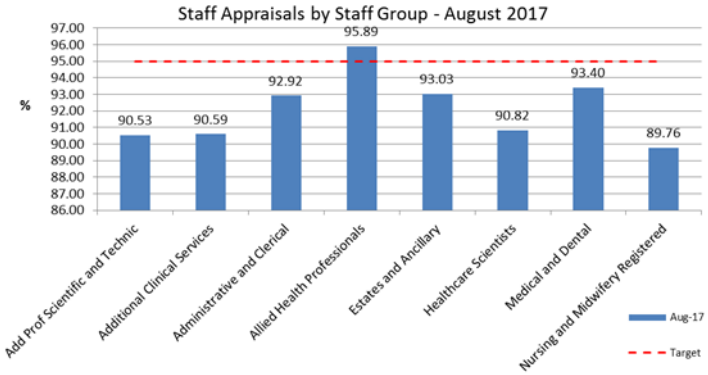
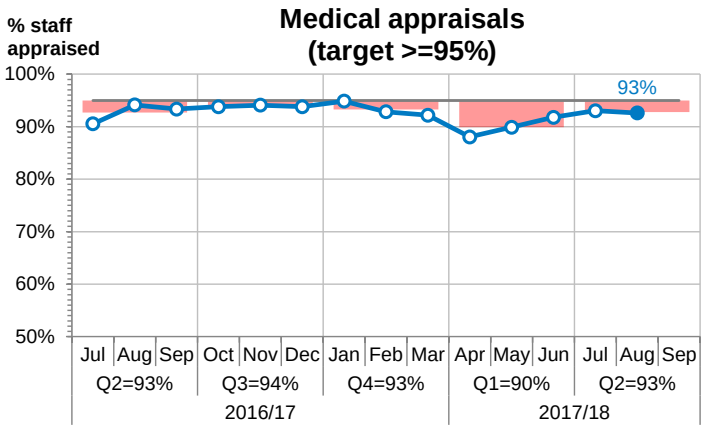


Chart 73



The medical appraisal rate for August 2017 is 93.40%, an increase of 0.79% from July 2017 (92.61%).

The new guidance and the new policy are now understood amongst the clinicians.

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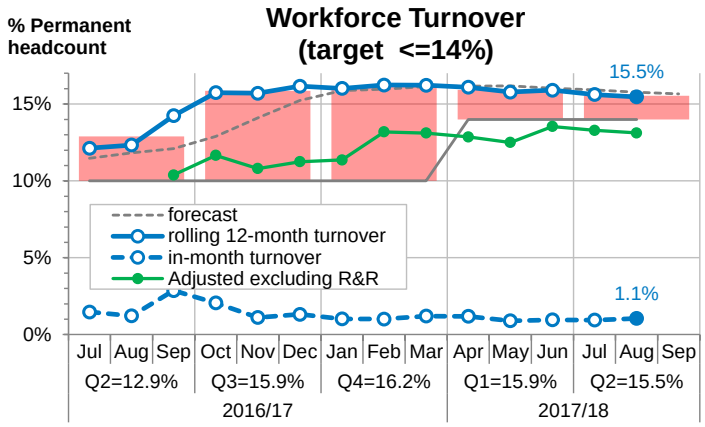
Workforce Turnover

Chart 74

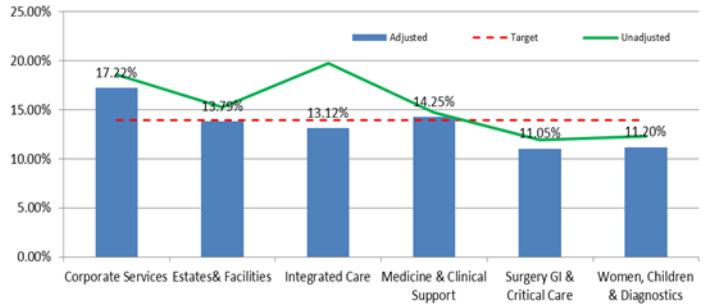


The Trust's turnover figure is reported and compared nationally as an unadjusted figure, meaning that the data includes retire and return employees and TUPE transfers out of the organisation. The Trust target of 13.94% is based on the national average turnover rate for medium size Foundation Trusts in 2016/17.

The rolling 12-month permanent headcount unadjusted turnover figure at the end of August 2017 is 15.47%. For comparison the turnover rate in August 2016 was 12.33%.

The adjusted rolling 12 month permanent headcount turnover figure at the end of August 2017 is 13.12%. This is a decrease of 0.17% compared to the July 2017 figure of 13.29%.

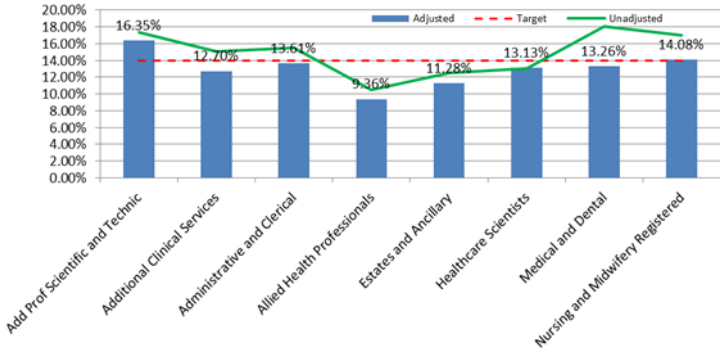
Chart 75



Of the adjusted permanent headcount leavers in July 2017 29% have moved to other NHS organisations of which 25% are within Greater Manchester. 17% of the adjusted leavers have retired.

The Registered Nursing & Midwifery turnover has seen a slight increase from the previous month, which takes them marginally above the Trust target.

Chart 76



Workforce Efficiency

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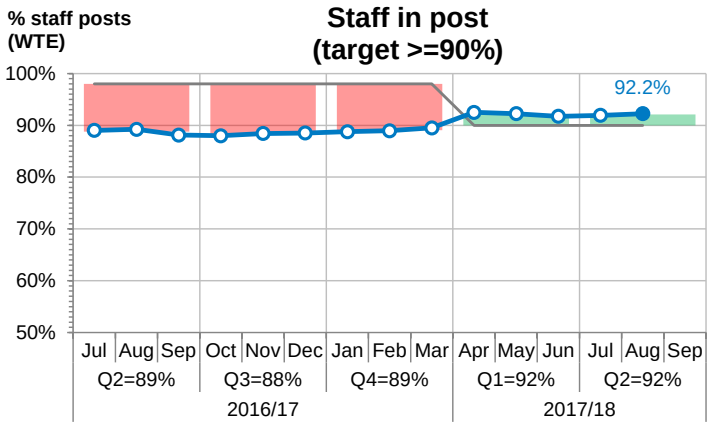
Chart 78



The Trust staff in post figure for August 2017 is 92.25% of the establishment, which is an increase of 0.31% from 91.94% in July 2017.

Only one area falls below the '90% Staff In Post target' - Estates & Facilities - with the highest percentage vacancy rate at 12.75% (49.74 FTE vacancies); There is active recruitment to 39 posts within E&F. The Medicine Business Group has the second highest percentage vacancy rate at 9.30% (112.54 FTE vacancies)

Registered Nursing and Midwifery have the highest number of vacancies at 195.10 FTE, equating to 12.29% of the establishment for that staff group. Additional Clinical Services and Add Prof Scientific and Technical staff are slightly over established at 100.84% and 102.70% respectively; attributed to the Medicine & Clinical Support Business Group which has actively over-established roles in order to counter act the shortages of registered nursing staff.

Chart 79

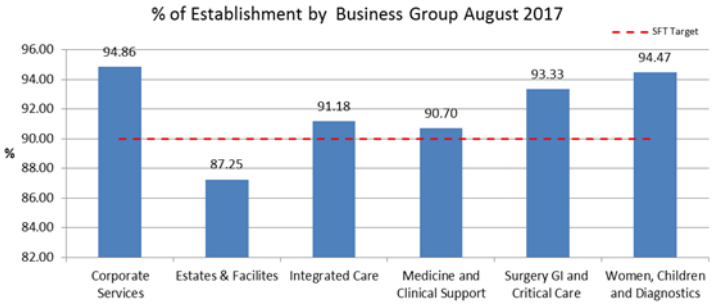


Chart 80

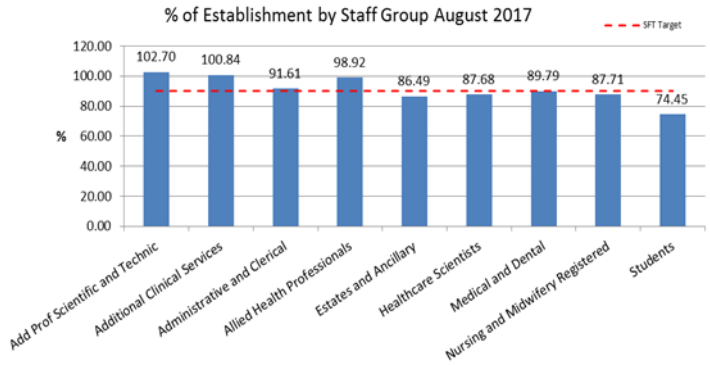
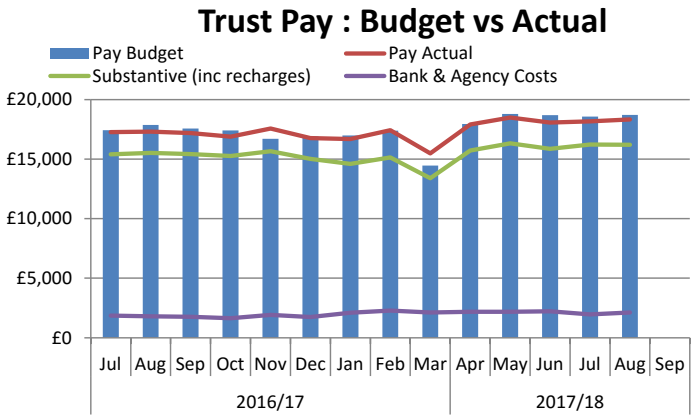


Chart 81

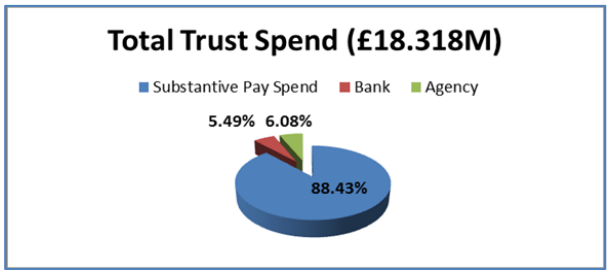


The total pay spend in August 2017 was £16.2M, excluding bank and agency spend (details overleaf). This is a marginal decrease of £12K compared to July 2017.

Total spend, including bank and agency, equates to £18.32M, which is £396K under the total pay budget for the month.

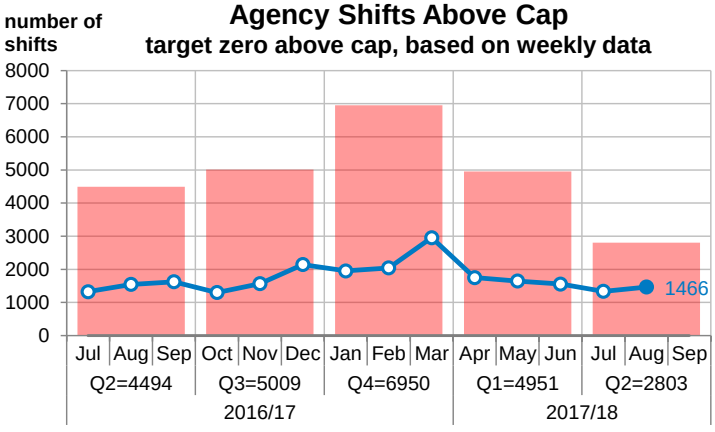
The total spends on bank staff in August 2017 was £1.01M, which is 5.49% of the total ay spend. Agency spend was 6.08% of total pay expenditure, a figure of £1.11M.

Chart 82



For the 5 week period from 31st July to 3rd September 2017, there were 1,446 shifts worked that were above the agency cap. This equates to an average of 293 per week; a decrease from the average of 334 shifts reported in the previous month.

Chart 83



This decrease in the average number of shifts is reflected across all business groups except Child & Family, which saw a slight increase of 1 shift per week (82 shifts in total for the period). Medicine saw the biggest decrease in shifts above cap, with an average of 29 shifts per week less than the previous period. This reduction was predominantly for medical staff. Medicine had a total of 991 shifts above cap (an average of 198 per week) during this period, with S&CC using 249 (average of 50 per week) shifts above cap.

Adverts for bank medical staff have attracted a number of applicants and recruitment is on-going for new doctors.

Chart 84

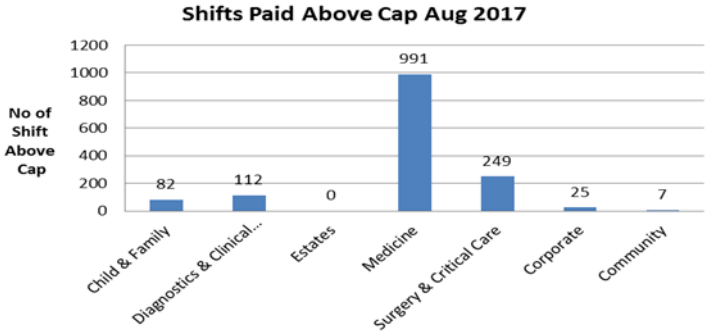
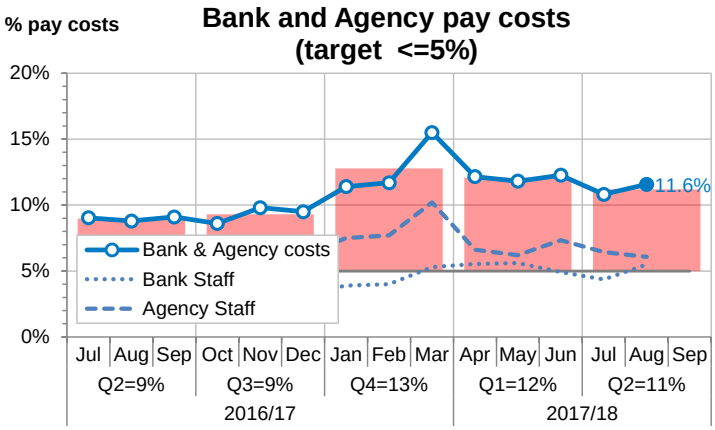


Chart 85



Bank and agency costs in month (August 2017) account for 11.57% (£2.12M) of the £18.32m total pay costs. This is an increase of 0.76% from the position reported in July (£1.96m).

The Medicine Business Group bank and agency spend has reduced from £1.2m in July 2017 to £773,000 in August 2017, but continues to have the highest spend on bank and agency equating to 36.46% of the Trust overall bank and agency spend and 4.22% of the Trust total paybill.

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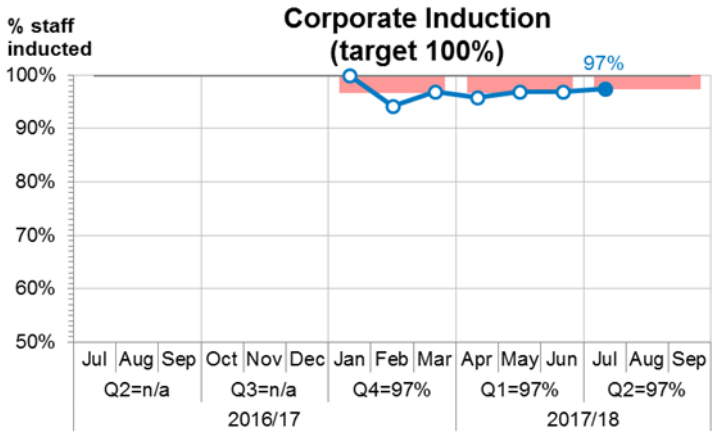
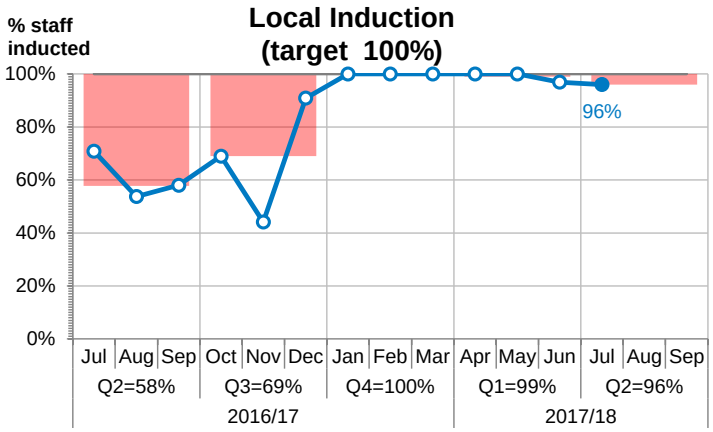
Workforce Induction

Chart 86



Corporate Welcome attendance is 100% in August 2017 which is attaining the Trust target. A 3% increased from July 2017.

Chart 87



Local Induction compliance is 100% in August 2017, achieving the target.

Local induction has been reviewed and a new checklist implemented to support safe practice.

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Staff Engagement

To be developed

Sickness Absence

Chart 87

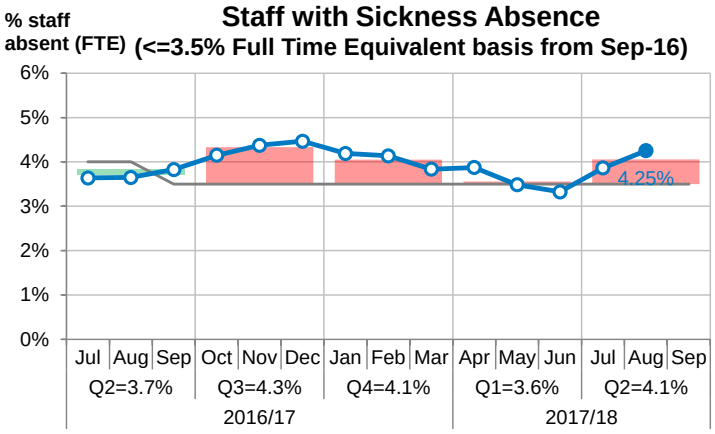


Chart 889

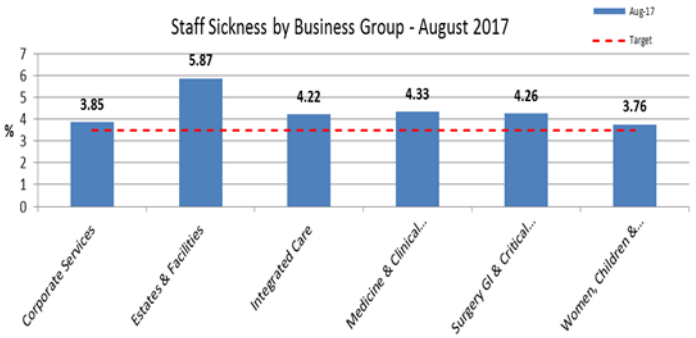
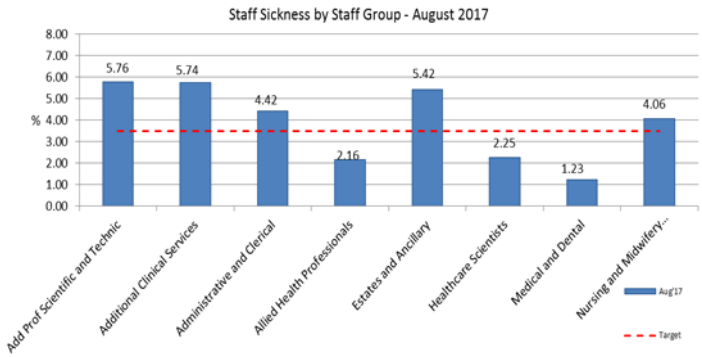


Chart 90



The in-month unadjusted sickness absence figure for August 2017 is 4.25%; an increase of 0.39% compared to the previous month. The sickness rate for comparison in August 2016 was 3.65%.

The unadjusted cost of sickness absence in August 2017 is £460,715, an increase of £27,553 from the adjusted figure of £433,162 in July 2017. This does not include the cost to cover the sickness absence.

The top three reasons for absence in August 2017 are: Back Problems and Other Musculoskeletal Problems including injury/fracture at 27.73% (a 1.04% decrease from July 2017), Stress related illnesses at 27.03% (a 1.39% increase from July 2017), and Cough, Cold, Influenza including Asthma and Chest Problems at 9.9.52% (a 0.33% decrease compared to July 2017).

All Business Groups are above the 3.5% target in August 2017. Estates & facilities BG have seen the highest increase of 1.5% from the previous month followed by Integrated Care BG with an increase of 0.46% from the previous month. The 12-month rolling sickness percentage for the period September 2016 to August 2017 is 3.96%.

The unadjusted short term sickness for September 2016 to August 2017 is 1.14%, which is comparable with the adjusted short term sickness figure reported last month. The long term sickness for September 2016 to August 2017 is 2.82% which is also comparable with the adjusted long term sickness figure reported last month.

The 'Add Prof Scientist and Technical' Staff Group has the highest sickness rate at 5.76% (2.26% above the 3.5% target) in August 2017. Of the 5.76%; 29.94% is in Corporate Business Group, 6.35% in Medicine & Clinical Support Business Group and 3.05% is in Surgery GI & Critical Care Business Group, and the two highest reasons given are stress at 2.61% and musculoskeletal problems at 1.34%.

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Essentials Training

Chart 89

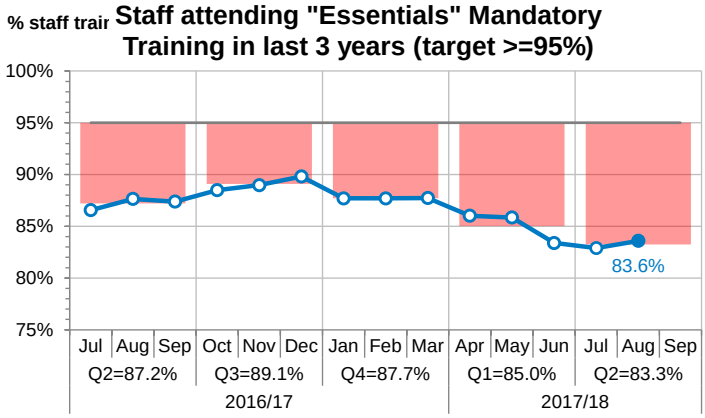


Chart 90

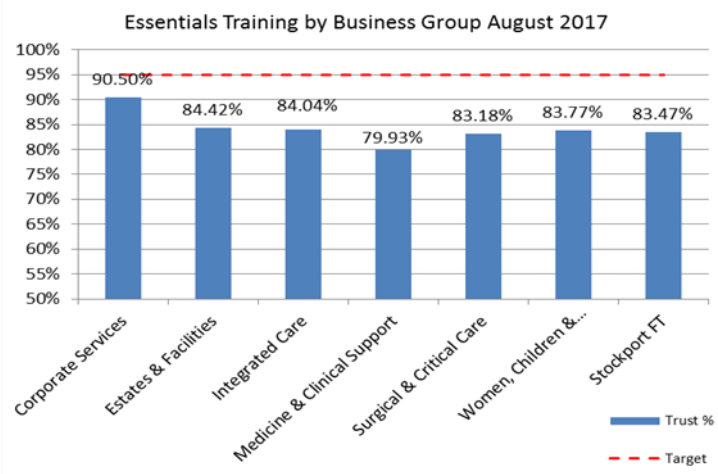
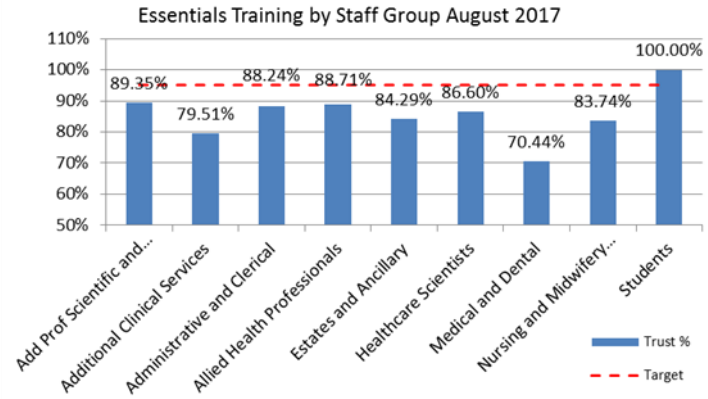


Chart 91



In August 2017, compliance is 83.6% against the 95% target; All Business Groups are below the target and have prepared improvement plans to address the issued with key subjects. The OD and Learning team are producing weekly reports to target areas that are consistently non-compliant.

The Mandatory Training review meeting took place on the 8th September with all disciplines to ensure that training topics are accurately reflected against staff profiles. The new training matrix will be launched in November alongside a training brochure inclusive of all Statutory, Mandatory and Essential to role training.

E-learning clinics are offered on a weekly basis at Pinewood House with telephone support 9-12 Monday to Friday.

The Head of OD and Learning attended the GM Streamlining meeting and agreed to pilot the new e-learning for health (e-lfh) Core skills packages. The Cultural Ambassadors will be reviewing the packages throughout the month of September.

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Integrated Performance Report
Financial Table

Stockport NHS Foundation Trust

Income and Expenditure Statement	Trust Annual Plan	Year to Date		
		Plan	Actual	Variance
	£k	£k	£k	£k
INCOME				
Elective	41,546	18,226	17,286	(940)
Non Elective	80,546	32,689	32,799	110
Outpatient	31,591	13,011	13,074	63
A&E	13,048	5,459	4,913	(546)
Community Services	27,995	13,604	13,572	(32)
Non-tariff income	54,406	22,305	22,712	407
Clinical Income from Patient Care Activities	**249,132**	**105,292**	**104,355**	**(937)**
Private Patients	55	23	92	69
Other Non-NHS Clinical Income	917	382	298	(84)
Other Clinical Income	**972**	**405**	**390**	**(15)**
Research & Development	569	232	200	(32)
Education and Training	6,950	2,972	3,023	51
Stockport Pharmaceuticals/RQC	5,461	2,300	2,188	(111)
Other income	14,584	6,627	7,093	466
Other Income	**27,564**	**12,130**	**12,504**	**374**
TOTAL INCOME	**277,667**	**117,827**	**117,249**	**(579)**
EXPENDITURE				
Pay Costs	(213,463)	(92,689)	(90,960)	1,729
Drugs	(16,414)	(7,602)	(7,923)	(321)
Clinical Supplies & services	(21,786)	(9,597)	(9,493)	104
Other Non Pay Costs	(38,078)	(16,932)	(17,177)	(245)
TOTAL COSTS	**(289,741)**	**(126,820)**	**(125,553)**	**1,267**
EBITDA	**(12,073)**	**(8,993)**	**(8,305)**	**688**
Depreciation	(9,982)	(3,789)	(3,575)	215
Interest Receivable	63	26	20	(6)
Interest Payable	(1,003)	(370)	(369)	0
Other Non-Operating Expenses	-	-	-	-
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed assets	-	-	(3)	(3)
Donations of cash for PPE	-	-	-	-
PDC Dividend	(4,375)	(1,822)	(1,822)	(0)
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(27,400)**	**(14,948)**	**(14,054)**	**894**

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28th September 2017
Subject:	Care Quality Commission Inspections		
Report of:	Interim Director of Nursing and Medical Director	**Prepared by:**	Interim Director of Nursing

REPORT FOR NOTING

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

Summary of Report

The purpose of this report is to provide the Trust Board with details of the Trust response to concerns raised during the CQC visit on 22nd /23rd June 2017. The final reports have not been received from the CQC although it is anticipated that their publication is imminent.

The Board is asked to note:

- The progress against the CQC action and assurance plan
- The context of more comprehensive and sustainable long term quality improvement
- The expectation that the CQC reports from the March and June 17 inspections will be published imminently.

Attachments:

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

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1. BACKGROUND

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. The outcome of their inspections is published on their website. The CQC ask 5 key questions and use these for the basis of their report:

Are they safe?	*Safe*: you are protected from abuse and avoidable harm.
Are they effective?	*Effective*: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
Are they caring?	*Caring*: staff involve and treat you with compassion, kindness, dignity and respect.
Are they responsive to people's needs?	*Responsive*: services are organised so that they meet your needs.
Are they well-led?	*Well-led*: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture

2. CQC INSPECTION

Board members will be aware of the correspondence received from the CQC following their unannounced inspection in June 2017. The letter received at the time identified a number of significant shortcomings and required the Trust to develop an action and assurance plan (AAP). At the request of the CQC, the plan was prepared and submitted four days after the letter of concern was received (June 30th).

Since submission of the AAP, the focus has been on implementation of the individual actions outlined in the plan. Each action has a completion date, and where the action cannot be delivered, or the completion date cannot be met, an exception report has been submitted to the CQC to describe the rationale behind a change in the plan, or in the anticipated date of completion. An evidence file has been developed to provide assurance that the actions have been completed.

Management of the AAP has been coordinated by three 'silver command' meetings per week, attended by senior managers and executives. These were run as 'sprint sessions' with a focus on the delivery of actions. The progress of these meetings has been under weekly review by a single CQC leadership group, chaired by the Chief Executive. The methodology is now being replicated to support the delivery of the urgent and emergency care plan and the implementation of 'SAFER'.

From the 18th September the 'silver command' meetings have been held separately by each business group, who will manage their own plan and actions. Each business group will offer weekly assurance to the single CQC leadership group. Delegating the management of this process to business group level is a conscious step towards embedding the processes outlined in the plan.

3. CURRENT SITUATION

Each of the actions within the plan (8.1, 6th September 2017) is colour coded according to delivery status:

Blue (complete)	121 actions
Green (on track but incomplete)	72 actions
Amber (off track but recoverable)	2 actions
Red (off track, not recoverable)	0 actions

4. FUTURE DEVELOPMENTS

The AAP was developed in a short period of time to address very specific concerns raised following the CQC inspection. While in the short term, resolution of these concerns is a critical step, these actions are transactional in nature, and resolve only very specific individual issues. On a different day, inspecting a different area of the trust, the inspectors could have identified a different set of concerns. It is the identification and resolution of these unrecognised issues that is of critical importance.

In this context, what is far more important that the AAP, is developing and embedding a transformative change. Driving a culture of high quality care, will require the setting of very clear standards, explicit understanding of who is accountable for these standards, and a process of oversight and assurance that supports them. Every member of staff must clearly understand their role in ensuring the consistent delivery of high quality care to all our patients.

4.1 Quality Plan

We are currently developing a trust quality plan. This plan will explicitly state our key quality standards, as well as outlining a process of oversight and assurance. This will include immediate and longer term actions, creating the right conditions upon which we can consistently improve upon our performance. The quality plan will include a dashboard of quality indicators, suitable for review in oversight meetings. The work to develop this will commence on the 25th September with a workshop for a cross section of staff facilitated by AQUA.

4.2 Consolidated Improvement Plan

The Trust currently manages a number of separate action plans in response to concerns raised by the CQC, separate concerns raised by the Health Education North West team and the flow of emergency cases through the hospital.

To avoid confusion, duplication or contradiction, these plans are currently being consolidated into a single ‘consolidated improvement plan’. This plan will be completed by the end of September.

4.3 Ward Accreditation Scheme

One of the key actions in the AAP was the establishment of ward oversight audits. In these audits senior clinical staff appraised the wards against the key concerns raised by the CQC.

Development of a ward accreditation scheme formalises this process of ward inspections,

broadening the remit to include all critical themes relevant to delivery of high quality ward care. This scheme will set explicit expectations, and establish a process for of assessing against these standards. The accreditation scheme is currently in its final draft form and will be launched in October. Further work will be undertaken to extend the accreditation scheme to other clinical areas of the trust.

4.4 **Business Group Performance Reviews**

Business group performance reviews have historically focused upon three main areas, finance, operational performance and staffing. From this month, the first hour of every bi-monthly business group performance meeting will focus upon the quality of patient care. This quality review will include appraisal against clear standards in areas such as mortality review, morbidity meetings, critical incident investigations, infection prevention measures, learning from critical incidents, ward accreditation, clinical audit oversight, falls and pressure sores. The format of these reviews and the standards against which business groups are appraised will be outlined in the quality report.

4.5 **Structure to Deliver Quality**

A report has been commissioned from the Trust's internal auditors (MIAA) to look at our committee and reporting structures. This will report in October 17 and give an insight into the actions we need to take to assure ourselves of the quality of services within the organisation.

It is anticipated that an appointment will be made to the post of Deputy Director of Nursing on Tuesday 26th September. This post has been vacant for several months. A new post of Deputy Director of Quality Governance is to be established. The post holder will report to the Director of Nursing and Quality.

Clinical staff are key to the delivery of high quality services. Leadership development programmes are being developed for senior medical, nursing and allied health professional staff.

5. RECOMMENDATIONS

The Board is asked to note:

- The progress against the CQC action and assurance plan
- The context of more comprehensive and sustainable long term quality improvement
- The expectation that the CQC reports from the March and June 17 inspections will be published imminently.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Safe Staffing report		
Report of:	Interim Director of Nursing and Midwifery	**Prepared by:**	Corporate Lead Nurse Workforce

REPORT FOR INFORMATION

Corporate objective ref:	-----	Summary of Report The report provides an overview, by exception, of actual versus planned staffing levels for the month of August 2017. The report highlights the percentage of temporary staff utilised. The report outlines recruitment and retention initiatives to address the shortfall of Registered Nursing (RN) staff. Key points of note are as follows; Average fill rates for Registered staff (including RN and Registered Midwives (RM) and care staff remains above 90% for both day and night duty. Although the average rates are above 90% 11 medical wards , 2 surgical wards and 3 areas in child and family report below 90% Registered staff in month . Medicine reports, including maternity leave and long term sick ,98 whole time equivalent (WTE) vacancies(22.21%) .Surgery and critical care report 55 WTE vacancies including LTS and Maternity (15.4%) . Temporary staff, both agency and NHS professionals have been utilised to support the clinical areas to support safe staffing levels. Recruitment initiatives are not providing sufficient recruits to address the underlying vacancy rates. The levels recruited are supporting the monthly turnover only. The Board of Directors is asked to note the contents of this report.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	Safe staffing	
Equality Impact Assessment:	☐ Completed ☐ Not required	

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

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1.0 INTRODUCTION

1.1 As part of the ongoing monitoring of staffing levels, this paper presents to the Board of Directors a staffing report of actual staff in place compared to staffing that was planned, for the month of August 2017.
Work-streams to support safe staffing continue, with a monthly Safe staffing group chaired by the Interim Director of Nursing and Midwifery.
The Board of Directors is asked to note the contents of this report.

2.0 BACKGROUND

2.1 NHS England is not currently RAG (Red, Amber and Green) rating fill rates. A review of local organisations shows that fill rates of 90% and over are adopted with exception reports provided for those areas falling under this level.

August 2017	DAY	NIGHT
RN/RM Average Fill Rate	91.2%	91.3%
Care Staff Average Fill Rate	104.2%	112.1%

3.0 CURRENT SITUATION

3.1 **Registered Nurse vacancies.**
Medicine reports 73 WTE established RN vacancies. When long term sick (LTS) and maternity leave are factored in this increased the WTE vacancy rate to 98 (22.21%) .
There are 24 offers in place. These have not been calculated in as we cannot guarantee these nurses will commence in post. They are factored in 4 weeks before the start date .

3.2 Surgery and critical care reports 33 WTE vacancies. With LTS and maternity leave this equates to 55 WTE (15.48%) 17 offers have been made and these are not factored in until 4 weeks before the date they are due to commence.
Within surgery and critical care theaters indicate that they have had successful recruitment initiatives to recruit anaesthetic and recovery staff. Scrub staff recruitment continues to be a challenge with continuous adverts and recruitment initiatives not attracting any applicants.

3.3 **Temporary Staffing**
Temporary staffing has been broken down into business groups to enable the board to have clarity as regards percentages utilized. In previous months there has been a focus on the Emergency Department temporary staffing. In month this is 19% RN and 20% unregistered care staff.

Business Group	**RN**	**CARE STAFF**
Medicine	18%	20%
Child & Family	3%	5%
Surgical & Critical	9%	12%
Community	2%	3%

3.4 **Community**.
Community reports continued difficulties recruiting to band 6 roles as there is a specific course that band 5s need to compete to enable them to achieve a band 6. The business

group continues to support training and development to address this. Community unregistered care support staff is required (circa 13 wte vacancies) . The business group is liaising with the Trust workforce lead nurse as regards a coordinated care staff recruitment event in September to support them to recruit the numbers of care support staff that are required**.**

Recruitment and retention

4.0

4:1 Local recruitment campaigns continue with monthly weekend recruitment open days for theatre practitioners and RNs. From October 2017 evening open events are also planned. Event bright, Facebook, Instagram and text campaigns are also ongoing.

4:2 A paper is to be presented to the Senior Management Team meeting September 2107 requesting consideration of an international campaign to prepare for winter 2018 . The request is for 65 WTE non EU ward nurses and 30 theatre practitioners . Also a request for 24 EU nurses who meet the English language test criteria and nursing and midwifery Council (NMC) registration requirement is also proposed.

4:3 The adaptation course (supporting nurses who are trained in India and the Philippines to pass their English language test) which commenced in January 2017 is to be evaluated and a paper presented to decide if we should continue with the 2018 courses. As this is not the recruitment pipeline that we would have hoped for, Cohorts 1 and 2 have not evaluated well with a 50% drop out rate due to challenges with the academic level of passing the English language course. It is anticipated 4 of 24 will pass. The academic applicant level for cohort 3 is higher, so we hope that we see more pass this cohort.

4:4 'Drop in' retention clinics are being arranged, which have been launched at other local hospitals and are evaluating well. These are for staff that are unsettled and may be considering moving to other Trusts. Access to these appointments will be via open days, drop in sessions with the Workforce Lead Nurse, and contact by email. These initiatives will be tracked and retention information included in forthcoming staffing reports. In one week 2 RN staff has been retrieved from leaving following face to face and email contact by reallocating them to other areas in the Trust. Communication of this initiative will be via twitter and poster campaigns with support from Comms .

4:5 Focus groups will be arranged with the learning and development and workforce teams and staff from all high turnover nursing areas will be invited to review potential recruitment and retention initiatives.

4:6 Acuity audits have been completed in August for the ward areas, with the exception of AMU which has had to be redone, due to an administrative error which has compromised the results. Data and recommendations will be included in the September report once reviewed by the Interim Director of Nursing and the Business Group Directors.

5.0 Care hours per patient day (CHPPD)

August 2107 report also includes information relating to care hours per patient day (CHPPD). This is the staffing metric advised by the Carter review which aims to allow comparison between organisations to a greater extent than previously, whilst noting that location specific services (specialty centres for example) will influence the final measure.

The CHPPD calculates the total amount of Nursing (RN and Care staff) available during a month, and divides this by the number of patients present on the in-patient areas at midnight. This gives an overall average for the daily care hours available per patient (all nursing and midwifery staff). During the Carter pilot stages, 25 trusts were included and

their results showed CHPPD range from 6.3 to 15.48 CHPPD and a median of 9.13. For August 2107, our report shows an average CHPPD of 7.7.

6.0 RISK & ASSURANCE

6.1 Safe staffing levels have been challenged by the levels of Registered Nurse vacancies at band 5. A reliance on temporary staffing has been required in the medical and surgery and critical care business groups to support wards and departments safe staffing. In medicine additional established care support staff have been employed (42 WTE which equates to plus 12 when LTS and maternity are factored in) to mitigate the risk and provide additional assurance.

7.0 CONCLUSION

7.1 Staffing levels have been maintained above an overall average of 90% with a number of areas reporting less than 90% staffing levels at RN , supported by temporary workers and non-registered care staff .

8.0 RECOMMENDATIONS

8.1 The Executive Team are asked to note the contents of this report

Appendix A– Unify entry

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Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RWJ - Stockport NHS Foundation Trust

Period: August_2017-18

Please provide the URL to the page on your trust website where your staffing information is available

www.stockport.nhs.uk/112/safe-staffing

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Head of Nursing Comment
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall	
Site code	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours									
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Neonatal Unit	420 - PAEDIATRICS		2325	1950	0	0	1627.5	1312.5	0	0	83.9%	n/a	80.6%	n/a	246	13.3	0.0	13.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Tree House	420 - PAEDIATRICS		2640	2610	405	405	1620	1554	0	0	98.9%	100.0%	95.9%	n/a	419	9.9	1.0	10.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Jasmine Ward	502 - GYNAECOLOGY		930	925	465	465	620	609	0	0	99.5%	100.0%	98.2%	n/a	184	8.3	2.5	10.9	Staffing levels stable
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Birth Centre	560- MIDWIFE LED CARE	501 - OBSTETRICS	1860	1702.5	465	465	1240	1180	310	310	91.5%	100.0%	95.2%	100.0%	63	45.8	12.3	58.1	Staffing levels caused by sickness.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Delivery Suite	501 - OBSTETRICS		2790	2595	465	442.5	1860	1630	310	280	93.0%	95.2%	87.6%	90.3%	250	16.9	2.9	19.8	Staffing deficit in all maternity areas caused by RM vacancies and short term sickness.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Maternity 2	501 - OBSTETRICS	560- MIDWIFE LED CARE	1627.5	1395	930	930	620	620	310	310	85.7%	100.0%	100.0%	100.0%	458	4.4	2.7	7.1	Staffing deficit caused by sickness and vacancies.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4650	4614	775	739	4092	4070	0	0	99.2%	95.4%	99.5%	n/a	326	26.6	2.3	28.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Surgical Unit	100 - GENERAL SURGERY	101 - UROLOGY	2126.5	1919.5	810	767	891	815	682	702	90.3%	94.7%	91.5%	102.9%	587	4.7	2.5	7.2	Additonal Care Staff have been used to support the ward. Vacancies have been recruited to however still awaiting start days
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	100 - GENERAL SURGERY	1395	1311	1395	1371	682	682	682	702	94.0%	98.3%	100.0%	102.9%	709	2.8	2.9	5.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1627.5	1342.5	1395	1468.5	682	682	682	1001	82.5%	105.3%	100.0%	146.8%	661	3.1	3.7	6.8	Additonal Care Staff have been used at night to support dependency and acuity on the ward. Vacancies have been recruited to however still awaiting start days
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1395	1284	1162.5	1162.5	682	682	682	726	92.0%	100.0%	100.0%	106.5%	467	4.2	4.0	8.3	Additonal care staff have been required to support a patient requiring 1:1 supervision overnight at the beginning of the month
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS		934.5	970.5	1009.5	1123.5	682	682	495	550	103.9%	111.3%	100.0%	111.1%	400	4.1	4.2	8.3	1 RN working in a supernumery capacity has contributed to this. Action plan in place; this is completely appropriate. Additonal CSW shifts have been used at night to support dependency and acuity on occasions
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D6	100 - GENERAL SURGERY		1395	1329	1162.5	1168.5	682	682	682	671	95.3%	100.5%	100.0%	98.4%	674	3.0	2.7	5.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		1567.5	1282.5	1674	1683	682	583	1023	1254	81.8%	100.5%	85.5%	122.6%	590	3.2	5.0	8.1	There are a significant number of Registered Nurse vacancies some have been recruited to and are awating pre-employment checks. Care Staff numbers have been increased to ensure safe numbers of staff are present on the ward. Matrons are ensuring presence on the ward daily and staff are reallocated to support the area as required. 4 beds have been temporarilly closed to support the shortfall and maintain safety
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SAU	100 - GENERAL SURGERY	101 - UROLOGY	1627.5	1609.5	1116	1074	868	868	682	682	98.9%	96.2%	100.0%	100.0%	347	7.1	5.1	12.2	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A1	300 - GENERAL MEDICINE		1395	1215	1209	1149	1023	759	682	649	87.1%	95.0%	74.2%	95.2%	757	2.6	2.4	5.0	Suboptimal Registered Nurse staffing. Ward is closely monitored by Matron. Recruitment remains ongoing.Never less that 2 Registered Nurses on duty .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A3	320 - CARDIOLOGY		1423	1394.5	976.5	914.25	1023	847	682	682	98.0%	93.6%	82.8%	100.0%	763	2.9	2.1	5.0	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		1581	1363.5	1627.5	1537.5	682	682	682	649	86.2%	94.5%	100.0%	95.2%	963	2.1	2.3	4.4	Sub optimal Registered Nurses day duty, Rehabilitation ward, never less that 2 Registered Nurses on duty. Ward closely monitored by Matron Recruitment ongoing.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		744	651	372	364	682	669.5	372	644.5	87.5%	97.8%	98.2%	173.3%	815	1.6	1.2	2.9	Additional Care Staff recruted to support acuity. Registered Nurse levels days suboptimal but always 2 Registered Nursing staff on duty . Matron assurance for safe care, additional cae support workers on night to support ward area and dependency .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU	300 - GENERAL MEDICINE		4092	3875.5	3348	3364.5	3720	3357	3069	3388	94.7%	100.5%	90.2%	110.4%	1437	5.0	4.7	9.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE		1674	1308	837	1077	1364	800	682	847	78.1%	128.7%	58.7%	124.2%	448	4.7	4.3	9.0	Ward currently has significant RN vacancy however bleepholders support ward . Never less than 2 RN per shift increased numbers of CSW to support ward area and care delivery
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	300 - GENERAL MEDICINE		1209	751.5	604.5	936	682	671	682	682	62.2%	154.8%	98.4%	100.0%	473	3.0	3.4	6.4	Recognised to have significant RN vacancy - Posts recruited to awaiting start date and completion of OSCE. Over establishment of HCA to support direct care delivery. Ward never left with less than 2 RN
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		837	822	837	889.75	682	627	682	671	98.2%	106.3%	91.9%	98.4%	415	3.5	3.8	7.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	300 - GENERAL MEDICINE		1209	1014	1069.5	1389	682	682	682	979	83.9%	129.9%	100.0%	143.5%	653	2.6	3.6	6.2	
RWJ09	THE MEADOWS - RWJ88	Bluebell Ward	318- INTERMEDIATE CARE		1209	1209	2077	2009.5	682	682	682	682	100.0%	96.8%	100.0%	100.0%	754	2.5	3.6	6.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	430 - GERIATRIC MEDICINE		1276.5	1029	744	687	682	682	682	649	80.6%	92.3%	100.0%	95.2%	500	3.4	2.7	6.1	RN vacancies being recruited to, over establishment at CSW level to support care delivery. Never less than 2 RN per shift.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	300 - GENERAL MEDICINE		1209	939	604.5	1012.5	682	682	682	814	77.7%	167.5%	100.0%	119.4%	470	3.4	3.9	7.3	The ward currently has significant RN vacancies. Ward closely monitored by Matron. Never less than 2 Registered Nurses on duty, recruitment is ongoing. Over established at Hca to support ward staffing numbers.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Coronary Care Unit	320 - CARDIOLOGY		837	837	465	428.5	682	682	341	396	100.0%	92.2%	100.0%	116.1%	163	9.3	5.1	14.4	
RWJ03	STEPPING HILL HOSPITAL - RWJ09	Clinical Decisions Unit	300 - GENERAL MEDICINE		372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	79	9.0	9.0	18.1	
RWJ09	CHERRY TREE HOSPITAL - RWJ03	Devonshire Centre for Neuro-Rehabilitation	314 - REHABILITATION		1069.5	1051.5	1999.5	1909.5	682	670	682	676	98.3%	95.5%	98.2%	99.1%	542	3.2	4.8	7.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		1951.5	1621	2309.5	2122	1023	792	1364	1386	83.1%	91.9%	77.4%	101.6%	976	2.5	3.6	6.1	Sub optimal Registered Nurse staffing , never less that 3 Registered Staff on Day shift to support 31 bed ward. Active recruitment ongoing. Additional HCA recruited to support care delivery - awaiting start dates
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2278.5	2251.5	1581	1972.5	1023	1012	1023	1364	98.8%	124.8%	98.9%	133.3%	970				
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2278.5	2241	1581	1974.5	1023	990	1023	1606	98.4%	124.9%	96.8%	157.0%	1013	3.2	3.5	6.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Olders People's Unit	430 - GERIATRIC MEDICINE		1162.5	915	790.5	775.5	682	671	682	671	78.7%	98.1%	98.4%	98.4%	657	2.4	2.2	4.6	Significant RN vacancies. Over establishment at CSW level to support care delivery. Some RN vacancies recruited awaiting dates. Never less than 2 RN per shift.
		Total			56699	51701	36634.5	38149	35572.5	32950	22257	24964.5	91.2%	104.1%	92.6%	112.2%	19229	4.4	3.3	7.7	

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Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Strategic Risk Register		
Report of:	Director of Nursing & Midwifery	**Prepared by:**	Risk & PCS Team Manager

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report** The strategic risk register reports on distribution of risk across the Trust and presents in greater detail those risks which have an impact upon the stated aims of the Trust. The information for this report was collated 31st August 2017 The headlines for this report are: • Currently there is one unacceptable risk scoring 25: • Risk 1881 - Failure to deliver 4 hour Performance Target within ED • There are no new strategic risks added this month and four strategic risks have been closed or mitigated to a lower risk rating: • Risk 2640 – Inadequate resourcing of Pharmacy Services • Risk 3126 – Medicines for use of patients is stored safely and all medicines administration processes are adhered to • Risks 2806 – Non-compliance with the Trust Alert & Hazards SOP. • Risk 3129 – Failure to adhere to requirements of DNA CPR legislation The Board of Directors is asked to note the contents of the risk register
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment: Not required	

Attachments:	Strategic Risk Register

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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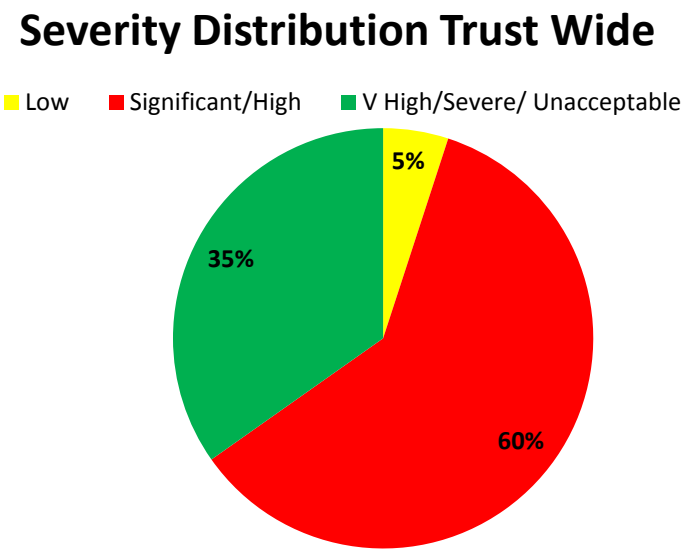
Trust Wide Risk & Severity Distribution

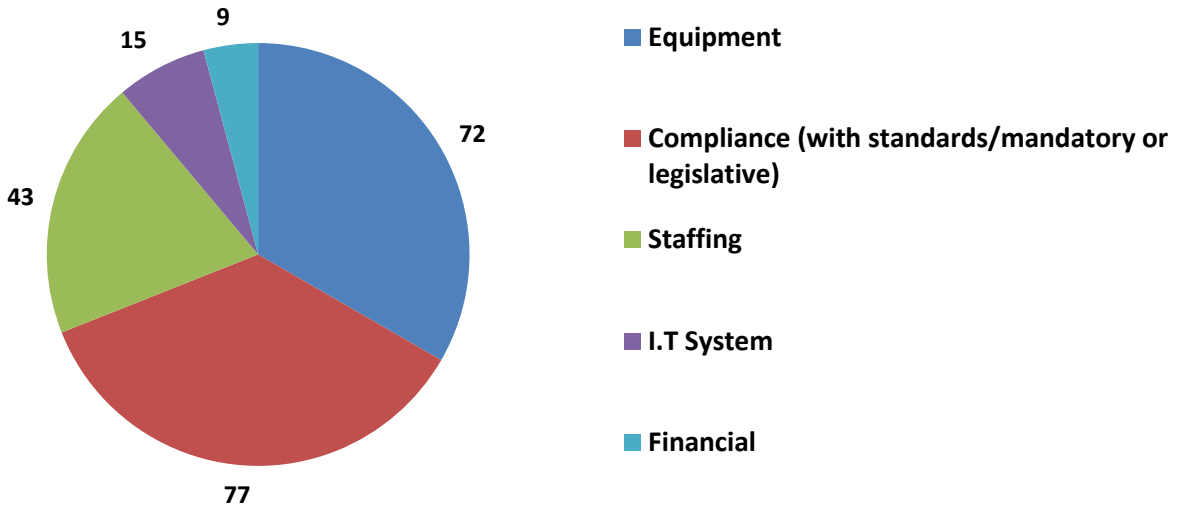
1.1 There are currently 299 live risks recorded on the Trust Risk Register system compared to 280 last month and of these 61 are Strategic Risks.

1.2 Trust wide distribution of all Risks is shown below:

	Low				Significant			High			Very High		Severe	Unacceptable
Score	1	2	3	4	5	6	8	9	10	12	15	16	20	25
August 2017	0	3	2	10	1	26	32	40	1	80	20	53	30	1



1.3 Top Five Sources of Risk across the Trust:



2.1
Currently there are 15 strategic risks on the register with a rating of 15 or over.

Strategic risk distribution across business groups *(These are all the risks 15 and above where the impact is on the strategy of the Trust not just within the service delivered by the business group)*

Business Group	Low	Significant/High	Very High/Severe/Unacceptable
Medicine	0	0	0
Surgery & Critical Care	0	0	0
Diagnostic Clinical Support	0	0	2
Corporate Risk (Inc. Finance, HR, Trust Exec Team, Corporate Nursing)	0	0	13
Child & Family	0	0	0
Community Healthcare	0	0	0
Estates & Facilities	0	0	0

3.1 Closed Risks & Mitigated Risks
In this month, there have been four strategic risks closed or mitigated to a lower risk rating:

- Risk **2640** – Inadequate resourcing of Pharmacy Services
- Risk **3126** – Medicines for use of patients is stored safely and all medicines administration processes are adhered to
- Risks **2806** – Non-compliance with the Trust Alert & Hazards SOP.
- Risk **3129** – Failure to adhere to requirements of DNA CPR legislation

3.2 New Strategic Risks

There are no new strategic risks added this month.

3.3 Changes in Risk Rating

All strategic risks must be reviewed monthly.
Risk **2879** – Use of Temporary Staffing has been reviewed and the rating reduced from 20 to 16.
Risk **3104** - Non Delivery of the 2017/2018 CIP has been reviewed and rating reduced from 20 to 15.

Key for Committees:
QAC – Quality Assurance Committee
WOD – Workforce & Organisational Development Committee
FS&I – Finance, Strategy & Investment Committee

Strategic Risk Register

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	1881	Compliance	**23-Jun-2011**	Sue Toal	QAC	ST	**Failure to deliver 4 hour Performance Target within ED** *Failure to achieve this target would represent a significant corporate risk to the Foundation Trust both financially and reputation.*	Existing internal escalation processes Daily monitoring of staffing rotas in ED and on-call The trust Unscheduled Care Plan- monthly meetings Whole health economy collaboration to deliver this target	20	5	5	25	DTOCs - Ownership of longer term issues DTOCs - Clarity of Roles and Responsibilities Clarity of Roles and Responsibilities Junior Doctors Batching of jobs e.g. TTO's RAT Model - 1hr from arrival to consultant (95th Centile) Triage Plus Model - 15 min to Triage (95th Centile)	**10**	Achieving 95% in the 4 hour Performance Target within ED	Jan 2016 20 ↓ Dec 2016 20 ↓ Feb 2017 25

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Human Resources	2879	Finance	**7-Jan-2016**	Emma Cain	WOD	JSh	**Use of Temporary Staffing** *Risk to patient care through ongoing or increasing use of temporary staffing*	Weekly ECP meetings/Nursing Staffing Meeting/Weekly Agency Usage Review Meetings/ Weekly Temporary Staffing Tracker meetings/ Agency Programme Board/ Reporting to BoD/F&P & PPC. Agency Programme Board in place. Completion of the agency diagnostic tool and development of associated action plan. Review of current expenditure in order to ascertain the current position against the monitor cap rates and the impact of the future sliding scale. Action taken to address those who are outside the agency cap levels to bring the cost within the available cap parameters, whilst continuing to review the rationale for the use of the temporary staff to identify actions to reduce overall need for continued use. Implementation of weekly tracker meetings, development of a centralised Temporary Staffing Team. Daily SITREP meeting. Medicine Business Group to address staffing and agree appropriate arrangements for medical cover.	20	5	4	16	For nursing shifts, the Trust continues to attend the partnership meetings arranged by NHSP at which GM Trusts take a collaborative approach in agreeing agency usage and agreed rates. Reduce medical agency usage by inviting agency workers to join our internal bank Currently in discussions with Sth Mcr regarding a collaborative bank scheme for medical locums	**12**	Reduction in cost and use of Temporary Staffing	Jan 2016 20 Aug 2016 16 Oct 2016 16 April 2017 25 June 2017 20 Aug 2017 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Finance	3104	Financial	**02-May-2017**	Kay Wiss	FS&I	FP	**Non Delivery of the 2017/18 CIP**	In order to improve decision making and financial control within the Trust, the Trust agreed a new framework for delivery of its Transformation and CIP through the FIP in May 2016. Due to the change in Executive responsibilities, an independent review of the CIP governance and process was commissioning and for the new financial year the Trust has agreed to some amendments and further steps to ensure control and accountability, these included: "Weekly key issues report to the Executive Management Team on the development of ideas and opportunities into CIP projects at pace to deliver the overall target; "The merging of Financial Improvement Group (FIG) A and FIG B, which will now be chaired by the CEO, to ensure Accountable Officers (Executive Directors) and Senior Responsible Officers (Business Group Directors) are held to account for their delivery/change programmes. This new approach will support communications across the Trust to assist in understanding the inter-dependencies between projects and how we can mitigate the impacts and deliver change together; "Ensuring the Transformation Resource is utilised by the Business Groups to help develop major change programmes to enable sustainable clinical change but still ensuring the ownership of the target remains with the SROs; "The Performance Management Framework implemented in April 2017 is used to ensure under performance is escalated and managed. The framework will aim to set expectations in terms of translating divisional plans and objectives into agreed targets and aligning with finance, workforce and operational risks of delivery. "Revised programme and project documentation, which can capture 'cause' and 'effect', including financial and non-financial benefits.	20	5	4	15	Present to Finance and Performance Committee in June The Trust is completing a Financial Recovery Plan at the request of NHSI Identify further actions from Financial Recovery Plan	**15**	CIP delivery	May 2017 20 Aug 2017 15

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Finance	3124	Financial	**5-Jul-2017**	Kay Wiss	FS&I	FP	**Failure to have sufficient cash reserves to operate**	Daily cash reconciliation Cash flow forecast on a 13 week basis with a 15 month look ahead Cash Action Group meets on a monthly basis Cash reporting to Finance and Performance Committee Cash reporting to Board of Directors as part of IPR Liquidity days reported to NHSI as part of the Trust's Use of Resources finance score Updated Finance and Performance Committee on the process to draw down a revolving working capital facility.	20	5	4	20	Re-write Treasury Management Policy to include the revolving working capital facility. To be approved at F&P on 19th July To assess the impact of the RWCF being charged at 6% interest instead of 3.5%. Stress testing of the 13 week cash flow by the Cash Action Group on a monthly basis As part of Finance and Performance meetings highlight the Trust cash position and the inter-dependencies on a monthly basis	**5**	Availability of sufficient cash	New Risk
Trust Executive Team	2889	Compliance	**13-Jan-2016**	Collin Wasson	QAC	CW	**7 day working** *The Keogh Review has recommended 10 standards to support the NHS in improving clinical outcomes and patient experience at weekends.* *4 of these standards have been prioritised and there is a risk that at present the trust cannot achieve them in the given timeframes:*	Some achievement to target as above. The Trust has made progress in certain areas including : Extending palliative care team support for community and hospital over Saturday and Sunday, 8am to 430pm Rota changes of consultants in Medicine Business Group to provide Consultant Physical presence on AMU from 8am to 5pm on Saturday and Sunday; to provide Consultant delivered ward rounds on B2/E1 (stroke unit) on Saturday and Sunday; to provide in reach Consultant Cardiology input to AMU and CCU on Saturday and Sunday Radiology staff on site 24/7 to provide plain film x rays, mobile x rays, theatre imaging and CT scans. There is now continuous CT provision on site providing swifter patient access to CT scanning for trauma and stroke patients out of hours. Aqua reviews into mortality have compared favourably the mortality figures for weekdays and weekends both internally and in comparisons across England	20	4	5	20	Expansion of medical "cold " Consutlant resource Development of GI bleeder rota Development of radiological intervention service Increase general surgical presence with Healthier together	**12**	Achievement of standards in 7/7 working	Jan 2016 20 Jan 2017 20

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Diagnostic & Clinical Support	2130	Clinical procedures	**22-Aug-2012**	Sara Wilson	QAC	ST	**Insufficient capacity in Endoscopy to meet the current demand resulting in a breach in targets**	A business case written in 2014 demonstrated the need for an expanded and updated unit. An options paper was submitted to Exec team in July 16 requesting decision on next steps. The department has referral criteria to support effective and appropriate decision making on whether care is required on an inpatient or outpatient basis. The nurse inpatient coordinator triages and works with referring medical colleagues with the aim of ensuring the correct care is delivered on an IP basis. Referrals are triaged by nurse endoscopists to validate full information receipt and suitability to progress request. Nurse endoscopists and nursing team are working flexibly to cover maximum number of unused lists as possible, including WLIs where required to increase capacity Weekly demand and capacity review meetings match nurse availability with list coverage. Weekend lists are currently not being undertaken due to limited nursing team capacity. Mediscan are commissioned to deliver 10 additional weekend lists a month. When a patient cancellation occurs, the admin team and inpatient coordinator work together to try ensure this capacity is used by an in/outpatient. Targets are closely monitored through regular validation process, with concerns escalated to senior team Endoscopy cancellation procedure has been developed Nursing and nurse endoscopist teams are now being managed and supported in accordance with the attendance management policy.	20	4	4	16	Commencement of a weekly Endoscopy utilisation meeting with involvement from Gastro and Surgery business groups using 6 4 2 methodology. Improve sessional productivity, adding 1 unit to selected endoscopists list in discussion with Endoscopy Lead Clinician Urgent review of acute GI bleed patient pathway and gastro bleed slot rotas. Compile daily start and finish audit of endoscopy lists, to be reported back monthly at endoscopy steering group Undertake endoscopy nurse workforce review to optimise service delivery, to include nurse led consent and nurse led pre assessment. Continue to support estates/procurement in establishing plans for unit expansion.	**12**	Endoscopy target to be achieved	Jan 2016 16 March 2016 20 June 2016 20 Sept 2016 20 Nov 2016 16 Jan 2017 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	2644	Compliance	**4-Nov-2014**	Colin Wasson	QAC	CW	**Upper GI Bleed Service Provision (Non Compliance with NCEPOD Gastrointestinal Haemorrhage (Time to Get Control) published in 2015 and NICE Guidance 141)** *NICE Clinical Guidance 141 has Quality standards at present the Trust is fully compliant with 2 standards, partially compliant with 3 standards and non-compliant with 4 (claim of breach of duty).*	Trust has protocol for Upper GI Bleeding and for Transfusion in Massive haem., Introduction of Blatchford score for risk assessment (NICE 141 priority) Access to Medical Senior Decision Maker for ED (9am-7pm Ac Phy, 7pm-9am Gen Phy) Appointment of Band 6 flow champion (improves utilisation of endoscopy lists) Updated Gastro consultant job plans : Gastro consultant in endoscopy every session of the week bar one (access to experienced endoscopists) Access to Theatres for Unstable patients Endoscopy within 24 hrs can be offered to patients with the exception of those being admitted on Saturdays and on Sundays preceding bank holidays (NICE Standard 3) In hours the appropriate endoscopic treatment for non variceal bleeding can be offered (NICE Standard 4) Aspirin and antibiotic therapy advice is a given as per guidance (NICE Standards 6 and 10)	20	4	4	16	Implement daily consultant endoscopy sessions 7/7 Expand gastroenterology team Development of bleeding rota	**8**	Full compliance with the NICE/NCEPOD guidance	Nov 2015 20 Jan 2016 16 Nov 2016 16 Jan 2017 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	3031	Tissue Viability	**8-Nov-2016**	Joanne Convey	QAC	JM	**Reducing the Incidence of Avoidable Pressure Ulcers**	Integrated Tissue Viability Service advises/disseminates evidence based guidelines Trust wide on pressure ulcer prevention and management strategies to support staff in clinical practice. - Equipment contract to supply pressure relieving mattresses, cushions and bedframes (Hillrom/Nightingale contract in acute and Ross Care contract in the community) -Static mattress audit within acute hospital. - Monthly nursing indicator audits which includes pressure area care, - Monthly data collection for safety thermometer survey across hospital and community sites. - Safety cross completed on all wards for grade 2 and above hospital acquired pressure sores (incidence) which is reported externally each month via open and honest reporting. - All organisationally acquired category 2 and above ulcers are reported locally as a clinical incident. - All organisational acquired pressure ulcers have a pressure ulcer ProForma completed to identify any lapses in care. - RCA and investigation of all avoidable organisational pressure ulcers meeting the criteria of an SI -TV link nurses with signed R&R on all wards/community teams - Quarterly Risk reports indicating prevalence and numbers of pressure ulcers developing in hospitaland on community caseloads. Feedback to contracts monitoring, Community/hospital nursing managers and to the Board. - Pressure Ulcer prevention and management training is mandatory for all clinical staff including, nursing, medical and AHP staff. - Training database maintained of all staff who have attended PU prevention and equipment training who are employed by SFT	16	4	4	16	Work streams within key aress to be established (1) Critical Care and Surgery (2) Theatres (3) Community (4) Urgent Care (5) Women and Children's (6) Medicine including elderly care and rehab Standardised wound care formulary and promotion of direct purchasing to minimise dressing spend and standardisation of wound care practice React to Red to be disseminated to care homes All organisational avoidable pressure ulcers to be raised as a safeguarding concern Introduce pressure ulcer reporting process that enables determination of avoidable/unavoidable within 48 hours for (1) Acute Quarterly trends/changes in practice report to commissioners. Care homes to commence PU proforma completion DATIX/TV referrals to include photograph of pressure ulcer, DATIX software to be updated and community media systems improved to facilitate this action	**12**	Reduction in pressure ulcers incidents	Aug 2016 16 ↓ Jan 2017 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Diagnostics & Clinical Support	1555	Compliance	**28-April-2010**	Caroline Culverwell	QAC	ST	**Failure to meet the 62 day Cancer target standards**	Monthly Cancer Board chaired by Trust Lead Cancer Clinician There is an established team of experienced Cancer Trackers and Cancer MDT Coordinators who are tracking all cancer patients to ensure they are treated within 31 and 62 days. Cancer Services Manager monitors performance on a daily basis using the 'Predictor tool' Cancer Access Manager undertakes weekly Tumour specific PTL meetings with Business Manager and Cancer Pathway Tracker. Weekly Trust-wide PTL chaired by the Director of Operations An escalation policy is in place to alert business groups of any issues causing delay to patient pathways	12	4	4	16	Cancer Services Manager to spend more time reviewing PTLs/Predictor as no Cancer Access Manager currently in place. Implementation of pathway improvement plans to support improvement of 62 day performance Replace Cancer Access Manager or provide other support to enable Cancer Services Manager to devote time to service Improvements 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) Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	**8**	Compliance with National Standards	Jan 2016 12 Oct 2016 16 Feb 2017 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
HR	3145	Compliance	**13-Jul-2017**	Judy Haykin	WOD	JS	**MCA and DOLs missing profiles from staff competencies**	This profile is on 3194 of staff profiles The current competency report demonstrates 87.03% compliance	16	4	4	16	Spot check other competencies to establish if there is a risk in other areas also Request via SR that IBM globally apply MCA and Dols Competency requirement to all clinical staff Data cleanse the mandatory compliance report to ensure all staff is included from the clinical areas.	**12**	Achieve MCA and DOLs requirement	New

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	3125	Compliance	**6-Jul-2017**	Colin Wasson	QAC	CW	**Patients Living with Diabetes must be cared for safely and appropriately**	E Learning for all clinical staff Key trainers on all wards Clear guidance available on the microsite related to hypo and hyper management Previous launch of the "think glucose" campaign	20	5	3	15	Diabetes team to develop a breifing for all staff regarding lessons learnt in Diabetes Poster to be displayed in rlevent areas regarding the safe management of diabetespatients and diabetes emergencies Diabetes nurses to undertake a full competency assessment of staff on A11 Medical consultants to be complaint with e learning re Diabetes 95% compliance with e learning requirement re diabetes Diabetes nurses to deliver systemetic training to all nurse in medical wards Commission CHKS to undertake a review of mortiality data for past three years with a specific focus on diabetes Trust to commission external review of diabetes management Medical Director to disucss diabetes management in trsut induction meeting with new doctors Case note review of all patient deaths wher diabetes codeds as primary condition Diabetes managmeent to be subject of grand round	**5**	Better outcome for Diabetes patient	New Risk

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	3130	Compliance	**6-Jul-2017**	Cath Marsland	QAC	CW	**Failure to comply with CQC requirements as per the CQC action plan**	Project management team managing process and action plan with Head of Risk and Customer Services	20	5	3	15	Formal development of and writing of TOR for a Corporate Governance Task and Finish Group Formal development of and writing of TOR for a Learning and Organisational Development Task and Finish Group Formal TOR for Nursing Task and Finish Group Formal commencement of Silver Command TOR Development of a CQC Turnaround leadership Team and TOR to " To monitor and support the effective delivery of all work-streams and turnaround actions under the CQC Action and Assurance Plan	**0**	Achieve compliance with CQC requirements	New Risk

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	3131	Compliance	**6-Jul-2017**	Cath Marsland	QAC	CW	**MCA and DOLS compliance**	MCA and DOLS microsite MCA and DOLS E Learning as mandatory MCA and DOLS as training	20	5	3	15	Safeguarding team will attend the medical sisters meeting to discuss MCA and DOLS to provide updates on compliance, learning from cases and offer support. Ward Managers will cascade this learning at their ward meetings. A Poster which highlights the main tenants of MCA and DOLS requirements will be put in patient and staff areas. These posters will be reviewed on a monthly basis by Matrons to ensure they remain visible and are up to date with current practice Training compliance with regard to MCA and DOLS on A11 is at 73%. The Matron for A11 has been tasked with ensuring that this figure is 95% by target date Training compliance with regard to MCA and DOLS in The Medicine Business Group is at 83%. Head of Nursing has been tasked with ensuring improvement to 95% (Trust standard) A training session on MCA and DOLS will be delivered to the Trust Board	**5**	Achieve MCA and DOLS compliance	New Risk

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
HR	3135	Compliance	**8-Jul-2017**	Judy Haykin	WOD	JS	**National eLearning local Display Issue `Safe use of insulin `**	All registered staff are taught how to care for a diabetic as part of their training. The Diabetes team have developed posters to assist staff in safe management The Diabetes microsite in the Trust is well developed and has easily to follow guidance Earlier implementation of diabetes link nurses	15	3	5	15	Visit ward areas to assist with logging on to package if required. .Deliver drop in sessions for staff that require assistance Chase the remedy service desk to implement a fix for browser compatibility/internet explorer compatibility	**6**	Achieve learning outcome for nurses regarding care of diabetic patient	New Risk

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	3088	Infection Prevention and Control	**23- March- 2017**	Nesta Featherstone	QAC	JM	**Upsurge in the IP agenda against decreasing Medical hours and Nursing personnel.**	The Health & Social Care Act (H&SCA). Introduced in 2006, it was a requirement for provider registration with regulator, requirement for providers to ensure protection against HCAI, and new code of practice on infections This was updated in 2008, which required registration with the Care Quality commission with a duty to protect patients against HCAIs. This was updated in 2010 and in 2014 and now includes community practices. The H&SCA 2008 and regulations are law and must be complied with Mandatory Surveillance Introduced in 2001 but has expanded exponentially. Since the last job plan was written for the IP doctor role mandatory surveillance has been introduced for MSSA bacteraemia's and E coli bacteraemia's in 2011; all MRSA bacteraemia's have to have a Post Infection Review since 2013; since April 2015 all patients with C difficile who have been in-patients for 72hrs or more have to have a root cause analysis (RCA) carried out (53 patients for 2015/16) and the community -acquired cases (84 patients) have to have a mini RCA carried out. There has also been a requirement to investigate the MSSA bacteraemia's more thoroughly (56 in 2015/16) and from April 2017 there is a Quality Premium to reduce E coli bacteraemia's by 10% (221 cases in 2016/17) - so there will need to be consideration for each of these will each needing a mini RCA The Care Quality Commission (CQC) As the regulator will judge compliance around 10 compliance criteria's as well as regulation 15. The CQC has enforcement powers that it may use if registered providers do not comply with the law. Infection prevention and control- NICE quality standard 61 Healthcare-associated infection NICE quality standard 113	15	3	5	15	To develop an action plan following the workshop To review clerical support for the IP service & microbiology as a whole service Pathology manager and IT data analyst to learn each other's collection process to assist in cross working Due to the loss of two consultant microbiologists a new job description and job plan to be reviewed. To review & develop whole IV service	**6**	Achieve the IP agenda	April 2017 15

6. 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)*

QUALATIVE MEASURE OF CONSEQUENCE

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

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Draft Alliance Provider Agreement		
Report of:	Interim Managing Director SNC Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

Attachments:	Annex A – Draft Alliance Provider Agreement v8.2 Annex B – Draft Scheme of Delegation

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the final version of a draft Alliance Provider Agreement to the Board of Directors for approval.

2. BACKGROUND

2.1 Board members will be aware that, due to a pause in the MCP Procurement process, it has become necessary to establish formal Alliance arrangements in order to progress implementation of the New Models of Care. Fundamental to establishment of the formal Alliance arrangements is completion of an Alliance Provider Agreement by the four Stockport Together providers.

2.2 Preparation of an Alliance Provider Agreement document has been coordinated by Mr K Spencer, Interim Managing Director, with legal support being provided by Hempsons on behalf of the Stockport Together Providers. Draft versions of the Alliance Provider Agreement have been shared with Board members for comment and the draft document was the subject of a 'walk through' session for Board members held on 19 July 2017. The draft document was further updated as a result of feedback from this session and was agreed in principle on 27 July 2017.

3. CURRENT SITUATION

3.1 The latest draft version of the Alliance Provider Agreement, updated 14 September 2017, is attached for reference at Annex A of the report. Board members should note that this version has been updated since 27 July 2017 to incorporate additional feedback from Stockport Metropolitan Borough Council (SMBC). The amendments have not resulted in material changes to document content, but provide additional clarity for the relevant entries. All parties have agreed this final draft version and will be undertaking a formal approval process with their respective governing bodies.

3.2 A formal Scheme of Delegation will be an integral part of the Alliance arrangements and will be essential to ensure that all staff conduct business within relevant delegated limits. The Trust's Deputy Director of Finance has been leading on the preparation of the Scheme of Delegation and a draft document was also considered by the Board on 27 July 2017. The document has been shared with all parties to the Agreement and no amendments have been proposed.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Approve the draft Alliance Provider Agreement included at Annex A to the report.
- Approve the draft Scheme of Delegation included at Annex B to the report.

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DATED 2017

(1) STOCKPORT NHS FOUNDATION TRUST

(2) STOCKPORT METROPOLITAN BOROUGH COUNCIL

(3) PENNINE CARE NHS FOUNDATION TRUST

AND

(4) VIADUCT CARE

ALLIANCE PROVIDER AGREEMENT 2017/18

Draft	Date	Author
V001	28 March 2017	Hempsons
V002	6 April 2017	Hempsons
V003	12 April 2017	Jo Ellis
V004	20 April 2017	Hempsons
V005	27 April 2017	Hempsons
V006	4th May 2017	Jo Ellis
V007	11 May 2017	Hempsons
V008	16 June 2017	Keith Spencer
V009	8th September 2017	Michael Cullen
V10	14 September2017	Keith Spencer

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THIS AGREEMENT is made the day of **2017**
BETWEEN

(1) **Stockport NHS Foundation Trust,** Stepping Hill Hospital, Poplar Grove, Stockport, Cheshire, SK2 7JE (**SFT**)

(2) **Stockport Metropolitan Borough Council,** Fred Perry House, Edward Street, Stockport, SK1 3UR (**SMBC**)

(3) **Pennine Care NHS Foundation Trust,** Trust Headquarters, 225 Old Street, Ashton-under-Lyne, Lancashire, OL6 7SR (**PCFT**)

(4) **Viaduct Care,** 4th Floor, Stopford House, Stockport, SK1 3XE (**Viaduct**)

Each a "**Party**" together the "**Parties**".

The Parties are together referred to as "**We**", "**Us**", "**Our**" or the "**Parties**" as the context requires.

BACKGROUND

(A) The Parties are part of the Stockport Together Programme. This Agreement is an integral part of the vision to promote integrated services that deliver personalised care, and it is anticipated that this Agreement will facilitate the objectives of the Stockport Together Programme during a transitional period to a full Accountable Care Organisation.

(B) The Parties intend to ensure integrated, high quality, affordable and sustainable health and care services are delivered in the most appropriate way to the GP registered population (health care) and resident population (social care) across Stockport.

(C) The Parties have agreed to form an Alliance to progress the work of Stockport Together Programme and, in particular, to establish an improved financial, governance and contractual framework for the delivery of integrated health and social care services for the adult population in Stockport.

(D) The Parties [have approved] [intend to approve] a suite of Business Cases through their existing assurance processes to deliver the objectives of the Stockport Together Programme. This Agreement sets out the basis on which the Parties will work together, through the formation of an Alliance Provider Board, to deliver the Business Cases.

(E) Over the period of this Agreement, We will work together positively and in good faith in accordance with the Integration Principles and on a 'Best for Project' basis to achieve the Integration Objectives.

(F) This Agreement supplements and operates in conjunction with existing Services Contracts: it does not replace those contracts for the delivery of existing services and requires SMBC to delineate and describe its commissioning functions in order to complement the existing contractual relationships between the CCG and health providers. The Parties acknowledge that fundamental to the success of the Stockport Together Programme is a shift from a reactive and crisis driven model of care to one that is proactive, anticipatory and seeks to maintain people in a community setting for as long as possible. The Parties acknowledge and accept that the new model of care will change the pattern of utilisation and will require a review of specifications under the respective Services Contracts and internal SMBC commissioning and provision arrangements

IT IS AGREED AS FOLLOWS:

1 Definitions and Interpretation

The provisions of this Agreement are to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2 Status and Purpose of this Agreement

2.1 We agree to form an Alliance to allow us to act collectively. We have agreed to develop and enter into this Agreement for the development a governance framework for decision-making and delivery of the Business Cases in the transition period. In order to implement the new models of care set out in the Business Cases, this agreement will support the flexible use of all resources set out in Schedule X

2.2 This Agreement sets out the key terms we have agreed with each other including the governance arrangements for the Alliance to meet the two key aims of:

(a) Delivering the new models of care as described in the business cases;

(b) Providing a governance framework for the integrated transitional management team and neighbourhood teams

2.3 We recognise that the successful implementation of the Business Cases will require strong relationships and the creation of an environment of trust, collaboration and

innovation.

2.4 This Agreement supplements and works alongside all existing Services Contracts and SMBC internal commissioning and provision arrangements. This Agreement sets out how We will work together in a collaborative and integrated way and the Service Contracts and SMBC internal commissioning and provision arrangements set out how We will provide the Services.

2.5 Each of Us will perform Our respective obligations under Our respective Services Contract and internal commissioning and provision arrangements.

3 Term

3.1 This Agreement will come into force on the Commencement Date will operate until such time that one of the Parties withdraws from the agreement.

4 Integration Principles

4.1 The Integration Principles agreed by Us are to deliver sustainable, effective and efficient health and social care services with significant improvements over the term of this Agreement. In particular We have agreed the following Integration Principles for the Services:

a. High quality care and support is delivered that is personalised, joined up and coordinated around the person

b. People will be more in control of their own health and wellbeing

c. Safer and stronger communities are built which are more able to meet their own needs

d. Primary care is sustainable and is the fundamental building block upon which integrated health and social care is delivered

e. Progressive and impactful integration overcomes fragmentation, and resources are deployed to where they are most needed

f. The focus of service delivery changes from the current emphasis on the management of illness to an approach based on early intervention, prevention, self-management and choice

g. Care is delivered in the right place at the right time by the right person, every day of the week, enabling care and support to be delivered wherever possible close to people's homes rather than in hospital

h. Staff will be given the autonomy and time to care in a system which places a greater emphasis on helping people devise solutions that fit their needs rather than the needs of organisations.

5 Alliance Governance

5.1 We agree to establish an Alliance Provider Board with overall responsibility for overseeing the implementation of the Business Cases. The terms of reference of the Alliance Provider Board are set out in Schedule 3.

5.2 We agree that the Alliance Provider Board will be responsible for the management of this Agreement. Each Party will retain its statutory and regulatory responsibilities in relation to provision of the Services.

5.3 The Alliance Provider Board will be made up of an executive level representative of each Party who has the delegated authority to make decisions on behalf of the Party they represent. It will be for each of the Parties to identify their executive level representative and delegate authority to make decisions on behalf of that Party to that representative, within the scope of their role and as defined by that Party.

5.4 There may be some matters where Our respective Boards/governing Bodies need to retain the ability to reserve the approval of some decisions for that Board/Governing body. The limits of that authority will be recorded in Our own respective schemes of delegation and schedule of reserved matters, all of which will be appended to the this agreement to ensure openness and clarity in decision making.

5.5 Where there are limits on the delegated authority of an Alliance Provider Board member (as confirmed in the individual Parties relevant scheme of delegation for the Board Member) that member shall advise the other members of those limits and what additional approvals or authorisations will be required to participate in and make decisions at meetings of the Alliance Provider Board

5.6 The members of the Alliance Provider Board will identify an individual who they will ask to be the chair of the Alliance Provider Board. The chair will be a non-voting independent member of the Alliance Provider Board.

5.7 The members of the Alliance Provider Board will be responsible for reporting to their appointing Party through established assurance processes. Each Party will put in place arrangements for the feedback loop into their assurance processes and notify the other Parties the basis on which its member reports back to it.

5.8 We agree to establish an Integrated Transitional Management Team that will report and be accountable to the Alliance Provider Board. The terms of reference of the Integrated Transitional Management Team are set out in Schedule 4.

5.9 The Integrated Transitional Management Team will have operational responsibility for the delivery of the Services and implementation of the Neighbourhood and Intermediate Tier Business Cases.

5.10 The Integrated Transitional Management Team will meet with the Alliance Provider Board [once a month] to provide assurance on all clinical, practitioner, governance, finance and performance issues.

6 Neighbourhood Teams

6.1 A core part of the implementation of the Business Cases is the development of neighbourhood leadership teams. We have agreed that each of the eight Neighbourhoods will have an Integrated Neighbourhood Leadership Team (INLT), consisting a Lead GP, Integrated Team Leader and Senior Practitioner. Each INLT will be responsible for the implementation of the Neighbourhood Business Case for their Neighbourhood.

6.2 We agree to appoint a Lead GP for each Neighbourhood whose role and responsibilities will be as set out in Schedule 7 (Lead GP Role and Responsibilities).

6.3 We agree to appoint an Integrated Team Leader for each Neighbourhood whose role and responsibilities will be as set out in Schedule 8 (Integrated Team Leader Role and Responsibilities).

6.4 The INLT will be accountable to the Integrated Transitional Management Team

6.5 The INLT shall have responsibility and accountability for implementation of the Neighbourhood Business Case for their Neighbourhood including:

(a) Deployment of the existing employed workforce in Neighbourhoods to achieve the objectives set out in the Neighbourhood Business Case;

(b) The neighbourhood element of the workforce plan within the overall Stockport Together Workforce Plan;

(c) Investment in neighbourhood schemes 2017/18 as set out in the Neighbourhood Business Case; and

(d) Engaging the wider neighbourhood team in the delivery of the Neighbourhood Business Case.

6.6 The INLT will provide clinical and professional leadership with regard to the Services in its Neighbourhood.

6.7 Each INLT will receive from the Integrated Transitional Management Team a monthly dashboard which informs the INLT of its performance against the Neighbourhood Business Case.

6.8 Each quarter the INLT and Integrated Transitional Management Team will meet to review the performance of the Neighbourhood against its objectives and progress against implementation of the Neighbourhood Business Case.

6.9 The INLT will inform the Integrated Transitional Management Team of any support required to implement the Neighbourhood Business Case.

6.10 Where the INLT is failing to deliver the Neighbourhood Business Case the INLT will meet with the Managing Director to agree an action plan. In the event that the INLT is failing to meet the requirements of the action plan within 3 months of it being agreed the matter will be referred to the Alliance Provider Board.

7 Integration Objectives

7.1 We will work together to achieve the Integration Objectives set out in Schedule 2.

7.2 We must communicate with each other and all relevant Staff in a clear, direct and timely manner to optimise the ability for each of Us, and the Provider Board to make effective and timely decisions to achieve the Integration Objectives.

8 Aligned Resources

8.1 We acknowledge that each of us may receive transformation funding and deploy significant resources in the delivery of current models of care and that these funds remain separate under this Agreement. This is aligned with the integrated

commissioning arrangements that relate to the delivery of services to the over 65's.

8.2 We agree that in order to facilitate the work of the Alliance Provider Board we will align the resources used for the delivery of the business cases for reporting and oversight to the Alliance board

8.3 We agree that the Alliance Provider Board will make decisions about the operational commitment of the aligned resources within the agreed financial envelope and subject to any restrictions set out in the schemes of delegation of the members of the alliance board and schedules of reserved matters appended to this agreement. Resource commitment decisions made by the Alliance Provider Board will require unanimous agreement and each party will retain actual spending decisions within their existing scheme of delegation.

8.4 The INLT will recommend to the Integrated Transitional Management Team for its approval or rejection how the Services should be delivered and how aligned resources should be deployed in the Neighbourhood.

8.5 The Integrated Transitional Management Team will make recommendations to the Alliance Provider Board for its approval or rejection how the Services should be delivered and how aligned resources should be deployed, having considered the recommendations received from the INLTs and any restrictions set out in the appendices to this agreement.

8.6 For the avoidance of doubt this Agreement does not create a pooled fund under section 75 of the National Health Service Act 2006.

9 Host

9.1 We agree that SFT will be the Host of the INLT.

9.2 The Host will enter into a memorandum of understanding in the form set out in Schedule 5 with each INLT.

9.3 The Host will be responsible, when requested, for entering into contracts and making payments to third parties on behalf of the Alliance Provider Board, the Integrated Transitional Management Team and the INLTs. The entering into all such contracts and payments will be in accordance clause 8.3 in that they must be contained within the agreed financial envelope and subject to any restrictions set out in the schemes of delegation of the members of the alliance board and schedules of reserved matters

appended to this agreement

9.4 The Host shall procure that the Alliance Provider Board, the Integrated Transitional Management Team and the INLTs have all necessary licences and consents to perform their roles. Where such licence or consent is required from one of Us We agree that We will grant such licence or consent.

9.5 We agree that where the Host enters into an agreement with a third party on behalf of the Alliance Provider Board, the Integrated Transitional Management Team and the INLTs We shall keep the Host fully indemnified for any Losses incurred by the Host except to the extent that such Losses are incurred as a result of the Host's negligence or other wrongdoing.

10 Transparency

10.1 We will provide to each other all information that is reasonably required in order to achieve the Integration Objectives and to design and implement changes to the ways in which Services are delivered.

10.2 We have responsibilities to comply with competition laws and We acknowledge that We will all comply with those obligations.

11 Services Contracts

11.1 Each of Us must perform Our respective obligations under, and observe the provisions of, any Services Contract and internal SMBC commissioning and provision arrangements to which We are a party.

11.2 Nothing in this Agreement relaxes or waives any of Our obligations pursuant to any Services Contract.

12 Confidentiality and Freedom of Information

12.1 We agree that We must comply with the terms of General Condition 20 of the NHS Standard Contract (Confidential Information of the Parties) as if set out here in full, including any variations that are made from time to time during the Term of this Agreement.

12.2 We agree that We must comply with the terms of General Condition 21 the NHS Standard Contract (Data Protection, Freedom of Information and Transparency) as if set out here in full, including any variations that are made from time to time during the

Term of this Agreement.

13 Personnel

13.1 We recognise the importance of following good employment practice particularly when undertaking the required service redesign and changes to operating practices. We confirm that staff will remain employed by, and subject to, the terms and conditions, policies and procedures of their existing employer.

14 Notices

14.1 Any notices given under this Agreement must be in writing and must be served in the ways set out below in this Clause 14.1 at the addresses set out in this Agreement. The following table sets out the respective deemed time and proof of service:

Manner of Delivery	Deemed time of delivery	Proof of Service
Personal delivery	On delivery	properly addressed and delivered
Prepaid first class recorded delivery domestic postal service	9.00am on the second Business Day after posting	properly addressed prepaid and posted

14.2 The nominated addresses We will each use to send notices to each other are as set out at the start of this Agreement. Each Party may, on reasonable notice to all the other parties, provide a new nominated address.

15 General legal provisions

15.1 This Agreement constitutes the whole agreement between the Parties and supersedes any previous agreements between the Parties relating to the INLTs. Each Party acknowledges that, in entering into this Agreement, it has not relied on, and will have no right or remedy in respect of, any statement, representation, assurance or warranty (whether made negligently or innocently) other than as expressly set out in this Agreement. Nothing in this Clause will limit or exclude any liability for fraud or for fraudulent misrepresentation.

15.2 This Agreement will be governed by the laws of England and the courts of England will have exclusive jurisdiction.

15.3 No variation or waiver of this Agreement or any part of it will be effective unless made in writing, signed by or on behalf of all the Parties and expressed to be such a variation or waiver.

15.4 This Agreement and the documents referred to in them are made for the benefit of the Parties, their successors and permitted assigns, and are not intended to benefit, or be enforceable by, anyone else.

15.5 The Parties will attempt to resolve any dispute between them in respect of this Agreement by negotiation in good faith.

15.6 Failure to exercise, or any delay in exercising, any right or remedy provided under this Agreement or by law will not constitute a waiver of that or any other right or remedy, nor will it preclude or restrict any further exercise of that or any other right or remedy.

15.7 No single or partial exercise of any right or remedy provided under this Agreement or by law will preclude or restrict the further exercise of that or any other right or remedy.

15.8 A Party that waives a right or remedy provided under this Agreement or by law in relation to another Party, or takes or fails to take any action against that Party, does not affect its rights in relation to any other Party.

15.9 Except as otherwise provided in this Agreement, no Party may assign, sub-contract or deal in any way with, any of its rights or obligations under this Agreement or any document referred to in it.

15.10 Nothing in this Agreement is intended to, or will be deemed to, establish any formal partnership between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party.

15.11 No person other than a Party to this Agreement will have any rights to enforce any term of this Agreement whether under the Contract (Rights of Third Parties) Act 1999 or otherwise.

15.12 This Agreement may be executed in any number of counterparts, each of which when executed will constitute an original of this Agreement but all the counterparts will together constitute the same Agreement.

IN WITNESS OF WHICH We have signed this Agreement on the date written at the head of this Agreement.

DULY EXECUTED

SIGNED by [INSERT NAME]	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
STOCKPORT NHS FOUNDATION TRUST	**)**	

SIGNED by [INSERT NAME]	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
STOCKPORT METROPOLITAN BOROUGH COUNCIL	**)**	

SIGNED by [INSERT NAME]	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	**)**	Title:
PENNINE CARE NHS FOUNDATION TRUST	**)**	

SIGNED by [INSERT NAME]	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	**)**	Title:
VIADUCT HEALTH	**)**	

SCHEDULE 1
DEFINITIONS AND INTERPRETATION

1 **Interpretation**

1.1 References to any statute, statutory instrument, regulations, directives or guidance are references to those as from time to time amended, replaced, extended or consolidated and includes any subordinate legislation for the time being in force made under it.

1.2 References to a particular organisation will be deemed to include a reference to any assign(s) of or successor(s) to such organisation or any organisation which has taken over any or all of either or both of the functions or responsibilities of that organisation. References to other persons will include their successors and permitted transferees and assigns.

1.3 Clause, schedule and paragraph headings will not affect the interpretation of this Agreement.

1.4 References to clauses and schedules are to the clauses and schedules of this Agreement; references to paragraphs are to paragraphs of the relevant schedule.

1.5 A person includes a natural person, corporate or unincorporated body (whether or not having a separate legal personality) and that person's legal and personal representatives, successors and permitted assigns.

1.6 Words in the singular will include the plural and vice versa; words denoting the masculine gender include the feminine gender; words denoting persons include bodies corporate and unincorporated associations and partnerships.

1.7 Use of the term “including” or “includes” will be interpreted as being without limitation.

1.8 Any obligation in this Agreement on a person not to do something includes an obligation not to agree or allow that thing to be done.

1.9 The following words and phrases have the following meanings:

“Agreement”	means this Agreement;
“Alliance Provider Board”	means the board appointed to act on behalf of the Parties established under Clause 5.1 of this

	Agreement;
"Business Cases"	means the following business cases endorsed by each of the Parties: a. Core Neighbourhoods; b. Intermediate Tier; c. Acute Interface; d. Out Patients; e.
"Integration Objectives"	means the objective set out in Clause 4.1;
"Business Day"	means any day which is not a Saturday, Sunday or a bank or public holiday in the United Kingdom;
"Commencement Date"	means 2017
"Host"	means the host of the INLT, which shall be SFT;
"Integrated Neighbourhood Leadership Team" or **"INLT"**	means the Lead GP, Integrated Team Leader and Senior Practitioner for a Neighbourhood;
"Integrated Team Leader"	means the senior District Nurse or Social Worker appointed as Integrated Team Leader for each Neighbourhood
"Integrated Transitional Management Team"	means the integrated management team appointed to act on behalf of the Parties under Clause 5.8 of this Agreement;
"Indirect Losses"	means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis;

“Lead GP”	means the Lead GP for a Neighbourhood, appointed by Viaduct
"Losses"	means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or at common law but, to avoid doubt, excluding Indirect Losses;
“Neighbourhood”	means any of the following areas: (a) Bramhall; (b) Cheadle; (c) Stepping Hill; (d) Heatons; (e) Marple; (f) Tame Valley; (g) Victoria; and (h) Werneth;
“Neighbourhood Business Case”	means the business case endorsed by the Parties;
"NHS Standard Contract"	means the NHS Standard Contract published by NHS England from time to time;
“Senior Practitioner”	means the Senior District Nurse or Social Worker for each Neighbourhood who forms part of the INLT and is the opposite profession to the Integrated Team Leader to provide professional governance and supervision in the team;
"Service Users"	means the people that live in and around Stockport and are in receipt of the Services;
“Services”	means the community health and social care services as described in Schedule 6 (Scope of the Services) and provided by a Party pursuant to its Service Contract or by any of the Parties pursuant

	to the Services Contracts, as the case may be;
“Services Contracts”	means the services contracts to be entered into between each Party and Stockport CCG for the provision of the Services;
“Staff”	means all persons (whether clinical or non-clinical) employed or engaged by any Party or by any sub-contractor in the provision of the Services;
"TUPE"	The Transfer of Undertakings (Protection of Employment) Regulations 2006;
“Aligned resources”	means the funds of each Party within the remit of this Agreement as set out in Clause 8.2

SCHEDULE 2
INTEGRATION OBJECTIVES

The intention is that our alliance agreement will provide the governance framework that enables delivery of the key objectives of the four Providers to:

a. ensure the long term sustainability of the health and care system

b. secure best value for the Stockport public sector budget in terms of outcome per pound spent

c. ensure that integrated health and care services are delivered coherently and that fragmentation of service delivery is minimised by reducing organisational, professional and service boundaries

d. ensure that resources are directed to the right place in order to adequately and sustainably fund the right care for patient outcomes

e. support the process of implementation of and transition to, the new Stockport Together care models in order to deliver improved outcomes for people

SCHEDULE 3

ALLIANCE PROVIDER BOARD TERMS OF REFERENCE

1. Purpose of the Alliance Provider Board

The Alliance Provider Board will have overall responsibility for overseeing the implementation of the Stockport Together Business Cases:

a. Core Neighbourhoods including Healthy Communities

b. Intermediate Tier

c. Acute Interface

d. Out Patients

2. Objectives of the Alliance Provider Board

The Alliance Provider Board will:

a. Provide assurance to the Parties on the delivery of integrated service solution;

b. Provide assurance to the Parties on benefits realisation of the Stockport Together Business Cases;

c. Hold the Transitional Leadership Team to account for implementation of the integrated service solution and benefits realisation; and

d. Take decisions based on the recommendations of the Transitional Leadership Team.

e. Ensure that in meeting the objective and targets set for Stockport Neighbourhood Care, the delivery of the Partners' other core functions and statutory duties is protected.

3 Authority and Decision Making

3.1 The Alliance Board will have delegated authority arising from its members to approve or reject items presented for consideration within the authority delegated to the members from their employing Party. In order to be binding on the Parties, the decisions of the Alliance Provider Board will need to be made by consensus, i.e. all four parties to the alliance must agree.

3.2 It will be for each of the Parties to identify their executive level representative and delegate authority to make decisions on behalf of that Party to that representative, within the scope of their role and as defined by that Party and as restricted by its scheme of delegation and schedule of reserved matters.

3.3 The members of the Alliance Provider Board will be responsible for reporting decisions made by the Board and any obstacles to decision making to their appointing Party through established assurance processes. Each Party will put in place arrangements for the feedback loop into their assurance processes and notify the other Parties the basis on which its member reports back to it.

3.4 The Alliance Provider Board will operate within each parties procurement and contracting procedure rules.

4 Membership

4.1 The Alliance Provider Board will be made up of an executive level representative of each Party who has the delegated authority to make decisions on behalf of the Party they represent.

4.2 The members of the Alliance Provider Board will identify an individual who they will ask to be the chair of the Alliance Provider Board. The chair will be a non-voting independent member of the Alliance Provider Board

4.3 No one can deputise on behalf of any members of the group without prior approval from the Alliance Chair. Nominated deputies must have delegated decision making authority for the respective Party.

4.4 Members of the Transitional Leadership Team may be in attendance at Board meetings at the invitation of Alliance Provider Board.

5 Organisation of the Alliance Provider Board

5.1 Meetings of the Board will be held on a monthly basis

5.2 Additional meetings may be held, as required, at the discretion of the Board

5.3 7 working days' notice must be given of an Alliance Provider Board meeting. This may be varied with the agreement of all members.

5.4 All parties must be represented for a meeting to be quorate

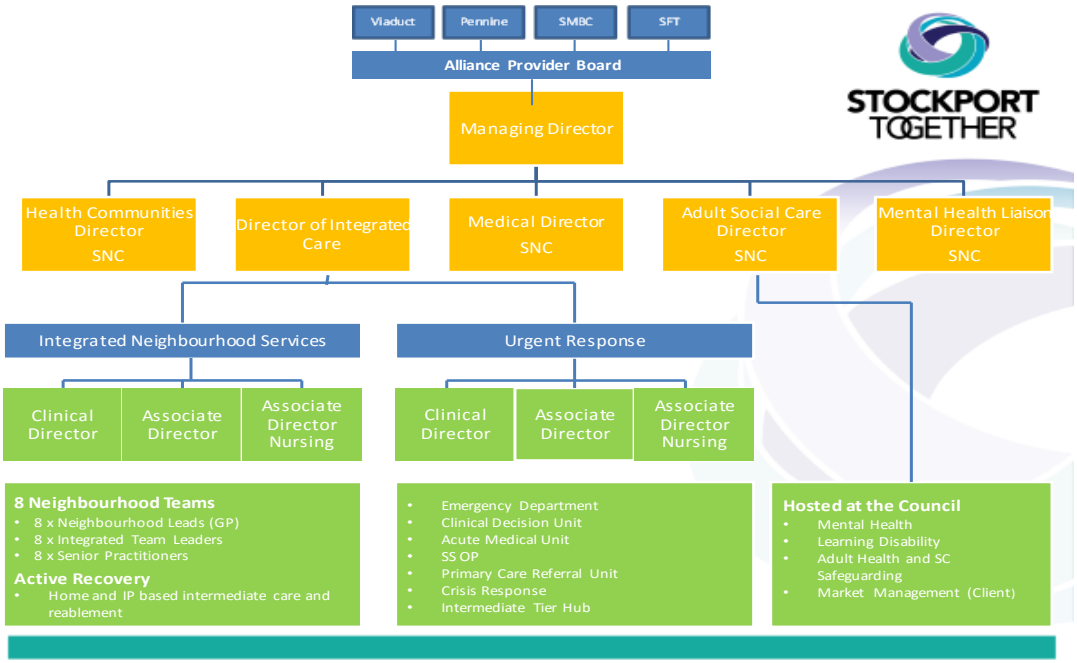
5.5 Board Papers will be circulated 7 working days in advance of any meeting in order to allow members to seek views and where appropriate secure the necessary approvals and authority from their individual organisation

5.6 Records will be kept of the proceedings, decisions and advice of the group including brief minutes and more detailed decision summary documents. Support to the Alliance Provider Board will be provided by the Stockport Together Programme Office.

SCHEDULE 4

TRANSITIONAL LEADERSHIP TEAM TERMS OF REFERENCE

1. The Transitional Leadership Team is made up of the posts marked in orange below.



2. The Transitional Leadership Team will be responsible for:

(a) Day to day operational delivery of Services to meet required performance standards;

(b) Transforming the Services into the new integrated service solution (as described in the Stockport Together Business Cases);

(c) Ensuring benefits realisation of the Stockport Together business cases

(d) Providing clinical/practitioner and operational assurance of the integrated service solution to the Parties.

SCHEDULE 5

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING is made the day of **2017**
BETWEEN

(1) **Stockport NHS Foundation Trust,** Stepping Hill Hospital, Poplar Grove, Stockport, Cheshire, SK2 7JE (**SFT**)

(2) **[Name] Integrated Neighbourhood Leadership Team (INLT)**

Background

1. This Memorandum of Understanding is entered into by the INLT and SFT as Host of the INLT pursuant to an agreement between SFT, Stockport Metropolitan Borough Council, Pennine Care NHS Foundation Trust, and Viaduct Health (the **Partners**).

INLT Obligations

2. The INLT will be responsible for the implementation of the Neighbourhood Business Case for the Neighbourhood.

3. The INLT shall have responsibility and accountability for implementation of the Neighbourhood Business Case for their Neighbourhood including:

   (a) Deployment of the existing employed workforce in Neighbourhoods to achieve the objectives set out in the Neighbourhood Business Case;

   (b) The neighbourhood element of the workforce plan within the overall Stockport Together Workforce Plan;

   (c) Investment in neighbourhood schemes 2017/18 as set out in the Neighbourhood Business Case; and

   (d) Engaging the wider neighbourhood team in the delivery of the Neighbourhood Business Case.

4. The INLT will provide clinical and professional leadership with regard to the Services in the Neighbourhood.

5. The INLT is accountable to the Transitional Leadership Team.

6. The INLT must act within the operational requirements set out in the Neighbourhood

Business Case. Where the INLT considers that the Neighbourhood Business Case needs to be varied or additional funding is required the INLT may make a recommendation to the Transitional Leadership Team.

7. The Transitional Leadership Team will make recommendations to the Alliance Provider Board for its approval or rejection how the Services should be delivered and how funds should be spent, having considered the recommendations received from the INLT.

8. Operational delivery of the Neighbourhood Business Case may only be varied where the INLT has received a notification from the Transitional Leadership Team that the Alliance Provider Board has approved the variation.

Roles and responsibilities

9. The Lead GP will:

   (a) provide leadership to all staff in the Neighbourhood to implement agreed components of the Neighbourhood Business Case;

   (b) provide clinical assurance of the integrated service solution in the Neighbourhood;

   (c) be accountable for delivery of the Neighbourhood Business Case in the Neighbourhood; and

   (d) be accountable for benefits realisation relating to the Neighbourhood Business Case in the Neighbourhood.

10. The Lead GP will have a commitment of 2 sessions per week.

11. The Lead GP may delegate some aspects of delivery to a Practice Manager or other GP but the Lead GP remains accountable for delivery, benefits realisation and clinical assurance.

12. The Integrated Team Leader will:

   (a) provide leadership to Integrated Neighbourhood Team;

   (b) be accountable for day to day operational management of district nursing and social care;

(c) provide assurance within their professional sphere of influence; and

(d) have overall accountability for the employed workforce within the Neighbourhood.

13. The Senior Practitioner will:

(a) support the Integrated Team Leader with leadership in the Integrated Neighbourhood Team; and

(b) provide assurance within their professional sphere of influence.

SFT Obligations

14. SFT shall procure that the INLT has all necessary licences and consents to perform its role.

15. The Partners shall make available to the INLT the funds required to implement the Neighbourhood Business Case, as approved by the Alliance Provider Board through SFT.

16. SFT will be responsible for entering into any agreements with, and making payments to third parties, on behalf of the INLT. Such agreements and payments may only be entered into where they have been approved by the Alliance Provider Board, whether in the Neighbourhood Business Case or otherwise.

Performance

17. Each INLT will receive from the Transitional Leadership Team a monthly dashboard which informs the INLT of its performance against the Neighbourhood Business Case.

18. Each quarter the INLT and Transitional Leadership Team will meet to review the performance of the Neighbourhood against its objectives and progress against implementation of the Neighbourhood Business Case.

19. The INLT will inform the Transitional Leadership Team of any support required to implement the Neighbourhood Business Case.

20. Where the INLT is failing to deliver the Neighbourhood Business Case the INLT will meet with the Managing Director to agree an action plan. In the event that the INLT is failing to meet the requirements of the action plan within 3 months of it being agreed

the matter will be referred to the Alliance Provider Board.

SIGNED by [INSERT NAME]	**)**	.....
Duly authorised to sign for and on	**)**	Authorised Signatory
behalf of	**)**	Title:
STOCKPORT NHS FOUNDATION TRUST	**)**	
SIGNED by [INSERT NAME]	**)**	.....
		Lead GP
SIGNED by [INSERT NAME]	**)**	.....
		Integrated Team Leader
SIGNED by [INSERT NAME]	**)**	.....
		Senior Practitioner

SCHEDULE 6

SCOPE OF THE SERVICES

The scope of the services are those set out in the suite of Stockport Together Business Cases, summarised as;

2017/18 Financial value £99,518,480

SMBC £31,903,052 (tbc)

PPL SG Integrated Neighbourhood Services	£26,407,564
PPL SG Boroughwide Services	£5,495,488

SFT £37,158,500 (not including Outpatients)

Acute Medicine & Emergency Department	£19,024,900
Community Services	£18,133,600

Viaduct £4,549,928

24 Hr Ambulatory Blood Pressure Monitoring & Home Blood Pressure Monitoring Service	£126,000
Health Spirometry Service	£85,000
Neighbourhood business case (Collaborative general practice)	£4,338,928

Pennine Care **£25,907,000 (tbc)**

SCHEDULE 7

LEAD GP ROLE AND RESPONSIBILITIES

Job Title: **Neighbourhood Lead (Lead GP)**

Responsible to: Clinical Director (GP), Neighbourhood Services, Stockport Neighbourhood Care

Accountable to: Medical Director (GP), Stockport Neighbourhood Care
Medical Director Viaduct Care;

Location: Variable across Stockport

Hours: 2 sessions per week

Remuneration: £350 gross per session

Contract Type: Fixed term contract for 2 years

Job Purpose

The successful applicant will be the Lead GP for one of the eight Neighbourhoods of Stockport Neighbourhood Care that are based upon GP registered populations in the Viaduct Care neighbourhoods. They will play a critical role in developing integration at a neighbourhood level and supporting delivery of the Neighbourhood business cases.

As a leader within the Alliance they will have specific responsibilities as a member of the Triumvirate neighbourhood leadership team. They will provide clinical leadership of the neighbourhood's multidisciplinary team and will be accountable for all in-scope staff and resources within the neighbourhood under delegated authority from the four providers under the Stockport Neighbourhood Care Alliance Agreement (Viaduct Care, Stockport NHS Foundation Trust, Stockport Metropolitan Borough Council, Pennine Care NHS Foundation Trust).

In addition, as a leader within Viaduct Care they will influence and shape the organisation's contribution to developments locally and ensure alignment of delivery with our vision and ambition.

Key Accountabilities and Responsibilities

As defined in the neighbourhood agreement, the Lead GP will be accountable for:

- leadership as a member of Neighbourhood Triumvirate of all staff in the neighbourhood to implement agreed components of the Neighbourhood Business Case and other relevant Stockport Together business cases;

- supporting delivery of the Neighbourhood Business Case and aligned in-scope operational budgets in the Neighbourhood; benefits realisation relating to the Neighbourhood Business Case in the neighbourhood; and
- clinical assurance of the integrated service solution in the neighbourhood

Responsibilities will include:

Leadership

- promote and support multidisciplinary working;
- work with the Clinical Directors, Director of Integration, Commissioners and other stakeholders to develop high quality services; and
- support the GP practices and Medical Director in the development of protocols that safeguard the wellbeing of the population and address public health, prescribing and other related NHS requirements.

Quality and assurance

- chair the Neighbourhood Quality Committee; and
- work within relevant governance protocols to ensure that complaints are responded to promptly and ensure learning is gathered, shared and changes implemented to prevent recurrence; and
- prompt review of significant events, recognising and implementing learning outcomes.

Operational

- attend Integrated Neighbourhood Team meetings;
- ensure services adhere to performance targets and contractual commitments, taking remedial action where appropriate; and
- engage in the implementation of the new models of care produced by the Stockport Together programme, plus any other projects to improve the health and social care of the neighbourhood's population and improve the resilience of the health and social care workers.

Communication

- effective communication, in particular, with Viaduct Care, Stockport Neighbourhood Care, other neighbourhoods, practices and the multidisciplinary team;
- whilst operating as an effective part of Stockport Neighbourhood care, also act as a representative for Viaduct Care, supporting its vision and objectives;
- facilitate engagement of the practices and staff within the neighbourhood to ensure that all practices have a voice and opportunities are equitably available; and
- collate and present the views from within the neighbourhood to Viaduct Care and Stockport Neighbourhood Care.

The Lead GP may delegate some aspects of delivery to a manager or other suitably qualified individual but the Lead GP remains accountable for delivery, benefits realisation and clinical assurance working with the Neighbourhood Triumvirate.

This job description aims to illustrate the range and nature of responsibilities held by the post holder. The list of duties and responsibilities is not exhaustive and the post holder is expected to be flexible in their approach. The duties associated with the post will inevitably vary and develop and therefore the role will be reviewed on a regular basis and changes made in consultation with the post-holder.

Performance Management

- Objectives for the post will be the subject of overall agreement and regular review between the post-holder, the Viaduct Care Medical Director and the Stockport Neighbourhood Care GP Clinical Director and annual performance review will be conducted by the Viaduct Care Medical Director with relevant input from the Alliance partners.

Confidentiality and Compliance with the Data Protection Act 1984

- The post holder must maintain confidentiality regarding information about patients, staff and other Viaduct Care business in accordance with the Data Protection Act 1984
- All employees of Viaduct Care must not, without prior permission, disclose any information regarding patients or staff. In circumstances where it is known that a member of staff has communicated information to an unauthorised person, those staff will be liable to dismissal. Moreover, the Data Protection Act 1984 also renders an individual liable to prosecution in the event of unauthorised disclosure of information

Health and Safety

- All employees must be aware of the responsibilities placed on them under the Health and Safety at Work Act 1974 to ensure that the agreed safety procedures are carried out to maintain a safe working environment for patients, visitors and employees
- Review and ensure systems are in place for the proactive management of risk registers

Infection Control

- All employees of Viaduct Care are required to contribute to the management of infection control and be proactive in awareness raising and prevention
- Ensure that all guidelines, protocols and procedures undertaken within the service are in line with evidence based practice for infection control

Safeguarding

- All employees of Viaduct Care have a responsibility to protect and safeguard vulnerable people (children and adults). They must be aware of child and adult safeguarding procedures and must speak to the Viaduct Care Medical Director in the first instance for further advice. All employees are required to attend safeguarding awareness training and to undertake additional training appropriate to their role.

Equality and Diversity

- Employees should promote diversity and equality of opportunity within Viaduct Care
- Build a culture where everyone is valued and equipped to do their job.
- All employees must carry out all duties and responsibilities of the post in accordance with Viaduct Care's Equality, Diversity and Human Rights policies, avoiding unlawful

discriminatory behaviour and actions when dealing with colleagues, service users, members of the public and other stakeholders.

Sustainability

- All employees of Viaduct Care have a responsibility for working in a low carbon environment, where energy is used wisely and not wasted. Environmental impact should be reduced by recycling where possible, switching off lights, computers, monitors and equipment when not in use, minimising water usage and reporting faults promptly.

Personal Specification

Factor	Essential	Desirable
Qualifications & training	Fully qualified GP GMC GP registration Evidence of annual appraisal & revalidation Registration on a Medical Performers List Enhanced DBS check (within 12 months) UK work permit (if required) Level 3 Child Safeguarding & Adult Safeguarding training Equality & Diversity training	MRCGP/FRCGP Other postgraduate qualifications Evidence of continued professional development UK driving licence Experience of working with the CCG, Federation or similar organisation
Experience & knowledge	At least two years' post qualification experience as a GP Experience of leading multi-disciplinary teams Experience of appointing, managing and developing staff Experience of meeting clinical & information governance standards compliant with CQC and other statutory requirements Experience of delivering to performance targets Experience of managing change Evidence of ability to work under pressure Knowledge of local health & social care initiatives & strategic developments Understanding of and commitment to upholding the Nolan Principles of Public Life	Evidence of leadership training Experience of evolving systems & processes Experience of strategic planning Experience of working with financial governance requirements Experience of contract negotiation & implementation Evidence of information governance training
Motivation & skills	Excellent interpersonal, influencing & negotiating skills Excellent written & verbal communication skills Ability to communicate complex information in an understandable form to a variety of audiences, listening to others and actively	Evidence of communication skills training Evidence of confidentiality training Ability to challenge models and suggest change in a positive & inclusive manner

	sharing information Ability to act as a positive role model promoting team working, respect, innovation & excellence Proficient IT skills Evidence of critical analysis skills Ability to work effectively independently and as a team leader & team member Counselling & feedback skills Willingness to share knowledge & collaborate across the multidisciplinary team & neighbourhoods Ability to develop & maintain effective working relationships with multi-disciplinary teams A commitment to team working, including collaboration/delegation and the ability to listen to and take into account the views of others Ability to work flexibly Ability to recognise limitations & take appropriate action Willingness to learn new skills Ability to demonstrate an understanding & adherence to confidentiality rules & concepts	
Other	Commitment to primary prevention & health/social care improvement Commitment to addressing health inequalities Commitment to enabling patient empowerment Ability to commit two sessions per week to the role	

SCHEDULE 8

INTEGRATED TEAM LEADER ROLE AND RESPONSIBILITIES

Title: **Integrated Team Leader**

Responsible to: Associate Director, Neighbourhood Services, Stockport Neighbourhood Care

Accountable to: Director of Integrated Care, Stockport Neighbourhood Care

Time commitment: Full Time

Role Summary

To be responsible for the day to day operational management of all in scope community nursing and social care staff

Key Responsibilities

The Integrated Team Leader will:

1. Working closely with the Neighbourhood Lead and Senior Practitioner, provide leadership to the Integrated Neighbourhood Team
2. Be responsible for day to day operational management of district nursing and social care;
3. Provide assurance within their professional sphere of influence; and
4. Have overall managerial responsibility for the employed workforce within the Neighbourhood.

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SCHEME OF RESERVATION AND DELEGATION FOR STOCKPORT TOGETHER

IN ACCORDANCE WITH THE ALLIANCE PROVIDER AGREEMENT

1. Background

1.1 Whilst the procurement and the Integrated Support & Assurance Process (ISAO) was paused in March 2017 and whilst it will take over 12 months to formally establish a new provider organisation, there was a need to

- Maintain the momentum of the implementation of the new models of care
- Ensure that the business cases can be effectively implemented
- Ensure the stability and safe governance of services with clear lines of accountability

1.2 The Provider Board consists of Stockport NHS Foundation Trust, Stockport Metropolitan Borough Council, Pennine Care Foundation Trust and Viaduct Health.

1.3 The Provider Board agreed to implement two aligned developments:

1.3.1 ***A transitional integrated management structure***

This features a single line of management accountability across community health services, adult social care, mental health services in the neighbourhoods and intermediate tier in addition to come elements of the hospital e.g. emergency department. This will be known as Stockport Neighbourhood Care and will be transitional until the outcome of the procurement process is known.

1.3.2 ***A neighbourhood integration agreement***

This allows the integrated neighbourhood leadership team to work collectively to implement the core neighbourhood business case and formalise the proposed lead GP

1.4 Stockport NHS Foundation Trust ran an aligned management restructure process in the summer of 2017 and this is a substantive structure change with three new business groups being created:

- Surgery
- Children, families and diagnostics
- Medicine

1.5 The business group that covers the integrated neighbourhood services and urgent response services will be referred to within Stockport Foundation Trust as “Integrated Care”.

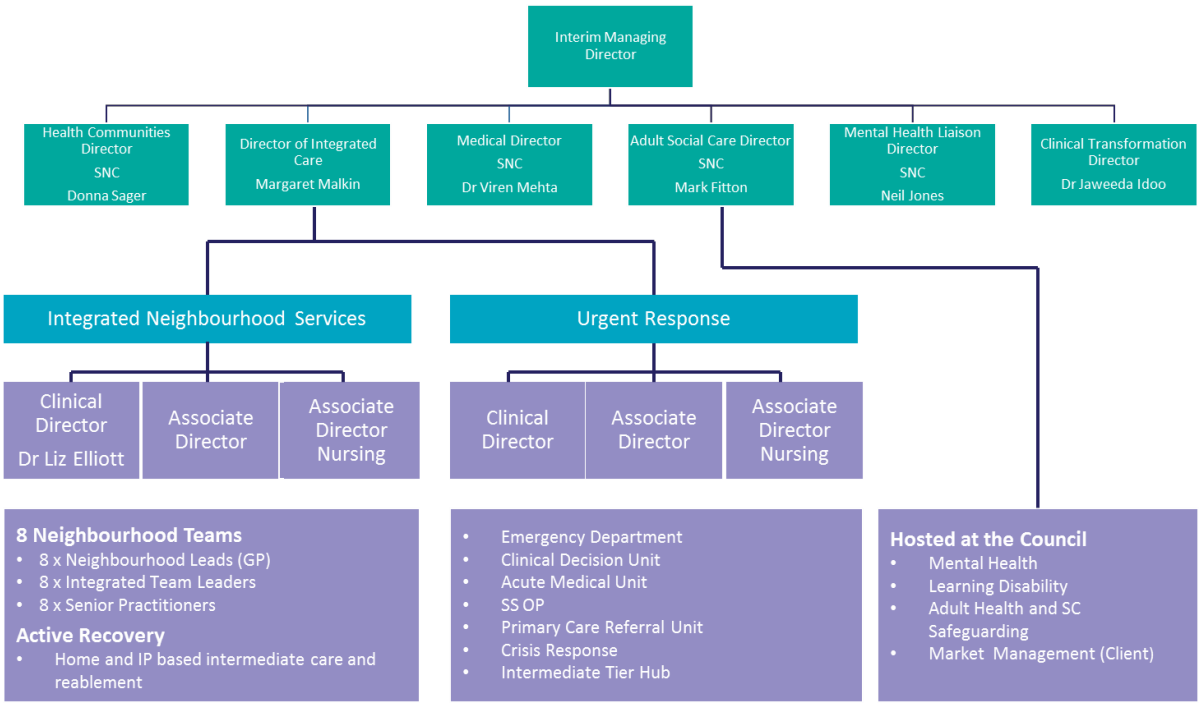
1.6 The principles in place on the management of the business groups are that there will be a leadership triumvirate which consists of:

(a) Hospital services – Business group director, Associate Medical Director and Head of Nursing.

(b) Stockport Neighbourhood Care – Clinical Director, Associate Director and Associate Director of Nursing.

1.7 The Stockport Neighbourhood Care organisational chart is shown below in figure 1.

Figure 1



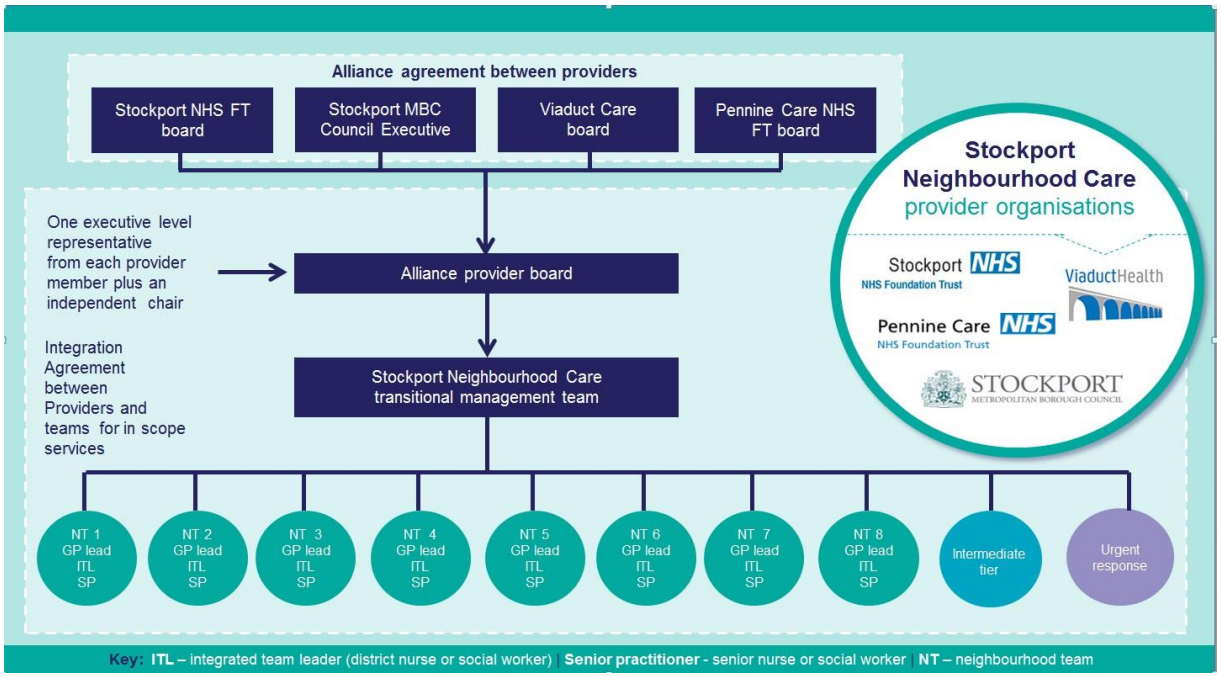
The key points to note from figure 1 are as follows:

- There will be 8 neighbourhood leadership teams all with a team consisting of a lead GP, an integrated team leader and a senior practitioner.
- Under Urgent Response the departments which are currently under the hospital structure are listed along with the new services as part of the implementation of the Stockport Together Business Cases
- The services from Stockport MBC and Pennine Care which are either part of SMBC or hosted are listed in the last box on the right

2. Alliance agreement

2.1 The alliance provider agreement commits the four providers to working collectively and to delegate some defined powers through an alliance provider board to the integrated transitional management team. This can be represented in Figure 2 below

Figure 2



2.2 The agreement is an interim arrangement and the key principles within this are as follows:

- The does not prejudge the outcome of the procurement process regarding organisational form
- This does not replace the existing contractual arrangements between providers and / or a provider and a commissioner. For example, Stockport CCG will continue to commission emergency department attendances via a contract with Stockport NHS Foundation Trust.
- This does not require the movement or viring of money between providers e.g. social care transfer of budget from SMBC to SFT.
- This does not replace or delegate any statutory or regulatory powers as governed by statute or within provider licences.
- All staff will remain with their lead employer

2.3 A formal alliance provider agreement has been drawn up by the four parties in conjunction with Hempsons Solicitors and this will be formal approved and adopted by each of the respective boards.

3. Alliance Provider Board (APB)

3.1 Membership

3.1.1 The APB will be made up on an executive level representative of each Party who has the delegated authority to make decisions on behalf of the Party they represent.

3.1.2 Each Party will identify their executive level representative and delegate authority to make decisions to that individual within the scope of their role and as defined by that Party.

3.1.3 Where an executive cannot attend the APB, a deputy may only attend if prior approval is sought from the Chair. The deputy must have delegated decision making authority for the respective Party and this may need to have been ratified in accordance with the Party's scheme of delegation prior to the meeting.

3.1.4 Other attendees may attend the meeting with prior approval of the Chair.

3.2 Powers reserved to the Board / Governing Body

3.2.1 There may be matters where the respective Party's Board or Governing Body need to retain the ability to reserve the approval of some decisions for that Board / Governing Body.

3.2.2. The limits of the authority will be recorded in the individual Party's scheme of delegation and therefore the individual copies of the scheme of delegation for each body should be made available to the APB for reference purposes. For example each Party will be required at their appropriate decision making board decide the level of authority the representative has.

3.2.3 It is the responsibility of each party executive member to advise of the decisions whether delegated authority is not possible or where a financial limit is exceeded at each meeting of the APB or where possible in advance of the meeting. The Party executive member is expected to confirm what the approval process is and a timescale for resolution.

3.3 Chairman of the APB

3.3.1 The Chair of the APB will be appointed by the executive Party members for the duration of the Alliance Provider Agreement.

3.3.2 The Chair will be a non-voting independent member of the APB.

3.3.3 In the absence of the Chair, an executive member will chair the meeting but will retain their voting right should the need arise.

3.4 **Reporting to existing Party assurance processes**

3.4.1 The executive member is responsible for reporting to their Party the outcomes of the APB through established assurance processes within their Party's governance structure. This should be defined for each Party and a timetable, where appropriate, for each Party provided to aid with planning. For example, dates for Board of Director meetings

3.5 **APB meeting structure**

3.5.1 Due to the commercial in confidence nature of the business within the APB, the meetings will be held in private.

3.5.2 Meetings will be held on a monthly basis with records kept of the proceedings, decisions and advice of the group including brief minutes and more detailed decision summary documents.

3.6 **Terms of reference**

3.6.1 The terms of reference of the APB are set out in the alliance provider agreement, schedule 3.

3.6.2 The APB being quorate is defined in the terms of reference as an executive representative or agreed deputy for all four Parties.

4. Integrated Transitional Management Team (ITM Team)

4.1 An ITM Team will be established and will be accountable as per figure 2 to the APB.

4.2 The terms of reference for the ITM Team meetings are set out in Schedule 4 of the alliance provider agreement.

4.3 The ITM Team will have operational responsibility for the delivery of the Services within the Neighbourhoods, the intermediate tier and urgent response.

4.4 Each of the 8 neighbourhoods defined within the Stockport Together Neighbourhood Business Case will have an Integrated Neighbourhood Leadership Team (INL Team). This will consist of a lead GP, an Integrated Team Leader and a Senior Practitioner. The INL Team will be responsible for implementation of the Neighbourhood Business Case for their Neighbourhood.

4.5 The INL Teams will be responsible to the ITM Team

4.6 A memorandum of understanding for the INL Teams will be signed between Stockport NHS Foundation Trust and each INL Team as set out in Schedule 5 of the alliance provider agreement.

5. Alliance Provider Board virtual pooled budget

5.1 The Transformation Fund will continue to be received by Stockport CCG and in accordance with the agreement of the locality finance group be paid to the provider who is recruiting the staff and paying for the services relevant to the Transformation Fund.

5.2 In the event that the Alliance Provider Board wishes to procure a contract on behalf of all parties, it has been agreed that Stockport Foundation Trust will act as the Host. The other Parties will then reimburse the Host. This will follow SFT's scheme of delegation in specific relation to procurement and contracting.

5.3 There is not an expectation that there will be an increase in waiver activity due to the Host arrangement and that best procurement practice is followed in the probity of public money. The Trust's policies on employment contracts will also need to be adhered to and off-payroll arrangements will not be permitted.

5.4 For clarity, this scenario is likely to occur with the Parties using funding outside of the Transformation Fund, from their own resources and therefore is expected to be an uncommon event but the alliance provider agreement has been drawn up to cover most eventualities.

6. Host arrangements

6.1 Stockport NHS Foundation Trust will be the Host of the Integrated Neighbourhood Leadership Teams.

6.2 The Host will enter into a memorandum of understanding in the form set out in Schedule 5 of the alliance provider agreement.

6.3 As the Host the Standing Financial Instructions and Scheme of Reservation and Delegation (SoRD) of Stockport NHS Foundation Trust will apply. The most important points from these documents which are of particular relevance to the Host arrangement are as follows:

6.3.1 Quotation, tendering & contracting procedures – section 34 of SoRD and Table B delegated limits.

6.3.2 Signing and sealing of contacts – section 38 of SoRD and Table B delegated limits.

6.3.3 Employment contracts – section 33(a) and (r) of SoRD (as a minimum)

6.3.4 Financial planning / budgetary responsibility – section 15 of SoRD

6.4 The roles within the Neighbourhood Teams and the ITM Team are employed by one of the different providers with the Stockport Together partnership. As these roles will work across the four providers it needs to be explicit to each of those post holders as part of the governance arrangements and accountability, what they are authorised to undertake and how this fits within each Parties scheme of delegation and organisational policies.

6.5 A protocol should be introduced where each person who has financial authority on behalf of multi-Parties has the following:

(a) A copy of the scheme of delegation and standing financial instructions for the relevant Parties that they are required to sign receipt and acceptance of

(b) Specimen signatures are obtained and individuals added to additional Party authorised signature lists

(c) A hierarchy approval diagram is provided from each Party to show the clear authorisation levels for approvals for each role and where countersignatures are required

(d) Agreement will need to be reached on if there is a breach in SFIs of another Party that this is formally managed within the HR policy of the employing organisation

6.6 Any changes to the scheme of delegations can only be made by the relevant Party through their existing governance arrangements. A recommendation may be made from the alliance provider board to each of the Party boards to make an amendment for common working but the impact of this risk would need to be assessed by each individual Party.

6.7 The locality finance group at which Director of Finance level representation is made from all parties should be the sub-group which reviews the scheme of delegations and make recommendations to the alliance provider board.

6.8 If the relevant Party amends their scheme of delegation then it is the Party Director of Finance responsibility to ensure that the relevant staff are notified throughout the alliance.

6.9 An overall document should be maintained to show what is regarded as “in scope” for the purposes of Stockport Neighbourhood Care.

WORKED EXAMPLES OF SCHEME OF DELEGATION

The Director of Integrated Care is Margaret Malkin who is a Stockport Foundation Trust employee.

Example 1 – Current SFT SoRD

- A SFT District Nurse team leader wishes to raise an order to cover a stock of £18,000 of dressings for the year. This is from their own budget.
- The District Nurse Team leader is an authorised SFT budget holder but with an authorisation limit of level 2 budget holder and therefore can only authorise to £5,000
- The requisition then gets passed to the Director of Integrated Care to authorise
- The requisition is processed by the SFT procurement team

Example 2 – Current SFT SoRD

- The SFT District Nurse Team Leaders decide to award one contract across the neighbourhoods for dressings for £200,000 from existing SFT budgets
- The £200,000 is in excess of the District Nurse Team Leaders authority and whilst one of them may sign the requisition it is then countersigned by the Director of Integrated Care.
- The requisition is then passed to the Chief Executive or nominated Deputy of SFT to authorise
- The requisition is processed by the SFT procurement team

Example 3 – Proposed working arrangement

- As part of the transformation funding a contract is let by SMBC
- The value of the contract requires authorisation of the invoices by the Director of Integration
- The Director of integration is added to SMBC scheme of delegation at a level to be defined by SMBC
- If an escalated level is required within SMBC then this is defined and follows the SMBC scheme of delegation and not SFT

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Use of Resources assessment framework		
Report of:	Director of Finance	**Prepared by:**	Deputy Director of Finance

REPORT FOR APPROVAL

Corporate objective ref:	S3: C10 S4: C12 C13	**Summary of Report** The Use of Resources assessment framework was published in August 2017 jointly from NHSI and the CQC. It is focussed on trusts demonstrating value for money, evidencing both efficiency and effectiveness. The assessments will be introduced in autumn 2017 and this report shows the Trust's current available performance against the metrics which are predominantly recorded against Carter metrics within the Model Hospital The report shows that the Trust has a significant risk of being rated as requires improvement or inadequate. The report recommends that the trust will continue to track the metrics through the Executive Team and report to the Finance and Performance Committee.
Board Assurance Framework ref:	S2,S3,S4	
CQC Registration Standards ref:	Well-Lead KLOE 6	
Equality Impact Assessment:	☐ Completed X☐ Not required	

Attachments:	Annex A – Sample Report Documentation

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

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1. INTRODUCTION

1.1 The Use of Resources: assessment framework (UoR) was published jointly by NHS Improvement and the Care Quality Commission in August 2017. As a public sector organisation, NHS Foundation Trusts are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money. This is even more important in times of fiscal constraint.

1.2 The UoR assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of the Lord Carter's review of "Operational productivity and performance in English NHS Acute hospitals".

1.3 The principles that underpin the UoR assessment are that it should

- Lead to a focus on better quality, sustainable care and outcomes for patients
- Be proportionate, minimising regulatory burden and draw on existing data collections where possible
- Be clear to Trusts what information will be looked for and what "good" looks like by making all data available to trusts through the Model Hospital
- Promote good practice to aid continuous innovation and improvement
- Help NHSI identify trusts' support needs through the Single Oversight Framework, as well as being a useful implementation tool for organisations

1.4 The framework mirrors the structure of the joint Well-Led framework and CQC's inspection approach, where key lines of enquiry (KLOEs), prompts and metrics are used for a balanced assessment of a trust.

1.5 NHS improvement will introduce UoR assessments alongside CQC's new inspection approach from autumn 2017. In autumn 2017, the CQC and NHSI will also consult on how UoR ratings should best be combined with other ratings to yield an overall trust-level rating, to be introduced from 2018.

1.6 In advance of the UoR assessments this report will give a position statement of the current data available and the Trust's assessment against peers, where possible to highlight to the Board where further financial, quality and operational improvements are required.

2. BACKGROUND

2.1 Figure 1 overleaf shows the overview of the key lines of enquiry (KLOEs) and they correspond to what is considered the main areas of productivity.

Figure 1

Use of resources area	Key lines of enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

2.2 The starting point of the UoR assessment will be an analysis of trust performance against a number of initial metrics, local intelligence gathered during NHSI's day-to-day interaction with the trust, as well as any other relevant evidence.

2.3 The analysis will be followed by a qualitative assessment carries out during a one-day site visit to the trust and using the KLOEs and prompts to help probe trust performance in a consistent and comparable manner. There will be a standard approach to the team sent to the trust and expect to meet with a number of the trust's board members and relevant operational service leads e.g. chief pharmacist.

2.4 All relevant evidence will be collated into a report and used to reach a proposed rating of outstanding, good, requires improvement or inadequate in accordance with CQC practice. NHSI will use the UoR draft report and proposed rating to identify potential support needs at trusts.

2.5 NHSI will submit the draft UoR assessment report and proposed rating to the CQC, which will consider it as part of the process of preparing and finalizing its trust-level inspection reports. The CQC will consider NHSI's report and recommendations in determining the trust's final UoR rating and will publish the final report and rating alongside the trust-level inspection report and the current Quality rating.

3. CURRENT SITUATION

3.1 The KLOE themes and initial metrics which will be taken as part of the initial metrics are shown below in Figure 2

Use of resources area	Initial metrics
Clinical services	Pre-procedure non-elective bed days Pre-procedure elective bed days Emergency readmissions (30 days) Did not attend (DNA) rate
People	Staff retention rate Sickness absence rate Pay cost per weighted activity unit (WAU) Doctors cost per WAU Nurses cost per WAU Allied health professionals cost per WAU (community adjusted)
Clinical support services	Top 10 medicines – percentage delivery of savings target Overall cost per test
Corporate services, procurement, estates and facilities	Non-pay cost per WAU Finance cost per £100 million turnover Human resources cost per £100 million turnover Procurement Process Efficiency and Price Performance Score Estates cost per square metre
Finance	Capital service capacity Liquidity (days) Income and expenditure margin Distance from financial plan Agency spend

3.2 Appendix 1 shows the metrics and rationale which sit behind the initial metrics in Figure 2.

3.3 Appendix 2 shows the data for the Trust as is currently available within the Model Hospital or trust data. Where current data is available but not showing on the Model Hospital this has also been shown.

3.4 There are limitations with the current data as it is predominantly based on reference costs submitted for 2015/16, the refresh of 2016/17 is not due to take place until October 2017. Therefore the data is likely to change both from a Trust perspective and also from the benchmark comparisons. Also until the data is published it is not clear how the non-recurrent sustainability and transformation funding (STF) will be treated, as this distorts the true underlying financial position for a trust.

3.5 The Trust when using the Model Hospital can choose to select its "peer group" and for the purposes of this exercise the following group was used - East Cheshire, Bolton, Wigan, Wrightington & Leigh, Tameside, South Manchester, Warrington and Salford. The data also provides comparisons to the overall national picture and the position of the Trust compared to the lower, median and upper quartiles are shown.

4. RISK & ASSURANCE

4.1 From the data available the Trust has a significant risk of being rated as requires improvement or inadequate. The key reasons for this against the criteria which have been published as the ratings characteristics and using the data in Appendix 2 is covered in the following points.

4.2 The financial use of resources metrics is an overall score of 3 which is classified under the current ratings as triggering significant concerns. However the Trust is currently delivering its financial plan but the gap identified within the CIP plan for the rest of the financial year means that unless the Trust is able to put a financial recovery plan to meet its financial obligations then the rating will deteriorate as the distance from plan will not be achieved and the cash position will worsen as a result.

4.3 The Trust has significant agency costs for medical and nurse staffing and this is partly highlighted in the metric for staff costs per weighted activity unit. There is work to be down within the metrics to clarify the split between permanent and agency staff. As other metrics have shown the Trust to be an outlier for agency costs, there is a risk that the difference between the Trust and the national position looks worse than 15/16 when the 16/17 figures are published. This is because other Trusts may have been able to reduce their temporary staffing spend.

4.4 The high vacancy rates for staff retention has not been fully published by staff group, however there is an indicator on nurse and health visitor which is being flagged as red within the Model Hospital without a benchmark comparator, at 69.7%. Clearly the ability to safely staff wards and provide a quality service is one of the areas highlighted in the CQC reports and therefore triangulates to this.

4.5 The estates cost per square metre is higher than our peers and the median on the national picture. This does need to align to our estate strategy and overall CIP plan and further investigation could be undertaken in this area to understand, for example, the effectiveness of backlog maintenance.

5. CONCLUSION

5.1 The UoR assessment process is due to commence in Autumn 2017 and will follow a nationally defined process. The Trust understands the information that will be collated and where the date will be derived from.

5.2 There is a significant risk that the Trust will be given a low rating from the UoR assessment and therefore the Trust needs to develop actions alongside the review of undertakings report and the well-lead review process to ensure that the Trust improves its overall score.

5.3 The metrics behind the assessment will continue to be reported to the Executive Team as part of their regular updates. Reports will be taken to the Finance & Performance

Committee on a bi-monthly basis on current performance against the metrics and will provide assurance on actions being taken to improve performance, where required. The performance against Carter metrics for the Trust is a developing agenda and therefore future reporting will be developed as more information is published.

6. RECOMMENDATIONS

6.1 The Board is asked to note the Trust's current position in relation to the use of Resources Assessment and;

6.2 To endorse the proposed arrangements for monitoring performance against the Use of Resources metrics.

Appendix 1

Area	Initial metrics	Rationale
Clinical services	Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. Better performers will have a lower rate of readmission.
	Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
People	Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
	Sickness absence	High levels of sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
	Pay cost per weighted activity unit (WAU, a unit of clinical output)	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
	Doctors cost per WAU	This is a doctor-specific version of the above pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	Nurses cost per WAU	This is a nurse-specific version of the above pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	AHP cost per WAU	This is an AHP-specific version of the above pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.

Clinical support services	Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. A low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
	Top 10 medicines	As part of the top 10 medicines project, trusts are set trust-specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines (complex medicines that are clinically comparable to the branded product), the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Corporate services, procurement, estates and facilities	Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
	HR cost per £100 million turnover	This metric shows the annual cost of the HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score for five individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
	Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance	Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
	Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
	Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
	Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
	Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.

Appendix 2 – Current initial metric assessment

Area	Metric	Data range	Trust score	Carter RAG	Lower quartile	Median	Upper Quartile	Peer median	Notes	Date range for 17/18	Trust Score	
Clinical Services	Pre procedure non elective bed days	2016/17	0.75						No comparison data available	Aug-17	0.83	
	Pre procedure elective bed days	2016/17	0.09						No comparison data available	Aug-17	0.08	
	Emergency readmissions (30 days)	2016/17	8.53%						No comparison data available	Jun-17	8.78%	
	DNA rate	2016/17	8.7%						No comparison data available	Aug-17	9%	
People	Staff retention rate								No overall data available in Carter - sample included below	Jul-17	15.62%	Trust
	- Nursing & Health visitors	Mar-17	69.7%									
	- Midwifery	Mar-17	93.5%									
	Sickness absence rate	Mar-17	3.83%					4.24%	Lowest in peer group, in higher part of quartile 2			
	Pay cost per weighted activity unit (WAU)	2015/16	2,406		2,033	2,146	2,298	2,291				
	Doctors cost per WAU	2015/16	373		462	517	558	461				
	Nurses cost per WAU	2015/16	918		644	710	782	801				
	AHP cost per WAU	2015/16	197		100	122	143	136				
Clinical Support services	Top 10 Medicines % delivery of savings target	Jun-17	90,220		236,740	n/a	295,920	n/a	4th lowest from group sample of 115 - Data not collected for 2016/17 and into 17/18			
	Overall cost per test (assumed pathology)	2015/16	2.24		n/a	n/a	n/a	1.98	In middle of 3rd Quartile			
Corporate, procurement, estates and facilities	Non pay cost per WAU	2015/16	1,046		1,197	1,320	1,410	1,266				
	Finance cost per £100m turnover	2015/16	705,340					860,520	Just into 3rd quartile, middle range of peer group, however lower than peer median			
	HR cost per £100m turnover	2015/16	761,290					725,990	At top of 2nd quartile, middle range of peer group, however higher than peer median			
	Procurement process efficiency and Price Performance Score								Data not currently collated and available			
	Estates cost per SQM	2015/16	344		n/a	326	n/a	284				
Finance	Capital service capacity	2016/17	1	3						Q1 17-18	2.44	4
	Liquidity (days)	2016/17	8	1						Q1 17-18	(0.40)	2
	Income & expenditure margin	2016/17	-0.85%	3						Q1 17-18	-12.30%	4
	Distance from financial plan	2016/17	1.41%	1						Q1 17-18	0.90%	1
	Agency spend	2016/17	11.42%	1						Q1 17-18	20.60%	2
	Combined score	2016/17	2	2								3

Use of Resources: assessment framework

August 2017

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

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Introduction

1. As public-sector organisations, NHS trusts and NHS foundation trusts (here together referred to as trusts) are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

2. NHS Improvement's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of *Operational productivity and performance in English NHS acute hospitals*. They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, our approach will focus on acute non-specialist services, due to the availability and quality of data in this area. As we develop metrics for specialist acute, ambulance, mental health and community services, we will include them in this framework before introducing Use of Resources assessments to providers of these services.

3. The principles that underpin the Use of Resources assessment are that it should:

   - lead to a focus on better quality, sustainable care and outcomes for patients
   - be proportionate, minimising regulatory burden, and draw on existing data collections where possible
   - be clear to trusts what information we will look for and what 'good' looks like – all data will be made available to all trusts through the Model Hospital[1]
   - promote good practice to aid continuous innovation and improvement

[1] https://model.nhs.uk/

- help us to identify trusts' support needs through the Single Oversight Framework, as well as being a useful improvement tool for organisations.

4. The framework mirrors the structure of the joint Well-Led framework and CQC's inspection approach, where key lines of enquiry (KLOEs), prompts and metrics are used for a balanced assessment of a trust.

5. NHS Improvement will introduce Use of Resources assessments alongside CQC's new inspection approach from autumn 2017. In autumn 2017 CQC and NHS Improvement will also consult on how Use of Resources ratings should best be combined with other ratings to yield an overall trust-level rating, to be introduced from 2018.

Use of Resources: the assessment

6. Use of Resources assessments are based on a number of KLOEs, which are the lens through which trust performance should be seen (see Figure 1). The KLOEs correspond to the main areas of productivity – clinical services; people (including doctors, nurses and allied health professionals – AHPs); clinical support services (including pharmacy and pathology services); corporate services, procurement, estates and facilities; and finance. Data relating to all these areas can be found on the Model Hospital.

Figure 1: Overview of key lines of enquiry

Use of resources area	Key lines of enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

7. The starting point for Use of Resources assessments will be an analysis of trust performance against a small number of initial metrics, local intelligence gathered during NHS Improvement's day-to-day interactions with the trust, as well as any other relevant evidence, such as specific data and analysis drawn from the work of the Operational Productivity directorate within NHS Improvement and made available to trusts through the Model Hospital.

8. This analysis will be followed by a qualitative assessment carried out during a one-day site visit to the trust and using the KLOEs and prompts to help probe trust performance in a consistent and comparable manner. NHS Improvement's assessment team, made up of approximately five senior staff, will obtain input from the leadership team with responsibility in the areas of clinical and operational services, workforce and finances. We are likely to meet the trust's chair, chief executive officer, medical director, nursing director, finance director, human resources director, chief operating officer, head of procurement, head of estates and chief pharmacist.

9. All relevant evidence will be collated into a brief report and used to reach a proposed rating of outstanding, good, requires improvement or inadequate in accordance with CQC practice. NHS Improvement will use the Use of Resources draft report and proposed rating to identify potential support needs at trusts.

10. NHS Improvement will also submit the draft Use of Resources assessment report and proposed rating to CQC, which will consider it as part of the process of preparing and finalising its trust-level inspection reports. CQC will consider NHS Improvement's report and recommendations in determining the trust's final Use of Resource rating and will publish the final report and rating alongside the trust-level inspection report and the current Quality rating.

Use of Resources: the evidence

11. The Use of Resources assessment centres on delivery and performance at trust level currently and looking back over the previous 12 months. We recognise that trusts do not work in isolation and are working with, and affected by, their local health and care economies. CQC will assess the way trusts are working in their local systems through the updated Well-Led framework.[2] The Use of Resources assessment focuses on how effectively trusts are using their resources in the context of the funds available to them.

12. NHS Improvement will draw on a wide range of evidence that will include a basket of initial metrics, additional data or information collected by us and shared by the trust, local intelligence from our day-to-day interactions with the trust, and evidence gathered during a qualitative assessment (see Figure 2).

Figure 2: Evidence for Use of Resources assessments

Initial metrics	• How is the trust performing on each initial metric? • Is the trust an outlier on any of the initial metrics?
Additional evidence	• Is the trust an outlier on any of the wider set of metrics (eg Model Hospital, Getting It Right First Time (GIRFT), data supplied by the trust)? • Is there any data or information, shared with us by the trust, which is used internally to assess productivity?
Local intelligence	• Are there any areas of finance and productivity not covered by the metrics where the trust's performance is notable? Are there any areas of unrealised efficiencies? • What do we know about the trust's performance more generally, eg cost improvement programmes, private finance initiatives, local health and care economy context?
Qualitative assessment	• Please see key lines of enquiry and prompts

[2] https://improvement.nhs.uk/resources/well-led-framework/

Initial metrics

13. The initial metrics are the starting point for the Use of Resources assessment (see Figure 3). They include productivity metrics drawn from the work of the Operational Productivity directorate in NHS Improvement and cover clinical services; people (workforce); clinical support services; and corporate services, procurement, estates and facilities. All such metrics are available to trusts through the Model Hospital. The initial metrics under the finance KLOE contain the Finance and Use of Resources theme metrics currently in NHS Improvement's Single Oversight Framework.

14. For all metrics we consider in assessing trusts' use of resources, we will ask the following general questions:

    - How does performance compare with the national average and the trust's peer group?
    - Has the measure improved or deteriorated in the last 12 months?
    - Is there a reason or relevant context for the trust's performance?
    - Has the trust implemented any activities or interventions to improve performance as appropriate in the given area? Have these been effective?

15. The metrics will be used as the basis for engagement with trusts to understand the drivers for performance in these areas, and no single metric (and indeed no single piece of evidence throughout the assessment) will determine a trust's Use of Resources rating. (See Appendix A for further details about the rationale for inclusion of the initial metrics.)

16. All the initial metrics will be made available through the Model Hospital. However, it is important to note that not all of the metrics available on the Model Hospital are included in the initial metrics for this assessment. Other metrics on the Model Hospital are intended to give a broader, more granular view of productivity to support trusts to drive their own improvement, alongside the assessment process. Where new robust, high quality metrics become available, we will consider whether they provide broader insight into the productivity of trusts and should become part of the initial metrics.

17. A number of metrics, including 'cost per test', have only been recently developed and are currently being refined. This will be taken into

consideration when performing the assessments. We are also working to develop productivity metrics for specialist, mental health, community and ambulance trusts. The Use of Resources assessment will be adapted and introduced for non-acute trusts as and when these metrics are available.

Figure 3: KLOE themes and initial metrics

Use of resources area	Initial metrics
Clinical services	Pre-procedure non-elective bed days Pre-procedure elective bed days Emergency readmissions (30 days) Did not attend (DNA) rate
People	Staff retention rate Sickness absence rate Pay cost per weighted activity unit (WAU) Doctors cost per WAU Nurses cost per WAU Allied health professionals cost per WAU (community adjusted)
Clinical support services	Top 10 medicines – percentage delivery of savings target Overall cost per test
Corporate services, procurement, estates and facilities	Non-pay cost per WAU Finance cost per £100 million turnover Human resources cost per £100 million turnover Procurement Process Efficiency and Price Performance Score Estates cost per square metre
Finance	Capital service capacity Liquidity (days) Income and expenditure margin Distance from financial plan Agency spend

Additional evidence and local intelligence

18. Additional evidence and local intelligence gathered during day-to-day interactions with trusts will give NHS Improvement a broader and more rounded view of trust performance, helping us understand the context in which the trust operates. This may include any other relevant and useful data, such

as information from the Getting It Right First Time (GIRFT) specialty programmes or other data contained on the Model Hospital, such as proportion of consultants with an active job plan, pharmacy staff cost per WAU, medicines cost per WAU, percentage of transactions on e-catalogue, and estates and facilities cost per WAU. It will help identify areas of good performance, unrealised efficiencies and areas for improvement that may have been missed by examining the initial metrics alone.

19. In a similar way to CQC's inspection process and as part of CQC's provider information return, trusts will be asked to provide brief, high-level commentary against each KLOE ahead of each assessment. Trusts will also be asked to review NHS Improvement's analysis of the initial metrics and share more recent data that they think might be helpful to inform the assessment. NHS Improvement will review all submissions to inform our understanding of the trust's performance and identify areas that would benefit from particular focus at the on-site assessment. Some additional evidence may occasionally be requested after the on-site assessment to support qualitative evidence collected on the day.

Qualitative assessment

20. The aim of the prompts (see Figure 4) is to get a better understanding of trust performance, contextual information and improvement action undertaken by the trust. NHS Improvement will rely on these during the site visit, but will not be bound by them. Assessment teams are likely to ask additional questions and will not necessarily use all the prompts during the assessment.

Figure 4: Prompts for key lines of enquiry

KLOE	Prompts
Clinical services: How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?	• How far are delayed transfers of care that are within the trust's control leading to a lack of bed capacity and/or cancellations of elective operations? • Is the trust improving clinical productivity (elective and non-elective) by doing what could reasonably be expected of it in co-ordinating services across the local health and care economy? • What percentage of elective and non-elective cases are admitted on the day of surgery for each specialty? • Has the trust engaged with the GIRFT programme? What improvements have been made as a result?
People: How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?	• How is the trust tackling excessive pay bill growth, where relevant? • Is the trust operating within the agency ceiling? • How well is the trust reducing its reliance on temporary staff, in particular agency nurses and medical locums? • Are there significant gaps in current staff rotas? What has the trust been doing to address these? • Is the trust making effective use of e-rostering or similar job management software systems for doctors, nurses, midwives, AHPs, healthcare assistants and other clinicians? How many weeks in advance are the trust's rosters signed off? • Is there an appropriate skill mix for the work being carried out (clinical and otherwise)? • Are new and innovative workforce models and/or new roles being investigated? Is the trust making effective use of AHPs to improve flow? • Is the trust an outlier in terms of sickness absence and/or staff turnover? • What proportion of consultants has a current job plan? How is job plan data captured?

Clinical support services: How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?	• Is the trust collaborating with other service providers to deliver non-urgent pathology and imaging services? • Is the trust an outlier in terms of medicines spend? • Is the trust using technology in innovative ways to improve operational productivity? For example, patients receive telephone or virtual follow-up appointments after elective treatment.
Corporate services, procurement, estates and facilities: How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?	• What is the trust doing to consolidate its corporate service functions? Which functions are being consolidated and how? • Is the trust an outlier in terms of procurement costs? • Is the trust looking for and implementing appropriate efficiencies in its procurement processes? • What is the value of the trust's backlog maintenance (as cost per square metre) and how effectively is it managed? • How efficiently is the trust using its estate and is it maximising the opportunity to release value from NHS estate that is no longer required to deliver health and care services?
Finance: How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?	• Did the trust deliver, and is it on target to deliver, its control total and annual financial plan for the previous and current financial years respectively? • What is the trust's underlying financial position? • How far does the trust rely on non-recurrent cost improvement programmes (CIPs) to achieve financial targets? • What is the trust's track record of delivering CIP schemes? • Is the trust able to adequately service its debt obligations? • Is the trust maintaining positive cash reserves? • Is the trust taking all appropriate opportunities to maximise its income? • How does the trust use costing data across its service lines? • To what extent does the trust rely on management consultants or other external support services?

Ratings characteristics

21. The ratings characteristics (see below) describe what outstanding, good, requires improvement and inadequate use of resources look like. This framework, when applied using judgement and taking into account good practice and recognised guidelines, will guide NHS Improvement and CQC when assessing trusts' use of resources and determining ratings.

22. The characteristics set out the kinds of factors that will be taken into account in making the overall assessment. Ratings will reflect all the available evidence and the specific circumstances of the trust. A trust will not have to demonstrate all the attributes in a ratings characteristic to have it applied to them nor will a characteristic be applied purely because the majority of the attributes are considered to be present. Where a trust is in special measures for financial reasons, the trust rating will be no better than 'requires improvement'.

Outstanding
The trust is achieving excellent use of resources, enabling it to provide high quality, efficient and sustainable care for patients.

The trust takes a proactive, and often innovative, approach to managing its financial and non-financial resources, which supports the delivery of high quality, sustainable care and achieves excellent use of its resources.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of care or rehabilitation, for example a discharge to assess model, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Clinical productivity improvements are achieved by, for instance, appropriately co-ordinating services across the local health and care economy and in line with good practice identified through the GIRFT programme.

The organisation actively involves patients in scheduling elective care, leading to low DNA rates. Effective capacity and demand planning, and patient-centred care pathways support low levels of emergency readmissions and pre-procedure non-

elective and elective bed days.

There is effective control over staff costs with expenditure on staffing not exceeding initial staffing budget, low pay bill growth and low pay cost per weighted activity unit (WAU). The trust is operating below or at its agency cap and has low staff turnover and sickness levels. Innovative and efficient staffing models and roles are used to deliver high quality and sustainable care, including by ensuring there is an appropriate skill mix for the work being undertaken.

The organisation makes extensive use of job planning to effectively organise and deploy its entire workforce, including consultants, nurses and AHPs, to maximise productivity.

The trust can demonstrate the use of technology in innovative ways to improve productivity, for example through telephone and virtual follow-up appointments, real-time monitoring and reporting of operational data, medical staff job planning through e-rostering and electronic shift booking systems, e-prescribing, electronic catalogues for procurement and electronic payments.

The trust has implemented efficiencies across the majority of its procurement and back office functions, pharmacy, and pathology services through collaborative arrangements, including consolidation wherever possible, and leads transformation initiatives in these areas.

The trust's estates management, human resources and finance functions are cost effective, which is reflected in, for example, low estates and facilities running costs and a well-managed property maintenance backlog.

Financial resources are used as efficiently and effectively as possible to provide the best possible value (that is, quality and cost) to patients and taxpayers, as demonstrated by the trust's income and expenditure position.

The trust is in surplus and has an excellent track record of managing spending within available resources and in line with plans. It delivered its financial plan in the previous financial year and is on track to deliver its financial plan and meet its control total in the current financial year.

The trust has an ambitious cost improvement programme (CIP), which is currently delivering against plan, and delivered its planned savings in the previous financial year. CIPs have been driven by recurrent efficiency schemes, including those of a transformational nature.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support[3] in the last 12 months.

Good

The trust is achieving good use of resources, enabling it to provide high quality and sustainable care for patients.

The trust is actively managing resources to meet its financial obligations on a sustainable basis to deliver high quality care and good use of resources. There is evidence of a systematic approach to identifying and realising efficiency opportunities.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Some clinical productivity improvements have been achieved by, for instance, engaging with good practice identified by the GIRFT programme.

There is some evidence of effective communication with patients in respect of scheduling care, which is manifested in the trust's DNA rates. There is evidence of pathway development and/or capacity planning at service-line level leading to reduced emergency readmission rates and pre-procedure non-elective and elective bed days.

Staff costs are generally well controlled, demonstrated by expenditure on staffing not exceeding initial staffing budget and by the trust's pay bill growth, pay cost per WAU and staff turnover and sickness levels. The trust is operating at or around its agency cap. There are some examples of staffing innovation replacing traditional models of care delivery (for example, use of nursing associates).

The organisation makes good use of job planning to organise and deploy much of

[3] As defined in Secretary of State's Guidance under section 42A of the National Health Service Act 2006.

its workforce effectively, in particular doctors and nurses.

The trust uses technology in some areas to improve productivity and effectiveness, for example by good utilisation of digital systems, medical staff job planning and e-rostering systems.

The trust continues to look for and has implemented some efficiencies across its procurement and back office functions, pharmacy and pathology services, including consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions are fairly cost effective, which is reflected in, for example, its estates and facilities running costs and an effectively managed property maintenance backlog.

The trust is in surplus and broadly on track to deliver its planned financial position in the current year. Or the trust is in deficit, but the planned position shows a marked improvement on the previous year and the trust is meeting its control total.

The trust is able to demonstrate delivery against a CIP which is forecast to deliver the planned level of improvement at the end of the year and has delivered planned savings in the previous financial year.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected in its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support.

Requires improvement

The trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care. The approach to identifying and realising efficiency opportunities is not embedded across the organisation.

A material number of patients are not receiving care in the best clinical setting and the trust is not doing enough to address delayed transfers of care for patients out of acute hospital settings. Suboptimal discharge planning and a lack of collaborative

working are resulting in relatively high rates of emergency readmissions.

Some clinical improvements have been made; however, these have been inconsistently implemented and have not sufficiently taken into account the sustainability of the trust's service lines.

Staff costs are not effectively controlled within budget, as evidenced by the trust's pay bill growth, pay cost per WAU, distance from the trust's agency cap, and staff turnover and sickness levels. The trust consistently struggles to fill gaps in rotas, and has not maximised the benefits of innovative workforce models and new roles (for example, use of nursing associates).

The trust's use of technology to improve productivity is elementary, for example failing to maximise the benefits of job planning, e-rostering systems or basic electronic catalogues for procurement.

The trust is still at early stages of considering the implementation of efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions could be more cost effective, which is reflected, for example, in its estates and facilities running costs and inconsistent management of its property maintenance backlog.

The trust is in deficit and is delivering a financial plan that does not improve on the previous year's position or meet its control total.

The trust did not realise its cost improvement programme for the previous financial year. Its current cost improvement programme is behind plan, and there is significant risk it will not be achieved by the end of the year.

The trust is not able to consistently meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is unable to maintain positive cash balances without the need for interim support or is expecting to require this support in its current plans.

Inadequate

The trust is not making adequate use of its resources, putting at risk its ability to provide high quality, efficient and sustainable care for patients.

The trust is not managing its resources in a way that supports the delivery of high quality care or demonstrates adequate use of resources is being achieved. There are significant and wide-ranging unmet efficiency opportunities.

The trust is unable to control its staff costs, including, for instance, unwarranted pay bill growth that is significantly higher than comparable peers, high pay cost per WAU, and agency costs that are more than 50% above the trust's agency cap. The trust's workforce is not being used effectively, demonstrated by substantial or frequent staff shortages, high turnover and staff sickness rates and ineffective job planning.

The trust's estates management, human resources and finance functions are inefficient, demonstrated by, for example, high estates and facilities running costs. There is no effective programme in place to repair and maintain the trust's estate.

The trust is not utilising its existing digital systems effectively and is doing little to use technology to improve efficiency; for example, there is no use of basic electronic catalogues for procurement and no payments are made electronically.

The trust has undertaken little or no work to implement efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

Plans for patient discharge or transfers are incomplete or significantly delayed, and as such patients are not moved into settings that are more appropriate for the delivery of their care or rehabilitation, or are not being cared for in the best clinical setting. Poor discharge planning and a lack of collaborative working are resulting in unacceptably high rates of emergency readmissions.

Few clinical improvements have been made, often implemented inconsistently and having little or no impact on the sustainability of the trust's service lines.

The trust is in deficit and its financial plan does not improve on the previous year's position or meet its control total. Or the trust is in deficit and off track to deliver its financial plan and is not expecting to recover within the financial year.

The trust's CIP is materially behind plan and it is not able to recover the position.

The trust is not able to meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is unable to maintain positive cash balances without the need for interim support.

Appendix A: Use of Resources metrics and rationale

Area	Initial metrics	Rationale
Clinical services	Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. Better performers will have a lower rate of readmission.
	Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
People	Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
	Sickness absence	High levels of sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.

	Pay cost per weighted activity unit (WAU, a unit of clinical output)	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
	Doctors cost per WAU	This is a doctor-specific version of the above pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	Nurses cost per WAU	This is a nurse-specific version of the above pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	AHP cost per WAU	This is an AHP-specific version of the above pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Clinical support services	Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. A low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
	Top 10 medicines	As part of the top 10 medicines project, trusts are set trust-specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines (complex medicines that are clinically comparable to the branded product), the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Corporate services, procurement, estates and facilities	Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.

	HR cost per £100 million turnover	This metric shows the annual cost of the HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score for five individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
	Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance	Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
	Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
	Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
	Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
	Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Presentation of Annual Fire Safety Report 2016/17		
Report of:	Chief Executive	**Prepared by:**	Head of Estates

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** *This report provides the Trust Board with the level of assurance expected in order to be compliant with the Regulatory Reform (Fire Safety) Order 2005 for all premises which the Trust own, occupy or manage. Compliance is achieved by applying the firecode through the Department of Health's fire safety policy. It clearly sets out the current fire safety strategy and management arrangements in place and reports on Fire risk Assessments, Audits, Training and false alarms concluding with an assurance statement.*
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☒ Not required	

Attachments:	Annex A – Chief Executive letter 'Annual statement of fire safety'

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

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1. INTRODUCTION

1.1 Stockport NHS Foundation Trust has a statutory duty to manage all risks associated with fire and to ensure that our staff, patients and visitors are safe from fire under the Regulatory Reform (Fire Safety) Order 2005 (the RRO). Additionally we are expected to comply with Department of Health guidance as detailed within the "Firecode" series of Health Technical Memoranda (HTM).

1.2 This paper provides assurance that we meet both our statutory obligations and are compliant with DoH Guidance and also updates the Board on progress against the fire strategy put in place across the Trust.

1.3 2013 saw the emergence of NHS Property Services Ltd as a principle landlord and most of our community healthcare services operate out of their premises. Until 2015 we were commissioned to undertake fire safety audits across their estate. However, this contract concluded at the end of March 2015 and NHS Property Services Ltd have yet to fully determine their ongoing fire safety arrangements. We have to ensure the safety of our staff so in addition to seeking their assurance over their standards of fire safety, it will be necessary to undertake a number of "sample" audits of community buildings to demonstrate due diligence which are summarised in section 4.3.

2. FIRE SAFETY STRATEGY

2.1 The strategy has two central elements – "Principles" and "Ownership". The Principles element involves a three staged approach:

i. Prevention. Essentially doing everything possible to avoid an ignition source coming into contact with combustible materials. Whilst the primary aim must always be to stop fires starting in the first place, the risk of fire can never be completely eliminated - so;

ii. Protection. Ensuring that should a fire start, our buildings are designed, built and maintained to confine fire and smoke to as small a space (compartment) as possible and that any outbreak will be detected early by our state of the art fire alarm system; and finally

iii. Response. Ensuring that staff are properly trained and equipped to respond appropriately according to their designated role and responsibility.

2.2 The second element, Ownership is paramount. Everyone has a part to play in achieving effective fire safety. Fires are prevented by staff being collectively vigilant and applying and abiding by relevant policies and procedures. The specialist role of the fire officers cannot by itself ensure any greater level of fire safety than we already have.

2.3 Furthermore, Health Technical Memorandum 05-01 (HTM) now makes it very clear that responsibility for fire safety includes everyone with a managerial role. For managers to discharge this responsibility, they need to be adequately trained.

2.4 These two elements will be discharged very broadly as described in the following table:

Element 1 **PRINCIPLES**	**Methods to achieve**	**Persons responsible**
Prevention	**Training Programmes:–** induction/mandatory/patient evacuation/fire warden/fire safety for managers/Local specific training **Policies and Procedures:-** e.g. Waste Management/Smoking Policy/etc. **Fire Risk Assessments and Fire Safety Audits** (NB reports are broken down into local management issues and issues that require Estates involvement)	**Fire Officers** to deliver **All Managers** to nominate their staff to attend as required and then employ the skills acquired **Fire Officers** to draft and/or contribute to policy/SOP development **All Managers** to ensure compliance and performance manage **Fire Officers** to undertake and report findings to relevant managers. **Managers** to action issues reported
Protection	**Fire Risk Assessments and Fire Safety Audits**	**Fire Officers** to undertake and report building defects to the Director of Estates & Facilities **Director of Estates & Facilities** to implement repairs/improvements to the fabric of buildings
Response	**Training Programmes:–** induction/mandatory/patient evacuation/fire warden/fire safety for managers/Local specific training	**Fire Officers** to deliver training and maintain response policies **All Managers** to designate fire wardens and arrange for training **Switchboard** to call the Fire and Rescue Service (FRS) NB Managing the situation until the arrival of the FRS is the responsibility of the most senior person present at the time.
Element 2: **OWNERSHIP**	**Training Programmes:–** induction/mandatory/patient evacuation/fire warden/fire safety for managers/Local specific training	**Fire Officers** to deliver **All Managers** to nominate their staff to attend as required and then employ the skills acquired **All Managers** to ensure compliance with policies and procedures and actively promote a fire safety culture

3. PRINCIPLES OF FIRE SAFETY MANAGEMENT

3.1 HTM 05-01 brings together all aspects relating to the management of fire safety within an NHS setting and therefore provides a framework for the implementation of the Department of Health's fire safety policy, offering an appropriate method for meeting statutory duties under the RRO.

3.2 HTM 05-01 requires those responsible for fire safety within healthcare premises in England to comply with prevailing legislation. In implementing a fire safety approach within the Trust we apply the following methodology:

Implementation of HTM 05-01 ' Managing Healthcare Fire Safety			
Requirement	**Process**	**Action**	**Assurance**
A risk Managed Approach	Annual Fire Safety Audit programme in line with HTM guidance – which identifies fire hazards and reviews the baseline fire risk assessment	1. Develop a prioritised list of works for completion via the capital programme 2. Details shared with the Business Group with follow up by the fire officer	All capital work identified from original fire risk assessment has now been completed
Comply with monitoring and reporting mechanisms	Regular review of systems and processes including the provision of training records	Fire safety managed and reviewed through: 1. Quarterly Risk & resilience Group 2. Estates Monthly Quality Board 3. Regular discussion with GMFRS	Evidence of review monitoring actions leading to completion or mitigation to reduce risk
Develop partnership initiatives with other agencies & bodies in the provision of fire safety.	Due diligence review of NHS Property Services	Review of management approach through inspection and discussions with NHS Property Service lead officers	Original due diligence review prior to transfer identified low risks (similar to those identified in the hospital

4. APPLICATION ACROSS STOCKPORT NHSFT

4.1 The original programme of Fire Risk assessments (FRA) were completed to provide a baseline for all buildings on the Stepping Hill site, Swanbourne, the Meadows and for the Devonshire Unit during 2009/10. Consequently an annual programme of Fire Safety Audits (FSA) has been established, the purpose of which is twofold;

- To ensure that the original FRA is still accurate and valid; and
- To identify any fire safety weaknesses and to initiate action accordingly.

4.2 The outcomes of these audits are reported to the relevant Business groups and Directorates. The reports break down into two areas;

- Those aspects that can only be addressed by the investment of capital and are therefore directed to the Estates Directorate for attention; and
- Those that should be addressed locally through management intervention.

4.3 Sample audits were completed on four community buildings which are managed by NHSPS and the findings listed below were reported to Margaret Malkin and NHSPS for action.

- South Reddish Clinic two issues were identified, no fire warden was in post and notices for manual call points were present.
- Hazel Grove Clinic no issues noted.
- North Reddish Clinic no issues noted.
- Adswood Clinic no issues noted.

5. FALSE ALARMS

5.1 False alarms drain our resources and interrupt normal service delivery. Additionally they place an unacceptable burden on the Fire and Rescue Service. Whilst they are responding to a false alarm they are not available for genuine emergencies.

5.2 There were a total of 37 fire alarm related false alarms reported in the period April 2016 - March 2017 affecting Trust buildings. This represents a slight increase on the previous year

5.3 Of the 37 false alarms only one was due to staff acting in good faith having smelled something unusual. Raising the alarm for genuine reasons is not to be discouraged. However, other false alarms are mainly preventable. Of the 36 preventable false alarms by cause:

- False alarm due to cooking – in the main, burnt toast (10 occasions) - 28%;
- False alarms caused by patients and visitors – this includes contractors and alarm activations by visitors “accidentally” breaking a call point (14 occasions) – 39% and
- False alarms due to technical apparatus faults (12 occasions) – 33%.

To put these figures into context, during 2010/11 the Trust experienced 62 false alarms – so good progress is being made.

6. FIRE SAFETY TRAINING

6.1 A total of 1,231 Trust staff received “Essentials” fire safety training last year. A further 770 new staff received induction training. Therefore a total of 2,001of our staff received fire training last year compared with 2,534 the year before. Two years ago saw the change from Mandatory to Essentials training with a corresponding reduction in attendance frequency from two to three yearly. Whilst the 2016/17 figures are lower than for 2015/16, the three year cycle means we should deliver training to 33% of staff each year whereas we have already trained 39% of the Trust’s 5,219 staff.

6.2 In addition to staff trained during the induction and mandatory processes the following table details additional resilience and fire safety training delivered over the year:

Title	Target Audience	Numbers attending
Locally Specific	Fire safety training for those working in areas of particularly high fire risk or with specific consideration across the hospital e.g. pharmacy, radiology, Treehouse etc.	120
Fire Warden	Staff delegated fire safety responsibilities at ward/dept. level	30
Evacuation Training	Patient facing staff from wards that would be involved in the evacuation of non-ambulatory patients	313
Volunteers	All volunteers to receive fire safety induction	102
Nursing Students	All students to receive fire safety induction	188
Doctors	All "new" intake of doctors to receive fire safety induction	200
International Nurses	All new staff to receive evacuation training	48

6. FIRE SAFETY ASSURANCE STATEMENT

6.1 The Board can be assured that our existing arrangements are comprehensive and robust. Our detailed systematic approach to the management of fire safety is in line with HTM 05-01 is clearly evident.

6.2 We can demonstrate clear protocols for fire risk assessments on properties we own. Flowing from the assessments we have developed and completed a programme of works that has reduced to as low as reasonably practicable the significant risks identified by the fire risk assessments.

6.3 We have procedures in place that monitor fire safety in all the properties we occupy but not for those that are owned by a third party – primarily NHS Property Services.

6.4 Essentials fire safety training for staff is well attended. We continue to develop training packages to move to more localised training within the workplace but this has been difficult to arrange and deliver for community staff.

7. RECOMMENDATIONS

7.1 The Board recognises the report and supporting Chief Executive letter as assurance that the Trusts Estates & Facilities directorate continue to operate safe managed systems for fire safety within all properties their staff, patients and visitors occupy.

7.2 The Board also recognises the assurance given within the report that Estates & Facilities plans and supporting actions ensure that the FT can continue to meet its statutory obligations under the RRO.

Annex A

Stockport NHS
NHS Foundation Trust

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Ann Barnes
Chief Executive
Stockport NHS Foundation Trust
Stepping Hill Hospital
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19th September 2017

Dear Ann,

Re: Annual Statement of Fire Safety – 1st April 2016 – 31st March 2017

I confirm that for the period 1st April 2016 to 31st March 2017, all premises which the organization owns, occupies or manages have had fire risk assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005. There are no significant risks arising from the fire risk assessments. The organisation achieves compliance with the Departments of Health's Fire Safety Policy by the application of Firecode.

Yours sincerely,

David Statham
Head of Estates

Richard Hardman
Fire Safety Officer

Ann Barnes
Signature of Chief Executive

19/9/17

Your Health. Our Priority.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 September 2017
Subject:	Committee Terms of Reference – Periodic Review		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

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

The purpose of this report is to present the Terms of Reference for the People Performance Committee and Finance & Performance Committee for approval following periodic review.

Attachments:	Annex A – Draft People Performance Committee Terms of Reference Annex B – People Performance Committee Self-Assessment Pro Forma Annex C – Draft Finance & Performance Committee Terms of Reference Annex D - Finance & Performance Committee Self-Assessment Pro Forma

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Terms of Reference for the People Performance Committee and Finance & Performance Committee for approval following periodic review.

2. PEOPLE PERFORMANCE COMMITTEE

2.1 The People Performance Committee completed a review of its Terms of Reference during a meeting held on 18 July 2017 and agreed that no amendments to the current Terms of Reference were required. Consequently, the Committee recommended the Terms of Reference included at Annex A to the Board of Directors for approval.

2.2 Board members will note that s7.1 of the Terms of Reference requires the Committee to complete an annual review of effectiveness. This review was also completed at the meeting held on 18 July 2017 and the outcomes of the review are included for information at Annex B of the report.

3. FINANCE & PERFORMANCE COMMITTEE

3.1 The Finance & Performance Committee completed a review of its Terms of Reference during a meeting held on 20 September 2017 and agreed a range of amendments to the current Terms of Reference. The proposed amendments are identified by means of strikethrough and/or bold font italics in the document included for reference at Annex C of the report. The Committee recommended the revised Terms of Reference to the Board of Directors for approval.

3.2 Board members will note that s7.1 of the Terms of Reference requires the Committee to complete an annual review of effectiveness. This review was also completed at the meeting held on 20 September 2017 and the outcomes of the review are included for information at Annex D of the report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Approve the draft Terms of Reference for the People Performance Committee included at Annex A to this report.
- Approve the draft Terms of Reference for the Finance & Performance Committee included at Annex C to this report.
- Note the outcomes of annual reviews of effectiveness included at Annex B and Annex D of the report.

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Stockport NHS
NHS Foundation Trust

PEOPLE PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee, to be known as the People Performance Committee *(hereinafter referred to as 'the Committee')*. The Committee has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to seek assurance on matters relating to workforce, education and learning, equality and diversity and organisational development. The Committee will also seek assurance on the development of strategic plans in these subject areas and make recommendations as appropriate to the Board of Directors.

2.2 The main functions of the Committee are to:

i. Review draft strategies relating to Workforce & Organisational Development and make recommendations as appropriate to the Board of Directors.

ii. Seek assurance on delivery of approved Workforce & Organisational Development-related strategies

iii. Consider and approve Workforce & Organisational Development-related policies

iv. Seek assurance on performance against Workforce & Organisational Development metrics and periodically review the range of agreed metrics

v. Monitor the effectiveness of controls to mitigate high level (score of 12 or above) Workforce & Organisational Development-related risks

vi. Obtain assurance on the effectiveness of learning and development activities across the Trust

vii. Approve annual workforce, education, commissioning and training plans having obtained assurance that such plans are consistent with Trust strategy

viii. Consider the outcomes from staff surveys and seek assurance on the effectiveness of associated management actions

ix. Obtain assurance on discharge of the Trust's responsibilities relating to equality and diversity

x. Consider evidence and/or proposals relating to Workforce & Organisational Development-related best practice and advise accordingly

xi. Consider initiatives aimed at promoting and sustaining a healthy workforce.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Non-Executive Director (Chair)
- Two x Non-Executive Directors (one of whom will be Deputy Chair)
- Director of Workforce & Organisational Development
- Chief Operating Officer
- Director of Nursing & Midwifery
- Deputy Medical Director

There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures to address any repeated instances of non-attendance.

3.2 The following post-holders shall routinely attend meetings of the Committee in an advisory capacity:

- Deputy Director of Workforce
- Head of Learning & Organisational Development
- Director of Medical Education
- Consultant in Occupational Health Medicine
- Head of Communications

3.3 Nominated deputies shall attend in the event of absence of any member; however this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in s3.1.

3.4 Other Officers of the Trust shall attend at the request of the Committee in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote.

3.5 ***Quorum***. No business shall be transacted unless at least four members, to include at least one Non-Executive Director, are present. Deputies in attendance do not count towards the quorum.

3.6 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

3.7 ***Frequency of meetings***. The Committee will, as a minimum, meet on a monthly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.6 above.

3.8 ***Minutes***. The minutes of meetings shall be formally recorded by a member of the Corporate Governance team, checked by the Chair and submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it.

3.9 ***Administration***. The Committee shall be supported administratively by the Corporate Governance team, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting and advising the Committee on pertinent areas.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS

5.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks. A Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6. RELATIONSHIP WITH OTHER COMMITTEES / GROUPS

6.1 The Committee will receive reports, in the form of Key Issues Reports, from the following Committees / Groups:

- Workforce Efficiency Group
- Equality & Diversity and Human Rights Steering Group
- Learning and Education Governance Committee
- Engagement and Culture Programme Steering Group

- Joint Consultative Committee
- Local Negotiating Committee

The Committee will also receive reports from any task and finish group it may elect to establish from time to time.

7. REVIEW

7.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

7.2 Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance team providing support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee. In addition, the annual review described in s7.1 will include a summary on compliance with the Terms of Reference.

COMMITTEE SELF-ASSESSMENT PROFORMA

Name of Committee: People Performance Committee Date: 18 July 2017

Question	Yes	No	N/A	Comments/ improvements needed or planned
Is there a work plan for the Committee and does the work plan cover the functions detailed in the Committee's terms of reference?	✓			Committee Chair and Director of Workforce & OD to re-assess work plan content.
Are the terms of reference subject to annual review by the Committee?	✓			
Does the composition of the Committee provide an appropriate range of skills and experience?	✓			
Do all Committee members participate fully in meetings in terms of providing effective scrutiny and constructive challenge?	✓			
Do all Committee members routinely attend meetings?		✓		Need to ensure regular attendance of Executive Director members.
Are meeting agendas manageable within the time allotted for meetings?		✓		The size of agendas often impairs the effective conduct of Committee business. Work plan to be re-assessed to streamline flow and greater use to be made of the consent agenda.
Are papers circulated in good time for members to be able to consider them properly?	✓			
Does the Chair keep the Committee focused while allowing sufficient debate?	✓			
Are decisions made on a firm evidence base?	✓			
Are actions agreed by the Committee clearly recorded, assigned appropriately and reviewed at subsequent meetings?	✓			
Does the Committee routinely report to the Board of Directors?	✓			

Any other comments?

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Stockport NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

DRAFT TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee, to be known as the Finance & Performance Committee *(hereinafter referred to as 'the Committee')*. The Committee has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to seek assurance on all aspects of the Trust's financial performance, ***operational performance and the planning and delivery of strategic change programmes.*** ~~financial strategy, investment and commercial activities. The Committee will seek assurance on matters relating to planning and delivery of the Trust's strategic change programmes.~~ ~~which incorporate the Trust Strategy and the Innovation Programme.~~

2.2 The Committee will also seek assurance on the Trust's response, and the effectiveness of this response, to strategic developments in the local and/or regional health economy.

2.3 The main functions of the Committee are to:

i. obtain assurance on the development and effectiveness of the Trust's financial plans

ii. review performance against key financial metrics and advise on Executive action to address any adverse trends

iii. obtain assurance on both the planning of cost improvement programmes and delivery of in-year programmes

iv. review draft Capital programmes, recommend to the Board of Directors for approval and obtain assurance on delivery of approved in-year Capital schemes

v. obtain assurance on the effectiveness of controls to mitigate high level Finance-related risks

vi. review proposed transactions that fall within the NHS Improvement definition of significant and material transactions and make recommendations as appropriate to the Board of Directors

~~vii. seek assurance on the effectiveness of the Trust's investment and borrowing policies~~

viii. obtain assurance on the effectiveness and sustainability of the Trust's commercial activities

ix. receive, review and recommend business cases with an investment value in excess of £1m (capital and/or revenue) to the Board of Directors as appropriate

~~x. consider the outcomes of post-implementation reviews for investments with a value in excess of £1m and seek assurance from management that any identified learning has been effectively addressed~~

~~xi. review and recommend to the Board of Directors, any formal financial submissions to NHS Improvement outside of normal monthly and/or quarterly returns~~

~~xii. receive, review and recommend Finance-related strategy documents to the Board of Directors as appropriate~~

xiii. validate Finance-related and IM&T-related policy documents

xiv. ***obtain assurance on both the delivery of key operational performance metrics and the effectiveness of management action to address any areas of under-performance***

~~xv.~~ obtain assurance on the preparation of ***the annual Operational Plan and compliance with relevant regulatory standards or best practice guidance.*** ~~annual plans for delivery of the Trust's Strategy~~

xvi. obtain assurance on ***delivery of the*** ~~progress with strategic change programmes detailed in the annual~~ ***Operational*** ~~Integrated Delivery~~ Plan ***including progress against strategic change programmes***

xvii. obtain assurance on benefits realisation from strategic change programmes and/or Innovation projects through consideration of post-implementation reviews.

~~xviii. advise on Executive action to address barriers to progress and/or mitigate risks to programme delivery.~~

~~xix.~~ obtain assurance on the effectiveness of controls to mitigate high level risks associated with ***financial performance, operational performance and*** strategic change programmes. ~~and / or Innovation projects.~~

xx. obtain assurance on the Trust's participation, and the effectiveness of participation, with external strategic change programmes such as; Stockport

Together, Healthier Together and Greater Manchester ~~Devolution~~ ***Health & Social Care Partnership***

xxi. receive, review and recommend documents relating to the Trust's ***Financial, Operational Performance and overall Strategy*** ~~overarching strategy~~ to the Board of Directors as appropriate

~~xxii. obtain assurance that the strategic planning activities of the Trust meet the requirements of any relevant regulatory standards or best practice guidance.~~

2.4 There is an expectation that reports to the Committee will be fully integrated, where appropriate, to ensure that the Committee is informed of the financial, operational and quality implications relating to the subject matter of reports.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Non-Executive Director (Chair)
- 3 x Non-Executive Directors (one of whom shall be Deputy Chair)
- ~~Deputy Chief Executive~~
- Director of Finance
- Chief Operating Officer
- Director of Workforce & Organisational Development
- Director of Nursing & ~~Midwifery~~ ***Quality***
- ***Director of Support Services & Partnerships***
- ~~Financial Improvement Director~~

There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.2 Nominated deputies shall attend in the event of absence of any member; however this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in s3.1.

3.3 Other Officers of the Trust shall attend at the request of the Committee. ~~in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate.~~ However, only members of the Committee are permitted to vote. The Chairman of the Trust and the Chief Executive will have a standing invitation to attend Committee meetings but are not permitted to vote.

3.4 ***Quorum***. No business shall be transacted unless at least five members, to include at least one Non-Executive Director and at least one Executive Director, are present. Deputies in attendance do not count towards the quorum.

3.5 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

3.6 ***Frequency of meetings***. The Committee will, as a minimum, meet nine times a year. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.5 above.

3.7 ***Minutes***. The minutes of meetings shall be formally recorded by a member of the Corporate Governance team, checked by the Chair and submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it.

3.8 ***Administration***. The Committee shall be supported administratively by the Corporate Governance team, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting and advising the Committee on pertinent areas.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS

5.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks. A Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6. RELATIONSHIP WITH OTHER COMMITTEES / GROUPS

6.1 The Committee will receive reports, in the form of Key Issues Reports, from the following Committees / Groups:

- Financial Improvement Group
- Cash Action Group
- ~~Health Informatics Strategy Board~~
- ***EPR Programme Board***

- Capital Projects Development Group

The Committee will also receive reports from any task and finish groups which may be established from time to time.

7. REVIEW

7.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

7.2 Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance team providing support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee. In addition, the annual review described in s7.1 will include a summary on compliance with the Terms of Reference.

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COMMITTEE SELF-ASSESSMENT PROFORMA

Name of Committee: Finance & Performance Committee Date: 20 September 2017

Question	Yes	No	N/A	Comments/ improvements needed or planned
Is there a work plan for the Committee and does the work plan cover the functions detailed in the Committee's terms of reference?	✓			
Are the terms of reference subject to annual review by the Committee?	✓			
Does the composition of the Committee provide an appropriate range of skills and experience?	✓			We probably need more strategic change expertise, based on how much the Trust is currently undertaking.
Do all Committee members participate fully in meetings in terms of providing effective scrutiny and constructive challenge?		✓		- More Executive input is need. Executive participation is often restricted to item they are presenting. - The Committee often feels like the NEDs seeking assurance/holding to account whilst the Execs are "on the receiving end". There would be a benefit from more challenge between the Execs and a feeling of more collective participation.
Do all Committee members routinely attend meetings?	✓			
Are meeting agendas manageable within the time allotted for meetings?		✓		- The Committee has agreed to extend meeting timings in order to effectively manage the volume of business. - The Chair will need to manage size of agendas and meeting flow.
Are papers circulated in good time for members to be able to consider them properly?	✓	✓		- Sometimes papers are a little late, but this would be hard to improve as data needs to be current. - The quality of papers is variable and they do not always clearly articulate the purpose, key points, present options and recommendations or triangulate data. As a result, the total volume of paper to be read at what is always relatively short notice is unrealistic. - Papers should be reviewed before submission and, if not up to standard, rewritten.

Does the Chair keep the Committee focused while allowing sufficient debate?	✓			- Yes, but scope for debate difficult in view of agenda size. - It is sometimes hard to pin down exactly what actions came from some of the discussions. This is also related to the point above on quality of the papers, meaning that significant time is spent trying to understand issues/dig for better understanding during the meetings. - When some papers are approved without discussion we should explicitly document that this was due to the assurance found there.
Are decisions made on a firm evidence base?	✓	✓		- We can on occasions have flaky evidence, EPR benefits are a prime example. - Papers need to focus more on the key issues and potential solutions with clear recommendations. - Some evidence/the basis of evidence appears to change between meetings, so it can be hard to be sure the base is firm. Information on CIP and strategic change programmes can be particularly variable
Are actions agreed by the Committee clearly recorded, assigned appropriately and reviewed at subsequent meetings?	✓			
Does the Committee routinely report to the Board of Directors?	✓			

Any other comments?

- The Committee needs to incorporate reporting on relevant Stockport Together developments.
- The Committee needs to fully integrate finance and performance aspects.