NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

31 JANUARY 2019

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 31 January 2019

Board of Directors Meeting
Thursday, 31 January 2019

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

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		**A Belton**
0935	**4.**	Patient Story – Dan's Story		**A Lynch**
	5.	**OPENING MATTERS**		
0955	5.1	Minutes of Previous Meeting: 29 November 2018	✓	**A Belton**
1000	5.2	Chair's Report	✓	**A Belton**
1005	5.3	Chief Executive's Report	✓	**L Robson**
1015	5.4	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
1020	6.1	Performance Report	✓	**H Mullen**
1050	6.2	Trust Strategy Update	✓	**H Mullen**
1110	6.3	Operational Plan 2019/20 – Progress Report	✓	**H Mullen**
1130	6.4	Corporate Objectives – Quarter 3 Progress	✓	**H Mullen**
	7.	**FINANCE & QUALITY**		
1135	7.1	Safe, High Quality Care Improvement Plan	✓	**A Lynch**
1145	7.2	Safeguarding Report	✓	**A Lynch**
1155	7.3	Learning from Deaths Report	✓	**C Wasson**
1205	7.4	Delivery Plan for Medium Term Financial Strategy	✓	**F Patel**
	8.	**GOVERNANCE**		
1215	8.1	Charitable Funds Annual Accounts	✓	**F Patel**
1225	8.2	Trust Risk Register	✓	**A Lynch**
1235	8.3	Board Assurance Framework	✓	**A Lynch**

9. CONSENT AGENDA

9.1 • Remuneration Committee Terms of Reference

10. DATE, TIME & VENUE OF NEXT MEETING

10.1 Thursday, 28 February 2019, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public on Thursday, 29 November 2018 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr D Hopewell	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Ms H Brearley	Interim Director of Workforce & OD
Mr P Buckingham	Director of Corporate Affairs
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mr H Mullen	Deputy Chief Executive
Mr F Patel	Director of Finance
Ms S Toal	Chief Operating Officer
Ms J Wood	Urgent and Emergency Care Improvement Director

In attendance:

Mr M Brearley	Interim CIP Director
Dr G Burrows	Deputy Medical Director
Mrs S Curtis	Membership Services Manager

270/18 Apologies for Absence

Apologies for absence were received from Mrs H Thomson and Dr C Wasson.

The Chair welcomed Board members and observers to the meeting.

271/18 Declaration of Interests

There were no interests declared.

272/18 Patient Story

The Chair reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board providing real and personal examples of the issues within the Trust's quality and safety agendas. The Chief Nurse delivered a presentation detailing Mrs Jay's Story which covered the following subject headings:

- What happened – the story
- Timeline
- What constitutes a serious incident?
- So, why was this not a serious incident?
- So, what did we do?

- So, what did happen?
- So, what did we do?
- So what?
- And the final word….

In response to a question from Mr D Hopewell, the Chief Nurse provided an overview of the Trust's new Incident Management Policy and advised that 'near misses' were also reported as part of the incident management process. In response to questions from Mr M Sugden and Mrs C Barber-Brown, the Chief Nurse briefed the Board on improved processes as a consequence of Mrs Jay's story and acknowledged that further consideration could be given to process improvement methodologies. In response to a question from the Chair, the Chief Nurse advised that the Trust did consider the carers' and families' experiences as well as the patient experience and noted that this subject would form part of a forthcoming Schwartz Round. In response to a further question from the Chair, the Chief Nurse confirmed that patients and families were provided with contact details of relevant Trust personnel who could be contacted in the event of any enquiries, and noted that this had also been the case with Mrs Jay's family.

The Board of Directors:

- Received and noted the Patient Story.

(16 minutes)

273/18 Minutes of the previous meeting

The minutes of the previous meeting held on 31 October 2018 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

(7 minutes)

274/18 Chair's Report

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. He noted that a copy of the Board Business Cycle for 2018/19 had been included for reference at Annex A of the report. The Director of Corporate Affairs advised that a draft Board Business Cycle for 2019/20 was being prepared which would take into account input from planning work. In response to a comment from the Chair, the Board of Directors wished to thank Mrs H Thomson for all her work as Interim Chief Executive and wished her the very best for the future.

The Board of Directors:

- Received and noted the Report of the Chair.

(2 minutes)

275/18 Report of the Chief Executive

The Deputy Chief Executive provided a verbal update on national and local strategic and operational developments. He noted the departure of the Stockport Neighbourhood Care Programme Director which had been referred to earlier during consideration of the Action Log. The Deputy Chief Executive then briefed the Board on the latest position with regard to Breast Services and advised that, at a meeting held on 26 November 2018, the Executive Management Group had agreed that a phased approach to the re-introduction of normal referral patterns should be adopted. He advised that the first phase, which would be implemented as soon as practicable, would be re-introduction of referrals to Stepping Hill Hospital from North Derbyshire CCG.

The Deputy Chief Executive emphasised the importance for managers to control spending, noting that the Trust's spending was above the Control Total for the year. He advised that extra financial controls had been put in place to try to mitigate the position and that the situation would be kept under close scrutiny. On a more positive note, the Deputy Chief Executive wished to congratulate colleagues in the Emergency Department who had been shortlisted as finalists in the 2018 iNetwork Innovation Awards. He advised that the team had been shortlisted for their work on access to full General Practitioner records in the Trust's Emergency Department.

The Board of Directors:

- Received and noted the verbal report of the Chief Executive.

(3 minutes)

276/18 Key Issues Reports

The Chair noted that, as agreed at a recent Board development session, the Committee Key Issue Reports, with the exception of the Audit Committee Key Issues Report, would be referred to during consideration of the Trust Performance Report.

<u>Audit Committee</u>

Mr D Hopewell presented a Key Issues Report which detailed matters considered at a meeting of the Audit Committee held on 13 November 2018. He briefed the Board on the content of the report and made specific reference to the 'Alert' section of the report. Mr D Hopewell advised that the Committee had reviewed an Internal Audit Progress Report and had noted an outcome of Moderate Assurance with regard to an HR Processes: Voluntary Service Review. He reported that the Committee had considered outcomes of the review and noted recommendations relating to both identity checks and completion of Disclosure and Barring Service (DBS) checks for volunteers. Mr D Hopewell advised that, while relevant actions had been agreed by management, the Committee had referred these matters to the Interim Director of Workforce for further clarification and had requested a progress report at its next meeting in January 2019.

In response to a question from Mrs C Anderson, the Interim Director of Workforce noted that she was unable to confirm timescale for the volunteer DBS review at this stage as identification of any gaps was ongoing and would need to be established first. The Board then considered, and subsequently approved, proposals for revised Annual Review of Committee arrangements for implementation in Q4 2018/19. It was noted that the revised arrangements would align the Committee reviews more closely with our financial and operational year and would ensure that Committees were fit for purpose to provide appropriate review and assurance to the Board for the coming year.

The Board of Directors:

- Received and noted the Audit Committee Key Issues Report.
- Approved proposals for Annual Review of Committee arrangements for implementation in Q4 2018/19.

(3 minutes)

277/18 Trust Performance Report – Month 7

The Chief Nurse briefed the Board on the Quality section of the Performance Report. She briefed the Board on the following subject matters which had been considered by the Quality Committee:

- Falls
- Emergency C-Section Rate
- Medication Errors
- Complaints
- HSMR
- NEWS2 (National Early Warning System) implementation
- Security Incidents Report.

In response to a question from the Chair, the Chief Nurse provided further clarity regarding the NEWS2 system. She advised that the system was due to be launched on 4 December 2018 and noted that the Trust was on track regarding associated staff training. Dr M Cheshire then referred the Board to the Quality Committee Key Issues Report from a meeting held on 20 November 2018. He referred the Board to the 'Alert' section of the report and advised that the Committee had requested that the Chief Pharmacist present an assurance report on Medication Errors at the Committee's meeting on 22 January 2019. He then referred the Board to the 'Assurance' section of the report and noted considerable progress made against both the Quality Improvement Plan and Quality Improvement Priorities for 2018/19.

With regard to the storage of records, Dr M Cheshire advised that the first batch of bespoke storage cabinets had now been received which would address an action in the Safe, High Quality Care Action Plan. In response to a question from the Chair, the Chief Nurse briefed the Board regarding progress against the Quality Improvement Plan, noting good progress made in this area. The Chief Nurse advised that the Plan would be updated accordingly following the forthcoming publication of the CQC Report.

The Director of Finance briefed the Board on Finance key issues. He advised that the Trust had an annual plan of a deficit of £34m after the delivery of £15m of recurrent Cost Improvement Programme (CIP). The Director of Finance noted that at the end of Month 7, whilst there had been positive movement in the achievement of CIP, the Trust was still forecasting a shortfall of £3m in 2018/19. With regard to the forecast financial performance for the remainder of the year, the Director of Finance reported that the Trust was facing financial risks relating to the increased winter costs and the possibility of contractual penalties imposed by Clinical Commissioning Groups (CCGs). He advised that the consequence of these risks could lead to a potential year-end deficit of £38m.

The Director of Finance briefed the Board on a number of actions taken to mitigate the risk of the potential overshoot. He reported moderate assurance that these actions should manage the year-end forecast to £34m as planned. Mr M Sugden commented that the Finance & Performance Committee had highlighted the CIP shortfall and the 2018/19 financial performance as key areas of concern. In response to a question from the Chair, the Director of Finance noted that further clarity on some of the mitigating actions should be available in January 2019, including outcomes of negotiations with CCGs regarding financial penalties and a clearer position regarding agreed winter funding. The Chair reiterated the seriousness of these issues to the Board.

Mrs C Barber-Brown made reference to the Orthopaedic presentation delivered by Mr D Johnson at the October Board meeting which had provided an example of joining up quality and financial aspects. She queried whether any such initiatives were getting traction through the Getting It Right First Time (GIRFT) programme and if they were having a positive effect on CIP. The Chief Operating Officer advised that a report on plans in this area would be presented to the Finance & Performance Committee in December 2018, including an update on progress regarding development of the Clinical Services Efficiency Programme. The Deputy Chief Executive commented that, for the remainder of 2018/19, managerial grip was particularly important to ensure the Trust achieved the planned £34m deficit as transformational changes took time to embed. This comment was further endorsed by the Chief Operating Officer and the Director of Finance in response to a question from Dr M Cheshire regarding service transformation. In response to a request from Mr M Sugden, it was agreed that assurance on CIP Planning for 2019/20 would be reported to the Finance & Performance Committee in December 2018 and the Board of Directors in January 2019.

In response to a question from Mr D Hopewell, regarding controls on staff expenditure, the Director of Finance advised that Mr M Brearley, Interim CIP Director, had been specifically tasked to review agency costs and associated processes to ensure grip and control. Mr D Hopewell noted the need to embed the controls into ongoing processes, including recruitment process. The Chief Operating Officer acknowledged the comment and advised that this issue had been scheduled for discussion with business groups the following week. The Interim Director of Workforce commented on the significant overall workforce costs, not just costs relating to agency staff. She noted that an early indication from the work undertaken by the Interim CIP Director suggested that the issue did not relate to the processes but to compliance. The Interim Director of Workforce noted that the Trust would need to make brave decisions to manage workforce risks and that workforce issues would need to be triangulated with patient safety, risk and finance.

The Chief Operating Officer then briefed the Board on Operational key issues. She reported that the main elective care challenges related to activity against plan and continuing increase in referrals. The Chief Operating Officer briefed the Board on the Trust's plans to increase Orthopaedic activity over the winter period which would be enabled by the introduction of an Elective Orthopaedic Unit. She advised that this initiative would allow operating to continue during Q3 and Q4 and, as well as safeguard activity and income, would strengthen the Trust's position with regard to the Theme 3 plans for Orthopaedics across Greater Manchester. The Chief Operating Officer advised that Day-Case activity recovery plans were in place for Ear, Nose & Throat (ENT), Urology and Ophthalmology with an expectation that plans would be delivered by year-end.

The Chief Operating Officer briefed the Board on the continued increase in GP referrals and noted the consequent adverse impact on the following operational standards: Referral to Treatment (RTT); Cancer 62-day standard; 6-week diagnostic standard; and Clinical Correspondence. In response to a question from Dr M Cheshire, the Chief Operating Officer advised that the Trust was undertaking more activity compared to last year. She also confirmed that, going forward, the intention was not to have a 'stand-alone' winter plan, but to incorporate winter planning as part of the overall operational plan for the year. In response to a question from Ms A Smith, who raised a concern regarding staff resilience during the unrelenting operational pressures, the Interim Director of Workforce briefed the Board on initiatives and mitigating actions in place to safeguard the wellbeing of staff.

In response to comments from Mr M Sugden and Mrs C Barber-Brown, the Chief Operating Officer agreed to raise the Board's concerns in relation to increased referrals with NHS Improvement at the Quarterly Review Meeting on 3 December 2018. The Deputy Medical Director briefed the Board of a meeting held with the new Chair of Stockport Clinical Commissioning Group to discuss increased referrals. She noted that a meeting was also planned with the Chair and Chief Executive of Viaduct to review clinical pathways between primary and secondary care. The Chief Operating Officer then briefed the Board on Non-Elective Care and advised that challenges with regard to Urgent Care remained significant. She briefed the Board on three main actions to address and improve patient flow in the areas of Overnight Breaches, Early Discharge and Stranded Patients.

The Interim Director of Workforce briefed the Board on Workforce key issues and provided an overview of mitigating actions with regard to the Staff Friends & Family Test results, Agency expenditure and Nurse staffing in Urgent Care. The Chief Nurse was pleased to report an improvement in nurse staffing rates over the past few weeks. She also noted the expected adverse effect the winter period would have on staffing and briefed the Board on mitigating actions in this area. Mrs C Anderson commented that the People Performance Committee had been pleased to note confirmation from the General Medical Council that the Trust had been removed from Enhanced Monitoring.

The Board of Directors:

- Received and noted the Trust Performance Report for Month 7.
- Received and noted Key Issues Reports from the following Committees:

- Quality Committee
- Finance & Performance Committee
- People Performance Committee

(52 minutes)

278/18 Winter Plan 2018/19

The Urgent & Emergency Care (UEC) Improvement Director presented a Winter Plan Update report which provided a summary of progress made to support the opening of proposed winter beds and implementation of specific schemes for winter 2018/19. She noted that the report also included an update on actions taken and next steps to reduce the numbers of stranded patients. The UEC Improvement Director briefed the Board on the content of the report and made particular reference to the Key Risks detailed in s6 of the report. She provided a detailed overview of risks relating to winter and stranded patients and briefed the Board on mitigating actions in these areas. The UEC Improvement Director noted the funding gap and the ability to staff the additional bed capacity as key areas of concern. With regard to issues relating to stranded patients, the Chief Operating Officer briefed the Board on the introduction of weekly 'Red to Green' meetings to support work in this area.

In response to a question from Mrs C Barber-Brown, the Chief Operating Officer and the UEC Improvement Director provided further clarity regarding plans to reduce the numbers of stranded patients. Dr G Burrows noted that greater clarity was expected in the next week or so with regard to targets in this area. In response to a question from Dr M Cheshire, who queried co-ordination between hospital and out-of-hospital care, the Director of Corporate Affairs advised that these functions were controlled by the Urgent Care Delivery Board and the Alliance Provider Board. The Chief Operating Officer briefed the Board on outcomes and actions agreed at a Discharge Workshop held on 28 November 2018 which had been attended by representatives from the Trust, the Clinical Commissioning Group and the Stockport Metropolitan Borough Council. In response to comments and concerns raised by a number of Board members, the Chair noted an urgent need to address concerns regarding the way in which system leadership was being operated. The Director of Corporate Affairs commented on the need for a clear system leadership model which would subsequently require commitment from all relevant health & social care partners.

Mr M Sugden raised concerns regarding various aspects in the Winter Plan, noting the funding gap and the ability to staff escalation beds as key areas of concern. He also commented that the actions appeared to be very much hospital-centric with a lack of clarity on actions committed to by partners. The Director of Finance and the Chief Nurse acknowledged the concerns relating to staffing and noted that timely improvement of the stranded patient position was crucial in order for the plan to work. Board members agreed that an additional meeting would be convened in December 2018 to consider Winter Planning and Preparation as Board members felt there was currently limited assurance available regarding the deliverability of the Winter Plan. The Chair noted that this would be the final Public Board meeting to be attended by the UEC Improvement Director as she was leaving the Trust at the end of December 2018. The Board wished to thank the UEC Improvement Director for all her work over the past seven months and wished her the very best for the future.

The Board of Directors:

- Received and noted the Winter Plan Report 2018/19.

(32 minutes)

279/18 Financial Oversight Briefing

The Chair, Mr M Sugden, the Chief Operating Officer and the Director of Finance provided a verbal briefing on matters discussed during Enhanced Oversight Meetings held with NHS Improvement. It was noted that there was an expectation for the Trust to deliver financial improvements at a greater pace.

The Board of Directors:

- Received and noted the verbal briefing.

(3 minutes)

Mr M Brearley joined the meeting.

280/18 Medium Term Financial Strategy

The Director of Finance presented a report seeking approval of the Medium Term Financial Strategy (MTFS). He briefed the Board on the content of the report and advised that since the draft MTFS had been presented to the Board in July and September 2018, the Trust had sought independent advice from Attain on the draft Strategy and had received feedback from NHS Improvement (NHSI) on the expectations of the 2019/20 financial plan. The Director of Finance advised that, as a consequence, changes had been made to s7 and s8 of the Strategy. He referred the Board to Table 10 included in s7.1 of the Strategy and provided an overview of changes to the figures since the Board's previous consideration of the draft MTFS. He then referred the Board to s8 of the Strategy and noted the inclusion of additional narrative regarding the Clinical Services Efficiency Programme.

In response to a comment from Mrs C Barber-Brown, who noted a link between the Clinical Services Efficiency Programme and Improvements 1, 2 and 4 detailed in Table 10 of the Strategy, the Director of Finance provided further clarity regarding the Clinical Services Efficiency Programme. In response to a question from Mr D Hopewell, regarding non-correlation of figures in s5 forecast and Table 10 included in s7 of the Strategy, the Director of Finance acknowledged a typographical error and agreed to update the figures accordingly.

In response to a comment from the Chair, who noted that the MTFS would be of interest to the incoming Chief Executive, the Director of Corporate Affairs acknowledged the comment but noted a need for the Board to be decisive in approving the Strategy. He commented that the situation for 2018/19 or 2019/20 would not change considerably and that if the new Chief Executive had a different approach or new guidance was received from NHSI, the Strategy would be reviewed accordingly. Mr M Sugden endorsed these comments and noted that NHSI's current focus was on 2019/20 financial plans and ensuring that the Trust was on the right

trajectory for the remainder of 2018/19. Mr D Hopewell and Mr M Sugden commented that the detail on next steps was important.

Mr M Sugden left the meeting.

The Interim CIP Director advised that the Board was asked to approve the MTFS as a provisional strategy and noted that figures could be updated once further clarity was available regarding tariff. The Board subsequently approved the MTFS and agreed that the Strategy would be reviewed in March 2019. In response to a request from Mr D Hopewell, the Board agreed to review associated Delivery Plans at its meeting on 31 January 2019.

The Board of Directors:

- Received and noted the Medium Term Financial Strategy report.
- Approved the Medium Term Financial Strategy and agreed that the Strategy would be reviewed in March 2019.
- Agreed to review Delivery Plans at its meeting on 31 January 2019.

(15 minutes)

281/18 Brexit – Procurement Implications

The Director of Finance presented a report on Brexit Procurement Implications. He provided a brief overview on the content of the report which provided an update on risk assessments being undertaken on the supply of goods and services in the event of a 'No Deal' Brexit. The Director of Finance noted that a copy of a Supplier Assessment Questionnaire, which the Trust was required to return to the Department of Health & Social Care by 30 November 2018, had been included in Appendix 1 of the report.

The Board of Directors:

- Received and noted the Brexit – Procurement Implications Report.

(2 minutes)

Mr M Brearley left the meeting.

282/18 Strategic Staffing Review

The Chief Nurse presented a six-monthly Strategic Staffing Review Report to the Board of Directors. She advised that the report provided a comprehensive overview of the current nurse and midwifery staffing position on wards based on the results of planned six-monthly acuity assessments and establishment reviews undertaken in July, August and September 2018. The Chief Nurse briefed the Board on the content of the report and the Board was asked to:

- Note the work undertaken with regard to assurance of safe staffing across the wards.
- Note and support the actions to be undertaken following the staffing reviews in Q2 and Q3 2018.

- Support the recommendation that registered nurse levels need to be subject to continued scrutiny and that any incremental investment was to be made in line with recommendations that must follow Trust governance processes.

The Chief Nurse provided assurance that the Trust's nursing and midwifery establishment was correct. She noted, however, an issue regarding the fill of establishment due to vacancies. The Chief Nurse briefed the Board on the development of a tool by district nursing teams for reviewing case loads, which, she noted, had provided real assurance regarding staffing levels.

The Board of Directors:

- Received and noted the six-monthly Strategic Staffing Review.

(6 minutes)

283/18 Committee Terms of Reference – Annual Review

The Director of Corporate Affairs presented a report seeking Board approval for the Finance & Performance Committee and Audit & Risk Committee Terms of Reference following periodic review. He referred to the Audit Committee Key Issues Report considered earlier in the meeting and noted the revised approach approved by the Board for Annual Review of Committee arrangements for implementation in Q4 2018/19. He noted that this year's Annual Reviews for the Quality Committee and the People Performance Committee would follow the revised process. The Director of Corporate Affairs briefed the Board on the content of the report and noted that the proposed Terms of Reference for the Finance & Performance Committee and the Audit & Risk Committee, along with outcomes from the respective Committee Self-Assessments, had been included at Annex A-D of the report.

In response to comments from Mrs C Anderson and Mrs C Barber-Brown, the Director of Corporate Affairs referred the Board to s2.2 of the report relating to a proposal to reduce the financial threshold for business cases from £1m to £0.5m. He advised that while the proposal had been supported by the majority of Finance & Performance Committee members, the decision had not been unanimous and a counter-argument had been raised in relation to the change in practice impairing the Board's aim of empowering management to implement service developments. The Director of Corporate Affairs noted that the Committee had consequently agreed that the Board should determine whether the proposed amendment was approved. The Board of Directors subsequently approved the proposed amendment at s2.3 viii of the draft Terms of Reference, reducing the financial threshold for business cases from £1m to £0.5m.

In response to a comment from the Chief Operating Officer, the Director of Corporate Affairs agreed to amend s6.1 of the Terms of Reference for the Finance & Performance Committee to include Clinical Services Transformation Group in the list of Groups reporting to the Committee. In response to a question from the Chief Operating Officer, it was agreed that the Stranded Patient Board should report to the Operational Performance Group rather than the Finance & Performance Committee.

The Board of Directors:

- Approved Terms of Reference for the Finance & Performance Committee and Audit & Risk Committee and noted outcomes from the respective Committee Self-Assessments.

(8 minutes)

284/18 Trust Risk Register

The Chief Nurse presented the Trust Risk Register and briefed the Board on its content. She advised that the Risk Register had been considered by each of the Board Assurance Committees and the Executive Management Group. The Chief Nurse provided assurance that all known risks were articulated in the Risk Register, were linked with the Trust's Corporate Objectives and managed through Business Groups. In response to a question from Dr M Cheshire, who queried external risks such as nursing home closures, the Chief Nurse advised that this specific risk was included in the Trust Strategy and the Board Assurance Framework.

The Board of Directors:

- Received and noted the Trust Risk Register.

(4 minutes)

285/18 Consent Agenda

There were no Consent Agenda items.

286/18 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next public meeting of the Board of Directors would be held on Thursday, 31 January 2019, commencing at 9.30am in Lecture Theatre A, Pinewood House. He noted that arrangements would be confirmed for an additional meeting in December 2018 to consider Winter Planning.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
22/18	26 Jul 18	181/18	Winter Plan – Progress Report	The Urgent & Emergency Care Improvement Director advised that a fully-costed Winter Plan document would be presented to the Board of Directors on 27 September 2018. **Update 27 Sep 18** – The Urgent & Emergency Care Improvement Director advised that a Winter Plan report was included on the agenda but that the presentation of a fully-costed Winter Plan would now take place at the Board meeting on 31 October 2018. **Update 31 Oct 18** – A fully-costed Winter Plan on the agenda. Action complete.	Mrs J Wood (U&EC Improvement Director)
28/18	27 Sep 18	227/18	Trust Strategy	The Director of Support Services advised that a progress report would be presented to the Board of Directors on 29 November 2018 and noted that a further report would be presented to the Board at the end of the consultation period in January 2019. **Update for 31 Jan 18 –** Report included on the agenda. Action complete.	H Mullen (Director of Support Services)
29/18	27 Sep 18	229/18	Medium Term Financial Strategy	In conclusion of the discussion, the Board agreed that the strategy document required further refinement prior to re-presentation to the Board on 31 October 2018. **Update 31 Oct 18** – The Director of Finance advised that the strategy document was currently being reviewed by Attain and would be presented to the Board on 29 November 2018. **Update 29 Nov 18** – Report included on agenda. Action complete.	F Patel (Director of Finance)
30/18	31 Oct 18	245/18	Patient Story – Fractured Neck of Femur Presentation	It was agreed that the Chief Operating Officer would lead on responding to actions set out in the presentation. **Update 29 Nov 18** – The Chief Operating Officer advised the Board that she was meeting with Mr D Johnson in December 2018 to consider the actions and anticipated that the action would be closed by January 2019.	S Toal (Chief Operating Officer)

31/18	31 Oct 18	247/18	Report of the Chief Executive	It was agreed that a report on the Brexit-related contract review would be considered at the next Board meeting on 29 November 2018. **Update 29 Nov 18** – Report included on agenda. Action complete.	F Patel (Director of Finance)
32/18	31 Oct 18	250/18	Winter Plan 2018/19	In response to a question from the Chair, it was agreed that a report detailing progress in reducing the level of stranded patients and addressing staffing needs for additional capacity would be presented at the next meeting on 29 November 2018. **Update 29 Nov 18** – The Urgent & Emergency Care Improvement Director confirmed that this information was included in the Winter Plan Report on the agenda. Action complete.	J Wood (U&EC Improvement Director)
33/18	31 Oct 18	251/18	Stockport Neighbourhood Care	In response to a comment from Ms A Smith, the SNC Programme Director agreed to provide the Board with a follow up report, which would summarise key themes from neighbourhoods. **Update 29 Nov 18** – The Chief Operating Officer advised the Board that the Stockport Neighbourhood Care (SNC) Programme Director had left the position earlier than anticipated. A number of Board members raised concerns regarding the consequent lack of leadership and the impact on the SNC work. The Chief Operating Officer acknowledged the concerns and briefed the Board on initial interim arrangements. The Deputy Chief Executive agreed to prepare a briefing for Board members on SNC management arrangements by 14 December 2018.	S Ferguson (SNC Programme Director) / S Toal (Chief Operating Officer) H Mullen (Deputy Chief Executive)
34/18	31 Oct 18	251/18	Stockport Neighbourhood Care	In response to a comment from the Chair, the Board agreed that a Board development session on Stockport Together would be useful. The Chief Operating Officer agreed to liaise with the Director of Corporate Affairs with regard to identifying a date for the development session, whilst noting that the SNC Programme Director would be finishing in her post in December 2018. **Update 29 Nov 18** – The Director of Corporate Affairs advised that this item was included on a forward plan for Board development. Action complete.	S Toal (Chief Operating Officer)

35/18	29 Nov 18	277/18	Performance Report	In response to a request from Mr M Sugden, it was agreed that assurance on CIP Planning for 2019/20 would be reported to the Finance & Performance Committee in December 2018 and the Board of Directors in January 2019.	S Toal (Chief Operating Officer) / Mr F Patel (Director of Finance)
36/18	29 Nov 18	278/18	Winter Plan 2018/19	Board members agreed that an additional meeting would be convened in December 2018 to consider Winter Planning and Preparation as Board members felt there was currently limited assurance available regarding the deliverability of the Winter Plan. **Update for 31 Jan 19 –** Additional meeting held on 20 December 2018. Action complete.	P Buckingham (Director of Corporate Affairs)
37/18	29 Nov 18	280/18	Medium Term Financial Strategy	The Board approved the Medium Term Financial Strategy and agreed that the Strategy would be reviewed in March 2019.	Mr F Patel (Director of Finance)
38/18	29 Nov 18	280/18	Medium Term Financial Strategy	The Board agreed to review Delivery Plans at its meeting on 31 January 2019. **Update for 31 Jan 19 –** Report included on the agenda. Action complete.	Mr F Patel (Director of Finance)

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NHS
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Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

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

Attachments: Annex A – Board Business Cycle

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

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1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 The Trust continues to work to manage the challenge of maintaining patient flow through the hospital during the Winter period and it is clear that the pressures being experienced have had a consequent impact on our performance against key national targets and, in particular, performance against the A&E 4-hour standard. On behalf of the Board, I would like to thank colleagues and partner organisations, particularly those working in the Emergency Department, for their efforts in ensuring safe services during this difficult period. With regard to the Emergency Department, colleagues will be aware that building works to enhance capacity and flow have been underway in recent weeks and these works are scheduled to be completed by the end of January 2019.

2.2 Board members will be aware that the NHS Long Term Plan was published on 7 January 2019. The Plan summarises a series of improvements to be delivered in the following five key areas:

- Improving out of hospital care (primary and community services)
- Reducing pressure on emergency hospital services
- Delivering person-centred care
- Digitally enabled primary and outpatient care
- A focus on population health and local partnerships through Integrated Care Systems (ICS)

Clearly, content of the Long Term Plan will need to inform development of the Trust's plans for 2019/20 and beyond, and we will need to work effectively with partners in preparing the system plan required by October 2019.

3. BOARD DEVELOPMENT

3.1 We are delighted to welcome Mrs L Robson, who assumed the position of Chief Executive on 7 January 2019 and will be participating in her first Board of Directors on 31 January 2019. Mrs L Robson will be fully involved in the interview process with candidates for the Director of Finance and Director of Workforce positions which are scheduled to be held on 1 February 2019 and 4 February 2019 respectively.

3.2 Board members participated in a half-day Development Session on 25 January 2019 that

commenced with a fascinating Medical Simulation Exercise which was facilitated by Dr D Baxter, Director of Medical Education. Board members then participated in a session on Engaging Transformational Leadership which was led by Prof B Alimo-Metcalfe, Real World Group.

4. CHAIR ENGAGEMENTS

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

18 December 2018	Visited Ward B2
14 January 2019	Attended a meeting with colleagues from Stockport CCG, Viaduct Care and Housing Associations to discuss next steps for the 'Our Stockport' network of Chairs and Non-Executive Directors
15 January 2019	Visited Ward B6
17 January 2019	Chaired a Remuneration Committee meeting
22 January 2019	Participated in a Stockport Health & Wellbeing Board workshop
22 January 2019	Chaired Visited the Inpatient Therapies team

5. REGULATORY DEVELOPMENTS

5.1 The Care Quality Commission (CQC) published the Trust's inspection report on 21 December 2018 and, on behalf of the Board, I would like to thank staff from across the organization for their efforts which resulted in no deterioration in comparison with previous ratings, improvement of the ratings in 12 of 25 areas and the removal of all previous 'Inadequate' ratings. While the overall rating for the Trust remains as 'Requires Improvement', outcomes from the most recent inspection clearly represent progress in the right direction on our improvement journey.

5.2 Board members participated with NHS Improvement representatives in the latest Enhanced Oversight meeting held on 17 January 2019. The primary focus during this meeting was on the Trust's financial and operational plans for 2019/20 and the implications of the Control Total for 2019/20. Also discussed and agreed was the scope of support which NHS Improvement will provide during Quarter 4 to assist the Trust with the development of financial plans and the efficiency programme for 2019/20.

6. FORWARD LOOK

6.1 In the short term, there will be continued attention on the management of winter pressures in conjunction with system partners. The Board will also be focused on the development of the 2019/20 Operational Plan and analysis of the Control Total offer.

6.2 A copy of the Board Business Cycle for 2018/19 to inform future agenda planning is included for reference at Annex A of the report.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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BOARD BUSINESS CYCLE 2018/19

	April	May	June	July	September	October	November	December	January	February	March
Core Agenda Items	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports. Urgent Care Report.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.		Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.	Chair Report. CEO Report. Performance Report. Trust Risk Register. Key Issues Reports.
Strategy & Planning	Q4 Corporate Objectives.		Trust Strategy Progress Report. Stockport Together - Status. Theme 3&4 Update. EPR Report.	Q1 Corporate Objectives. Draft Trust Strategy. Winter Planning. Estates Strategy.	Winter Plan. Estates Strategy Trust Strategy.	Q2 Corporate Objectives. Theme 3&4 Update. Winter Plan. EPR Report.	Winter Planning. EPR Report		Q3 Corporate Objectives. Theme 3&4 Update. Draft Operational Plan	People Strategy Progress	Approve Corporate Objectives. Theme 3&4 Update. Estates Strategy Progress Report Approve Operational Plan
Financial		Annual Accounts.	ITFF Revenue Request. First Draft - MTFS	Medium Term Financial Strategy.	Medium Term Financial Strategy. Financial Recovery.		Procurement Contracts Review. Medium Term Financial Strategy				Revenue Budget. CIP Programme. Capital Programme Going Concern Statement.
Governance & Regulatory	NED Independence Statement. Register of Interests. Use of Common Seal.	Annual Governance Statement. Annual Report. Code of Governance Compliance. Governance Declarations. Review of Undetakings.	Corporate Governance Declaration. Board Assurance Framework.	EPRR Annual Report. CQC System Review Report.	Board Assurance Framework. Review of Undertakings.	EPRR Assurance Statement.			Board Assurance Framework.	Review of Undertakings. Registration Authority - Annual Report.	Board Assurance Framework.
Quality	Patient Story. FTSUG Report.	Patient Story. Annual Quality Report. Quality Improvement Plan.	Patient Story. CNST Incentive Scheme. Staff Survey Plan.	Patient Story. Learning from Deaths. Perinatal Mortality. Freedom to Speak Self-Assessment.	Patient Story. PLACE Assessment. People Strategy.	Patient Story. FTSUG Report. FTSU Self-Assessment	Patient Story. Strategic Staffing Review		Patient Story. Learning from Deaths.	Patient Story.	Patient Story. Strategic Staffing Review. Staff Survey Results.

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Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**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 national and local strategic and operational developments which include: • Chief Executive – General Summary • Cheshire East Place • Brexit Preparations
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed ☐ Not required

Attachments:	Nil

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ 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 national and local strategic and operational developments.

2. CHIEF EXECUTIVE - GENERAL SUMMARY

2.1 Since my arrival in the Trust on the 7 January 2019, I have received a very warm welcome indeed from everyone in the Trust, the wider Stockport system, as well as across Greater Manchester, East Cheshire and North Derbyshire. I am keen to meet as many people as possible and have already undertaken a number of "walkabouts" on the Stepping Hill Hospital site, focussing in particular around our emergency & urgent care pathways. I have met a number of our teams including the Medical Director's Team and Estates & Facilities and I am planning a programme of visits so that I can meet people from across our community and hospital services in the coming months.

2.2 Unsurprisingly at this time of year, we are experiencing relentless emergency and urgent care pressures. Our time is dominated by our efforts to maintain and improve our patient flow. This has to be a key priority because of the link between effective patient flow, and the safety and quality of care. Twice in recent weeks we have been at OPEL 3 escalation and I have been really impressed by the way our staff came together to deal with the severe pressure in our system. We do not want to be in this position on a regular basis; it is not good for our patients or staff, so we are really emphasising how patient flow is everyone's business and we have developed and are sharing a video throughout the Trust on how simple actions can help.

2.3 I have been struck by the extent to which Stockport is essentially a 'Type 1' system, in other words our performance is reported and judged almost exclusively around access to Emergency Department; this is not generally the case elsewhere in Greater Manchester or nationally. I chaired my first meeting of the Stockport Urgent & Emergency Care Delivery Board with partners from Stockport Metropolitan Borough Council, Care Commissioning Group, Primary Care, Pennine Care and staff from the Trust and this confirmed the paucity of other services and clinical models in place to provide North West Ambulance Service and the local community with other options when people need or seek urgent care. This is a key issue for us to address and strong collective leadership across Stockport will be essential to help this.

2.4 On my walkabouts within our Trust, I have seen many examples of excellent practice and of individuals and teams going the extra mile for our patients. We are continuing our daily quest to ensure we do everything we can to improve, and working increasingly in partnership with colleagues from primary care, Stockport Clinical Commissioning Group and Stockport Metropolitan Borough Council. Within the Stockport system, we have the beginnings of joint working and some really exciting models such as the Integrated Transfer Team. There is a real opportunity to ensure we realise the benefits of staff working together in an increasingly integrated way. Such an approach is central to addressing both the current emergency and urgent care pressures and also to the longer term vibrancy and sustainability of the patch.

2.5 The 7th January 2019 saw the publication of the Long Term Plan for the NHS. The Long Term Plan is a welcome direction for the NHS over the next number of years. It is underpinned by guidance on expectations for next year, which includes a focus on key

priorities and sets the scene for a transitional year around the national financial regime. This offers an opportunity for our Trust and local partners to consider current alignment of our ambitions and plans in the context of the Long Term Plan.

2.6 In terms of planning for 2019/20, our Directors of Finance; Strategy, Planning & Partnerships and Chief Operating Officer have been working hard with their teams to work through the activity, finance and deliverables for 2019. We know this will be a challenging year and it is essential that our focus and that of our partners is on delivery and ensuring maximum benefit for our patients and the people of Stockport and the surrounding areas.

2.7 Since my arrival, we have spent time as an Executive Team, considering how we are working and what changes we want to make to ensure we can balance the many demands on us and our Trust but also to place a real focus on creating a vibrant future for our organisation and the Stockport system. We will continue this work apace and engage across our Trust and system as we do so. I am pleased to report that following a recruitment process which was undertaken towards the end of the last calendar year and over the Christmas and New Year period, we will be interviewing for a substantive Director of Finance and Director of Workforce & OD at the beginning of February.

2.8 Increasingly I am meeting with senior leaders from across the Stockport patch, Greater Manchester and East Cheshire and North Derbyshire. I attended the Greater Manchester Provider Federation Board meeting on Friday 18th January 2019; this was a really good opportunity to meet with Chief Executive colleagues from Trusts across the patch, but also senior colleagues within Greater Manchester Health and Social Care Partnership and the Joint Commissioning Board. With changes being introduced nationally around the appointment of Regional Directors we welcome the confirmation that Professor Bill McCarthy, (currently Deputy Vice-Chancellor, University of Bradford), will be the Regional Director for NHSI and NHSE of the North West patch and that there was constructive discussion around new ways of working for the future.

3. CHESHIRE EAST PLACE (CEP)

3.1 The Trust is currently assessing the implications of potential developments set out in a draft document on Creating Sustainable Health & Care Services across Cheshire East Place. Board members will be aware from previous discussions of both the opportunities and challenges for the Trust that could result from future development of services in East Cheshire.

3.2 The Director of Strategy, Planning & Partnerships has monthly planning meetings with his counterpart from East Cheshire Hospitals NHS Trust and maintains regular contact with representatives from all partners with in an interest in developments. Board members can be assured that there is appropriate clinical leadership and engagement in place for developments in relevant service areas. At present, we anticipate that the final proposals will be subject to consultation during Quarter 3 2019/20.

4. BREXIT PREPARATIONS

4.1 The Trust reviewed the latest guidance on arrangements for exiting the European Union at an Emergency Preparedness, Resilience and Responsiveness (EPRR) meeting held on 17 January 2019. The arrangements are categorised into three themes:

1. Business Continuity Planning;
2. Medicines and Procurement; and
3. Workforce.

4.2 The Board of Directors are advised to note that:

a) The Trust has submitted a statement on the testing of Business Continuity plans for the last twelve months;
b) The Department of Health and Social Care (DHSC) has risk assessed nationally a number of suppliers that are critical to the NHS in preparation for a no-deal exit from the EU;
c) The DHSC published an update from the Chief Pharmaceutical Officer on the Supply of Medicines on 17 January 2019. The DHSC has worked with the industry to ensure national supply continues and therefore it is not appropriate to stockpile medicines locally;
d) The Trust risk assessed 385 suppliers of goods and services to the Trust and submitted the findings to the DHSC on 30 November 2018;
e) The supplier which caused a degree of concern was The Christie NHS FT, which provides radiopharmaceuticals to Stockport. Since the risk assessment submission, the DHSC Team will now lead the issue centrally;
f) DHSC has advised that trusts should develop contingency plans for any high risk suppliers not being dealt with centrally. This need to be undertaken collaboratively at STP level and only in exception circumstances is to be done at Trust level;
g) To date, there has been no feedback from our suppliers regarding any concerns in respect of continuity of supplies to the Trust;
h) There are no issues to report on workforce implications, other than to note that the Prime Minister recently announced that the £65 cost of applying for "settled status" will be scrapped.

4.3 Board members are requested to note that a Greater Manchester EPRR Brexit Workshop will be held on 30 January 2019. The Director of Finance and the Trust's EPRR Lead will attend the workshop.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Board of Directors' Key Issues Report

Report Date: 31/01/19		**Report of:** Quality Committee
Date of last meeting: 22/01/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Surgery, Gastroenterology & Critical Care Business Group Presentation • Committee Terms of Reference – Annual Review • Quality Metrics • Quality Improvement Plan - Quarter 3 Progress • Quality Improvement Priorities - Quarter 3 Progress • Safe, High Quality Care Improvement Plan • Safeguarding Report • NEWS 2 Implementation Update • Learning from Deaths Report • Clinical Audit Progress Report • Key Issues Reports: - Quality Governance Group - Safeguarding Group - Infection Prevention & Control Group • Trust Risk Register • Board Assurance Framework
	Alert	• The Committee considered a report prepared by the Chief Nurse which provided a comprehensive update on a range of activities and developments relating to Adult Safeguarding. The report, which served to draw together a number of themes in this area, is scheduled for consideration by the Board of Directors on 31 January 2019. The Committee agreed that the Board's attention should be drawn to preparation of a proposal for a revised Safeguarding Structure to provide more robust and sustainable services in the support of vulnerable adults and children.
	Assurance	• The Committee received positive assurance on the quality governance arrangements in place in the Surgery, Gastroenterology & Critical Care Business Group through a presentation delivered by Mrs K Hatchell, Business Group Director and Dr D Sandher, Associate Medical Director. The briefing demonstrated a clear understanding of effective governance arrangements together with the key risks and priorities for the Business Group.

		• The Committee took positive assurance from reports detailing progress at Quarter 3 against both the Quality Improvement Plan and Quality Improvement Priorities for 2018/19. There is a high level of assurance that all elements will be fully achieved by 31 March 2019. • The Committee considered a final report on the Safe, High Quality Care Improvement Plan 2018 which provided assurance that all elements had either been incorporated as business as usual activities, with appropriate monitoring arrangements in place, or were yet to be fully be embedded and had therefore been transferred to the 2019 Improvement Plan. The Committee also reviewed and endorsed the 2019 Improvement Plan, subject to a number of minor amendments, for submission to the Care Quality Commission on 23 January 2019. The submitted 2019 Improvement Plan will be presented to the Board of Directors for ratification on 31 January 2019. • The Committee took positive assurance from a report on National Joint Registry Results that had been considered by the Quality Governance Group on 16 January 2019. The report detailed excellent compliance with data input and the maintenance of excellent results and revision rates across a range of trauma and orthopaedic procedures.
	Advise	• In reviewing the Key Issues Report from the Quality Governance Group, the Committee noted an 'Alert' relating receipt of a Prevention of Future Deaths Report from the Coroner following a recent inquest which related to inconsistency of investigations and post-falls reviews. A response to the report is currently being prepared. The Committee also noted the involvement of Dr D Sandher in leading a quality improvement project to provide assurance on the safety of patients on the Outpatients Waiting List (OWL). The Medical Director also drew the Committee's attention to the Group's consideration of a risk relating to compliance with Eating Disorders standards and advised the Committee of work in progress to both address compliance and provide clarity on practice between partners. • The Committee reviewed a report which detailed progress with Clinical Audit and noted a Limited Assurance outcome from an audit on the Sepsis bundle carried out on the Acute Medical Unit (AMU). The Committee triangulated this information with an adverse position on the Sepsis Inpatient CQUIN reported to the Committee in November 2018. Consequently, the Committee will be looking to seek assurance on progress being made in this area by the Sepsis Steering Group. • The Committee conducted a review of its Terms of Reference and completed a Committee Self-Assessment, the outcomes of which will be considered by the Chair, Chief Executive and Committee Chair prior to presentation to the Board for approval in March 2019. The Committee also considered a draft Committee Annual Report, required as part of the revised annual review process, and endorsed the format for the report that had been prepared by the Chief Nurse. • The Committee considered its Work Plan and was advised by the Deputy Chief Nurse that a report on Equipment Replacement would be presented at the next meeting on 19 February 2019, following review by the Executive Management Group and assessment of cost pressures / investment priorities for 2019/20..

		• Through its consideration of various reports, the Committee identified two subjects for consideration for inclusion in the Board's Development Programme: These were: ○ Quality Improvement ○ Use of the Board Assurance Framework		
2.	Risks Identified	Nil		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Company Secretary

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NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 31/01/19		**Report of:** Finance & Performance Committee
Date of last meeting: 23/01/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Operational Performance Report • Performance Review Meetings - Key Issues • Referral to Treatment Report • Cancer 62-Day Standard Report • Financial Performance Report • Agency Utilisation Report • Health Visiting & School Nursing Contract 2019/20 • CIP Progress Report • Outpatients CIP Workstream • Ward Reconfiguration Report • Clinical Services Efficiency Programme • Operational Plan 2019/20 - Progress Report • CQUIN Progress Report • Financial & Performance Risks
	Alert	• The Committee reviewed the Operational Performance Report and held a detailed discussion on the factors impairing improvement against the A&E 4-hour standard and, in particular, progress against the three priority areas agreed by the Board, namely; overnight breaches, discharges earlier in the day and the level of stranded patients. The Committee acknowledged comparative Type 1 performance with other Greater Manchester providers but agreed that a report detailing analysis of the three priority areas, together with details of other factors affecting performance, should be prepared for consideration at the next Committee meeting on 20 February 2019. The Committee also noted the necessity of effective participation across system partners. • The Committee noted challenged performance in relation to Clinical Correspondence across a range of specialty areas. The Chief Operating Officer advised that a review had been commissioned to identify measures for improvement which is scheduled to be completed by mid-February 2019. The Committee requested a report on outcomes and planned actions for its meeting on 20 March 2019.

	Assurance	• The Chief Operating Officer presented a report which detailed performance against the 92% Referral to Treatment (RTT) standard together with progress in reducing the RTT waiting list size. The Committee noted good progress being made in reducing waiting list numbers and is able to report moderate assurance that the target reduction to the March 2018 baseline level will be achieved by 31 March 2019. The Committee noted the challenge in achieving the RTT performance standard with an improvement trajectory which results in attainment of the 92% level by 30 June 2019. • The Committee reviewed the Finance Performance Report for Month 9 which detailed a favourable variance of £0.7m against Plan as at 31 December 2018. While a continuing challenged position in terms of elective activity, the Committee is able to report a significant level of assurance on overall delivery of the 2018/19 financial plan. The Committee considered a report which detailed progress against the 2018/19 cost improvement programme and agreed that the report continued to provide a limited level of assurance on delivery despite identification and delivery of schemes with a recurrent value of £12.1m. Board members should note that contingency arrangements are in place to cover any shortfall in the overall £15m programme through the non-recurrent use of provisions, • Inherently linked with the CIP programme was a report presented by the Deputy Chief Operating Officer, which detailed progress with development of the Clinical Services Efficiency Programme, essential to the delivery of efficiency savings in 2019/20. While the Committee was assured on the overall approach and programme governance, the level of detail on the status of planned efficiency savings is not as advanced as the Committee would have expected at Month 9. Consequently, the Committee is only able to report limited assurance on the 2019/20 efficiency programme and has requested a further assurance report at its next meeting on 20 February 2019. The Committee received a presentation from Mrs A Dalton, Outpatients Programme Manager, which detailed developments being progressed by the Outpatients CIP Workstream. The Committee noted indicative benefits of circa £1.2m but acknowledged that the majority of benefits were unlikely to be realised until 2020/21. • The Interim Director of Workforce presented a report which detailed agency utilisation as at 31 December 2018 and the Committee noted a sharp increase in expenditure during December 2018. While the increase was in line with the forecast for Month 9, expenditure levels mean that the overall forecast expenditure for 2018/19 is currently £11.8m, significantly in excess of the £10.5m agency ceiling. • The Committee considered a report on the Cancer 62-Day Standard which was jointly presented Mr F Reid, Consultant Cancer Lead, and Ms J Pemrick, Head of Performance. The report detailed the factors resulting in deterioration of performance against the standard, a situation that is not peculiar to the Trust, with challenges such as significant increase in referrals being experienced by providers across Greater Manchester. For example, at Month 8, the Trust had experienced a 21.5% increase in 2-week wait referrals. The Committee noted actions required to both make best use of current capacity and increase capacity overall, and the inherent link to Diagnostic capacity and availability. Implementation of actions will have resource implications. The Committee has commissioned a follow-up report for its meeting in March 2019 with a request that this includes assurance on the planned response to the situation from

		Commissioners.		
	Advise	• The Committee considered a report from the Director of Finance which detailed progress with preparation of the Operational Plan 2019/20. The Committee noted work in advance of the next draft submission on 12 February 2019 and the likelihood of challenging discussions with Commissioners in the interim, in seeking alignment of activity level submissions. Board members should note that an updated position on progress with the Operational Plan will be presented at the Board of Directors meeting on 31 January 2019.		
2.	Risks Identified	• Delivery of the cost improvement programme • Achievement of the national standard for RTT performance • Compliance with the Cancer 62-day standard.		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Company Secretary

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Board of Directors' Key Issues Report

Stockport NHS Foundation Trust

Report Date: 31/01/19		**Report of:** People Performance Committee
Date of last meeting: 24/01/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Annual Review of Committee Terms of Reference and Committee Self-Assessment • Physician Associate Role (Presentation) • Staff Survey Results 2018 (under embargo) • Medical Engagement Scale Survey Report • Freedom to Speak Up Guardian Report • Workforce Flash Report • Month 9 Agency Utilisation Report • Policy Assurance Report • Trust Risk Register • Key Issues Reports: - Joint Consultative & Negotiating Committee - Culture & Engagement Group - Workforce Effectiveness Group • Consent Agenda: - Medical Education Update Report.
	Key Issues from meeting held on 13/12/2018	• The Committee was pleased to note that Dr S Rendell had agreed to continue in the role of Guardian of Safe Working. • The Committee received informative presentations on Workforce Analytics and the Culture Dashboard.
	Alert	• Ms S Woolridge, Head of Workforce Delivery, presented a report which detailed agency utilisation as at 31 December 2018 and the Committee noted a sharp increase in expenditure during December 2018. While the increase was in line with the forecast for Month 9, expenditure levels meant that the overall forecast expenditure for 2018/19 was currently £11.8m, significantly in excess of the £10.5m agency ceiling. The Committee noted that NHS Improvement had set the Trust's 2019/20 agency ceiling at £10.455m which equated to a reduction of £79k from the 2018/19 target. The Head of Workforce Delivery briefed the Committee on actions in place to reduce agency expenditure and the Committee noted that service reviews would play a key part in gaining a better understanding of long standing vacancies.
	Assurance	• The Committee received an informative presentation on the role of Physician

		Associates, delivered by Mr I Woodroffe and Ms F Khalid, Physician Associates. The Committee endorsed the role and noted, in particular, future opportunities and the positive impact the role had on the continuity of care. It was noted that the Physician Associate role was a good example of the introduction of new roles to improve staffing by changing traditional models of working. It was proposed that the presentation should also be delivered to the Executive Management Group to enhance wider understanding of the role and associated opportunities. • Ms C Durdle, HR Business Manager, presented a Policy Assurance Report and the Committee noted that significant progress had been made in the previous 12 months to ensure all employment procedural documents were in date and reflected current practice and statutory requirements. It was noted that the Committee would receive an Annual Assurance Review Report in June 2019. • The Committee conducted a review of its Terms of Reference and completed a Committee Self-Assessment, the outcomes of which would be considered by the Chair, Chief Executive and Committee Chair prior to presentation to the Board for approval in March 2019. • The Committee took positive assurance on the effective working of the Trust's Freedom to Speak Up arrangements from a report presented by Mr P Gordon, Freedom to Speak Up Guardian.		
	Advise	• The Committee undertook a detailed review of Workforce related risks on the Trust Risk Register and identified a number of risks which required further review. • The Committee received results of the 2018 Staff Survey (under embargo) and Medical Engagement Scale Survey. Whilst noting initial highlights, the Committee would receive more detailed reports regarding the results at its meeting in March 2019.		
2.	Risks Identified	• The likelihood of the Trust exceeding the 2018/19 Agency ceiling by approximately £1.3m based on the current year-end forecast of £11.8m.		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

Report To:	Trust Board	**Date:**	31 Jan 2019
Subject:	Integrated Performance Report		
Report of:	Deputy Chief Executive	**Prepared by:**	BI, Performance Team & Executive Directors

REPORT FOR ASSURANCE

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

Summary of Report

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

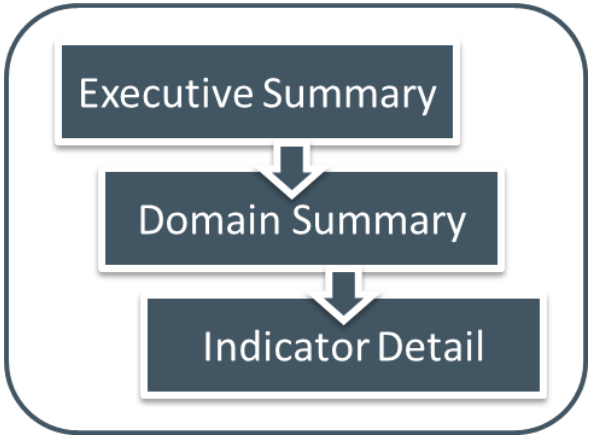
Attachments:

This subject has previously been reported to:

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

Introduction

The Board report layout consists of three sections:



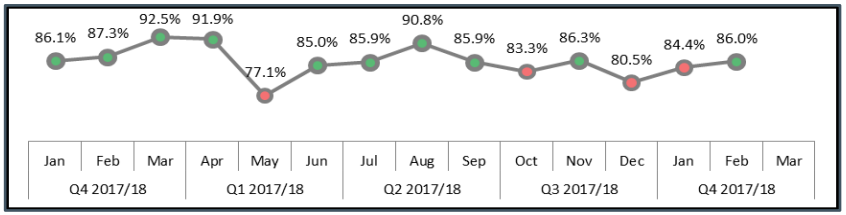
Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

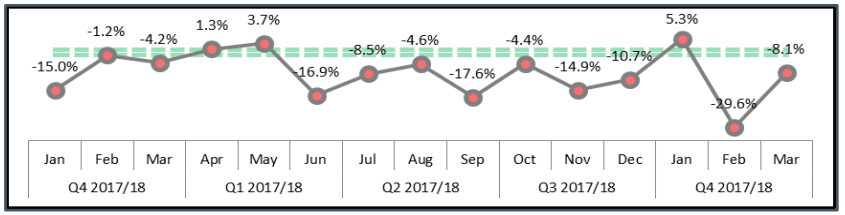
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

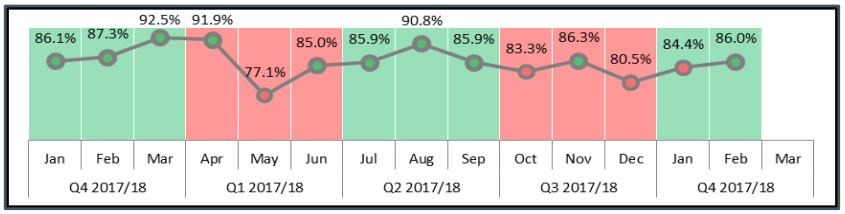
The following chart types are in use throughout the report:



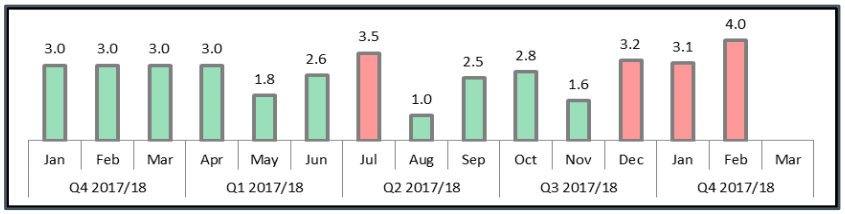
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



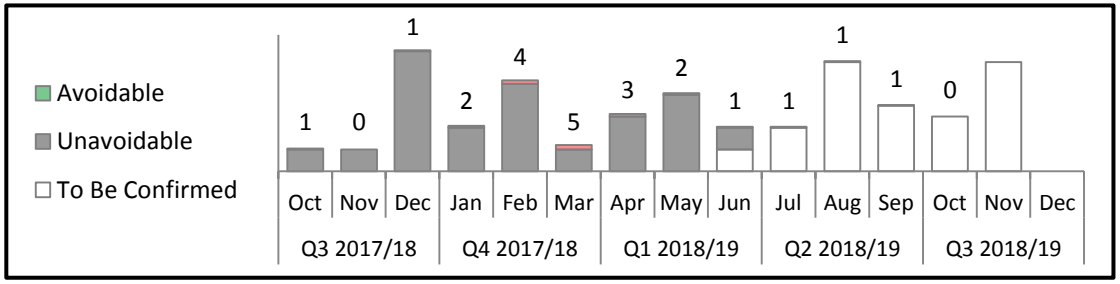
For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



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

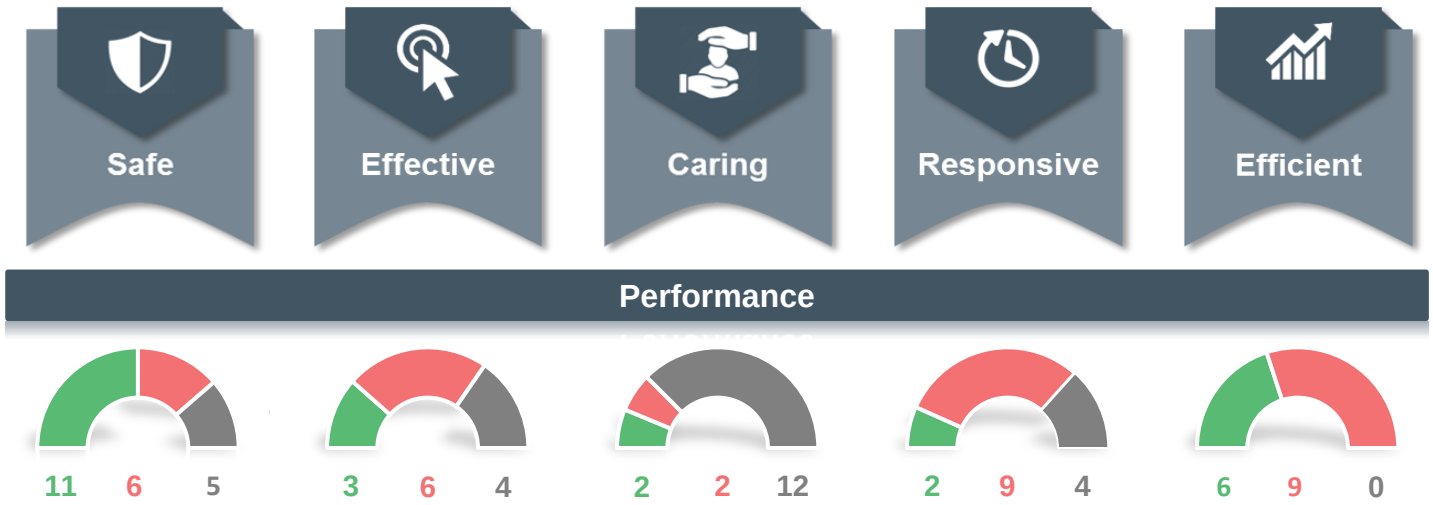


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.



Executive Summary

Stockport NHS Foundation Trust



Key Changes to the indicators in this period are:

Metrics changing from green to red in month:

-6 week Diagnostic Standard

Metrics changing from red to green in month:

- Mandatory Training
- Workforce Turnover
- Emergency C-Section Rate
-Hospital Category 3 Avoidable - Pressure Ulcers

Areas of notable improvement:

- Cancer 62-day standard
- Agency Shifts above Cap
- Complaints Response Rate
- Safety Thermometer
- Falls Causing Moderate Harm and Above

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Nov-18		11.90							8.62		11
C.Diff Infection Count (lapses in care)	CN&DQG	Nov-18	<=11 *	0							3		11
MRSA Infection Rate	CN&DQG	Nov-18		0.46							0.68		12
MSSA Infection Rate	CN&DQG	Nov-18		5.03							7.09		12
E.Coli Infection Rate	CN&DQG	Nov-18		16.47							16.84		13
E.Coli Infection Count	CN&DQG	Nov-18	<=25 *	4							20		13
Falls: Total Incidence of Inpatient Falls	CN&DQG	Dec-18	<=1033 *	82							956		14
Falls: Causing Moderate Harm and Above	CN&DQG	Dec-18	<=23 *	2							27		14
Pressure Ulcers: Hospital, Avoidable Category 2	CN&DQG	Nov-18	<= 9 *	0							9		15
Pressure Ulcers: Hospital, Avoidable Category 3	CN&DQG	Nov-18	<= 4 *	0							7		15
Pressure Ulcers: Hospital, Avoidable Category 4	CN&DQG	Nov-18	<= 1 *	0							3		16
Pressure Ulcers: Community, Avoidable Category 2	CN&DQG	Nov-18	<= 27 *	0							7		16
Pressure Ulcers: Community, Avoidable Category 3	CN&DQG	Nov-18	<= 7 *	0							4		17

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Avoidable Category 4	CN&DQG	Nov-18	<= *2* *	0							0		17
Safety Thermometer: Hospital	CN&DQG	Dec-18	>= *95%*	97.3%							95.7%		18
Safety Thermometer: Community	CN&DQG	Dec-18	>= *95%*	98.1%							96.0%		18
Medication Errors: Overall	CN&DQG	Dec-18		87							841		19
Medication Errors: Moderate Harm and Above	CN&DQG	Dec-18	<= *4%*	2.3%							4.5%		19
VTE Risk Assessment	CN&DQG	Dec-18	>= *95%*	97.2%							97.0%		20
Clinical Correspondence	COO	Dec-18	>= *95%*	64.7%							63.6%		20
Flu Vacination Uptake	DoW&OD	Dec-18	>= *75%*	71.7%									21
Discharge Summaries	MD	Dec-18	>= *95%*	89.5%							89.4%		21

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	Dec-18		62.54									22
Emergency C-Section Rate	CN&DQG	Dec-18	<= 15.4%	12.6%							17.4%		22
Never Event: Incidence	CN&DQG	Dec-18	<= 0	0							1		23
Duty of Candour Breaches	CN&DQG	Dec-18		3							25		23
Stranded Patients	COO	Dec-18	<= 35%	57.1%							49.4%		24
Delayed Transfers of Care (DTOC)	COO	Dec-18	<= 3.3%	6.1%							3.8%		24
Medical Optimised Awaiting Transfer (MOAT)	COO	Dec-18	<= 40	103							868		25
Bank & Agency Costs	DoW&OD	Dec-18	<= 5%	13.0%							11.7%		25
Mortality: HSMR	MD	Dec-18	<= 1	1.09									26
Mortality: SHMI	MD	Mar-18	<= 1	0.97									26
Mortality: Deaths in ED or as Inpatient	MD	Dec-18		157							1063		27
Mortality: Case Note Reviews	MD	Dec-18		35							344		27
Emergency Readmission Rate	MD	Oct-18	<= 7.9%	8.4%							9.1%		28

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Caring													
Patient Safety Alerts: Completion	CN&DQG	Dec-18	>= 100%	33.3%							70.4%		28
DSSA (mixed sex)	CN&DQG	Dec-18	<= 0	0							4		29
Complaints Rate	CN&DQG	Dec-18		0.6%							0.7%		29
Complaints: Response Rate 45	CN&DQG	Dec-18	>= 95%	78.6%							39.6%		30
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	Dec-18		0							10		30
Complaints Closed: Overall	CN&DQG	Dec-18		28							346		31
Complaints Closed: Upheld	CN&DQG	Dec-18		9							91		31
Complaints Closed: Partially Upheld	CN&DQG	Dec-18		14							165		32
Complaints Closed: Not Upheld	CN&DQG	Dec-18		5							90		32
Compliments	CN&DQG	Dec-18		76							316		33
Friends & Family Test: Response Rate	CN&DQG	Nov-18		25.8%							25.9%		33
Friends & Family Test: Inpatient	CN&DQG	Nov-18		94.8%							94.9%		34
Friends & Family Test: A&E	CN&DQG	Nov-18		84.5%							88.2%		34

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: Maternity	CN&DQG	Nov-18		97.5%		↑					96.7%	Δ	35
Staff Friends & Family Test	CN&DQG	Sep-18		72.0%		↓					74.6%		35
Diabetes Reviews	MD	Dec-18	>= 90%	100.0%		↑					80.2%	Δ	36

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Nov-18	>= 90%	93.1%							94.7%		36
Dementia: Assessment	CN&DQG	Nov-18	>= 90%	100.0%							100.0%		37
Dementia: Referral	CN&DQG	Nov-18	>= 90%								100.0%		37
Serious Incidents: STEIS Reportable	CN&DQG	Dec-18		21							155		38
Litigation: Claims	CN&DQG	Dec-18		8							55		38
Litigation: Key Risk Claims Rate	CN&DQG	Dec-18		100.0%							100.0%		39
A&E: 4hr Standard	COO	Dec-18	>= 95%	72.0%							77.7%		39
A&E: 12hr Trolley Wait	COO	Dec-18	<= 0	3							50		40
Cancer: 62 Day Standard	COO	Dec-18	>= 85%	82.3%							78.6%		40
Referral to Treatment: Incomplete Pathways	COO	Dec-18	>= 92%	82.7%							85.3%		41
Referral to Treatment: Incomplete Waiting List Size	COO	Dec-18	<= 22345	24246									41
Diagnostics: 6 Week Standard	COO	Dec-18	>= 99%	98.8%							99.2%		42
Elective Activity vs. Plan	COO	Dec-18	+/- 1%	-4.0%							-4.0%		42

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Elective Income vs. Plan	COO	Dec-18	+/- 1%	-3.5%							-3.5%		43
Outpatient Activity vs. Plan	COO	Dec-18	+/- 1%	-1.7%							-1.7%		43

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Financial Efficiency: I&E Margin	DoF	Dec-18	<= 2	4									44
Financial Controls: I&E Position	DoF	Dec-18	>= 0%	2.5%									44
Cash	DoF	Dec-18	+/- 1%	-16.7%									45
Financial Use of Resources	DoF	Dec-18	<= 3	3									45
CIP Cumulative Achievement	DoF	Dec-18	>= 0%	-0.1%									46
Capital Expenditure	DoF	Dec-18	+/- 10%	-26.5%									46
Financial Sustainability	DoF	Dec-18	<= 2	4									47
Sickness Absence Rate	DoW&OD	Dec-18	<= 3.5%	4.6%							4.3%		47
Appraisal Rate: Non-medical	DoW&OD	Dec-18	>= 95%	90.8%							93.9%		48
Appraisal Rate: Medical	DoW&OD	Dec-18	>= 95%	98.1%							97.4%		48
Statutory & Mandatory Training	DoW&OD	Dec-18	>= 90%	91.2%							90.2%		49
Workforce Turnover	DoW&OD	Dec-18	<= 13.94%	13.7%									49
Staff in Post	DoW&OD	Dec-18	>= 90%	90.5%							90.2%		50

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

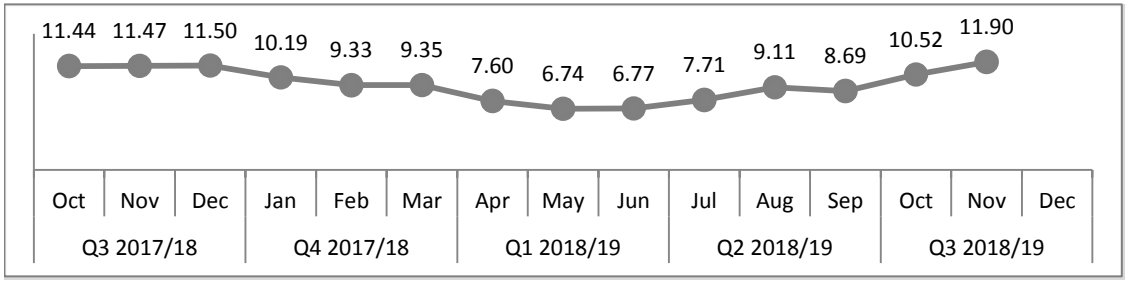
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	Dec-18	<= 0	866							8559		50
Agency Spend: Distance From Ceiling	DoW&OD	Dec-18	<= 3%	13.4%							13.4%		51

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

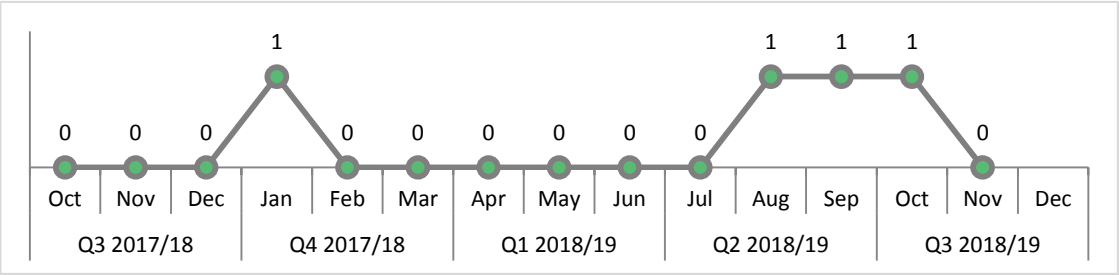
Indicator Detail

Nov-18	C.Diff Infection Rate
11.90	Average number of C.Diff infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable C.Diff infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The average number of Clostridium difficile infections for every 100,000 bed days, calculated using a rolling 12month number of Trust –attributable Clostridium difficile infections compared to a rolling 12 month average number of bed days per 100,00.



Actions
During November there were five cases of Clostridium difficile. Full investigations currently in progress for all cases The target rate is monitored through the infection prevention group

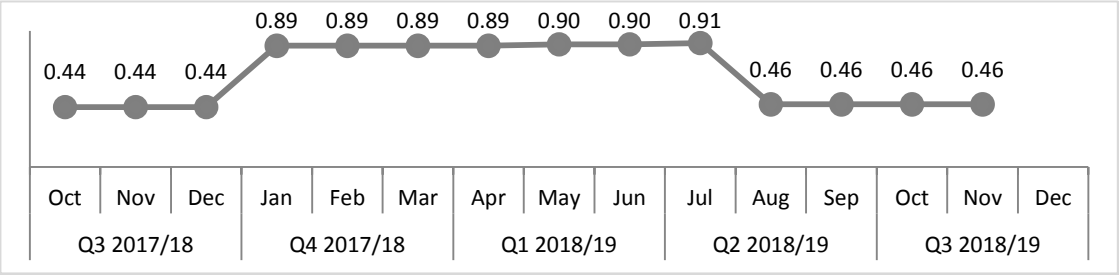
Nov-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care, in November we have had no lapses in care as the cases are still under investigation. Three cases during August, September and October have been deemed to be lapses in care.
<=11 *	



Actions
A review of the new NICE draft guidance to combat drug resistant UTI's with the antibiotic pharmacists and Consultant microbiologist has been undertaken. Awaiting final guidance to be published Further work will be undertaken with the new site coordinator team around isolation of patients following review and update of the isolation SOP Following a Clostridium difficile investigation the case will be presented to the harm free care panel. There remains one case from August and two cases from October under review and require a decision to determine whether there were lapses in care

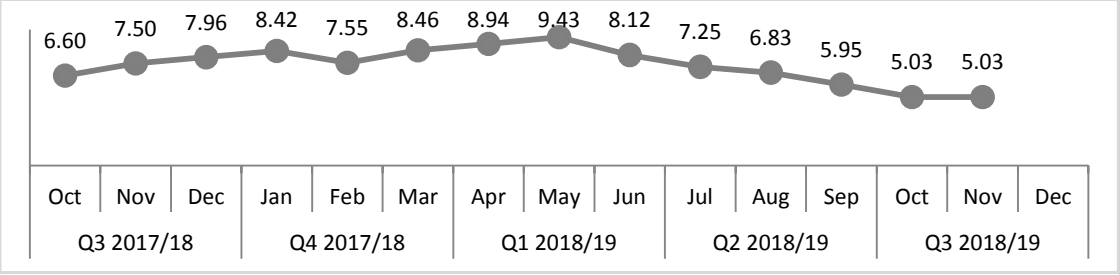
Indicator Detail

Nov-18	MRSA Infection Rate
0.46	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MRSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions
The MRSA target remains zero for 2018/19, in November there were zero cases of MRSA The target is monitored through the infection prevention group

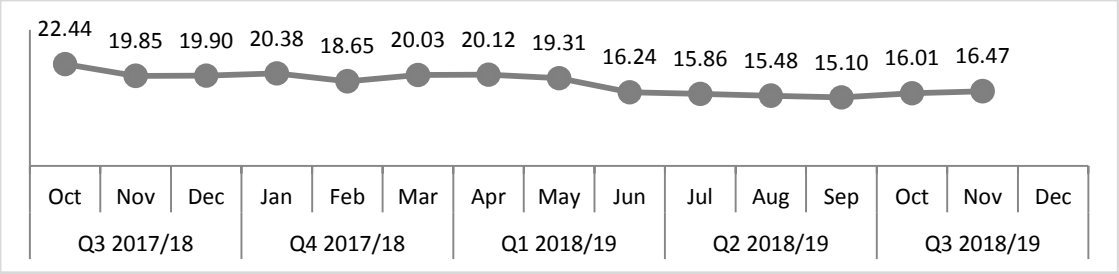
Nov-18	MSSA Infection Rate
5.03	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections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



Actions
The MSSA infection rate is monitored as a whole health economy with no target. The figures represented within this report are Trust acquired cases This is monitored through the Infection prevention group

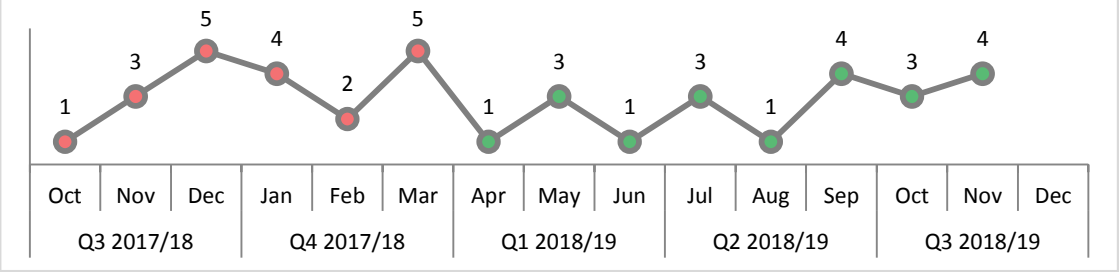
Indicator Detail

Nov-18	E.Coli Infection Rate
16.47	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions
Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups. The figures represented within this report are trust acquired cases A reduction plan has been developed collaboratively between the Trust, Health protection nurses and CCG. This plan will be monitored through the infection prevention group Discussions with the clinical director in laboratory medicine in regards to medical investigation of each case underway

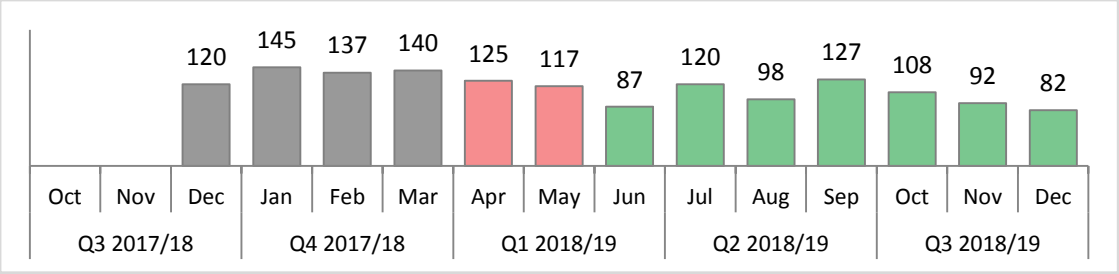
Nov-18	E.Coli Infection Count
4	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases
<=25 *	



Actions
This is monitored through the Infection prevention group

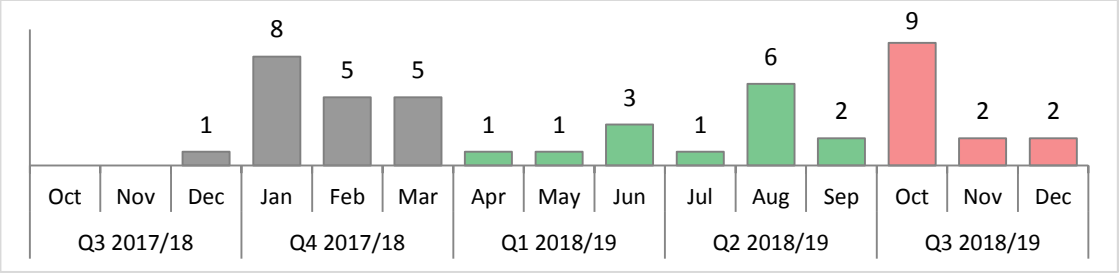
Indicator Detail

Dec-18	Falls: Total Incidence of Inpatient Falls
82	Total number of Inpatient falls
Target	The Trust target is a 10% reduction of inpatient falls for 2018/19 in comparison of 2017/18.
<=1033 *	



Actions
The number of in patient falls continues to reduce on a monthly basis. In December 2018 we had a total number of in patient falls of 82. This can be directly compared to December 2017 which had a recorded figure of 120 in patient falls. The Safer Mobility Collaborative will continue to work toward a continued reduction of in patient falls.

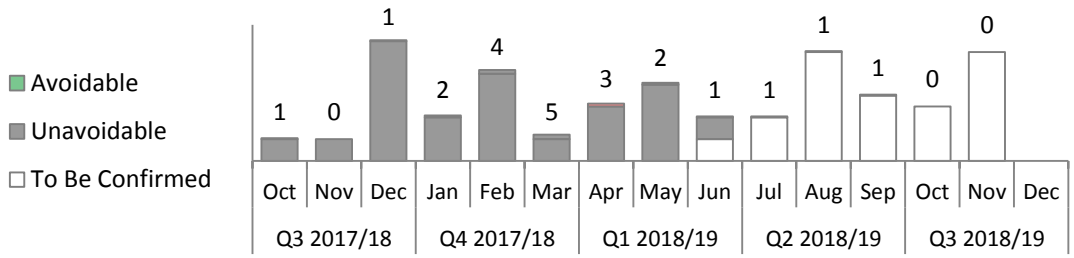
Dec-18	Falls: Causing Moderate Harm and Above
2	Total number of falls causing moderate harm and above.
Target	The Trust target set for falls causing moderate or above harm is a 25% reduction for 2018/19 in comparison with 2017/18
<=23 *	



Actions
In December 2018 there were two falls that resulted in moderate or above harm. One patient was transferred to a ward side room in the early hours of the morning and fell shortly afterwards. It is unclear if the fall was a result of a clinical condition or a slip, trip fall. The business group is investigating this incident. The fall resulting in moderate harm is also under investigation by the business group.

Indicator Detail

Nov-18	Pressure Ulcers: Hospital, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there has been a total of 10 category 2 pressure ulcers reported in the hospital. Avoidable = 0, Unavoidable = 0, TBC = 10. YTD = 9 avoidable category 2 pressure ulcers reported.
<= 9 *	

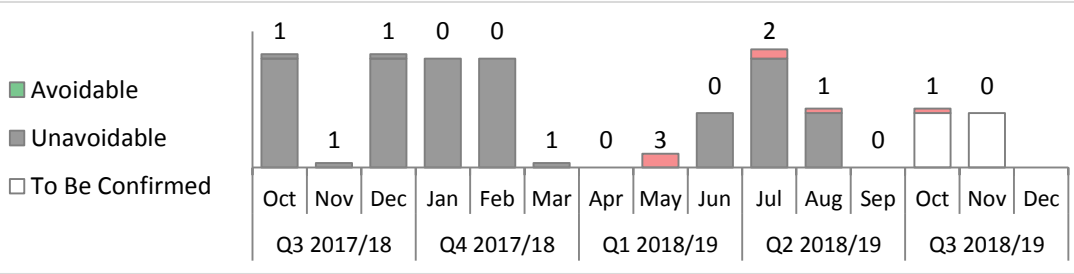


Actions

We have almost reached the threshold for numbers of avoidable pressure ulcers for the hospital with the outcome a number of incidents still to be confirmed.

A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well.
Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members.
Skin inspection mirror with prompts provided to nursing staff to support skin inspection
A new categorisation resource and competency package has been distributed to all clinical areas.
Medical device tool box training resource devised with a view to roll out to all BG from January 2019.
ACE accreditation audits continue with all areas audited to date achieving Bronze status or above.
The Non concordance care plan has been discontinued

Nov-18	Pressure Ulcers: Hospital, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there has been one category 3 pressure ulcers reported in the hospital Avoidable = 0, Unavoidable = 0, TBC = 1. YTD = There have been 7 avoidable category 3 pressure ulcers reported.
<= 4 *	



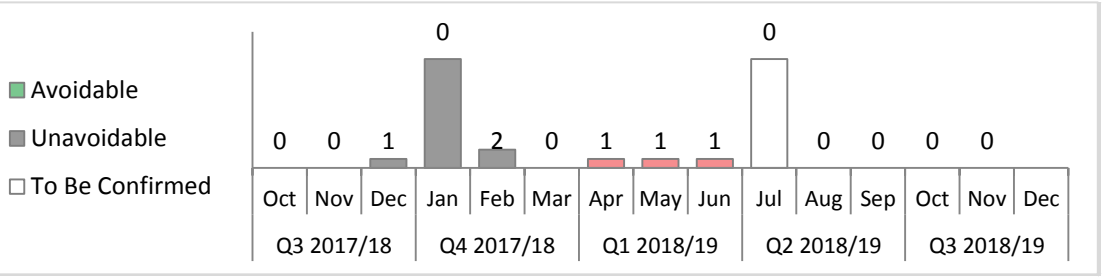
Actions

We have almost reached the threshold for numbers of avoidable pressure ulcers for the hospital with the outcome a number of incidents still to be confirmed.

A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well.
Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members.
Skin inspection mirror with prompts provided to nursing staff to support skin inspection
A new categorisation resource and competency package has been distributed to all clinical areas.
Medical device tool box training resource devised with a view to roll out to all BG from January 2019.
ACE accreditation audits continue with all areas audited to date achieving Bronze status or above
The Non concordance care plan has been discontinued

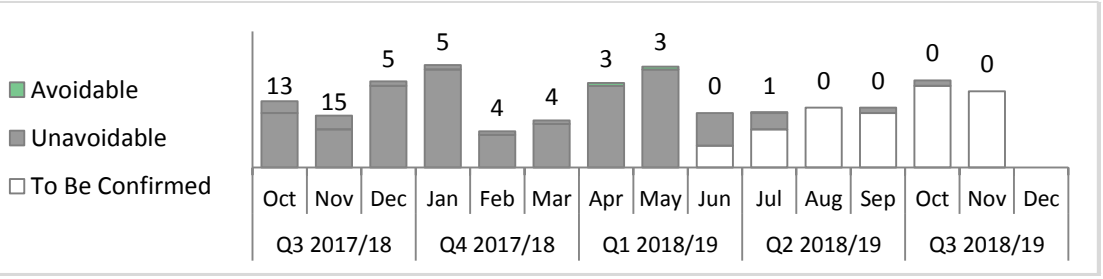
Indicator Detail

Nov-18	Pressure Ulcers: Hospital, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a hospital setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there have been no category 4 pressure ulcers reported in the Hospital. YTD = There have been 3 avoidable category 4 pressure ulcers reported.
<= 1 *	



Actions
We have almost reached the threshold for numbers of avoidable pressure ulcers for the hospital with the outcome a number of incidents still to be confirmed. A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well. Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. Skin inspection mirror with prompts provided to nursing staff to support skin inspection A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training resource devised with a view to roll out to all BG from January 2019. ACE accreditation audits continue with all areas audited to date achieving Bronze status or above The Non concordance care plan has been discontinued

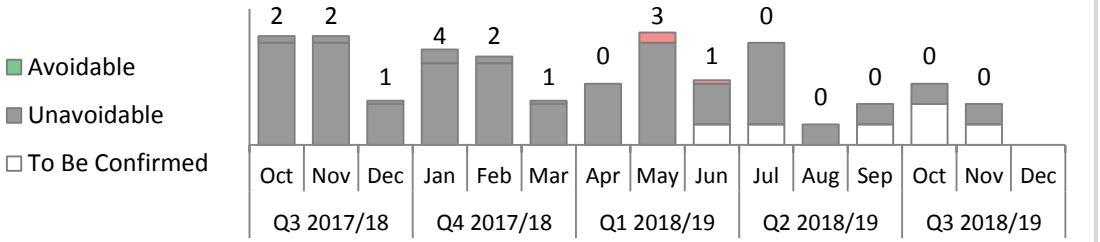
Nov-18	Pressure Ulcers: Community, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there has been a total of 14 category 2 pressure ulcers reported in the community Avoidable = 0, Unavoidable = 0, TBC = 14. YTD = There have been 7 avoidable category 2 pressure ulcers reported..
<= 27 *	



Actions
We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcer s in the community. A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well. Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members. Skin inspection mirror with prompts provided to nursing staff to support skin inspection A new categorisation resource and competency package has been distributed to all clinical areas. Medical device tool box training resource devised with a view to roll out to all BG from January 2019. ACE accreditation audits continue with all areas audited to date achieving Bronze status or above The Non concordance care plan has been discontinued.

Indicator Detail

Nov-18	Pressure Ulcers: Community, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there have been 2 category 3 pressure ulcers reported in the Community Avoidable = 1, Unavoidable = 0, TBC = 1. YTD = There have been 4 avoidable category 3 pressure ulcers reported.
<= 7 *	

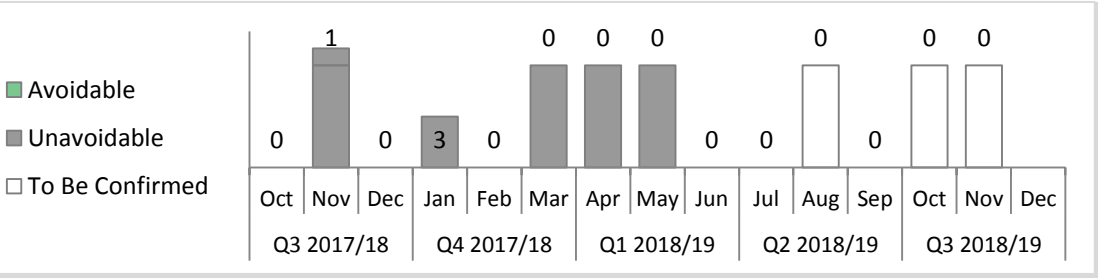


Actions

We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcer s in the community.

A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well.
Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members.
Skin inspection mirror with prompts provided to nursing staff to support skin inspection
A new categorisation resource and competency package has been distributed to all clinical areas.
Medical device tool box training resource devised with a view to roll out to all BG from January 2019.
ACE accreditation audits continue with all areas audited to date achieving Bronze status or above
The Non concordance care plan has been discontinued

Nov-18	Pressure Ulcers: Community, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a community setting.
Target	Pressure ulcers are reported as either avoidable (lapses in care), or unavoidable (no lapses in care were identified).This month (November data) there has been one category 4 pressure ulcers reported in the community. Avoidable = 0, Unavoidable = 0, TBC = 1. YTD = There have been 0 avoidable category 4 pressure ulcers reported in the community
<= 2 *	



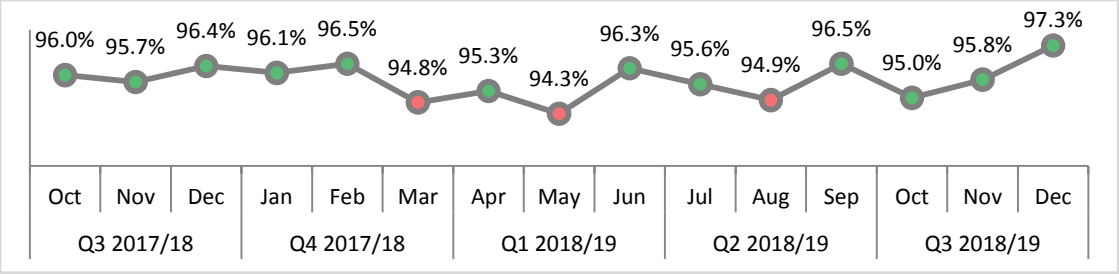
Actions

We are currently on trajectory for achieving our target for reduction in avoidable pressure ulcer s in the community.

A refreshed 3 hour pressure ulcer prevention update session has now been attended by 108 staff and is evaluating well.
Purpose T screening assessment is now being completed by all Podiatry and Specialist palliative care team members.
Skin inspection mirror with prompts provided to nursing staff to support skin inspection
A new categorisation resource and competency package has been distributed to all clinical areas.
Medical device tool box training resource devised with a view to roll out to all BG from January 2019.
ACE accreditation audits continue with all areas audited to date achieving Bronze status or above
The Non concordance care plan has been discontinued

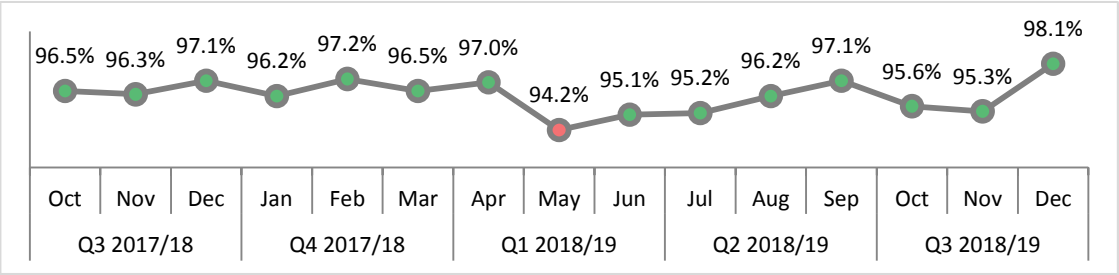
Indicator Detail

Dec-18	Safety Thermometer: Hospital
97.3%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for December show that we have achieved 97.3%.
>= 95%	



Actions
Weekly validation meetings continue to be undertaken to improve the quality of the data. Dates have been set throughout January / February to deliver training to the ward managers within the business groups. Also, an update will be provided at the Matrons Forum in January.

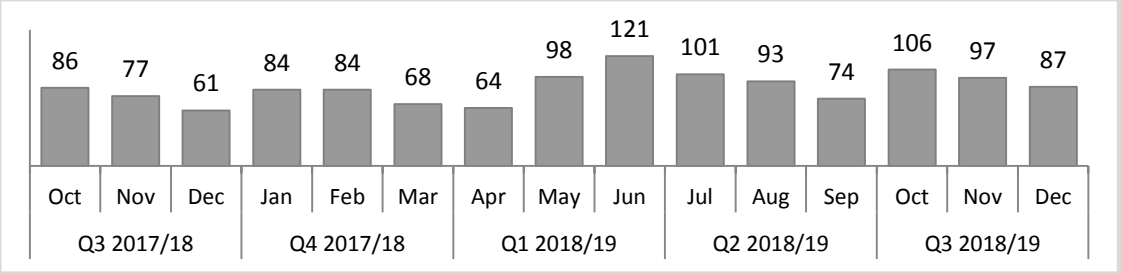
Dec-18	Safety Thermometer: Community
98.1%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for December show that we have achieved 98.1%.
>= 95%	



Actions
The target has been achieved in month.

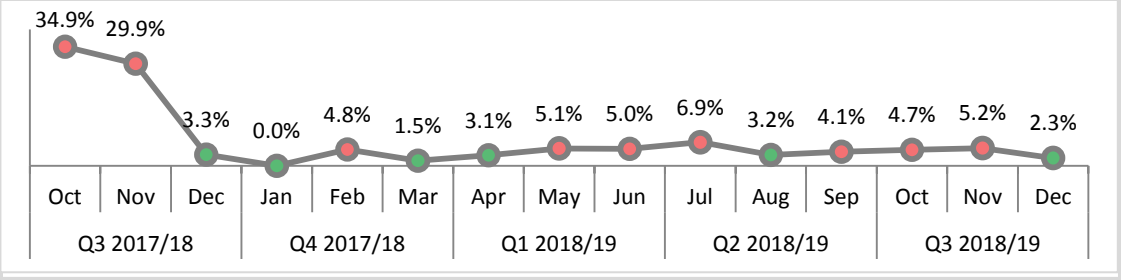
Indicator Detail

Dec-18	Medication Errors: Overall
87	Total number of Medication Errors.
Target	There has been a slight reduction in the number medication incidents reported for the month of December. This is for the 2nd month in row.



Actions
All medication errors are reviewed at the weekly patient safety summit. Learning is shared through the patient safety summit update, which is circulated weekly to all staff. In December, lessons identified that relate to medications included a reminder that Gentamycin levels must be checked prior to the administration of a 2nd dose of Gentamycin. a reminder regarding the responsibilities of the person who is second checking a medication for administration.

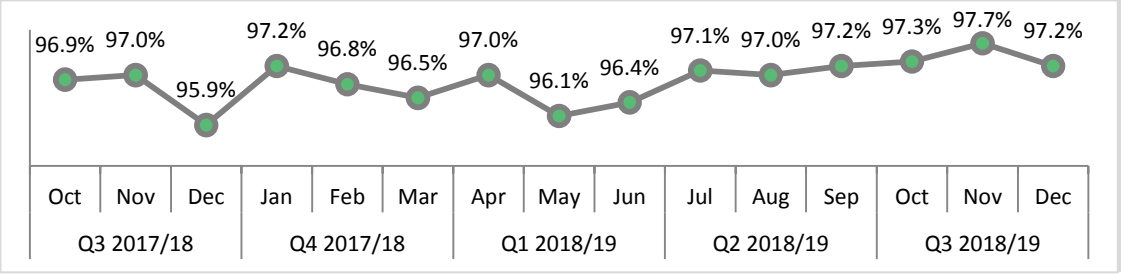
Dec-18	Medication Errors: Moderate Harm and Above
2.3%	The percentage of medication errors causing moderate harm and above.
Target	In December 2018, there were 2 incidents involving medication causing moderate harm or above to patients. This is a reduction compared to last month and below the target set.
<= 4%	



Actions
One incident,where a medication error occurred, the patient suffered a venous thromboembolism. A formal review found that this event was avoidable. The second incident involved a patient having a reaction to a chemotherapy infusion. All correct actions were taken at the time.

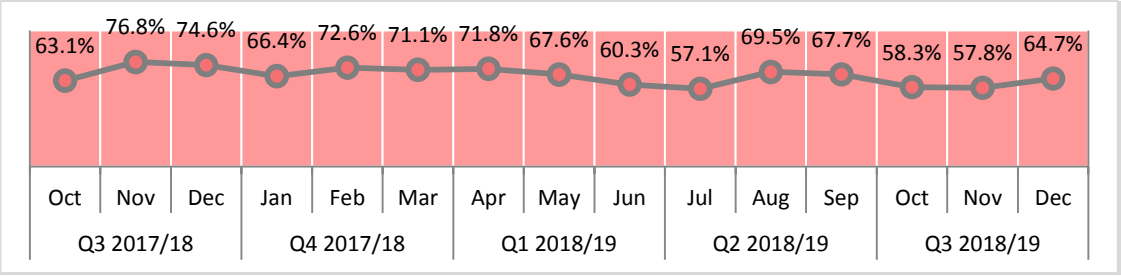
Indicator Detail

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



Actions
The target has been achieved in month

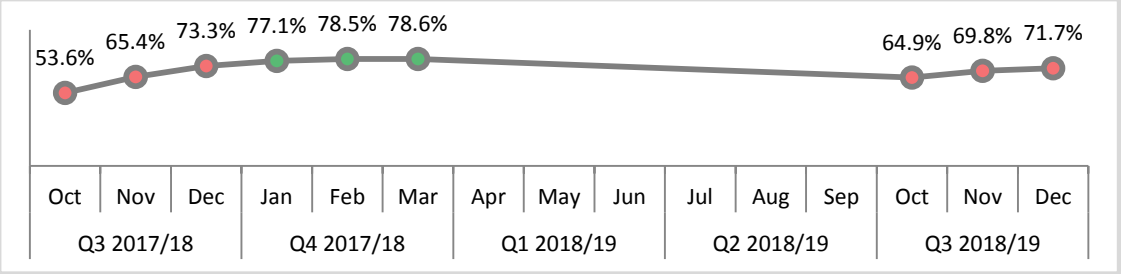
Dec-18	Clinical Correspondence
64.7%	The percentage of clinical correspondence typed within 7 days.
Target	There has been a slight improvement in performance in December.
>= 95%	



Actions
A review has been commissioned into the required capacity to deliver a sustainable service that facilitates appropriate turnaround times for clinical correspondence. This is scheduled to take place over the next 2 months.

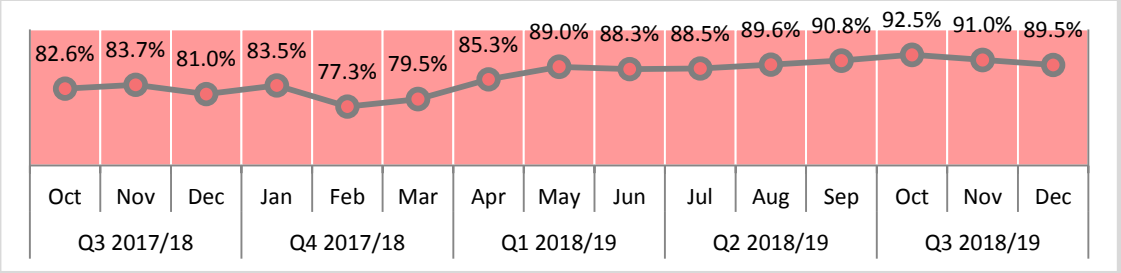
Indicator Detail

Dec-18	Flu Vacination Uptake
71.7%	The percentage of staff receiving the flu vaccination.
Target	72% of all staff (73% of frontline) have been vaccinated as at week 15 of the campaign, against a target of 75% by the end of week 22. Corporate Services have the highest uptake at 82%, whilst Estates & Facilities BG has the lowest uptake at 61%.
>= 75%	



Actions
Promotion of the flu vaccine to encourage uptake continues, supported by flu link nurses, the pharmacy shop and occupational health. Monthly staff compliance list information continues to be provided to managers to assist in the focus of encouraging staff to receive their vaccination. There is weekly communication of the position, screensavers and an on-going social media presence to support the campaign.

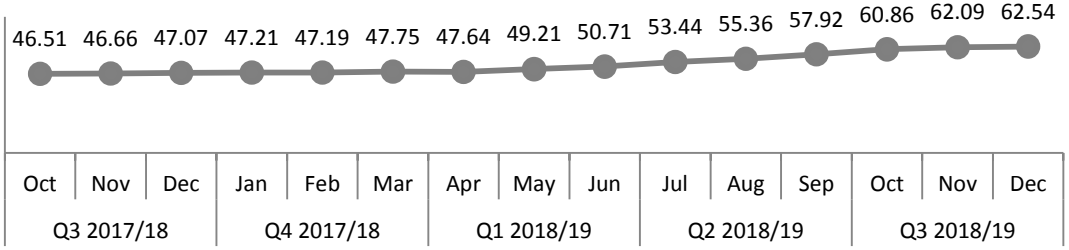
Dec-18	Discharge Summaries
89.5%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Good improvement over the year, but slight downturn over the last two months.
>= 95%	



Actions
Raised in the performance meetings with each business group, for renewed focus, in particular in the assessment areas.

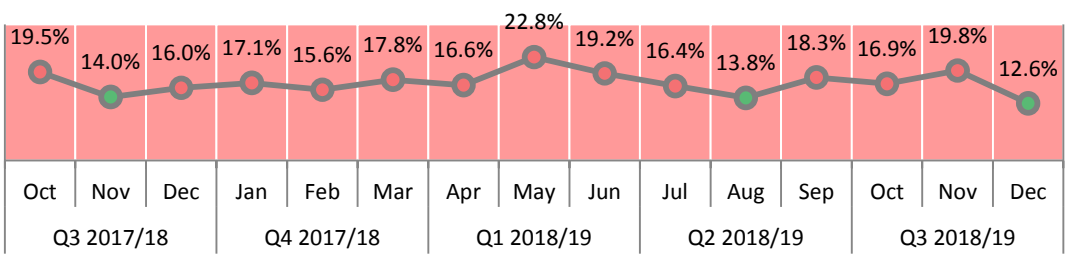
Indicator Detail

Dec-18	Patient Safety Incident Rate
62.54	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The average number of patient safety incidents for every 1000 bed days has risen for the eighth month running. 1409 incidents were reported in December 2018. 83% of these were recorded as no harm incidents.



Actions
A revised training package, to support investigators in identifying learning from incidents, is being delivered over the next few months. The template to support complex investigations is being revised and will be rolled out across the trust to assist in standardisation.

Dec-18	Emergency C-Section Rate
12.6%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	The target has been achieved in month.
<= 15.4%	



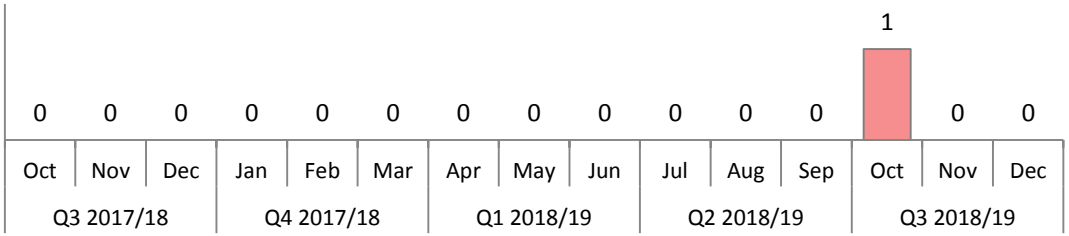
Actions
The quality committee received a deep dive in to women who have an emergency caesarean section in December. This demonstrated the trust is in line with other providers of maternity care in terms of a fluctuating baseline.

Indicator Detail

Dec-18	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	No "never events" were reported for the month of December 2018.
<= 0	

Actions

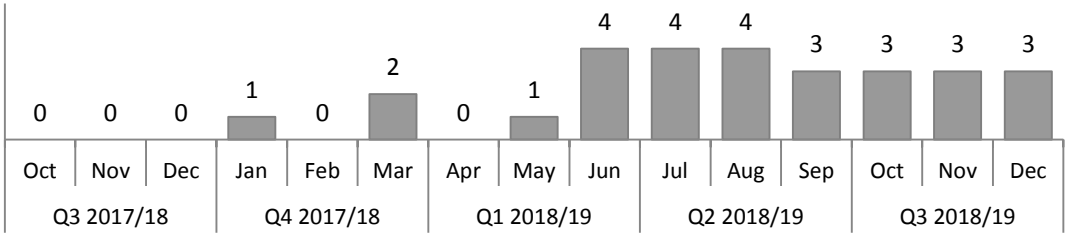
The last never event reported in the trust was in October 2018. This was a retained tampon following a vaginal birth.



Dec-18	Duty of Candour Breaches
3	Total number of Duty of Candour breaches in month.
Target	There were 3 incidents where the Duty of Candour was not opened in writing, within 10 days of the incident being reported on StEIS.

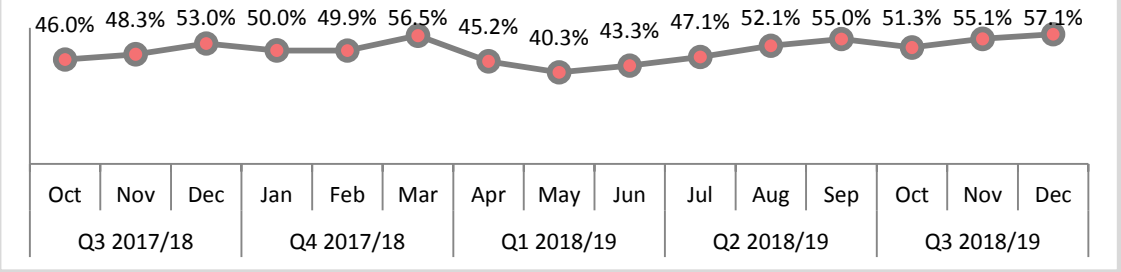
Actions

An additional field has been added to the Duty of Candour section of the incident form, to record when the Duty of Candour is due and if there has been a breach in the times scales.
Clear guidance has been made more prominent within that section of the form.
Duty of Candour is monitored weekly with the governance leads in each business group.



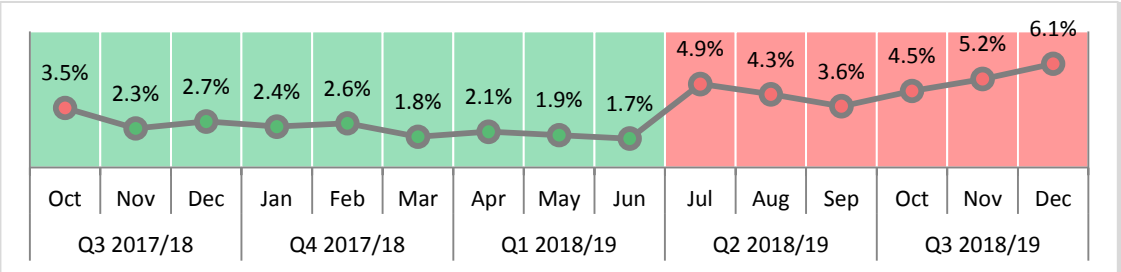
Indicator Detail

Dec-18	Stranded Patients
57.1%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The percentage of stranded patients has increased further in December.
<= 35%	



Actions
A full review is being undertaken jointly by SMBC and SCCG with a specific daily focus on stranded patients. In addition, there is a twice weekly Red to Green patient focused meeting with ward managers. Continuing Health Care pathway reviews are taking place across the DMOP wards.

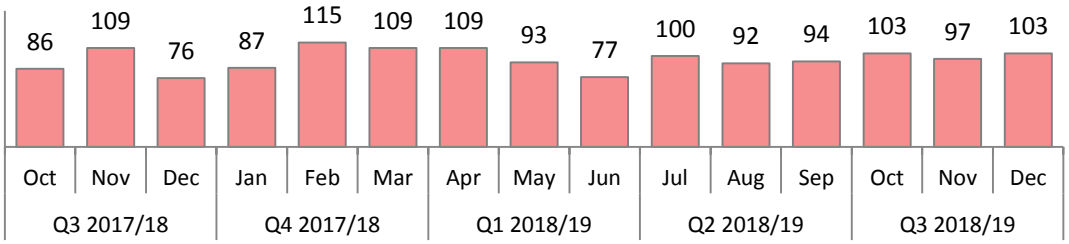
Dec-18	Delayed Transfers of Care (DTOC)
6.1%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	The number of patients classified as DTOC exceeds the Trust target position.
<= 3.3%	



Actions
Packages of care, both in and out of area are the primary driver for delays. Daily validation is now agreed by all partners and the Trust has resumed DTOC reporting.

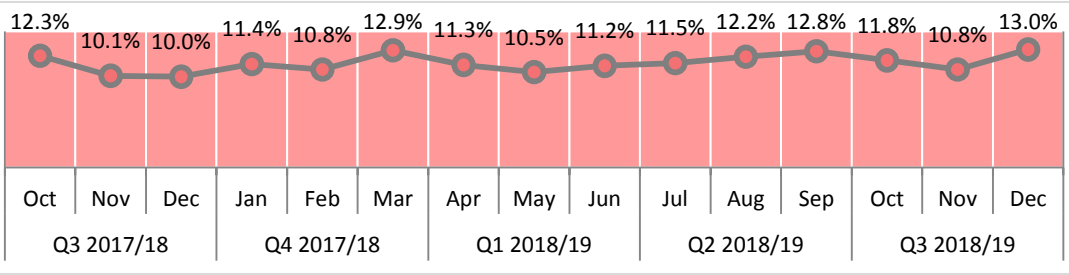
Indicator Detail

Dec-18	Medical Optimised Awaiting Transfer (MOAT)
103	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The number of patients classified as MOAT remains significantly above the Trusts target position.
<= 40	



Actions
Actions fro MOAT are aligned to Stranded and DTOC.

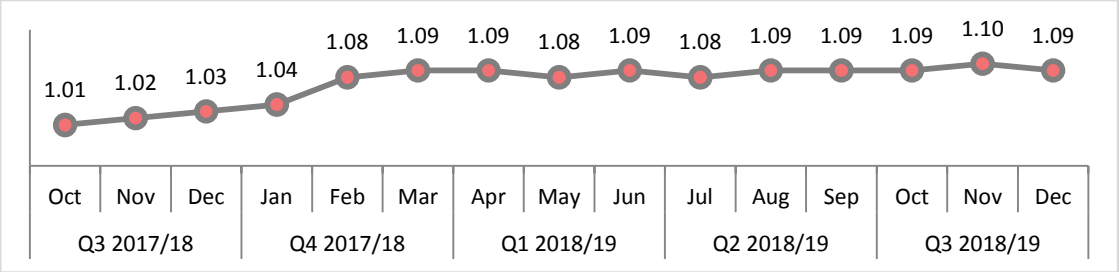
Dec-18	Bank & Agency Costs
13.0%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs account for 12.97% (£2.42M) of the £18.65M total pay costs; an increase of £427K from last month (£1.99M). Medicine & CS Business Group spend has increased by £277K to £1.015M & continues to have the highest spend; equating to 42% of the overall spend & 5.44% of the total paybill.
<= 5%	



Actions
The following work programmes continue to help reduce medical and nursing agency usage: Further Physician Associate recruitment in Urgent Care, Gastroenterology and Medicine. Using the information from the Liaison booking rate index to identify high cost outliers and serve notice or renegotiate rates where possible. Medical rota re-design in General Medicine. Key medical appointments in Microbiology, Acute Medicine, Gastroenterology and Medical Specialty trainee rotas. Specialties that are unable to attract substantive candidates, which are significantly staffed by agency workers, to be considered in the context of the service review and CSEP processes to understand if changes to the service model should be made.

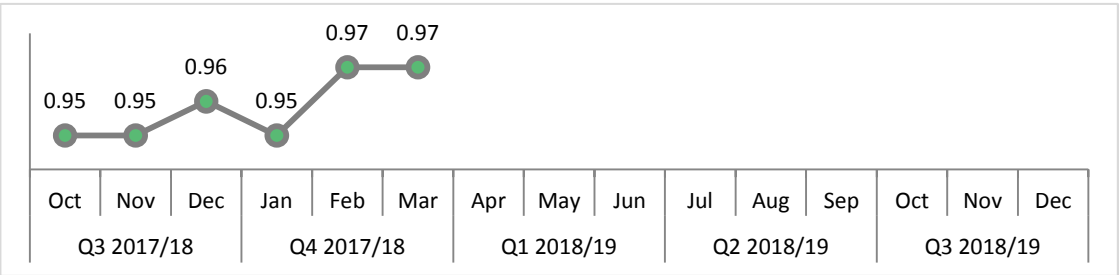
Indicator Detail

Dec-18	Mortality: HSMR
1.09	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	Deep dive into HSMR undertaken last month. Ratio maintained at static level.
<= 1	



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

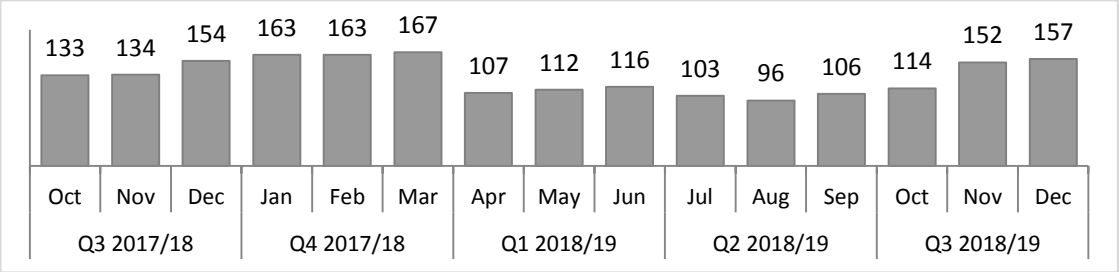
Mar-18	Mortality: SHMI
0.97	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	SHMI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



Actions
Actions as for HSMR

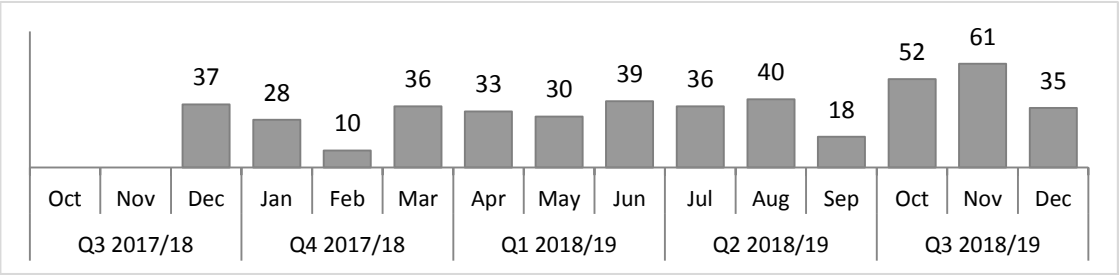
Indicator Detail

Dec-18	Mortality: Deaths in ED or as Inpatient
157	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	Increasing death rate reflects the increasing winter acuity.



Actions

Dec-18	Mortality: Case Note Reviews
35	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	22% of deaths were reviewed, aligning well with national expectations. Last month there were a high number of reviews due to the overview undertaken of AKI deaths.

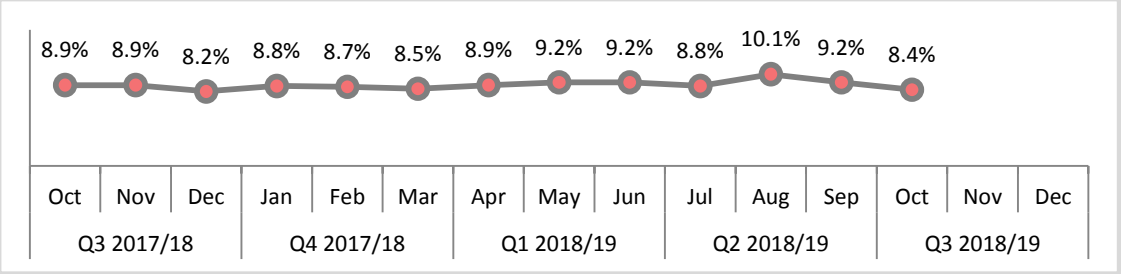


Actions

The goal of this work is to facilitate learning. Oversight by the quarterly report to the quality committee and bi-annual report to the board remains proportionate. This remains an area of considerable development, and still with further work to do.

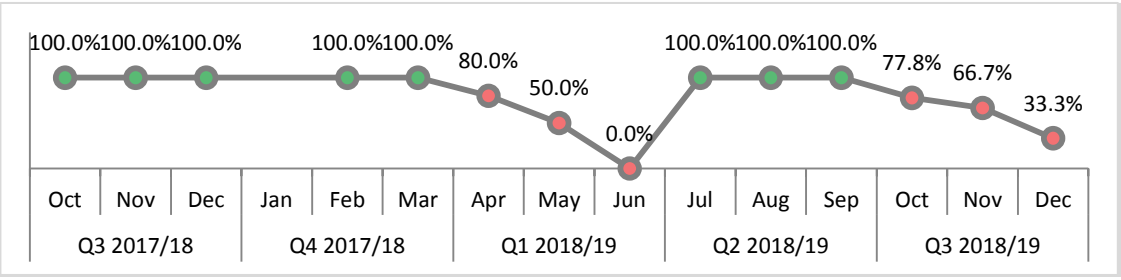
Indicator Detail

Oct-18	Emergency Readmission Rate
8.4%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	Aligns well with the Stockport Together initiative and neighborhood support, as well as the enhanced community support for the winter plan.
<= 7.9%	



Actions
A pleasing downturn in readmissions for each of the past two months. Given the winter pressures this is a good result, but currently is unlikely to reflect a consistent trend.

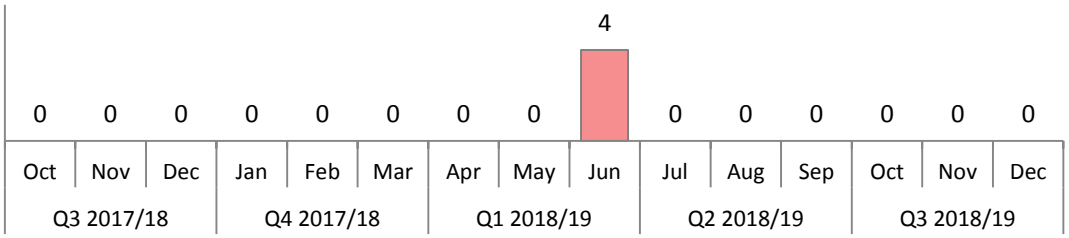
Dec-18	Patient Safety Alerts: Completion
33.3%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	3 safety alerts were due for completing for December 2018. All 3 were completed in December, but 2 were uploaded after the deadline.
>= 100%	



Actions
A new process for responding to alerts was put in place in July 2018. This had worked well and the October and November performance were due to circumstances outside the control of the trust. The performance in December was due to human error, however the new process should have prevented this from happening. A mapping exercise is being undertaken in January to ensure the process is robust and identify any further changes that need to be made.

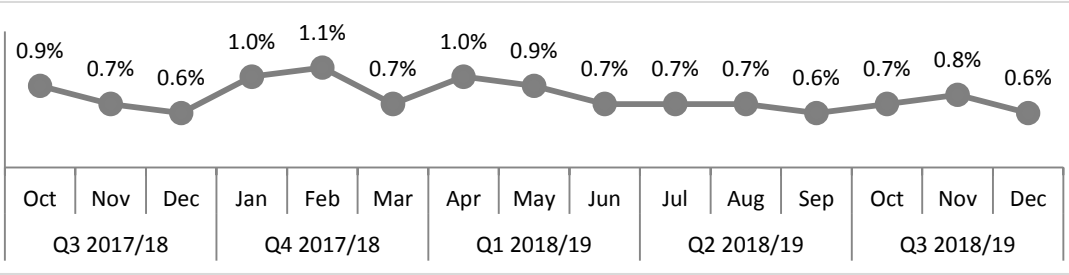
Indicator Detail

Dec-18	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	Total number of occasions that sexes were mixed on same sex wards.
<= 0	



Actions
There were no patients affected by a mixed sex breach in the month of December.

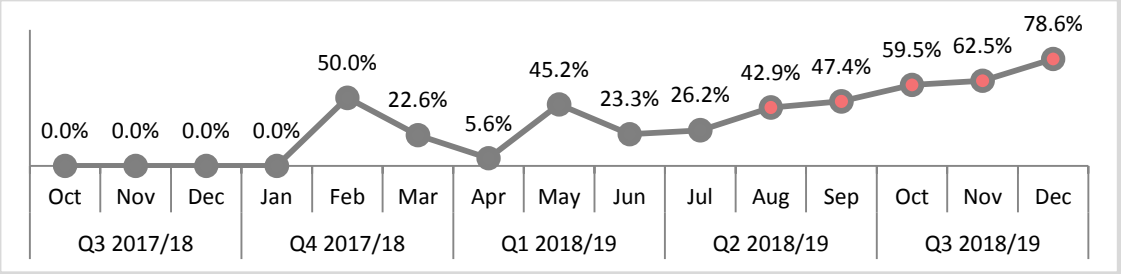
Dec-18	Complaints Rate
0.6%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	29 complaints were received in December 2018: Integrated Care = 8, Medicine = 9, Surgery = 8, WCDS = 4



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

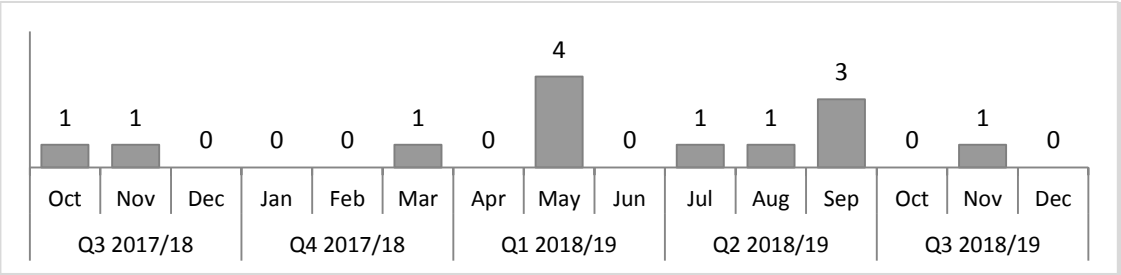
Indicator Detail

Dec-18	Complaints: Response Rate 45
78.6%	The percentage of formal complaints responded to within 45 days.
Target	In the month of December 2018, 32 responses were due out, 23 of which were sent on time resulting in a 71.9% response rate. The business group response rate is as follows: Estate & Facilities: 100%, WCDS: 80%, Int Care: 80%, Surgery: 80% and Medicine: 33.3%
>= 95%	



Actions
The Patient and Customer Services Team continue to liaise with the business groups and the executive team with the aim of improving the Trust complaints response rate. Complainant are also kept informed of any delays that occur resulting in the Trust not being to respond in the agreed timeframe.

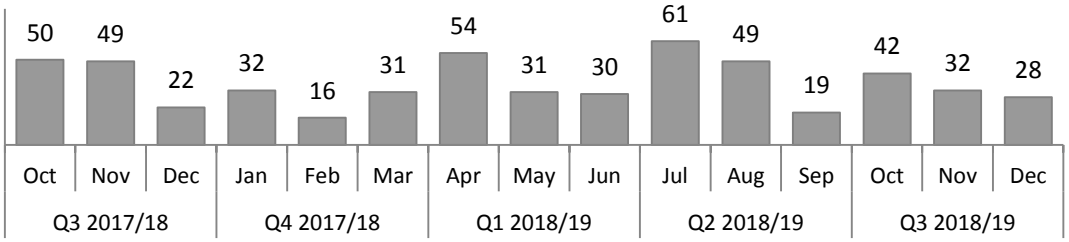
Dec-18	Complaints: Parliamentary & Health Service Ombudsman Cases
0	The total number of open Ombudsman cases.
Target	In December 2018,no new referral were received from the Parliamentary and Health Service Ombudsman. One final report was received in month in which the case was partially upheld.



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

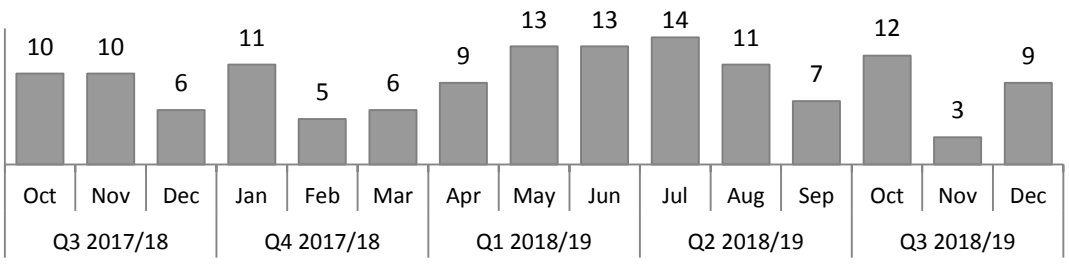
Indicator Detail

Dec-18	Complaints Closed: Overall
28	The total number of formal complaints that have been closed.
Target	In December 2018 28 cases were closed. Integrated care = 9, Medicine = 7, Surgery = 9, WCDS = 2 and Estate and Facilities = 1



Actions
Of the 28 closed in month, 22 were sent out in time - 1 was due out in September, 1 was due out in October, 3 were due in November. 7 cases were sent early as they were not due until January or February.

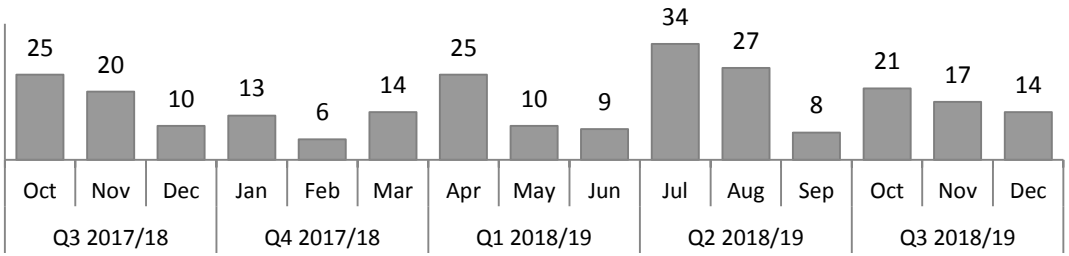
Dec-18	Complaints Closed: Upheld
9	The total number of upheld formal complaints that have been closed.
Target	For December 2018, 9 cases were upheld out of 28.



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

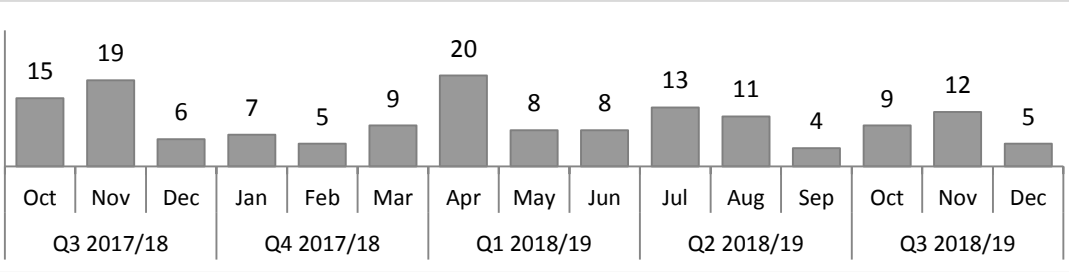
Indicator Detail

Dec-18	Complaints Closed: Partially Upheld
14	The total number of partially upheld formal complaints that have been closed.
Target	In December 2018, 14 cases were partially upheld out of the 28 closed.



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

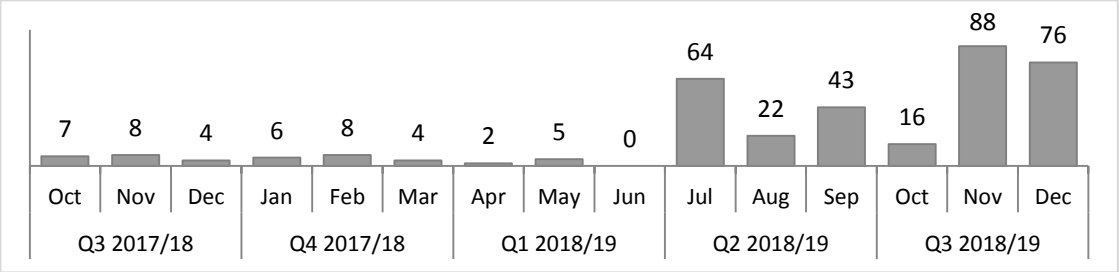
Dec-18	Complaints Closed: Not Upheld
5	The total number of not upheld formal complaints that have been closed.
Target	In December 2018, 5 cases were not upheld out of the 28 closed.



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

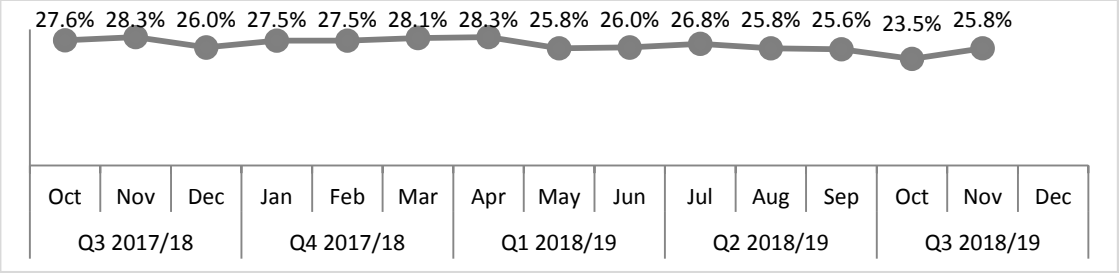
Indicator Detail

Dec-18	Compliments
76	Total number of compliments received.
Target	In December 2018, the Trust received a total of 78 compliments, including 2 received via Care Opinion. The business group breakdown is as follows: Int Care = 53, Medicine & Clinical Support= 15, Surgery GI & Critical Care = 3, Women, Children & Diagnostic Services = 1



Actions
Any compliments received by the patient and customers services team are shared with the chief nurse & director of quality governance who acknowledges them in writing. If a member of staff is identified, the chief nurse & director of quality governance will present them with a Proud to Care Certificate in recognition of their hard work. Following a successful pilot across 3 wards the Matron for Patient Experience and Quality Improvement has rolled out a process for capturing compliments on the datix system. This will enable us to capture a wealth of information from thank you cards, letters, gifts and verbal feedback from service users and members of staff. The information is populated on a dashboard for each clinical area and their respective business group.

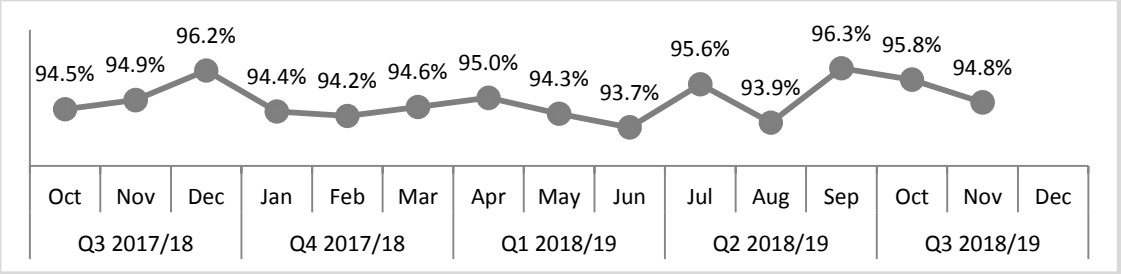
Nov-18	Friends & Family Test: Response Rate
25.8%	The percentage of eligible patients completing an FFT survey.
Target	The overall trust response rate for November 2018 for the Friends and Family test is 25.8%.



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

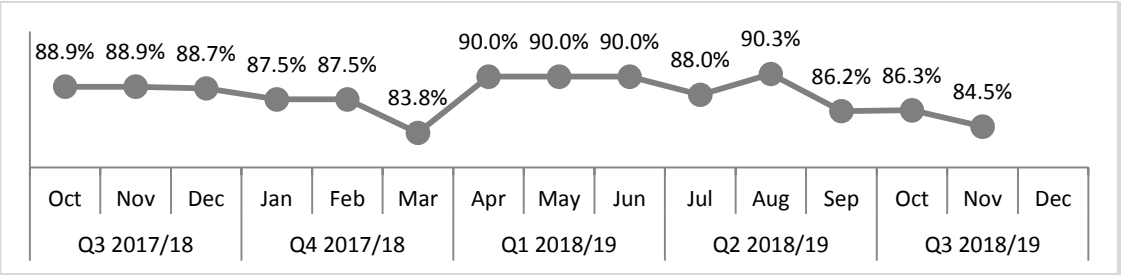
Indicator Detail

Nov-18	Friends & Family Test: Inpatient
94.8%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Inpatients for FFT in December are: Positive: Staff attitude (114), Care (69), Environment (33) Negative: Care (5), Staff attitude (5), Environment (4) The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

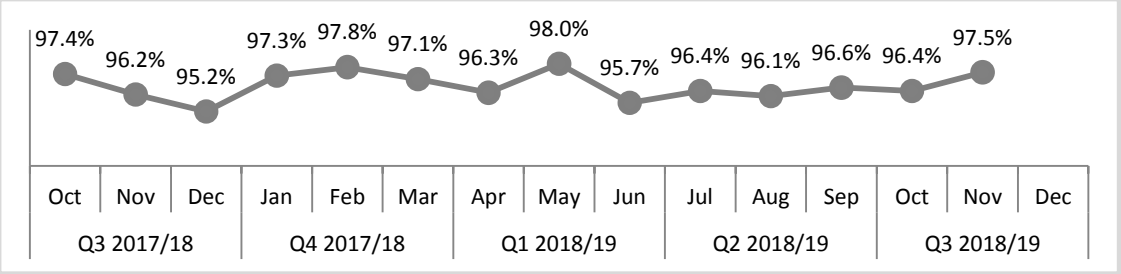
Nov-18	Friends & Family Test: A&E
84.5%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients in the Emergency Department who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Emergency Department for FFT in December are: Positive: Staff attitude (450), Care (157), Clinical treatment (147) Negative: Waiting time (45), Staff attitude (43), Clinical treatment (36) The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

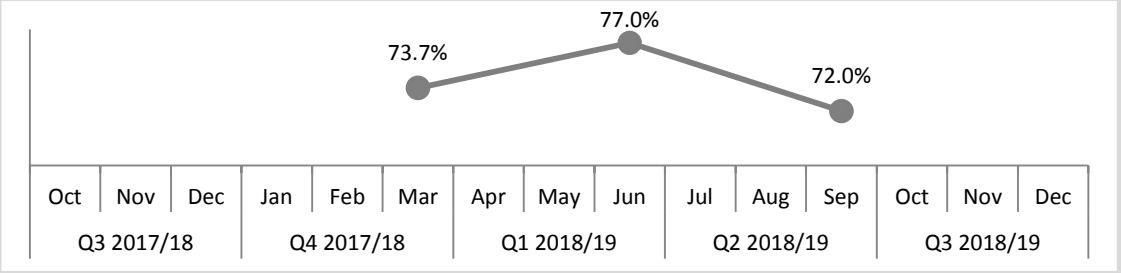
Indicator Detail

Nov-18	Friends & Family Test: Maternity
97.5%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients in the Maternity Department who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Maternity for FFT in December are: Positive: Staff attitude (24), Care (16), Environment (12) Negative: There were no negative comments. The Patient Experience Group and Patient Experience Action Group monitor results on a monthly basis.

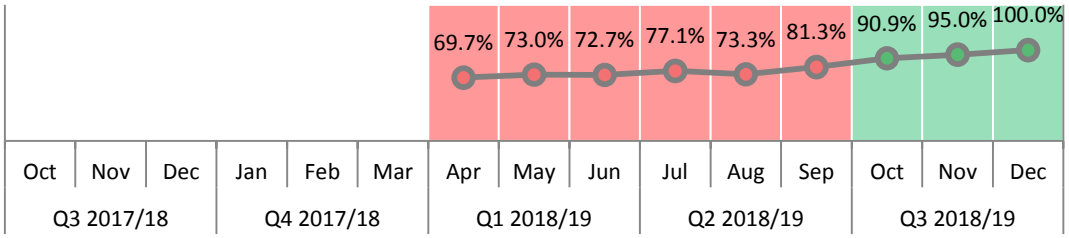
Sep-18	Staff Friends & Family Test
72.0%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The response for the staff Friends and Family survey recommending care and treatment has disappointingly reduced this quarter by 2%. Work continues to motivate staff and improve their work experiences and outlooks.



Actions
•To engage with groups of staff who are struggling with motivation and offer bespoke support (development opportunities, best practice awards, change workshops) •To explore exit interviews and leavers information to make positive changes •To support new staff in the trust with initiatives such as preceptor ship and buddies •Celebrating Stockport- with staff initiatives such as Celebration of achievements •Promoting staff initiatives via the cultural ambassadors for a more personal experience

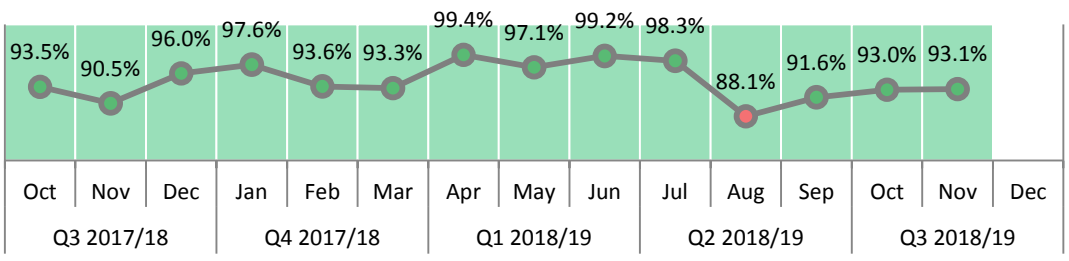
Indicator Detail

Dec-18	Diabetes Reviews
100.0%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	Target achieved and sustained.
>= 90%	



Actions

Nov-18	Dementia: Finding Question
93.1%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The Trust has a target of above 90% for the finding question within the FAIR process.
>= 90%	

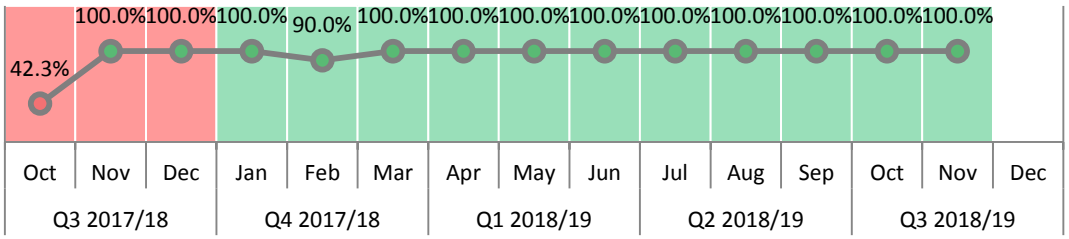


Actions

The target was achieved in month.

Indicator Detail

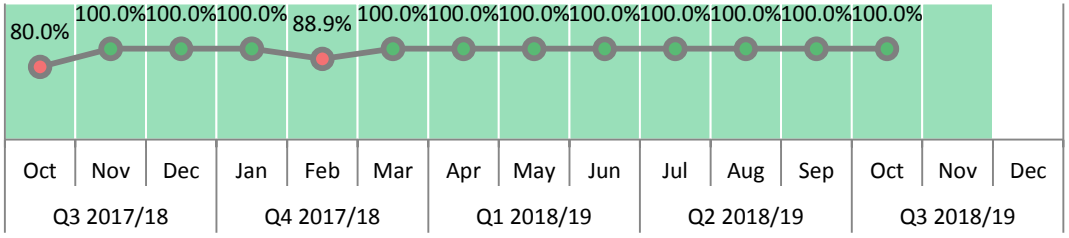
Nov-18	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The Trust has a target of above 90% for the finding question within the FAIR process.
>= 90%	



Actions

The target was achieved in month.

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

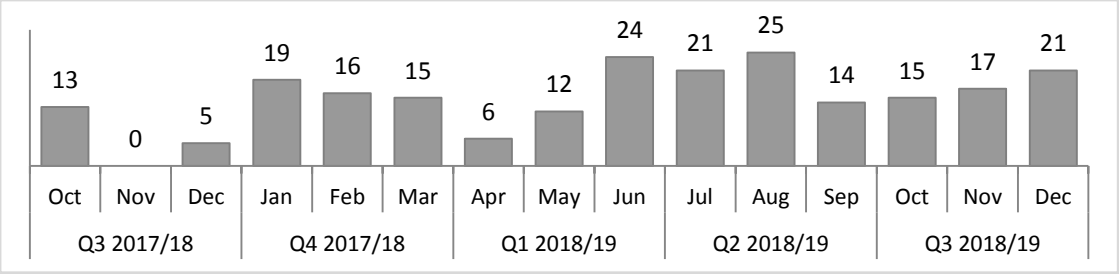


Actions

There were no patients requiring referral in November

Indicator Detail

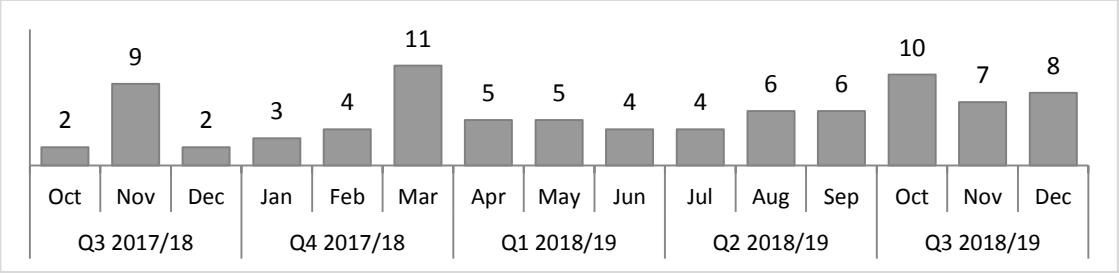
Dec-18	Serious Incidents: STEIS Reportable
21	The total number of STEIS reportable incidents.
Target	There have been 21 StEIS reportable incidents in the month of November. All serious incidents have been reviewed by the Chief Nurse & Director of Quality Governance and the Medical Director.



Actions

The 21 serious incidents were
8 cases where patients developed pressure ulcers; 3 category 3, 4 category 4 and 1 that was an infected cavity.
3 cases were maternity diverts
2 cases where there were IT system issues
2 cases where patients fell. 1 patient suffered a bleed and 1 patient sustained fractured neck of femurs
1 case where there was a power outage
1 case was an alleged assault of a patient
1 case was a transfer of a baby to another trust for head cooling
1 case was where patients were waiting more than 12 hours in emergency department and met the criteria of a 12 hour breach
1 case was a large chemical spillage
1 case related to a delay in treatment

Dec-18	Litigation: Claims
8	Total number of claims opened in month.
Target	In December 2018 the trust received 8 claims; 6 were alleged medical negligence claims, 2 were alleged employment liability claims.

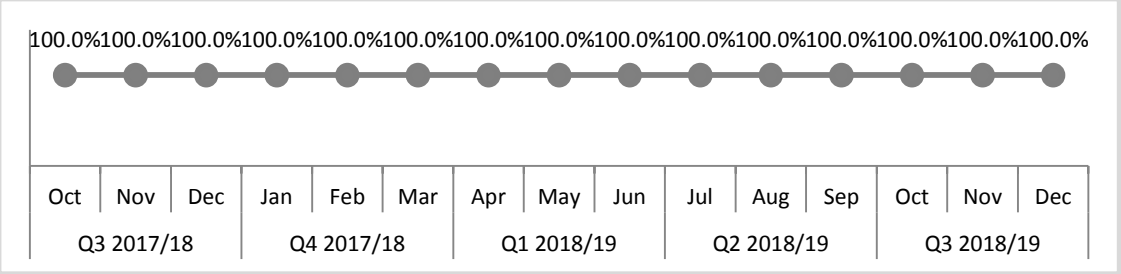


Actions

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

Indicator Detail

Dec-18	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	In December 2018, three claims were closed, of which one was unsuccessful against the trust.

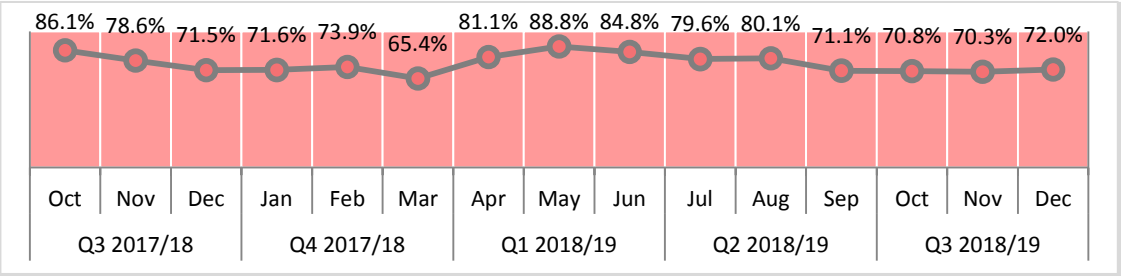


Actions

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

One claim settled this month related to obstetric care.
Once claim related to a failure of a surgical procedure.

Dec-18	A&E: 4hr Standard
72.0%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance for December was 72% against the 95% standard. There has been an increase in the number of confirmed adult Flu patients across the system, with a discernible increase in acuity resulting in additional requirement of side-rooms. There were up to 21 IMC beds closed in the community due to norovirus.
>= 95%	



Actions

The Trust has been unable to open all planned escalation capacity due to the inability to staff safely.

Post New Year, a MADE event has been running, with senior cover on all white board rounds, and the activation centre open.

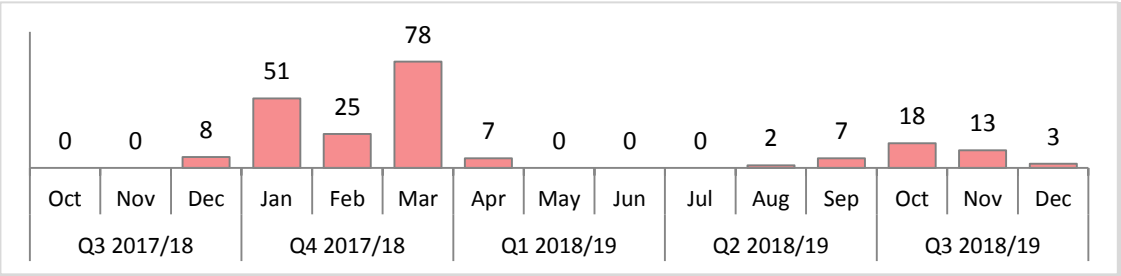
The OPEL cards have been revised and relaunched to provide direction on actions to be undertaken at times of escalation.

Utilisation Management are currently supporting the Trust in the implementation and sustainability of the SAFER principles.

Overnight wait to be seen has improved in January to date, due to the additional Consultant cover from 4pm to midnight.

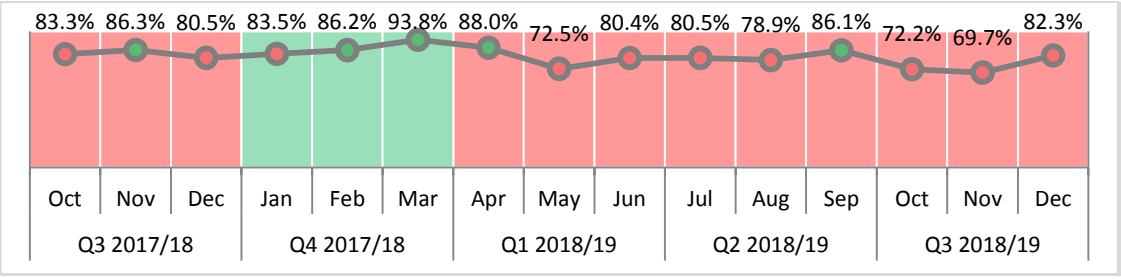
Indicator Detail

Dec-18	A&E: 12hr Trolley Wait
3	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	There were three 12hr trolley waits reported in December. No patient harm was identified.
<= 0	



Actions
Patient flow constraints were the underlying cause of the three breaches in month. The work on reducing the number of stranded patients within the hospital will directly impact and improve patient flow.

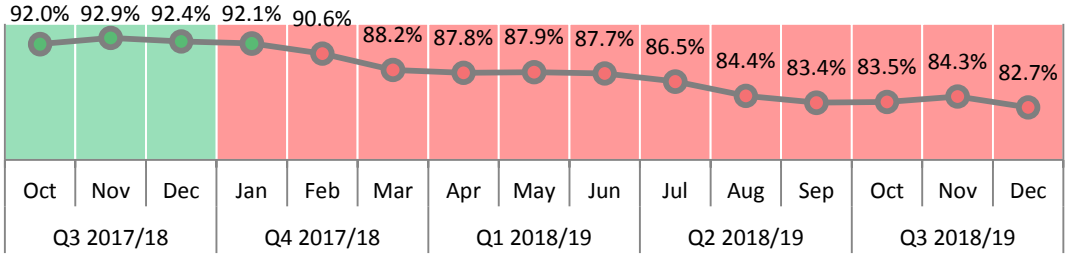
Dec-18	Cancer: 62 Day Standard
82.3%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	The latest position for December is 82.3%, which is a significant improvement on recent months. Diagnostic capacity and the sustained increase in referrals continue to challenge compliance with standard.
>= 85%	



Actions
A deep dive paper describing the factors affecting cancer performance was presented to the Finance & Performance committee in January. Members from GM cancer are visiting the Trust in early March to discuss transformational funding and how this may support pathway improvements. The Chief Operating Officer will be the Executive lead for the Trusts' Cancer Quality & Service Improvement group going forward. Although the position is showing as 82.3%, the Organisation is optimistic that the 85% standard will be met in December.

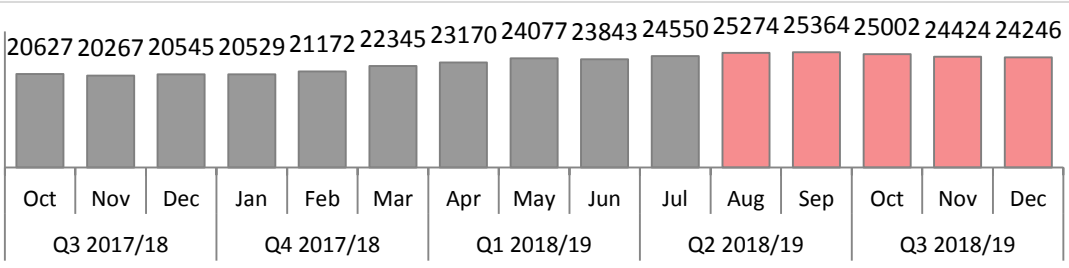
Indicator Detail

Dec-18	Referral to Treatment: Incomplete Pathways
82.7%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	Performance has deteriorated in month, with an increase in patients waiting beyond 18 weeks.
>= 92%	



Actions
Specialty level plans are in place to improve the Incomplete pathways position over the coming months, which forecasts 9 specialties fully compliant, and an overall Trust performance of 89.8% by the end of Q1. However, key Consultant vacancies will affect the ability to recover as planned if locum cover is not able to be secured. Additionally, anticipated winter pressures may affect elective activity which will have an adverse affect on recovery plans.

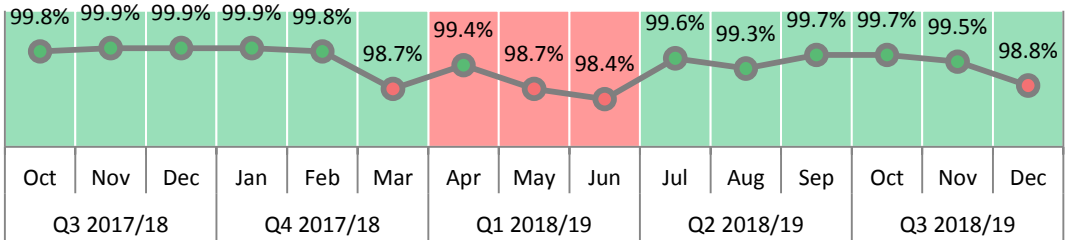
Dec-18	Referral to Treatment: Incomplete Waiting List Size
24246	The total number of patients on an open pathway.
Target	The Trust continues to reduce the elective waiting list size, with a further reduction of circa 200 in December.
<= 22345	



Actions
Data quality work will continue alongside improved pathway tracking processes. Activity plan recovery will also support an overall reduction in waiting list size. Although GP referral growth has slowed, the number of referrals remains higher than the previous year.

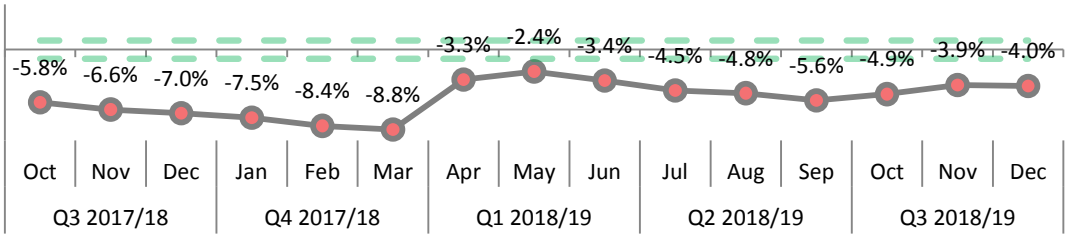
Indicator Detail

Dec-18	Diagnostics: 6 Week Standard
98.8%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust failed to achieve the diagnostic standard in December. This was in the main due to the National shortage of contrast medium which is required to undertake MR arthrogram examinations.
>= 99%	



Actions
The Trust will continue to liaise with the provider to understand supply chain issues. Patients requiring these examinations will continue to be prioritised on a clinical and waiting time basis.

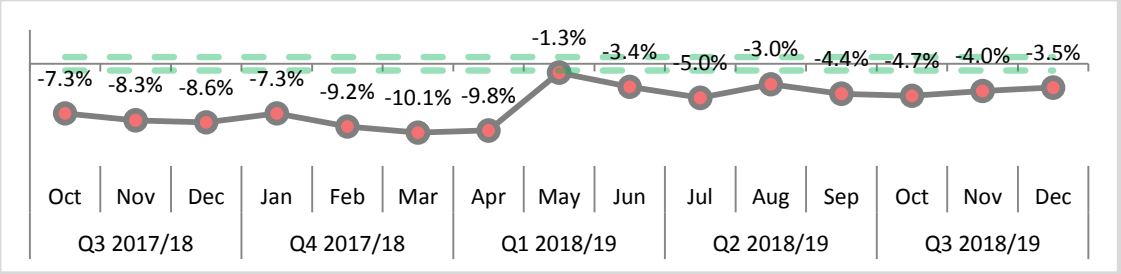
Dec-18	Elective Activity vs. Plan
-4.0%	The percentage variance between planned elective activity and actual elective activity.
Target	Although Elective activity remains 4% behind plan at month 9, it should be noted that the associated income is more favourable.
+/- 1%	



Actions
The activity recovery plans continue to be implemented. This will be closely monitored via the weekly Ops Group. Month to date, elective activity appears on track to achieve.

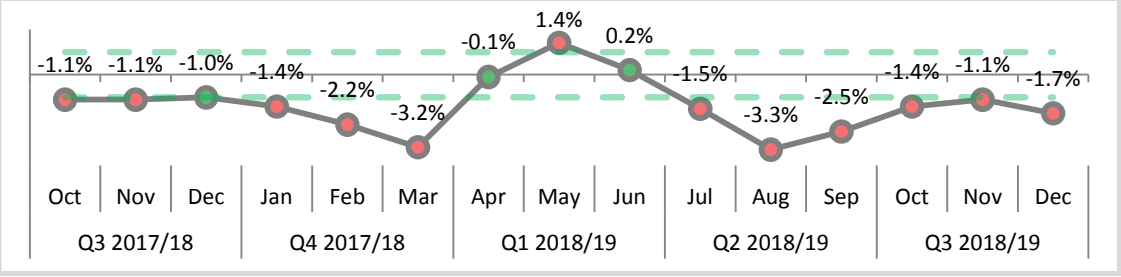
Indicator Detail

Dec-18	Elective Income vs. Plan
-3.5%	The percentage variance between planned elective income and the actual elective income.
Target	The elective income variance continues to improve, mainly due to case-mix.
+/- 1%	



Actions
The risk to elective income is directly proportional to the ability to deliver the activity during the winter period if the impact is above that anticipated. Grip and control actions across the Business Groups has seen a positive impact on the run-rate.

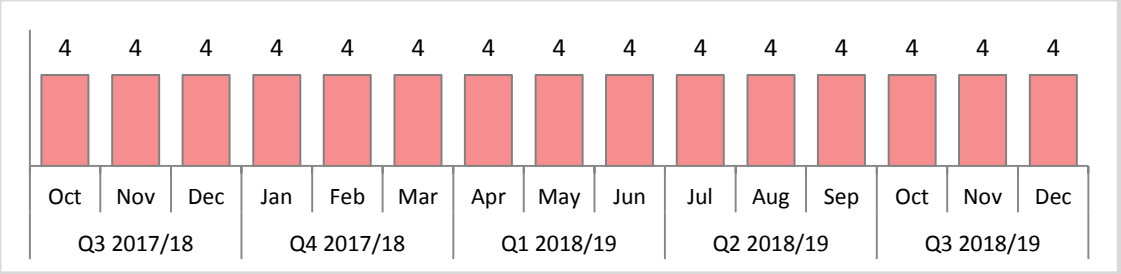
Dec-18	Outpatient Activity vs. Plan
-1.7%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Outpatient activity drifted to 1.7% behind plan in month.
+/- 1%	



Actions
January to date, Outpatient activity appears on track to achieve plan. It should be noted that the plan includes inflated spells associated with the Anticoagulant pathway whose change has reduced the requirement for patient monitoring.

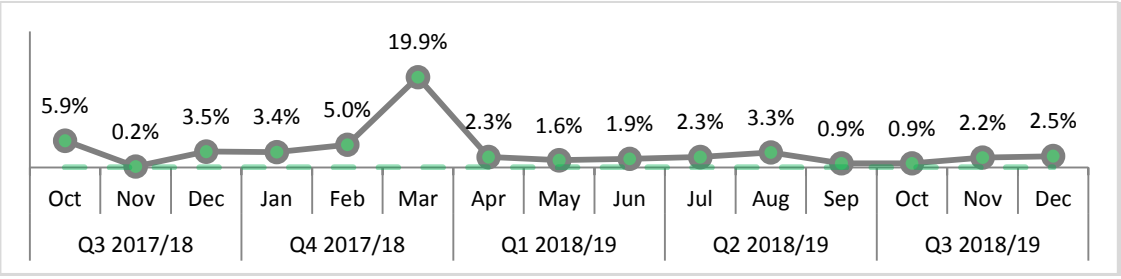
Indicator Detail

Dec-18	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	The Trust's 2018/19 Operational Plan does not deliver the target of a score of a 2 or better, as the planned deficit of £34m is a deficit of 12%. To improve from a 4 to a 3 the planned deficit would need to improve by circa £30m to a deficit of less than £3m (within 1% of planned operating income).
<= 2	



Actions
The financial outlook for the Trust remains difficult; in the twelve months to 31st March 2019 the Trust is planning a loss of £34m (£93,000 per day) even after the achievement of a £15.0m CIP. This is a deterioration of £12m from the £22m loss in 2017/18, where the Trust relied on non-recurrent measures to achieve the year-end position. The Trust's underlying position continues to be monitored by NHSI through the Enhanced Financial Oversight and Use of Resources processes, and is working closely with colleagues to improve the underlying run-rate. The Trust has received a control total offer for 2019/20 from NHS Improvement to support the journey to break even, and is considering this as part of planning for the year ahead.

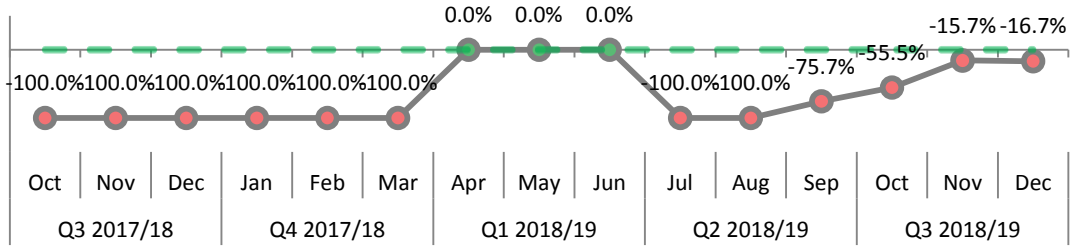
Dec-18	Financial Controls: I&E Position
2.5%	The percentage variance between planned financial position and the actual financial position.
Target	The Trust has lost of £26.3m in the nine months of the financial year to date, an average loss of £96,000 per day. The planned deficit was £27.0m so this is £0.7m favourable to the profiled plan. The Trust is reporting significant assurance on the delivery of this metric.
>= 0%	



Actions
As the Trust is favourable against the financial plan at this stage of the financial year, the Trust is scoring a 1 (best) under the NHSI use of resources (UoR) metric within the Single Oversight Framework. There is an action plan in place to mitigate the non-delivery of CIP. Despite the elective income performance, winter demands, risk of additional contract penalties due to operational performance, risk on Stockport Together and EPR, there is now significant assurance that the operational finance plan will be delivered at the end of 2018/19. This is due to the grip and control actions undertaken across the business groups and forecast winter spend remaining within the expected envelope due to staffing shortages across nursing and medical.

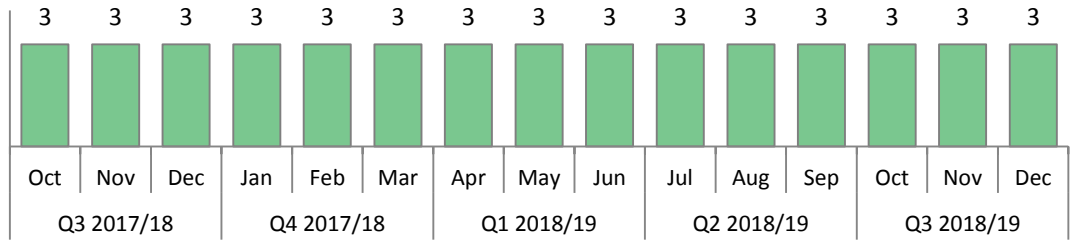
Indicator Detail

Dec-18	Cash
-16.7%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st December 2018 was £7.6m. The graph shows that the Trust has accessed borrowing each month since September 2018. The forward risk is forecasted as a green, as the Trust has applied and received confirmation of revenue support.
+/- 1%	



Actions
Cash in the bank on 31st December 2018 was £7.6m, which is £0.8m less than last month but still in excess of the present minimum cash balance to be maintained i.e. the Trust has borrowed more than needed. This is due to payments being received earlier than expected from CCGs, changes in payment dates with other NHS organisations and capital cash payments behind plan. The Trust borrowed £2.9m in December, increasing the total borrowed to date to £13.4m. The Trust is forecasting to borrow £26.4m in the current financial year.

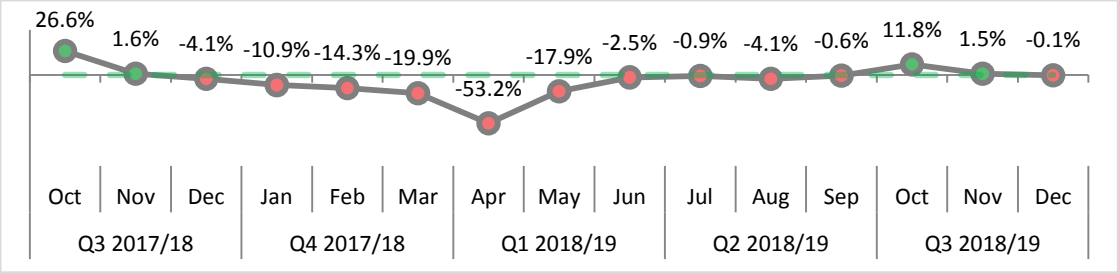
Dec-18	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's overall Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns.
<= 3	



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

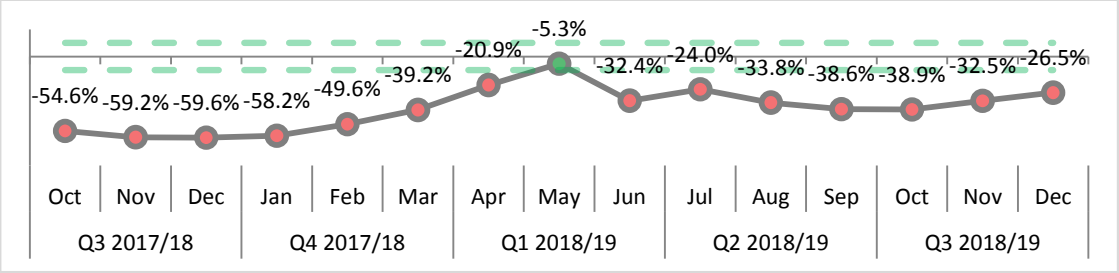
Indicator Detail

Dec-18	CIP Cumulative Achievement
-0.1%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is in line with the profiled plan to date with £9.0m delivered to date. £10.8m of CIP has been delivered against the £15.0m in year target. The unidentified gap remains at £2.3m.
>= 0%	



Actions
Whilst the Trust is in line with its profiled CIP plan to date there is a significant risk to the delivery of the total CIP programme in 2018/19. The phasing of the CIP means that the level of savings required increases again in the last quarter of the year. There is a further risk of delivery in 2019/20 as there is not the required level of recurrent savings delivered to date. Recurrently £7.7m of savings have been delivered against the £15m requirement. Even with potential mitigation the Trust can only provide moderate assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

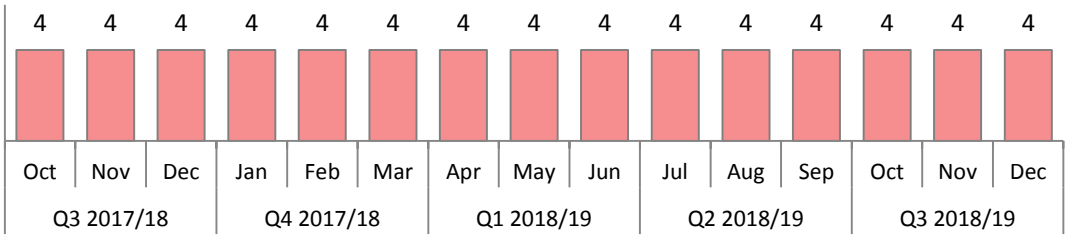
Dec-18	Capital Expenditure
-26.5%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £6.2m have been incurred to date against a plan of £8.4m so is £2.2m behind plan. This relates to equipment which is £1.0m behind plan and estates schemes which are £1.1m underspent.
+/- 10%	



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

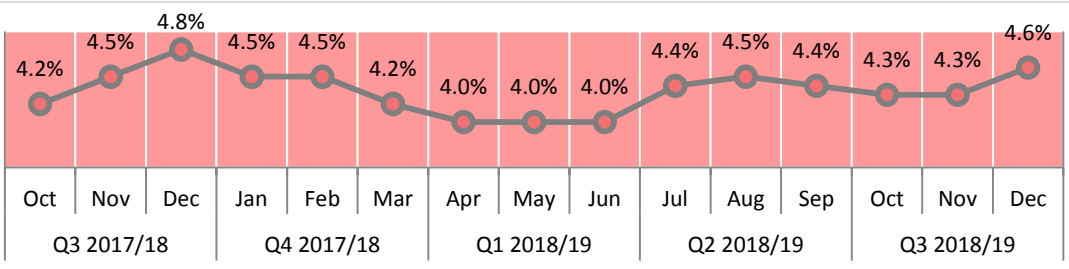
Indicator Detail

Dec-18	Financial Sustainability
4	A calculated score based on the Capital Service Capacity (the degree to which the Trust's generated income covers its financial obligations) and Liquidity in days (the number of days of operating costs held in cash or cash-equivalent).
Target	For the two metrics on financial sustainability the Trust scores a 4 (worst). This is not expected to change.
<= 2	



Actions

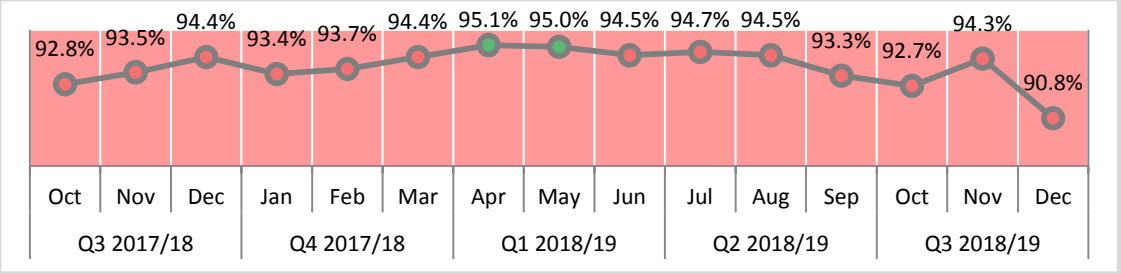
Dec-18	Sickness Absence Rate
4.6%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure is 4.57%; an increase of 0.28% compared to the adjusted November 2018 figure of 4.29%. The sickness rate for comparison in December 2017 was 4.83%. The 12-month rolling sickness percentage for the period January 2018 to December 2018 is 4.32%.
<= 3.5%	



Actions
The unadjusted cost of sickness absence in month is £544,353; an increase of £63,673 from the adjusted figure of £480,680 in the previous month. This does not include the cost to cover the absence. Following the approval of the People Strategy actions are now underway to review the underpinning and supporting strategic plans, including the health and wellbeing strategy which is being refreshed. A plan is in place to improve the publicising of all the initiatives in place to support staff to proactively manage their health and wellbeing, as well as the facilities available when staff become unwell. A review of the associated policy documentation is underway.

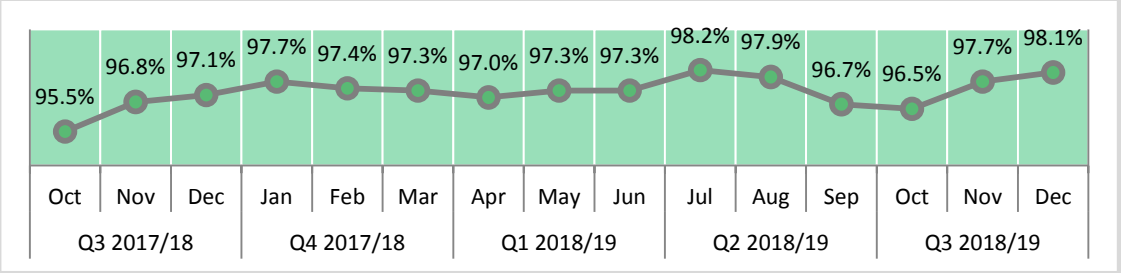
Indicator Detail

Dec-18	Appraisal Rate: Non-medical
90.8%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The appraisal rate has fallen again this month by 3.9%.There are a lot of business groups where large numbers have become non compliant this month .This is believed to be that they previously have been completed at the holiday period or year end ,in large numbers.
>= 95%	



Actions
Reminder emails to managers have been targeted to hot spots in the trust. Monthly report sent to all managers. Business groups tasked with having a recovery plan in place by March 2019

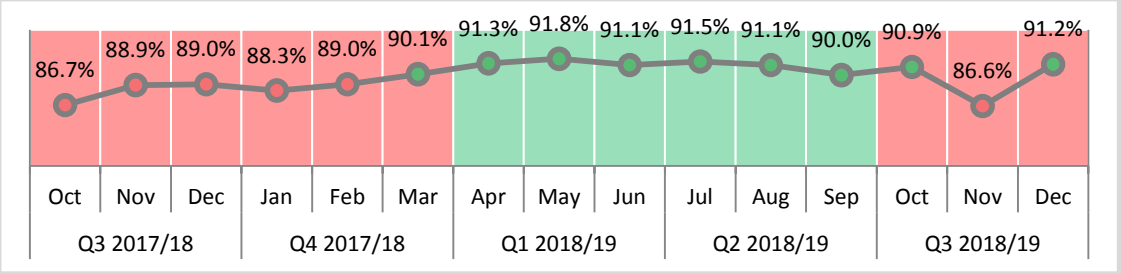
Dec-18	Appraisal Rate: Medical
98.1%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate is 98.09%, an increase on the last month's figure of 97.73% and above the Trust target of 95%.
>= 95%	



Actions
Performance is above target

Indicator Detail

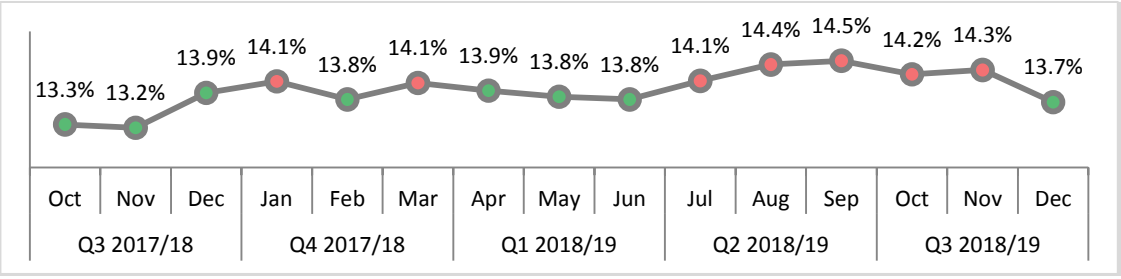
Dec-18	Statutory & Mandatory Training
91.2%	The percentage of statutory & mandatory training modules showing as compliant.
Dec-18	The statutory and mandatory training compliance is 91.2%, above target.
>= 90%	



Actions

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

Dec-18	Workforce Turnover
13.7%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month unadjusted turnover figure at the end of December 2018 is 13.70%. The adjusted rolling 12-month permanent headcount turnover figure for the period to December 2018 is 12.93%, both of which fall below the Trust target.
<= 13.94%	



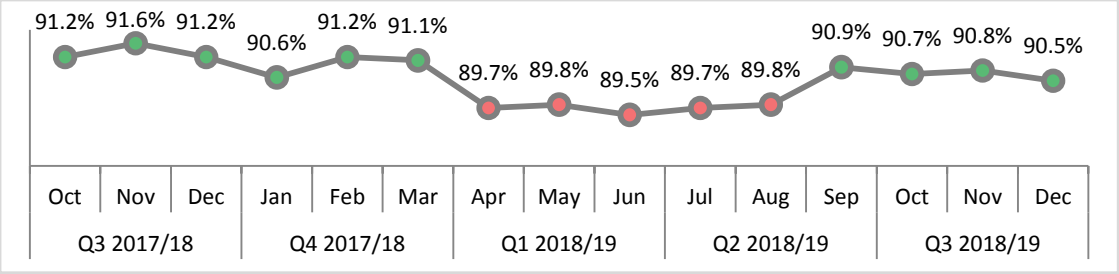
Actions

The highest adjusted leaving reasons are: Relocation 16.38%, Work Life Balance/Dependents 15.46%, Retirement 14.68%, and Promotion 14.68%.

Activity to address hot spot areas of turnover continue; with a refreshed nursing recruitment campaign supporting substantive recruitment from within the UK; undertaking international recruitment to attract doctors from overseas to our hard to fill vacancies and development of 'new roles'

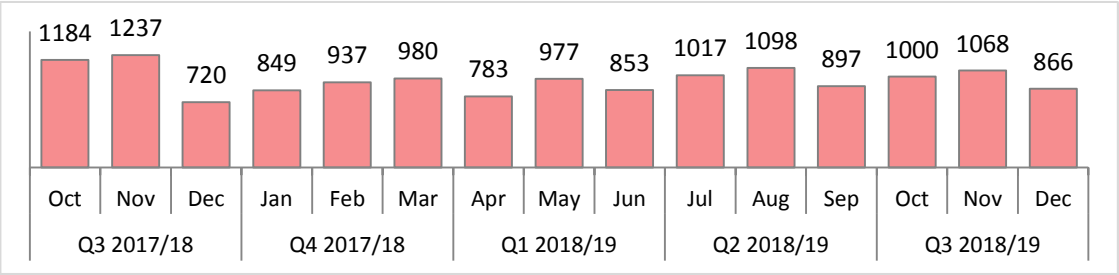
Indicator Detail

Dec-18	Staff in Post
90.5%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for December 2018 is 90.52% of the establishment, which is a decrease of 0.26% from 90.78% the previous month. Above the 90% target
>= 90%	



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

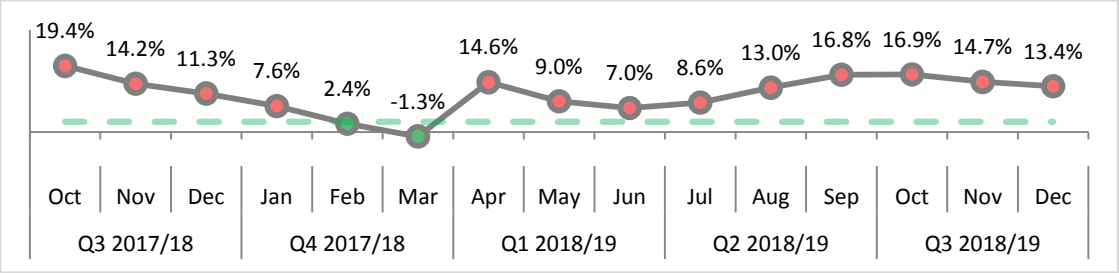
Dec-18	Agency Shifts Above Capped Rates
866	Number of agency shifts above above the provider spend cap.
Target	A total of 866 shifts above the NHSI cap rate were paid during the 4 week period from 3rd to 30th December; equating to an average of 217 shifts per week. This is an increase of 3 shifts per week compared to November's figures and an increase of 37 shifts per week compared to the position in December 2017.
<= 0	



Actions
Medicine & Clinical Support had the highest number of agency cap breaches with an average of 108 shifts per week. NHSI additional support is being arranged. In addition the interim CEO commissioned an independent review into the systems and processes in place, including a view on compliance and assurance. The report has been concluded an has provided a good level of assurances on our systems and processes.

Indicator Detail

Dec-18	Agency Spend: Distance From Ceiling
13.4%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	Agency spend was 5.79% of total pay expenditure, a figure of £1.08M.
<= 3%	



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

Safer Staffing Report

Dec-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
AMU	4,092	3,282	3,348	3,138	3,720	2,752	3,069	2,872	80.2%	93.7%	74.0%	93.6%	1530	3.9	3.9	7.9	0	0	0	0
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	139	5.1	5.1	10.3	0	0	0	0
D4	1,163	1,020	791	708	682	671	682	682	87.7%	89.6%	98.4%	100.0%	465	3.6	3.0	6.6	0	0	0	0
A3	1,442	1,255	977	917	1,023	880	682	671	87.1%	93.9%	86.0%	98.4%	740	2.9	2.1	5.0	0	0	0	0
A10	2,888	2,318	2,046	2,136	2,046	1,738	1,364	1,353	80.3%	104.4%	84.9%	99.2%	770	5.3	4.5	9.8	0	0	0	0
A11	1,581	1,361	1,628	1,448	682	637	682	638	86.1%	88.9%	93.4%	93.5%	812	2.5	2.6	5.0	0	0	0	0
A12	1,907	1,865	1,442	1,495	682	682	1,023	1,177	97.8%	103.7%	100.0%	115.1%	539	4.7	5.0	9.7	0	0	0	0
B4	1,209	1,190	713	668	682	682	682	770	98.4%	93.6%	100.0%	112.9%	467	4.0	3.1	7.1	0	0	0	0
B2	1,209	894	605	791	682	682	682	682	73.9%	130.8%	100.0%	100.0%	497	3.2	3.0	6.1	0	0	0	0
B6	1,442	1,217	1,302	1,271	682	715	1,023	1,034	84.4%	97.6%	104.8%	101.1%	655	2.9	3.5	6.5	1	0	0	0
Bluebell Ward	1,209	1,167	2,077	2,029	682	652	682	580	96.5%	97.7%	95.6%	85.0%	686	2.7	3.8	6.5	0	0	0	0
C4	1,209	887	605	1,079	682	693	682	814	73.3%	178.4%	101.6%	119.4%	480	3.3	3.9	7.2	3	0	0	1
Coronary Care Unit	837	844	465	410	682	737	341	308	100.9%	88.2%	108.1%	90.3%	149	10.6	4.8	15.4	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,070	1,070	2,000	1,934	682	682	682	759	100.0%	96.7%	100.0%	111.3%	493	3.6	5.5	9.0	0	0	0	0
E1	1,940	1,460	2,310	2,235	1,023	847	1,364	1,375	75.3%	96.8%	82.8%	100.8%	968	2.4	3.7	6.1	0	0	0	0
E2	2,279	2,243	1,581	1,972	1,023	989	1,023	1,364	98.4%	124.8%	96.7%	133.3%	1028	3.1	3.2	6.4	0	0	0	0
E3	2,279	2,272	1,581	1,581	1,023	990	1,023	1,331	99.7%	100.0%	96.8%	130.1%	1064	3.1	2.7	5.8	0	0	0	0

Safer Staffing Report

Dec-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
A1	1,395	1,328	1,209	1,157	1,023	979	682	675	95.2%	95.7%	95.7%	98.9%	774	3.0	2.4	5.3	0	0	0	2
B3	935	941	837	885	682	693	682	814	100.6%	105.7%	101.6%	119.4%	518	3.2	3.3	6.4	0	0	0	0
C6	935	1,139	1,104	1,176	682	924	682	1,100	121.8%	106.5%	135.5%	161.3%	624	3.3	3.6	7.0	0	0	0	0
D1	1,679	1,379	1,349	1,355	682	671	1,023	1,078	82.2%	100.4%	98.4%	105.4%	684	3.0	3.6	6.6	0	0	0	0
D2	1,619	1,366	1,442	1,720	682	616	682	1,188	84.4%	119.3%	90.2%	174.2%	589	3.4	4.9	8.3	0	0	0	0
D6	1,307	1,236	1,044	760	682	638	682	671	94.6%	72.8%	93.5%	98.3%	631	3.0	2.3	5.2	0	0	0	0
M4	1,224	1,068	977	833	682	682	572	473	87.3%	85.3%	100.0%	82.7%	363	4.8	3.6	8.4	0	0	0	0
SAU	1,836	1,734	729	603	1,023	899	682	583	94.4%	82.7%	87.9%	85.5%	487	5.4	2.4	7.8	0	0	0	0
Short Stay Surgical Unit	1,851	1,617	797	753	869	821	682	706	87.4%	94.5%	94.5%	103.5%	607	4.0	2.4	6.4	0	0	0	0
ICU & HDU	4,689	4,167	372	360	4,092	3,924	341	341	88.9%	96.8%	95.9%	100.0%	344	23.5	2.0	25.6	1	0	0	0
Birth Centre	930	810	465	443	620	590	310	310	87.1%	95.2%	95.2%	100.0%	22	63.6	34.2	97.8				
Delivery Suite	2,790	2,663	465	435	1,860	1,810	310	310	95.4%	93.5%	97.3%	100.0%	237	18.9	3.1	22.0				
Maternity 2	1,628	1,628	930	878	682	682	341	321	100.0%	94.4%	100.0%	94.1%	519	4.4	2.3	6.8				
Jasmine Ward	930	925	465	465	620	620	0	0	99.5%	100.0%	100.0%	na	217	7.1	2.1	9.3	0	1	0	0
Neonatal Unit	2,325	1,995	0	0	1,628	1,397	0	0	85.8%	na	85.8%	na	407	8.3	0.0	8.3	0	0	0	0
Tree House	3,255	2,880	465	465	2,170	2,036	0	0	88.5%	100.0%	93.8%	na	567	8.7	0.8	9.5	0	0	0	0
	57,449	51,587	36,487	36,465	35,698	33,351	23,698	25,320	89.8%	99.9%	93.4%	106.8%	19072	4.5	3.2	7.7	5	1	0	3

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : Decemeber 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	89.8% of expected Registered Nurse hours were achieved for day shifts. This is the 5th Month that staffing has been below the 90% benchmark. Any Registered Nurse numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Director of Quality & Deputy Chief Nurse.	December 89.8% November 89.9% October 87.9%	The lowest RN staffing levels during the day were on Ward C4 at 73.3%. This has been supported by an increase in non-registered staff to 178.4%. There are never less than 2 RN on duty. The business group is reviewing the harm free care metrics that have been reported for this ward in month and are requested to report back findings to the Chief Nurse in light of results.
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	93.4% of expected Registered Nurse hours were achieved for night shifts.	December 93.4% November 93.4% October 91.2%	The lowest RN night staffing levels are reported on Ward AMU at 74.0%. . Closely supported by business group Matron and Associate Nurse Director who closely review harm free care metrics alongside staffing levels to assure safe care. Successful recruitment events have been ongoing with RNs awaiting start dates after completed HR processes.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	99.9% of expected Non-registered hours were achieved for day shifts.	December 99.9% November 104.0% October 100.6%	The lowest non registered staffing levels for day duty is on Ward D6 at 72.6%. This is supported by RN levels at 94.6%. The ward is closely monitored by business group Matrons; recruitment for non-registered staff is on-going with start dates awaited for those recruited. Harm free care metrics are reviewed alongside staffing levels.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	106.8 % of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed & is predominately due to wards requiring 1:1 support for patients following a risk assessment or to support Registered Nurses staffing numbers when there are unfilled RN shifts.	December 106.8 % November 108.9% October 108.2%	The lowest levels of non-registered night duty staffing at 82.7% on M4 which is supported by 100% RN levels. The ward establishment has been recently restructured. Some further alignment within the business group of non-registered establishment is on-going to support safe staffing levels. The business group closely monitors the ward and review harm free care metrics alongside staffing levels.

BOARD PAPERS – Quality, Safety & Experience Section : November 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered nurse safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	December 197 WTE filled	Of the RN 197 WTE the fill rate overall is 66% of the shifts requested .This breaks down to of the filled filled 66% of requested shifts ,42% are NHSP and agency 24%. In month substantive vacancies are 167 WTE RN.
Non-registered safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	December 187 WTE filled	Of the non-registered 187 WTE the fill rate overall is 70%. Non-registered shifts are not cascaded to agency.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Trust Strategy Update		
Report of:	Director of Strategy, Planning & Partnerships	**Prepared by:**	Associate Director Strategy & Planning

REPORT FOR INFORMATION

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

Summary of Report

This paper provides an update on the consultation process with staff and partners on the refreshed Trust strategy and seeks support from the Board of Directors on the proposed next steps.

The Board are recommended to:

- note the update on progress, specifically the feedback themes that have emerged to date
- support detailed development of the clinical services strategy as a next priority
- endorse the proposed actions outlined in section 4

Attachments:	Annex A - Consultation Sessions Complete Annex B - Consultation Sessions Planned

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

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1. INTRODUCTION

1.1 This paper provides an update on the consultation process with staff and partners on the refreshed Trust strategy.

2. BACKGROUND

2.1 The consultation process for the Refreshed Trust Strategy began in October 2018, following agreement by the Board of the refreshed strategy in September 2018. Sessions booked from 1st October to 31st December 2018 focused on staff and key partners/stakeholders. All sessions were presented by one or a combination of the following staff:

- Hugh Mullen, Director of Strategy, Planning and Partnerships
- Andy Bailey – Associate Director Strategy & Planning
- Rebecca Simmons – Assistant Business Manager or
- Philippa Desborough – PMO Manager,

2.2 A member of the planning team was also in attendance to record and document discussions. A number of sessions have also been attended by Holly Cubitt, Head of Communications in order to link consistent feedback on communications and any future tools or preferred methods of delivery in which to engage with staff.

3. CURRENT SITUATION

3.1 Sessions

3.1.1 The approach has been to utilise existing forums or set up specific strategy briefing sessions to talk to as many staff and partners as possible, essentially adopting a 'roadshow' approach. Briefings have all included a core set of slides with some content adapted appropriate to the audience.

3.1.2 As of 24 January 2019, 38 sessions have taken place. A total number **of 653 staff and partners have received the briefing in person** and had the opportunity for discussion and to provide feedback (see annex a). Four sessions with some of our external partners have proved difficult to accommodate thus far, but arrangements are in train to hold these with the various stakeholders.

3.2 Feedback

3.2.1 Comments and feedback at each session is captured and recorded by a member of the Strategy & Planning Team. Common themes emerging from the consultation period is summarized in the table below.

Theme	Proposed action/response
Not in language that front line staff will understand, needs to be basic; focus on the point and purpose of the strategy, some elements are not consistent	• Full review of written documents with support from Head of Comms • Produce revised version at end of consultation period

Provide a summary document for managers to disseminate/hold sessions	• Develop summary document with support from Comms; feedback is drawing out ideas of what would be most useful for managers
Staff potentially not understanding how their work contributes to delivering the aims of the strategy	• Develop some examples of how different roles contribute to our five priorities – tailor these to different staff groups; identify some staff members as real examples
Sequencing of the five priorities in the briefing presentation and strategy document – comments received this suggests a priority order	• Acknowledged no intended priority order of how these have been presented • Look at way of presenting these different visually
Leadership development priority: • wording suggests it does not include non-clinical leaders • seems to focus on leadership only and not staff development more broadly	• Look at alternative wording at end of consultation process for discussion by EMG
Not enough emphasis on some services: • End of Life services • Community teams	• Meet with Palliative Care lead – will incorporate some content on this area • Associate Nurse Director to support development of more positive emphasis on community services
Financial priority – potential conflict between development and investment in services whilst the Trust is borrowing money and has a significant deficit	• Links between quality, operational performance and clinical services efficiency to be clearer in terms of how these support delivery of our financial priorities
Clinical Services Strategy – acknowledgement that very little of this is well defined	• Strategy & Planning team to develop a structured approach to development and facilitate support to services – to start Jan 2019

3.3 **Communication & Engagement**

3.3.1 Communications materials were prepared in advance of the consultation period which included; the revised strategy document and two 7 minute briefings on the strategy and the consultation period. Dissemination of these was done via Team Brief and via two 'Weekly Update' emails to all users specifically on the strategy in November and December. Materials were also sent prior to each briefing that was arranged and updates on progress provided regularly at Team Brief. .

3.3.2 The sessions concluded that few staff had either taken the time, or had the opportunity to read and consider this information disseminated in advance. Although time consuming the face-to-face briefings proved to be an invaluable approach to deliver a consistent message about the strategy and were generally warmly received.

3.3.3 The majority of sessions involved useful two-way dialogue and the feedback recorded is extensive, the table above is a high level summary of the consistent themes.

3.3.4 The exercise also highlighted a number of key points in terms of engagement:

- Staff and partners were appreciative of the efforts made to go and talk to them about the strategy
- The content and strategic approach was largely supported but there was an appetite for some of the 'how' and 'when' from staff
- The consistent message from the community staff we met is that they feel at arm's length from the acute part of the organization and find it difficult to identify being part of the Trust
- Further proactive engagement with our community teams will be key to driving forward some of the transformation agenda with the Stockport system
- Regular and meaningful communication about the strategy is key to continued engagement, to our staff

3.4 **Clinical Services Strategy**

3.4.1 The consultation period has also crystallised that the next priority of strategy development should be our clinical services strategy. This will need to link with the priorities and development of our operational plan for 2019/20 and also the recently published long term 10 year NHS plan.

3.4.2 This is a timely opportunity for the new Chief Executive (CEO) to form a view on our clinical service priorities. Any significant work on has not yet been undertaken allowing time to consider the future direction. It is recommended that the Executive Team and Board review services aligned to our operational plan priorities, with a principal role taken by our clinical leaders to progress development of specific clinical services strategies. The work will be supported by the Strategy & Planning team.

4. NEXT STEPS

4.1 The Strategy and Planning team met with the Communications team in early January to discuss next steps following the end of this consultation period. A number of points were agreed that are seeking support from the Board. These are:

- To write to everyone who attended a briefing session to say thank you, and to outline the next steps and how they can continue to engage in strategy development
- Review the amend content of the refreshed strategy in line with the comments discussed in 3.2.1 and other comments received – present a revised version to the Board of Directors in February 2019
- Develop a Executive Summary strategy document (2-4 pages) to be used for management cascade and an easy reference tool for all staff
- Add questions to the annual communications survey in early February, for staff to inform how they wish to continue to receive updates and progress on the strategy
- Develop case studies of how our staff play a role in delivering the strategy
- Support development of departmental strategies where appropriate – offer consistent templates, guidance and support and to ensure alignment to overall

Trust objectives

- Develop patient engagement phase (meeting arranged with Matron for patient experience)
- Develop and increase governor's understanding and engagement – linked to one of the CQC 'should do' actions

4.2 The Strategy and Planning team will continue to meet with the communications team on a quarterly basis to review and develop communication of the Trust strategy and updates.

5. CONCLUSION

5.1 The approach taken to date has been received positively and provided the chance to engage with teams and members of staff who otherwise would not have had this opportunity. It has also afforded the opportunity to reflect on some of the content in the refreshed strategy and understand how this is received and understood by our staff

5.2 The briefing sessions have concluded that vastly different levels of awareness of the strategy exist and that we cannot over communicate any messages about the Trust's priorities and strategic aims.

6. RECOMMENDATIONS

6.1 The Board are recommended to:

- Note the update on progress, specifically the feedback themes that have emerged to date
- Support detailed development of the clinical services strategy as a next priority
- Endorse the proposed actions outlined in section 4

ANNEX A - *Consultation Sessions Complete*

Sessions Complete

Meeting	Venue	Date/Time of Meeting	Number of Attendees
Strategy & Planning Team Session	Pinewood House	23.10.18 14.00 - 15.30	10
Trust Members Annual General Meeting	Edgeley Park	09.10.18 15.00 - 18.30	44
Council of Governors	Lecture Theatre Pinewood House	25.10.18 16.00 - 18.00	20
Information/IT/EPR (Session 1)	EPR Meeting Room	29.10.18 14.00 - 15.00	8
JLNC Meeting	Oak House	09.11.18 16.25	11
Information/IT/EPR (Session 2)	EPR Meeting Room	12.11.18 09.00 - 10.00	9
JCNC	Committee Room Oak House	12.11.18 13.45 - 14.45	10
Surgery, GI & CC BG Assurance Board	Committee Room Oak House	14.11.18 14.00 - 14.45	18
Women, Children & Diagnostics Quality Board	Education Room Maternity	14.11.18 15.00 - 16:00	15
Pharmacy Technical Staff Team Meeting	Pharmacy Tea Room	15.11.18 08:45 - 09:30	29
Palliative Care	David Waterman's Office	15.11.18 11:00 - 12:00	1
Pharmacy Manufacturing and Aseptics Teams	Pharmacy Loading Bay	19 Nov 13.00 - 14.00	32
All staff drop in	Maternity Education Room	20.11.18 12.00 - 13.30	2
Finance Team	Pinewood House	20.11.18 15.00 - 16.00	56
Estates & Facilities Finance & Performance Board	Estates Conference Room	21.11.18 10.00 - 10.45	13
Therapy Board	Pinewood House	21.11.18 11.00 - 12.00	17
Integrated Care Quality Board	Rowan Suite	22.11.18 11.00 - 12.00	14
Medicine Operational Planning Session	DMOP	22.11.18 14.00 – 15.00	18
Pharmacists Team Meeting	Pharmacy	28.11.18 08:45 - 09:30	22
East Cheshire CCG Management Meeting	New Alderley House	28.11.18 1.00pm	17
HR Directorate Dialogue	Lecture Theatre Pinewood	28.11.18 14.30 - 15.00	38
QCNW Team Strategy Specific Session	QCNC Main Office	29.11.18 13.00 - 14.00	9
Viaduct - Senior Management Team	Kingsgate House	29.11.18 16.00 - 17.00	4

All staff drop in	Pinewood G18	29.11.18 15.30 - 17.00	0
Community drop-in session	Hazel Grove Clinic Room 2	06.12.18 3.30-5pm	2
Community drop-in session	Kingsgate House	07.12.18 3.30-4.30	4
All staff drop in	G15 Pinewood House	10.12.18 09.00 - 10.30	3
Stockport CCG Wider Management Team	Stopford House	10.12.18 1pm - 2pm	12
Ward Managers Meeting (Surgery)	Lecture theatre A	12.12.18 09.00 - 10.00	9
NHSI	Hugh Mullen's Office	13.12.18 09.00 – 10.00	1
Estates & Facilities Staff drop-in 1	Lecture Theatre B	13.12.18 16.00 - 16.30	25
Theatres Team Meeting	Theatres	17.12.18 18.00	21
Estates & Facilities Staff drop-in 2	Lecture Theatre B	19.12.18 08.00 - 08.30	62
Children's Therapies Strategy Meeting	Beckwith House -	20.12.18 14.30 - 15.30	17
Estates & Facilities Staff drop-in 3	Lecture Theatre A	07.01.19 13.00 – 13.30	48
Ward Managers (Medicine)	DMOP Conference Room	09.01.19 11.00 – 11.30	19
Corporate Quality Board		22.01.19 09.00 – 11.30	10
Stockport Council Corporate Leadership Team	Town Hall	22.01.19 11.30 – 12.00	3
		Total	**653**

ANNEX B - *Consultation Sessions Planned or to be arranged*

Sessions Planned

Meeting	**Venue**	**Date/Time of Meeting**
Active Recovery (follow up to one of the community drop in sessions)	9th Floor Regent House	14.02.19 13.30 – 14.30
To be confirmed		
GM Combined Authority Strategy Session		
North Derbyshire CCG		
Pennine Care		
Health Watch		

Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Operational Plan 2019/20 – Progress Report		
Report of:	Director of Strategy, Planning & Partnerships	**Prepared by:**	Associate Director Strategy & Planning

REPORT FOR APPROVAL

Corporate objective ref:	S1, S2	**Summary of Report** This report provides the Board of Directors with an update on progress in preparing the Trust Operational Plan The Board are recommended to: • Note the current position • Discuss the risks and agree any further actions to be put in place
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	Annex A – Technical Planning guidance on operational plan content Annex B – GM letter - 2019/20 Operational Planning & Contracting Round

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

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1. INTRODUCTION

1.1 This report provides an update on progress in preparing the Trust Operational Plan in line with internal and external submission timescales.

2. BACKGROUND

2.1 Previous updates to the Board reflected on last year's operational plan and outlined the steps being taken to improve preparation for this year's operational planning round; this included

- Development and board approval of a consistent planning framework
- Introduction of a revised and more robust internal governance structure
- Increased executive oversight of operational plan development
- Increased engagement with business groups on capacity and demand and activity planning

2.2 The operational planning guidance *"Preparing for 2019/20 Operational Planning and Contracting"* was released on the afternoon of Friday 21st December 2018.

2.3 Further technical guidance including requirements of the content for the operational plan narrative was not published until 11 January 2019 (see Annex A).

2.4 The first submission in accordance with the planning timetable was made on the 14 January 2019. This was the draft activity plan – the submission is included for information. There are aspects within these numbers that are likely to change as discussions on the contract with the CCG and system partners' progress. Updates to our planned activity template will form part of the draft submission due 14 February and final submission by 4 April

2.5 On 23 January a letter was received from Greater Manchester Health and Social Care Partnership outlining GM expectations in light of the national guidance published (see Annex B).

2.6 Critically, in advance of the next draft plan submissions on 12th February 2019, GM are asking localities to provide an update by 7th February 2019 covering the following:

- Assurance that the locality has been working collectively to ensure plan alignment and has carried out consistency testing across CCGs and Providers.
- A headline summary of the plans to be submitted on 12th February 2019.
- A full copy of the CCG planning template that will be submitted on 12th February 2019.
- Any outstanding issues or risks

2.7 The Trust is also now in receipt of its control total offer which was discussed in detail by Finance and Performance Committee on 23 January. This subject will be discussed within the Private Board on 31 January 2019.

3. CURRENT SITUATION

3.1 Activity

3.1.1 As stated, a draft activity submission was made on the 14 January. This was the culmination of detailed demand and capacity planning carried out by the business groups and corporate teams. Engagement and involvement of the Clinical Directors is critical to delivery of these plans.

3.1.2 The activity template requires a reconciliation between the pre-populated projected out-turn for 2018/19 based on historic data and current GP referrals trends and the proposed plan for 2019/20.

3.1.3 The activity is profiled by point of delivery across the financial year recognising that a significant proportion of activity should take place in the first half of the financial year. The plan is also split by commissioner and agreed with the commissioner so that the regulator has confidence in the agreement of plans across health economies.

3.1.4 The Activity Plans are based on our core capacity and, understanding demand by Point of Delivery and the requirements of achieving access targets. The plans are then overlaid with the impact of known service developments and changes.

3.1.5 A decision was taken at the Executive Contract Oversight group on the 3rd January 2019 and agreed at EMG that "stretch" targets needed to be given to specialties in order to close a gap in income from the first internal submissions; the exception being where planned service changes were to occur or demand had significantly dropped and was unlikely to recover.

3.1.6 The Trust is expected to meet the RTT standards and subsequently some assumptions have been made in our draft activity submission on the volume of activity required to deliver this. However this needs further discussion with Stockport CCG as the increase in referral rates is what is driving the issue.

3.1.7 For elective activity, and it is imperative that we hit plan from April 2019, although it should be noted that the draft plan submitted will be a significant challenge to deliver the activity target. For non-elective activity, the Stockport Together benefits have largely not been realised yet and this is why the Trust position differs from CCG assumptions at present.

3.2 Operational Plan Narrative

3.2.1 Initial narrative has been produced by the responsible leads, however following the publication of mandated guidance in mid-January by NHSI; this now needs to be revised as to ensure the content covers requirements and expectations.

3.2.2 Given this is not ready for Board approval at this juncture, it is recommended the Board defer authority to the Chief Executive and Chair to agree the final version of this narrative prior to its submission by 14 February. A final version will be circulated to Board members.

3.3 **Financial Planning**

3.3.1 The most significant challenge at present is reaching an agreed position with the CCG and system partners on our draft activity plan and financial assumptions. The Board should note that current planning assumptions are a distance apart, and reaching a resolution within the timescales for the draft submission may not be possible. Largely due to this context the finances and activity, and hence the overall plan, are not ready for presentation to the Board of directors for approval.

4. NEXT STEPS

4.1 The key next steps in order to prepare the draft submission by the 14 February are as follows:

- Executive Team to agree funding of pressures and service development/business case priorities for 2019/20
- Trust Board to discuss and agree control total offer
- Greater pace and development of CIP and clinical services efficiency plans in order to reach £14.2m requirement
- Progressing contract discussions with CCG and other partners
- Confirmation of draft capital plans
- Preparation of revised narrative in light of guidance published

4.2 These steps will be monitored by the governance arrangements in place of a weekly executive oversight meeting and additional meetings by senior managers and the Executive Team at present to ensure deadlines are met.

5. RISKS

5.1 The most significant risk at present to submission of our draft plan is reaching agreement with the CCG on activity and finances.

5.2 The Trust does need to have agreement from its commissioners to secure the majority of the contract income within its plans at the start of the financial year and there needs to be transparency if there are elements of the financial plan which are not signed up to in contracts.

5.3 The activity plans need to be owned by the business groups and be delivered with a clear understanding of the resources which are needed to deliver the plan. The resources include staffing, theatre and out patients.

5.4 Arrangements in place to ensure progress is made are:

- Executive Oversight Group are monitoring deadlines and discussion of progress/key issues for resolution are being escalated as required (weekly) for discussion by the Executive Team
- Executive Team to agree parameters of plan for 2019/20 and clearly communicate priorities to business groups
- Financial scenarios are prepared in draft form subject to on-going contract discussions

6. RECOMMENDATIONS

6.1 The Board are recommended to:

- Note the current position
- Discuss the risks and agree any further actions to be put in place

NHS Improvement

Technical guidance for NHS planning 2019/20

Annex C: NHS Improvement guidance to trusts for operational plans

January 2019

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. How to use this guidance

This technical document is Annex C of *Technical guidance for NHS planning 2019/20;* and supports the main planning guidance *NHS operational planning and contracting guidance* (published 10 January 2019**)**[1] It should not be read in isolation but alongside, and in the context of, the main planning guidance documents.

Annex C is detailed guidance for all NHS trusts and NHS foundation trusts on their 2019/20 operational plans only. It outlines our objectives and requirements for provider plans, our view of what operational plans should contain and our approach to the review of, and response to, those plans.

Throughout the document we refer to NHS trusts and NHS foundation trusts collectively as 'trusts' or 'providers', except where we specifically make separate reference to either group.

2. Objectives for providers' 2019/20 operational plans

NHS operational planning and contracting guidance is the full guidance, replacing the preparatory guidance published in December 2018. It accompanies five-year indicative clinical commissioning group (CCG) allocations and sets out the trust financial regime for 2019/20, alongside the service deliverables, including those arising from year one of the NHS Long Term Plan.[2] CCGs and trusts should take action from April 2019 to begin implementing the measures set out in the NHS Long Term Plan.

The development of operational plans for 2019/20 will enable the NHS to progress against the overall tests set by the government to:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how we manage demand effectively
- make better use of capital investment.

[1] https://www.england.nhs.uk/deliver-forward-view/
[2] https://www.england.nhs.uk/long-term-plan/

As highlighted in the *Operational planning and contracting guidance 2019/20*, the organisations within each sustainability and transformation partnership (STP) and integrated care system (ICS) will be expected to take collective responsibility for the delivery of their system operating plan, working together to ensure best use of their collective resources.

The guidance also describes a single operational planning process for commissioners and providers, with clear accountabilities and roles at national, regional, system and organisational level.

The quality standards for patient services are clearly set out in the NHS Constitution[3] and in the fundamental quality and safety standards published by the Care Quality Commission (CQC) in *Guidance for providers on meeting the regulations.*[4] These quality standards continue to define the expectations for provider services.

For providers to achieve and maintain high quality services, those services also need to be underpinned by affordable and sustainable financial plans. Building on the joint financial improvement actions from recent years, it is important that providers plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS.

Technical guidance for NHS planning 2019/20[5] sets out the arrangements for NHS commissioners and providers to submit operational plans for 2019/20. This annex outlines our overarching requirements for the 2019/20 operational plans of providers. Please also refer to the suite of technical guidance annexes to support the preparation of plans at https://www.england.nhs.uk/deliver-forward-view/. Please read these alongside the provider-specific NHS Improvement supplementary technical guidance for finance, workforce and activity plans available on the NHS Improvement planning webpage. Most the annexes will be published in early January 2019, with the balance by 31 January 2019.

[3] www.gov.uk/government/publications/the-nhs-constitution-for-england
[4] www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
[5] https://www.england.nhs.uk/deliver-forward-view/

NHS Improvement's overarching objectives for 2019/20 planning

All providers will have robust, integrated operational plans for 2019/20 that demonstrate the delivery of safe, high quality services that meet the NHS Constitution standards or delivery of recovery milestones within available resources.

The development of operational plans for 2019/20 will enable the NHS to progress against the overall tests set by the government to:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how we manage demand effectively
- make better use of capital investment.

3. Summary of operational plan submissions

The operational plan collections are designed to enable us to test delivery of the requirements articulated in Section 2 above. Table 1 below summarises the plan submission requirements, identifying what needs to be submitted, where and when. This year, for both NHS trusts and NHS foundation trusts, the operational plan submissions will include (both draft and final plans):

- a finance return
- an activity and performance trajectory return:
  - this will contain annualised activity data for the 2018/19 forecast outturn (pre-populated) and 2019/20 operational plan, supporting the alignment process of provider-commissioner activity plans
  - for both NHS trusts and NHS foundation trusts, this submission is required of acute, specialist acute and ambulance trusts only
  - NHS mental health and community trusts do not need to submit activity returns
- a workforce return

- a triangulation return:
  - a linked file detailing the required triangulation checks between finance, activity and workforce plans and a requirement to provide commentary where plans do not appear to be aligned
  - a pilot finance/workforce bridge comparison
  - a pilot finance/activity bridge comparison
- an operational plan narrative (maximum 19 pages), which should take forward the local health and care system's STP and outline the provider's approach to activity, quality, workforce and financial planning for 2019/20; see Section 4 for further details
- assurance statements from all NHS trusts and NHS foundation trusts; submissions should be made in accordance with the national planning timetable
- an STP-led contract and plan alignment template, to be submitted to both regional NHS England and NHS Improvement planning email addresses as outlined in *Technical guidance for NHS planning 2019/20* on 19 February, 5 March and 11 April 2019 by ICSs/STPs supported by organisations within their area to arrive at an aligned position.

Relevant providers' initial draft activity plans should be submitted to NHS Improvement by 12 noon on Monday 14 January 2019.

Providers' full draft plans should be submitted to NHS Improvement by 12 noon on Tuesday 12 February 2019.

Providers' final 2019/20 plans should be submitted to NHS Improvement by 12 noon on 4 April 2019. The final operational plan should include updated versions of:

- finance return
- activity and performance trajectory return (acute, specialist acute and ambulance providers only)
- workforce return
- triangulation return
- operational plan narrative
- assurance statements.

Table 1: NHS Improvement plan submission requirements

Submission requirement	Technical annex	Deadlines	Submission method
Plan narrative including quality	Annex C	12 February 2019 4 April 2019	Through online portal
Financial plan	Annex C and NHS Improvement technical guidance	12 February 2019 4 April 2019	Through online portal
Activity plan and performance trajectories	Annex C and NHS Improvement technical guidance	14 January 2019 *(acute and specialist acute trusts only, waterfall, activity and commissioner allocation tabs only)* 12 February 2019 4 April 2019	Through online portal
Workforce plan	Annex C and NHS Improvement technical guidance	12 February 2019 4 April 2019	Through online portal
Triangulation form	Annex C and in form	12 February 2019 4 April 2019	Through online portal
Assurance statements	Annex C and NHS Improvement technical guidance	4 April 2019	Through online portal

4. Requirements of operational plans

In line with the overarching objectives for operational planning above and underpinned by the expectations for the NHS summarised in the main planning guidance, NHS Improvement expects provider operational plans for 2019/20 to:

- be realistic and deliverable:
  - based on reasonable assumptions for activity, that the provider has sufficient capacity to deliver

  - supported by contracts with commissioners, signed by 21 March 2019, that reflect this level of activity and balance risk appropriately
  - underpinned by coherent and well-modelled financial projections
  - supported by agreed contingency plans wherever risks across local health system plans have been jointly identified
- be stretching, representing the maximum that each provider can reasonably be expected to deliver
- confirm agreement to their financial control totals for 2019/20 to qualify for the receipt of Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and marginal rate emergency tariff (MRET) funding. Delivery of control totals for 2019/20 to contribute to financial balance across the NHS will form a core part of the financial oversight regime and the provider oversight arrangements:
  - currently set out in the Single Oversight Framework[6] that NHS Improvement has put in place and which may develop over the period of the guidance
  - providers should take advantage of the opportunities identified in the Carter reviews for improved productivity[7] and the Getting It Right First Time (GIRFT) reports,[8] using the Model Hospital where available to gain visibility of opportunities
  - providers should continue to apply the rules on agency spend[9] introduced by NHS Improvement and restrictions on the growth of their pay bill; information is available in the guidance on rules for all agency staff working in the NHS
  - providers should engage with commissioners to ensure alignment with local adoption of the NHS RightCare programme
- be consistent with sustainability and transformation plans:
  - the position of each provider (on finance, activity and workforce) should be consistent with the ICS/STP footprint financial plan for 2019/20 to be submitted on 19 February 2019 and with the system control for that ICS/STP area
  - the aggregate of all operational plans in a footprint will need to reconcile with the ICS/STP position

[6] https://improvement.nhs.uk/resources/single-oversight-framework/
[7] www.gov.uk/government/publications/productivity-in-nhs-hospitals
[8] http://gettingitrightfirsttime.co.uk/
[9] www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

  - they should reflect the strategic intent of the ICS/STP and the organisational impact of the key issues agreed as critical to their locality
- provide for a reasonable and realistic level of activity:
  - plans should demonstrate the capacity to meet this through the provision of bed numbers
  - activity should be profiled to take account of seasonality plans and should be in line with the currency, definitions and criteria set out in the technical guidance, irrespective of locally agreed currency and definitions for contracted activity volumes
- demonstrate, through the performance trajectory section of the activity return, improvement in the delivery of core access standards as set out in the NHS Constitution and national planning guidance (accident and emergency (A&E), and ambulance response times, referral to treatment (RTT), cancer, and diagnostic waiting times)
- be internally consistent; individual activity, workforce and finance elements of the plans should be cross-checked and internally consistent.

In relation to capital, providers are expected to:

- continue to work with STPs/ICSs to deliver their estates strategies, including land disposals, with these strategies continuing to be a key to accessing capital for all sectors going forward. NHS capital is very constrained and therefore it is vital that capital plans are realistic and based only on self-funding and funding that has already received approval. Provider capital plans for 2019/20 should be based on self-funding plus agreed STP capital or specific programme capital. Providers should not assume new funding from sources such as the Independent Trust Financing Facility (ITFF) or emergency financing applications unless these already have approval, or if not already approved, have been agreed for inclusion within financial plans by the NHS Improvement capital and cash team
- explain in their narratives how their proposed capital investments are consistent with their clinical strategies and how they demonstrate the delivery of safe, productive services
- given the constrained level of capital resource identified in the Spending Review from 2016/17 to 2020/21, demonstrate that the highest priority

schemes are being assessed and taken forward within plans that are affordable to the organisation

- where they are required to submit business cases for NHS Improvement, Department of Health and Social Care (DHSC) or HM Treasury approval, present robust strategic, economic, commercial, management and financial cases, including clear links between the investment case and activity and financial projections as well as workforce and productivity assumptions
- follow the key business case documentation requirements which may require the approval of strategic outline cases, outline business cases and full business cases
- outline how they plan to make better use of the NHS estate including maximising and accelerating disposals of surplus land and property.

In relation to quality and workforce, it will be important that providers can demonstrate:

- development and implementation of an affordable plan to make improvements in quality, particularly for providers in special measures
- application of a robust quality improvement methodology
- a plan for achieving the four priority standards for seven-day hospital services in an affordable way
- the application and monitoring of an effective quality impact assessment approach for all cost improvement programmes (CIPs)
- workforce productivity, particularly through effective use of e-rostering and less reliance on agency staffing
- triangulation of quality, workforce and finance indicators.

In short, trusts' operational plans must:

- provide for a reasonable and realistic level of activity profiled to take account of seasonality
- demonstrate the capacity to meet this
- provide adequate assurance on the robustness of workforce plans and the approach to quality
- be stretching from a financial perspective, planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of PSF, FRF and MRET funding
- take full advantage of efficiency opportunities (including those identified by the Carter reviews, GIRFT reports and the Model Hospital)
- demonstrate improvement in the delivery of core access and NHS Constitution standards
- contain affordable, value-for-money capital plans that are consistent with the clinical strategy and clearly demonstrate the delivery of safe, productive services
- be aligned with commissioner plans and underpinned by contracts that balance risk appropriately
- be consistent with and reflect the strategic intent of STPs, including the specific service changes, quality improvements and increased productivity and efficiency identified in the STPs, and with the system control total for the STP/ICS area
- be internally consistent between activity, workforce and finance plans.

Financial framework for providers

Section 3.3 of the *NHS operational planning and contracting guidance 2019/20* sets out details of the financial framework for providers. We have summarised the changes to the framework for 2019/20:

1. Provider Sustainability Fund (PSF)

- £1 billion will transfer into urgent and emergency care prices
- the £200 million targeted element of the PSF will be transferred into a financial recovery fund as detailed below
- the value of the PSF therefore reduces from £2.45 billion in 2018/19 to £1.25 billion in 2019/20
- £155 million of the PSF will be allocated to the non-acute sector, as we have in 2018/19 with £1.095 billion available to support the provision of emergency services in acute and specialist trusts
- control totals will be set on the basis that for every £1 in PSF the provider must improve its bottom line position by £1
  - providers will be eligible to earn their allocated PSF if they sign up to control totals
  - quarterly payments of PSF will be made in arrears subject to delivering the planned year-to-date financial performance only.

2. Financial Recovery Fund (FRF)

- created to support efforts to secure the financial sustainability of essential NHS services, with providers able to cover current day-to-day running costs while they tackle unwarranted variation
- allocated so that we can secure financially sustainable, essential NHS services within as many ICSs/STPs as possible
- in 2019/20 can only be accessed by providers in deficit who sign up to their control totals
- control totals will be set on the basis that for every £1 in FRF the provider must improve its bottom line position by £1

3. Marginal rate emergency tariff (MRET) funding

- in 2019/20, the contract value agreed via the blended payment approach will be reduced by the agreed 2017/18 value of both the MRET and 30-day readmission rules
- providers will be eligible to receive additional central income equal to the MRET value confirmed by providers and commissioners as part of the autumn 2018 exercise, if they sign up to their control totals
- control totals will be set on the basis that for every £1 in MRET funding the provider must improve its bottom line position by £1
- MRET funding will be paid quarterly in advance, subject to providers agreeing their control total.

4. Provider financial management

- all providers will be expected to plan against rebased control totals which will be communicated in early January 2019
- 2019/20 control totals for trusts in deficit will reflect a further 0.5% efficiency requirement on top of the 1.1% efficiency factor included in the tariff
- it is important that providers plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS
- at a national level we have assumed a level of non-recurring benefit from gains on disposal of assets. We will work with providers to identify these opportunities and have adopted a revised approach to the treatment of these financial gains in the control total regime; providers will not be able to use any of these gains to deliver their original 2019/20 control total
- providers that sign up to their control totals and are therefore eligible to earn PSF will be exempt from most contract sanctions; the sanction for 52-week waits applies to all providers and commissioners; where a commissioner applies contract sanctions, the use of the resultant funding will be subject to sign-off by the joint NHS England/NHS Improvement regional teams
- NHS Improvement is working with DHSC to develop changes to the cash regime for providers, including reviewing the rate of interest payable on both historic debt and on all new loans. We are also considering a process for restructuring historic debt on a case-by-case basis once a recovery plan has been agreed.

5. Operational plan narrative (both draft and final plans)

As outlined above in Section 4, as part of their draft and final operational plans, all providers are required to submit a narrative that supports the finance, activity and workforce returns alongside quality. This narrative should address NHS Improvement's key requirements of provider plans, as set out in Section 4. The supporting narrative submitted at 12 February 2019, although 'draft', should represent a full account of the operational plan at that date.

Although there are no templates for the narrative element of operational plans, we set out below what the plans need to demonstrate. We recommend providers use this structure as far as possible to help with the consistency of plans.

Structure, format and length

Based on the guide below, the operational plan narrative should not be longer than 20 pages. Quality is far more important than quantity: we want to be able to understand each plan. Inability to summarise coherently and concisely will itself be considered as part of the assessment of risk.

It should be easy for us to reconcile the content in the written narrative with data in the finance, activity and workforce templates.

Activity planning (maximum two pages)

A fundamental requirement of the 2019/20 operational planning round is for providers and commissioners to have realistic and aligned activity plans. It is therefore essential they work together transparently to promote robust demand and capacity planning.

In the operational plan narrative, providers should support their activity returns with a written assessment of activity over the next year, based on robust demand and capacity modelling and lessons from previous years' winter and system resilience planning.

They should provide assurance to NHS Improvement that:

- activity returns are underpinned by agreed planning assumptions, with explanation about how these assumptions compare with expected growth rates in 2019/20

- they have sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible and describing assumptions about length of stay
- activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, in particular A&E, RTT, incomplete pathways, cancer, and diagnostics waiting times
- extra capacity can be mobilised if needed as part of winter resilience plans – for instance, extra escalation beds arrangements are in place for managing unplanned changes in demand.

Quality planning (maximum four pages)

Quality standards for patient services are clearly set out in the NHS Constitution and in the CQC quality and safety standards. They continue to define the expectations for the services of providers. Providers should have a series of quality priorities for 2019/20 set out in a quality improvement plan. This plan needs to be underpinned by the local STP, the provider quality account, the needs of the local population and national planning guidance. To create these priorities, providers need to consider:

- national and local commissioning priorities
- the provider's quality goals, as defined by its strategy and quality account, and any key milestones and performance indicators attached to these goals to measure improvements in care
- key risks to quality and how these will be managed.

For the 2019/20 operational plan narrative, providers should outline their approach to quality in a narrative with three sections:

- approach to quality improvement, leadership and governance
- summary of the quality improvement plan (including compliance with national quality priorities)
- summary of the quality impact assessment process and oversight of implementation.

We will use this narrative to seek assurance that the approach to quality is sound and robust. Where appropriate, we may ask individual providers for more information, such as their detailed quality improvement plan.

1. Approach to quality improvement, leadership and governance

Providers should outline their approach to quality improvement including:

- a named executive lead for quality improvement
- a description of the organisation-wide improvement approach to achieving a good or outstanding CQC rating (or maintaining an outstanding rating) including the well-led domain, and the governance processes underpinning the improvement approach
- details of the quality improvement governance system, from the front line to the board, with details of how assurance and progress against quality improvement priorities are monitored
- how quality improvement capacity and capability will be built in the organisation to implement and sustain change
- measures being used to demonstrate and evidence the impact of the investment in quality improvement.

2. Summary of the quality improvement plan

Providers should detail their quality improvement plans in relation to local and national initiatives to be implemented during 2019/20. Providers must ensure their plans for quality are affordable and, in particular, that quality plans are triangulated with plans for finance, activity and workforce. Quality plans should include (but are not limited to):

- existing quality concerns (from internal intelligence, variations in care highlighted through initiatives such as GIRFT and RightCare, CQC, the quality account or other parties) and plans to address them
- the top three risks to quality and how the trust is mitigating these
- how learning from relevant national investigations has or will be implemented, including the Gosport Independent Panel (https://www.gosportpanel.independent.gov.uk/panel-report/)

- for providers of acute services, the degree of compliance with the four priority standards for seven-day hospital services as demonstrated through the new board assessment framework; this should include the date by which they expect to achieve compliance if they have not already done so, and how links are being made between seven-day hospital services and improvements to patient flow, length of stay and patient outcomes
- how the provider is learning from deaths in line with the National Quality Board guidance /www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf (all trusts except ambulance – guidance for ambulance trusts will be published during 2019/20)
- plans to reduce Gram-negative bloodstream infections by 50% by 2021, which are aligned with wider health economy plans
- confirmation that a national early warning score (NEWS2) is fully embedded within acute and ambulance trusts, and that the recognition, response and appropriate escalation of patients who deteriorate are measured and improved.
  https://improvement.nhs.uk/news-alerts/safe-adoption-of-NEWS2/
  www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

Trusts should also consider the Long Term Plan and reflect relevant initiatives in their narrative.

3. Summary of quality impact assessment process and oversight of implementation

Each provider should have an effective quality impact assessment (QIA) process for service developments and efficiency plans in line with National Quality Board guidance[10] (examples include seven-day services and cost improvement programmes). Providers must complete QIAs for all CIPs which are developed before and during the financial year, and trust medical directors and nursing directors must sign off the QIA, to confirm that quality of care will not be adversely affected. This section should include:

- a description of the governance structure for creating CIPs, including acceptance and monitoring of implementation and scheme impact (whether positive or negative)

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

- a narrative setting out how the governance structure operates, including:
  - how frontline/business unit-level clinicians create schemes
  - how potential risks are considered and how schemes are challenged before they are accepted, including whether there are different approaches based on risk thresholds, such as monetary value, risk score, etc
  - how key metrics are aligned to specific schemes and monitored through the year during and after implementing CIPs, to provide early warning of any adverse impact on the quality of care; metrics should measure impact on outcomes including patient experience
  - how intelligence is triangulated, particularly quality, workforce, activity and financial indicators; this should include the key indicators used in triangulation, how the trust board will use this information, and how this information will be used to improve the quality of care and enhance productivity
  - the QIA process and whether this is assessed against three core quality domains (safety, effectiveness and experience) or the five CQC domains (safe, effective, responsive, caring and well-led), and whether impact on staff is also considered
  - how QIAs receive sign-off by the trust medical director and nursing director
- a description of the process for board oversight of implementing CIPs, including how the board will identify and address potential deterioration in the quality of care. This should include how baseline data has been recorded before implementation of the change, including the duration of this data: eg to capture seasonal variations where the provider does not define specific metrics but uses generic quality measures.

The process for overseeing implementation should also enable the provider board to identify the cumulative impact of multiple CIPs on a particular pathway, service, team or professional group. This is important for all trusts but particularly for providers experiencing transactions, mergers or in special measures.

Workforce planning (maximum four pages)

To support the numeric workforce plan, providers must include the following in their operational plan narratives**:**

- demonstration that providers have a board-approved workforce plan and a robust approach to workforce planning, sign-off, monitoring and reporting that ensures sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services
- demonstration that the workforce plans are well-modelled and integrated with both financial, quality and activity plans to ensure the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients
- the current workforce challenges at both a local and STP/ICS level, including their impact. Please include the challenges within specific staff groups (eg adult nursing) and challenges such as, but not limited to, supply, retention, Long Term Plan, the impact of Brexit, overseas recruitment, changes to NHS nursing and allied health professional bursaries. Please use the table below as a template for capturing this information.

Description of workforce challenge	Impact on workforce	Initiatives in place
For example: Shortage of adult nurses	Difficultly in recruiting to establishment; difficulty in rostering, reliance on bank and agency	Plans to recruit 10 whole-time equivalent nurses from Philippines. Due to start February 2019. Scoping out new roles/ ways of working, to include nurse associate role.

- An outline of the current workforce risks, issues and mitigations in place to address them, capturing the impact on patient safety, service quality and national guidelines (for example, the documents on the NHS Improvement website around safer staffing and developing workforce safeguards). Please use the table below as a template for capturing this information.

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
For example: 50% turnover of Band 5 nurses within ICU within 12 months	High	Using bank staff as a temporary solution to cover gap. Identifying reasons for leaving through exit interviews and engagement with staff through focus groups. Implementing 'itchy feet' conversations.	Exit interview feedback analysed and identified main reason for leaving was limited career development and expectations of working in this area not met. Developing a career on a page document to identify the career pathway within ICU and also rotation working. This element is to be completed by January 2019.

- An outline of your long-term vacancies (hard-to-fill posts over six months) and how you are planning to fill these vacancies: for example, use of bank, agency, workforce transformational roles. Please use the table below to capture this information and provide numbers where available.

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
For example: Band 6 midwife. We started recruitment to this post in January 2018 and recruited two WTEs in March 2018 but have been unable to recruit to the additional five WTEs we require.	5 WTE	Impact on rostering and patient safety	We are developing our maternity support worker workforce, upskilling three WTE Band 3 healthcare assistants who are due to complete their training in March 2019. We will continue to advertise for the Band 6 midwife post and work with our STP to address this gap.

- engagement with commissioners and collaborative working to ensure alignment with the future workforce strategy of their local health system, ICS/STPs
- the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways (responding to known supply issues), detailing specific staff group issues and how new roles/new ways of working are being used: eg advanced clinical practitioners, apprenticeships, new and extended roles
- plans for any new workforce initiatives agreed with partners and funded specifically for 2019/20 as part of the Five Year Forward View and Long Term Plan demonstrating the following:
  - a link with the STP/ICS approach to workforce planning and how this will be supported through the operational plan, including an overview of the transformation activities which will impact on the organisation
  - how a balance in workforce supply and demand will be achieved
  - the right skill mix, maximising the potential of current skills and providing the workforce with developmental opportunities underpinning strategies to manage agency and locum use including spend avoidance. Approaches may include, but are not limited to, strengthening bank

staffing arrangements and using the flexible workforce by developing shared banks with other providers in the STP/ICS footprint. Providers should also consider the effective use of technology, including e-rostering and job planning systems, to enable more effective rota management and staff utilisation, focused on flexibility around patient need.

Operational plans should consider the impact of legislative changes and policy developments including (but not limited to) the opportunities identified in the Carter review for improved productivity, Long Term Plan, changes to the apprenticeship levy, the supply of staff from Europe and beyond, the immigration health surcharge and changes to NHS nursing and allied health professional bursaries, all of which should be taken into account in developing the workforce plan.

Financial planning (maximum six pages)

NHS operational planning and contracting guidance 2019/20 established the clear expectation that all providers will be expected to plan for and deliver against rebased control totals for 2019/20, to contribute to delivering financial balance across the NHS. Delivery of this expectation will require providers' plans to be stretching from a financial perspective, implementing transformational change through the STPs, and taking full advantage of efficiency opportunities to ensure the control totals for 2019/20 can be delivered.

Capital resources are constrained and will require prioritisation, so plans should only include schemes that are essential to the provision of safe, sustainable services, are affordable and offer value for money. Plans should be underpinned by robust financial forecasts and modelling and should be consistent with the strategic intent of the STP.

We therefore recommend providers divide their financial narratives as follows:

- financial forecasts and modelling
- efficiency savings for 2019/20
- agency rules
- capital planning.

1: Financial forecasts and modelling

Provider plans and priorities for quality, workforce and activity should align with the financial forecasts in their draft and final operational plans. The operational plan narrative should clearly set out how they make sure their plans are internally consistent.

To help providers demonstrate this, we will make available for mandatory submission a triangulation file that will include both reconciliation points and reasonableness tests between the differing elements of the operational plan. This file includes pilot bridge comparisons for the first time to help organisations assess whether the workforce and finance, and finance and activity, plans have been prepared on the same basis.

The plans will comprise financial projections based on robust local modelling and reasonable planning assumptions aligned with national expectations and local circumstances.

The forecasts should also be supported by clear financial commentary in the operational plan narrative.

Collectively the financial forecasts and commentary should explain how the control totals will be delivered and outline the key movements that bridge 2018/19 forecasts and plans for 2019/20, and clearly set out:

- the financial impact of implementing the new financial framework for providers and the planning assumptions set out in the *NHS operational planning and contracting guidance 2019/20* plus the impact of the 2019/20 national tariff; NHS Standard Contract and Commissioning for Quality and Innovation (CQUIN) guidance; it should also highlight any significant deviations from national assumptions
- the impact of activity changes, relating to underlying demand, quality, efficiency programmes, and the impact of other commissioning intent
- the provider should confirm that the agreed contract values are the same as those included in the plan; where there are differences, these should be disclosed and align with commissioner planning assumptions
- other key movements, including other changes in income expectations, revenue impact of any capital plans, or in-year non-recurrent income or expenditure

- the impact of initiatives, such as, but not limited to, CIPs, revenue-generation schemes, service developments and transactions.

The PSF, FRF and MRET funding are contingent on acceptance of the control total (receipt of which should only be included in plans where providers have agreed their financial control totals).

The narrative financial commentary should address:

- the assumptions underpinning these drivers
- the impact of these drivers on the overall financial forecasts – in particular, on performance against the Single Oversight Framework finance metrics
- the outcomes of any sensitivity analysis.

Operational plans will be developed before a final 2018/19 year-end financial position is known, so providers should use a projected year-end outturn for 2018/19 based on the most up-to-date and relevant information available. For the 12 February 2019 submission, the forecast outturn position used should agree with the Month 9 returns, and for the 4 April 2019 submission this should be updated to agree with the Month 11 position.

2: Efficiency savings for 2019/20

All providers should ensure they have a robust efficiency plan to enable them to deliver the control totals set for 2019/20 by NHS Improvement, with an emphasis on recurrent savings.

To achieve this, they should focus on the development and delivery of robust multi-year efficiency plans focusing primarily on increasing the productivity of the trust but also reflecting a growth in contribution from commercial income and overseas visitor cost recovery. Operational plan narratives should outline the key areas identified for operational efficiency including, but not limited to the areas within the joint NHS England and NHS Improvement efficiency plan (staff costs, procurement, pathology and imaging, community health and mental health services, medicines and pharmacy, corporate overhead reduction, estates infrastructure, reduced inappropriate interventions, patient safety, counter-fraud).

The efficiency plans should also reflect savings arising from collaboration and consolidation both within STP areas and wider networks, together with any opportunities identified through the commissioner-led programme.

The level of engagement with NHS Improvement operational productivity workstreams should be evident in the narrative.

Providers should set out their approach to identifying, quality assurance and monitoring the delivery of efficiency savings, including PMO arrangements.

3: Agency rules

Providers should outline how they will continue to make effective use of the agency rules and what they will do to ensure they will be able to contain spend within their annual agency ceiling. Providers should correctly analyse their paybill plan between substantive, bank and agency based on their best forecast of where they expect the spend to fall.

4: Capital planning

Providers' capital plans should be consistent with their clinical strategy, and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. They should:

- demonstrate that the highest priority schemes are being assessed and taken forward
- continue to ensure that the provider's own internally generated capital resource funds the repayment of existing and new borrowing related to capital investment
- be aware that DHSC financing is likely to be available only in pre-agreed and exceptional cases
- continue to procure capital assets more efficiently and maximise and accelerate disposals of surplus land and property
- highlight where capital investment plans support opportunities for improved productivity identified by Lord Carter's review
- where applicable, also clearly demonstrate which schemes are above their delegated limit and when business cases will be submitted for approval.

Link to the local sustainability and transformation plan (maximum two pages)

Significant progress on transformation is expected in 2019/20 operational plans so all providers are expected to reflect the implementation of the local health and care system's STP. See *NHS operational planning and contracting guidance 2019/20* for more details.

Although we acknowledge that local health and care systems will be at different stages of their strategic development, providers should briefly in their narratives:

- how the vision for their local ICS/STP is being taken forward through the operational plan, including the provider's own role
- how priority transformational programmes articulated in the local system operating plan affect the provider's individual organisational operational plan (for instance, setting out the most locally critical milestones for accelerating progress in 2019/20 and the key improvements in finance/activity/workforce/quality these programmes are planned to deliver).

Membership and elections (NHS foundation trusts only) (maximum one page)

For 2019/20, NHS foundation trusts should provide a high level narrative on memberships and elections, including:

- governor elections in previous years and plans for the coming 12 months
- examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public membership strategy and efforts to engage a diverse range of members from across the constituency over past years
- plans for the next 12 months.

Any NHS foundation trusts that did not have NHS foundation trust status as at 1 April 2018 should also detail the activities of their shadow council of governors and members.

Note on publication of providers' operational plan narratives

NHS Improvement and providers have a mutual duty of candour and transparency.

This is particularly important in the spirit of 'open book' planning encouraged for 2019/20. It is therefore appropriate to make providers' final operational plans accessible to the widest possible audience.

We are therefore asking providers to prepare a separate version of the final operational plan narrative in May/June 2019 suitable for external communication that can then be published online on provider websites. This separate document should be written for a wide audience and exclude any commercially sensitive information but must be consistent with the full version.

6. NHS Improvement review of providers' operational plans

Key criteria on which plans will be assessed

In reviewing providers' operational plans for 2019/20, we will seek assurance that all providers have plans that meet the requirements in Section 4.

Therefore, while recognising the statutory differences between NHS trusts and NHS foundation trusts, we will seek to:

- assess all provider plans against these shared criteria
- be consistent in our responses to common risk and plan characteristics – rather than to NHS trust or NHS foundation trust status.

Methodology for review of draft operational plans

Regional teams from NHS Improvement will work with providers to support the preparation of plans.

Timing of draft plan review

NHS Improvement will undertake risk-based reviews of the initial and draft operational plans for all providers after 14 January (activity only) and 12 February respectively. This work will be concluded before 29 March. We will do most of the review work in this period so that:

- feedback offered to providers on their draft plans can be incorporated into providers' final operational plans for 2019/20
- we can focus more effectively on monitoring and supporting delivery of those plans from April 2019 onwards.

Desk-based review work

Central and regional teams will do some desk-based review for all draft plans as part of the assurance process. This is likely to include review of the:

- operational plan narrative against NHS Improvement requirements of provider plans (see Section 4)
- activity plans to seek assurance on the robustness of demand and capacity planning and key assumptions underpinning the activity and trajectory submissions
- key assumptions underpinning the financial projections, together with an application of tests to each provider's own financial projections
- providers' assurances on quality and workforce to identify any areas for further follow-up
- several areas of joint risk assessment between NHS Improvement and NHS England, in recognition of the need for alignment and the impact of local health and care system interactions on individual organisations (see the joint assurance process outlined in *Operational planning and contracting guidance 2019/20* and *Technical guidance for NHS planning 2019/20*).

Interactions with providers

The draft plan review process in January and February 2019 will often combine desk-based work with face-to-face discussions between providers and their NHS Improvement regional teams.

Methodology for review of final operational plans

We will conduct a high level review of providers' final operational plans following the 4 April 2019 submission. This will largely entail corroboration of the material movements we expect to see based on the discussions and feedback to the provider after the ICS/STP submissions, but we will also identify and follow up unexpected movements.

We will consider the implications for providers of their final operational plans and monitor their delivery during 2019/20 through the routine oversight and assurance processes.

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Ref: NOC/KFW
Date: 22nd January 2019

To: Accountable Officers, CCG Chief Operating Officers, Provider Chief Executives

Dear Colleague

Re: 2019/20 Operational Planning & Contracting Round

The 2019/20 Operational Planning and Contracting Guidance was published on Friday 11th January 2019. Although we have an important paper and discussion scheduled for Partnership Executive Board next Monday 28 January which may adjust some of the arrangements described in the letter, the tightness of the planning timetable means that we need to share some information with you now on how we envisage the process being handled in Greater Manchester.

The Health and Social Care Partnership will pursue a single Greater Manchester approach to planning for 2019/20 in line with expectations for Integrated Care Systems. This includes alignment of NHS England and NHS Improvement processes and of commissioner and provider plans.

This will be a critical delivery year for Greater Manchester as: the fourth year of Taking Charge; the first annual plan developed in the context of the draft Health and Social Care Prospectus; and the first since publication of the Long Term Plan. This is also in the wider context of the launch of a number of key strategies that signal the next phase in the GM's journey as a devolved city region, including: the Public Services White Paper, the Local Industrial Strategy and the Spatial Framework.

Our expectation in GM of course is that, at locality level, commissioners and providers will have been working together to develop aligned plans fully connected to Locality Plans and informed by the reality of recent patterns of demand. Given the maturity of GM as an integrated system, the first test for an aligned system plan is one we should assume we can apply as a Partnership rather being applied through the national bodies in their regulatory role. It is therefore expected that there will be no significant alignment issues or surprises on receipt of the plans. If such issues do present, localities should expect swift challenge and urgent discussions to be convened.

This letter sets out how we can work together to produce an aligned system level plan for Greater Manchester for 2019/20. We will seek formal sign off for this approach at the Partnership Executive Board on 28th January, but we would expect that localities will already be underway with bringing local plans together.

1.0 System-Wide Aggregate Plan

1.1 In 2019/20, a single, system-wide aggregate plan is required for all STP/ICS and devolved areas. This builds upon the approach GM has taken to planning in the last few years in terms of alignment of plans between commissioners and providers, within localities and to the locality Investment Agreements covering the release of transformation funds.

1.2 We are proposing a representative, system group to ensure the alignment of the overarching plan (reporting into the Partnership Executive Board). This could perhaps be similar to the arrangement we set up to secure peer review and system ownership of Transformation Fund allocations through the Transformation Fund Oversight Group.

1.3 The Group will set an important signal for Greater Manchester: that we, collectively, can provide assurance on behalf of the GM system to the national regulators. This is a significant break from the historic position of national regulators receiving separate plans; reviewing them; and then attempting to reconstruct them into a picture that fits together.

2.0 The Development of Local Plans

2.1 Commissioners and providers will be undertaking joint discussions locally on activity and finance plans to satisfy triangulation and alignment on a system wide basis.

2.2 This joint work at locality level should support both draft and final stage submissions which will in turn help support validation and alignment at a GM system level.

2.3 The Partnership Team will play a supporting role to allow the High Level Group to fulfil its function in respect of the production of a GM system plan. This will include seeking assurance from localities that local plans are aligned – and, if this is not the case, supporting localities to resolve this rapidly.

2.4 To assist the Partnership Team to can carry out this role, CCGs will submit their plans to GMHSCP before the submission to the national team (see dates in the table at Appendix 1)

3.0 Financial Planning Framework

3.1 Five year indicative CCG allocations and the trust financial regime for 19/20 were published alongside the national planning guidance.

3.2 All NHS organisations within GM (CCGs, NHS Providers and NHSE Direct Commissioning & Corporate) are required to comply with this guidance as usual.

3.3 GMHSCP and NHSI finance teams will continue to work closely with individual organisations to support the development of organisational and locality plans.

4.0 CCG Business Rules

4.1 CCGs collectively are expected to deliver a breakeven position, after the deployment of Commissioner Sustainability Funding (CSF) and control totals will be set by NHSE on this basis. Within GM, we are seeking our fair share of national CSF to support more challenged CCGs to deliver against their control totals.

4.2 In addition, CCGs are expected to be able to maintain a 1% historic surplus - except where a CCG has a historic deficit and return to a 1% surplus can only be achieved on a phased basis.

4.3 This approach is in keeping with national guidance recognising that overspending CCGs will address cumulative deficits via accelerated recovery trajectory.

4.4 We expect that CCG plans support the delivery against constitutional and operational targets and activity levels are agreed that support delivery of this. These targets are set out in section 4 of the Operational Planning and Contracting Guidance.

4.5 CCGs are expected to agree activity and finance with their providers to facilitate a more efficient high level review process by GMHSCP. We acknowledge that this is an iterative process and that there may be areas of differences at draft stage that still require agreement by both parties in providing a reconciled view at final stage.

4.6 In such circumstances, localities will have actions in place to ensure resolution before submission of final plans to GMHSCP.

5.0 Provider Sustainability Funding

5.1 2019/20 is the first year of a re-set of the financial framework for NHS providers, building towards the removal of financial control totals from 2020/21. The Provider Sustainability Fund (PSF) has been reformed for 2019/20:

- £1bn has been transferred into urgent and emergency care prices to help to reduce the difference between average costs and national tariff prices;

- £200m has been used to contribute to a Financial Recovery Fund (FRF) totalling £1.05bn which will be used to support efforts to secure the financial sustainability of essential NHS services. The FRF will be allocated on a non-recurring basis and can only be accessed by Trusts in deficit who sign up to their control totals.

5.2 It is expected that consideration of control totals plus the application of PSF and FRF will result in the majority of trusts planning for a break-even position in 2019/20.

6.0 GM System Control Total

6.1 The GM control total is the sum of the provider control totals and commissioner plans. As a devolved area, the planning guidance requires GM to link a proportion of system PSF and any applicable Commissioner Sustainability Fund (CSF) to delivery of the system control total.

6.2 There is flexibility to vary the individual control totals across GM organisations which will be in agreement with NHSE/I and have a 'net neutral' impact on the GM control total. Any such changes will need to be agreed by 1st February 2019.

7.0 Management of GM Risk in 2019/20

7.1 As stated above, PSF and FRF will be allocated on agreement of control totals to with trusts. It is anticipated that all trusts will be offered a control total they can agree to, hence there will not be any PSF available as an 'upside risk' fund.

8.0 2019/20 Initial plan submission

8.1 As you will be aware there was an activity focussed check point on 14th January 2019, at which point both CCGs and Providers submitted the first draft of their 2019/20 activity plans. While recognising this was a very early submission, we intend to follow up this letter with one to each individual locality that captures:

1. A combined response to the submissions from a commissioner and provider perspective, drawing out our initial observations and key lines of enquiry.

2. The immediate areas of non-alignment between commissioner and provider plans, as demonstrated by the nationally available plan alignment tool.

3. An update on some demand and RTT modelling currently underway within the GM Health & Social Pare partnership team which should be a useful aid to assist with local growth calculations and assumptions.

9.0 Delivery priorities

9.1 The activity and finance plans described above will form a key part of the Partnership's 2019-20 Business Plan.

9.2 As in previous years, the Business Plan will set out what we will deliver in Greater Manchester in the year ahead.

9.3 Discussions in the High Level Group have identified an initial set of priorities including delivery of NHS Constitutional Standards; Urgent and Emergency Care Reform; and continuing to ramp up implementation of local neighbourhood models through the LCO Framework.

9.4 As with previous years we will expand, refine and confirm these priorities through the Partnership Executive and High Level Group. This will include testing that our programme of work will deliver against the national priorities set out in the Planning Guidance.

9.5 In advance of the next draft plan submissions on 12th February 2019, we are asking localities to provide an update by **7th February 2019** covering the following:

- Assurance that the locality has been working collectively to ensure plan alignment and has carried out consistency testing across CCGs and Providers.
- A headline summary of the plans to be submitted on 12th February 2019.
- A full copy of the CCG planning template that will be submitted on 12th February 2019.
- Any outstanding issues or risks

9.6 Similarly, we will require the same update prior to the submission of the final plans on 4th April 2019, by **1st April 2019.**

9.7 Specific details of the early submission requirement will be confirmed via the weekly GM system calls.

9.8 Upon review of the information received on 7th February a decision will be made as to which localities require an executive level meeting to discuss the plans on 11th February. Meetings will be arranged for all localities, and stood down where appropriate.

9.9 The national planning timetable, with key GM deadlines inserted can be seen in Appendix 1.

From now until April there is clearly a lot of work to do between us all as we refine the operational plans and we will support the GM localities via the usual routes including system

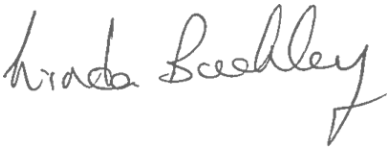
wide telephone conferences when appropriate. In the meantime if you have any queries or technical issues by all means contact either of the appropriate officers in NHSE/I:

Stuart Bethell - Assurance Team, GMHSCP, stuartbethell@nhs.net
Lesley Neary - Delivery Team, NHSI, lesley.neary1@nhs.net

Yours sincerely

Nicky OConnor
Chief Operating Officer
Greater Manchester Health and Social Care Partnership

Steve Wilson
Executive Lead, Finance & Investment
Greater Manchester Health and Social Care Partnership



Linda Buckley
Delivery and Improvement Director, Greater Manchester & Lancashire
Associate Lead for Delivery and Improvement
Greater Manchester Health and Social Care Partnership

APPENDIX 1 – NHS OPERATIONAL PLANNING TIMETABLE 2019/20

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	7January 2019
2019/20 CQUIN guidance published	January 2019
CCGs to provide GMHSCP draft activity plans	9 February 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Locality update prior to next draft submission	7 February 2019
CCGs submit draft plan templates to GMHSCP	7 February 2019
Locality review meetings – by exception	11 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 201
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Locality update prior to next submission	1 April 2019
CCGs submit final plan template to GMHSCP	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019

Report to:	Board of Directors	**Date:**	31st January 2019
Subject:	Corporate Objectives: 2018/19 – Q3 Update		
Report of:	Chief Executive	**Prepared by:**	Assistant Business Manager, Strategy and Planning

REPORT FOR NOTING

Corporate objective ref:	Master	**Summary of Report** To provide the Board of Directors with an update on progress of the corporate objectives for 2018/19 as at the end of Quarter three. Appendix One provides the full list of the strategic objectives and corporate objectives for 2018/19 along with progress and RAG rating. **Recommendations:** • Discuss and agree the position to date.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed	

Attachments:	Appendix One– Objectives Update Q3 2018/19

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

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1. INTRODUCTION

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

2. BACKGROUND

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

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

Objectives are shown as follows:

- Green – on track to achieve
- Red – not on track to achieve

3 CURRENT SITUATION

3.1 Objectives for the this year focus on:

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

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

currently not on progress to achieve are:

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

4. RECOMMENDATIONS

4.1 The Board of Directors are recommended to:

- Note progress for the quarter three and to discuss any variations from plan.

NHS Stockport NHS Foundation Trust

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

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Strategic Objective 1	**To achieve full implementation and delivery of the Trust's Refreshed Strategy 2018/22**	**Chief Executive**						
Corporate Objective 1a	To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** The draft Trust Strategy is still going through the consultation process which is nearing its end. So far over 600 staff have been spoken to. The Strategy and Planning and Communications team will take a revised Strategy to Trust Board at the end of January based on the consultation
Corporate Objective 1b	To lead the annual operational planning cycle in line with NHSI guidance	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** Work on the Operational Plan continues. A weekly Operational Planning group and bi-weekly Executive Oversight group have been set up to support this process. The first draft of the plan is due to be submitted 14th January 2019. The need for a development plan for Business Managers has been highlighted as part of this work
Strategic Objective 2	**To deliver outstanding clinical quality and patient experience**	**Chief Executive**						
Corporate Objective 2a	To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q3 Update** - In September the Trust had a unannounced CQC inspection of core services and an announced inspection of the well-led framework. The CQC published their report in December 2018, which demonstrated improvements in 11 areas of the grid and the removal of inadequate ratings in safe and well-led for ED and safe for medical wards. The Trust had 12 must do actions, and 4 should do actions from this inspection. The developed safeguarding structure provided assurance that the improvements planned have been realised, understanding that there is future work to do. The Trusts CQC actions plan is due to the CQC in January 2019.

NHS Stockport NHS Foundation Trust

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

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Corporate Objective 2b	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q3 Update** - The Quality Improvement Plan is on track for delivery as at the end of Q3 18/19. The Safety, Quality and Leadership group continues to meet. The Quality Faculty infrastructure was agreed. Unwarranted variance was reached in serious incident reporting and an extensive plan is in place as part of the CQC plan. The complaints response rate improved during Q3. NHSIs assessment of our use of resources resulted in an inadequate rating. A plan is in place to address the concerns.
Strategic Objective 3	**To strive to achieve financial sustainability**	**Chief Executive**						
Corporate Objective 3a	To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q3 Update -** Whilst the Trust financial forecast is still on plan for 2018/19 the Director of Finance has met and agreed i) Improvement in Business Group Financial forecast ii) Agreed level of winter funding iii) Utilisation of Trust reserves to achieve overall financial plan for 18/19 The Trust continues to provide a moderate to high level of assurance to the Board of Directors and Trust regulators through Enhanced Oversight meetings.
Corporate Objective 3b	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q3 Update** - At the end of quarter 3 the Trust has identified 12.7m in CIP against a 15m target. This is a gap of 2.3m. The Trust has financial provisions, contingencies and reserves to mitigate the gap. However, the Executive Team are continuing to exert focus on delivery of service improvements on the front line.
Corporate Objective 3c	To review and monitor a revised performance management framework	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** The revised framework was agreed at the end of quarter two. Implementation of this framework is on-going

NHS Stockport NHS Foundation Trust

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

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Strategic Objective 4	**To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including;** **a. Stockport Together/ Stockport Neighbourhood Care/ Integrated Service Solution** **b. Healthier Together** **c. Theme 3 & 4 Programmes (GM Health & Social Care Partnership)**	**Chief Executive**						
Corporate Objective 4a	i. To implement the new integrated service solution model of care working with our key partners ii. To realise the financial and non-financial benefits of the Stockport together business cases iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate	Chief Operating Officer	Provider Board					**Q3 Update -** The Stockport system wide leaders (CEO's) to review current arrangements and collaborative working
Corporate Objective 4b	To progress with planning for the realisation of the Healthier Together decision in line with GM defined timescales and investment	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** The commercial case was submitted to GM/NHSI at the end of quarter two. The Healthier Together full business case was discussed at Trust Board at
Corporate Objective 4c	To progress work streams relating to a)Theme 3 and b) Theme 4 in line with the GM Transformation Strategy	Director of Strategy, Planning and Partnerships/ Chief Operating Officer	Finance and Performance Committee					**Q3 Update -** Theme three - McKinsey modelling of theme three specialities and DGH archetypes has slipped and due to be completed by the end of January. Theme four - Discussions with the council are currently on hold. The finance team are preparing a proposal regarding the ledger system
Strategic Objective 5	**To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements (non-financial)**	**Chief Executive**						
Corporate Objective 5a	The Trust will complete an independently assessed Well Led Review by 30 September 2018	Director of Corporate Affairs	Audit Committee					**Q3 Update** - The Trust Board agreed not to proceed with this subject due to the proximity of a likely CQC well-led review in Q3 2018/19
Corporate Objective 5b	The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018	Chief Operating Officer	Finance and Performance Committee					**Q3 Update -** The Trust has agreed a recovery plan with Stockport CCG on RTT/waiting list size. The success of this recovery plan is dependant on: i. A decrease in referrals from GPs ii. Cleansing/validating the patient pathway to avoid duplication iii. Additional activity to bridge the gap in capacity Currently Stockport GP referrals remain on the increase at 4.5% affecting the Trusts ability to reduce waiting list size. The cancer standards are improving. The 2 week wait Breast capacity shortfall has been addressed and is currently compliant.

NHS Stockport NHS Foundation Trust

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

Key for progress	Forecasted to achieve	
	Not forecasted to achieve	

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:	Progress Q1	Q2	Q3	Q4	Narrative on progress
Corporate Objective 5c	The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan	Chief Operating Officer	Finance and Performance Committee					**Q3 Update -** The Trust failed to achieve the Q3 recovery actions. Future recovery will be focused on: i. Overnight breaches ii. Early discharges and ward processes iii. Decreasing the number of stranded patients Decreasing the number of stranded patients is imperative to plans and will have the most impact if not addressed. The full impact of the system wide winter plan is yet to be realised
Corporate Objective 5d	The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week	Medical Director	Quality Committee					**Q3 Update -** The latest seven day national audit results put the Trust in the upper quartile. Future mandated analysis will be by completion of a National self-assessment template which will be put through Board of Directors.
Strategic Objective 6	**To develop and maintain an engaged workforce with the right skills, motivation and leadership**	**Chief Executive**						
Corporate Objective 6a	To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum	Medical Director	Quality Committee					**Q2 Update -** Triumvirate development programme now initiated for Business Group leaders. Review of the future plan for the CD forum is underway
Corporate Objective 6b	To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement	Director of Workforce & Organisational Development	People Performance Committee					**Q3 Update -** The Trust has signed up to the NHSI Culture Programme. The Triumvirate leaders development programme is ready to commence in January 2019
Corporate Objective 6c	To develop programmes of work to ensure the Health and Wellbeing Strategy is embedded across the trust and supports all staff in improving their health and wellbeing, delivering an environment where staff wellbeing is integrated into day-to-day practices	Director of Workforce & Organisational Development	People Performance Committee					**Q3 Update -** The Health and Wellbeing agenda now forms part of our Culture and Engagement plan, and has been included in the People Strategy and implementation plan. The occupational health team will be supporting a review of the programme to align with our People Strategy objective. Resilience and Managing Mental Health at work is a core module of the Business Group Triumvirate development programme to commence in January 2019.

NHS Stockport NHS Foundation Trust

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

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Corporate Objective 6d	To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage	Director of Workforce & Organisational Development	People Performance Committee					**Q3 Update -** Proactive recruitment strategies have resulted in key appointments and increased scrutiny of Trust agency spend. This has led to increased conversions from agency to bank workforce.
Strategic Objective 7	**To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality**	**Chief Executive**						
Corporate Objective 7a	To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** Intersystem have changed their UK Senior Management Team. The Trust has written to Intersystem to initiate the dispute process outlined within the contract. There will be a paper presented to Trust Board in quarter three to consider options going forward.
Corporate Objective 7b	To refresh the Estates Strategy based on the six facet survey and master planning information	Director of Strategy, Planning and Partnerships	Finance and Performance Committee					**Q3 Update -** The Estates Strategy was agreed at Trust Board in September.
Corporate Objective 7c	To manage investment relating to the Trust's capital programme relating to; i. Medical equipment ii. IT iii. Estates iv. ED Patient Streaming	Director of Support Services/ Director of Finance	Finance and Performance Committee					**Q3 Update -** The Capital Programme is on track to spend in plan by year end. The only slippage is Healthier Together referenced in update 4b

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Safe High Quality Care Improvement Plan 2019		
Report of:	Chief Nurse & Deputy Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR APPROVAL

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

Summary of Report

Following the publication of the CQC report detailing their findings from the unannounced visit, well-led assessment and use of resources assessment, a draft improvement plan has been developed.

The plan outlines the actions that the trust is going to take, to address the 'must do' and 'should do' recommendations in the report.

Members of the Board are requested to ratify the action plan and support its implementation.

Attachments:

This subject has previously been reported to:

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

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1. INTRODUCTION

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

1.2 The improvement plan has been developed in conjunction with the executive directors and specialist leads within the trust.

2 BACKGROUND

2.1 In 2018, the Care Quality Commission rated Stockport NHS Foundation Trust as 'requires improvement' overall. Whilst this remains the same overall rating as the previous report, the CQC recognised the improvement that had been made, and the 3 'inadequate' ratings in the core services were removed.

2.2 Across the services, there were 12 ratings that showed an improvement.

2.3 The report identifies a number of areas where the trust requires improvement, which will contribute to the organisation meeting the objective of being rated 'good' overall at the next inspection.

2.4 The trust was issued requirement notices under 5 regulations

- Regulation 5 HSCA (RA) Regulations 2014: Fit and proper persons: directors
- Regulation 9 HSCA (RA) Regulations 2014: Person-centred care
- Regulation 15 HSCA (RA) Regulations 2014: Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014: Good governance
- Regulation 18 HSCA (RA) Regulations 2014: Staffing

2.5 The CQC requested a response by the Trust on the 23 January 2019.

3. CURRENT SITUATION

3.1 The improvement plan was developed with the executive directors and specialist leads to address the 12 'must do' and 45 'should do' recommendations in the report.

3.2 The improvement plan has been discussed at the Patient Quality Summit, Executive Management Group, and the Quality Committee.

3.3 The actions will be operationally managed by the named leads within the plan, and monitored through the Patient Quality Summit.

3.4 Oversight will be through the Quality Governance Group, and Quality Committee.

3.5 The plan was sent to the CQC on the 23 January 2019 as requested. However, it was agreed that as it had not been ratified through the full governance framework, that any changes that the Board wish to make will accepted after the 31 January 2019.

4 RISK AND ASSURANCE

4.1 The Board can be assured that when the actions identified in the improvement plan have been implemented, they will address the concerns raised by the CQC.

5. CONCLUSION

5.1 Members of the Board are requested to ratify the action plan and support its implementation.

Stockport NHS Foundation Trust

Safe High Quality Care Improvement Plan

Following the Care Quality Commission Report December 2018

Your Health: Our Priority

1. Purpose of this document

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

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

The **initial "RAG" rating** will be rated as follows:

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

The **overall current position rating** will be rated as follows:

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

Stockport NHS Foundation Safe, High Quality Care Improvement Plan

3. Introduction:

This plan describes the actions to be taken in order to ensure compliance with the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The plan has been developed in response to the Use of Resources Care Quality Commission inspection of September 2018, unannounced core services inspection in September 2018 and well led inspection in October 2018.

The plan is part of an overarching Quality Improvement Plan; however it purposely addresses the MUST and SHOULD do actions from the CQC Report published in December 2018.

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

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

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decision making is documented within patient records	require multi agency shared care arrangements. • The trust will ensure that staff clearly document in the notes of the person at the centre of the care decision, the best interest meetings and decisions							
The trust must ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs	• The trust will ensure that all patients who are unable to consent to stay within the care environment for care and treatment will have an application for or authorised DoLs in place. • The trust will treat all patients who have not had a formal supervisory body assessment, under best interest as defined by the Mental Capacity Act. • The trust will ensure that all patients who have a DoLs in place will have a copy of the application form, a Mental Capacity Assessment around the specific question of consent to stay within the care environment. • The trust will ensure that business groups complete a daily assessment of compliance to the standard.	• Quarterly audit of compliance with the agreed standards	Deputy Chief Nurse	Mar 2019	Operational Safeguarding Group	Safeguarding Group	Quality Committee	
The trust must take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs	• The trust will monitor the use of DoLs care plan and review processes. • The trust will ensure that a senior review of individualised care planning takes place • The trust will ensure that business groups have oversight of all	• Quarterly audit against standards.	Deputy Chief Nurse	Mar 2019	Operational Safeguarding Group	Safeguarding Group	Quality Committee	

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	patients requiring DoLs within their responsibility							

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Regulation 15 HSCA (RA) Regulations 2014: Premises and Equipment								
The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidance	• The trust will establish a task and finish group with agreed terms of reference. • The trust will develop a quality system for all medical equipment which includes a standard operating procedure. • The trust will identify all assets within Backtraq to clarify the need and frequency for maintenance including those where pieces of equipment that have no maintenance requirement. • The trust will agree standard reports in a format that satisfies the requirements of the Medical Devices Group and Medical Equipment Purchasing Group • The trust will review the Medical Equipment Policy, and alterations made to reflect the most current MHRA guidance. • The trust will recruit to the Quality Manager post. • The trust will develop a business case for RIFD Tracking and or an equipment library • The trust will assign appropriate planned maintenance profiles to assets • The trust will centralise contract control within the EBME and HSDU for all medical equipment • The trust will develop a business case for EBME Contract Manager.	• TOR of task and finish group and action plan • Audit of processes	Director of Estates and Facilities	Complete Jan 2019 Complete Feb 2019 Jan 2019 Feb 2019 Feb 2019 Jan 2019 Feb 2019 Feb 2019	Medical Devices Group	Safety and Risk Group	Finance & Performance Committee	

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

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust must improve performance in prescription of patients' regular medications.	• The trust will implement EPMA in ED to reduce different prescribing systems in use. • The trust will review other areas not using EPMA and consider implementation of EPMA for standardisation of prescribing. • The trust will implement an electronic chemotherapy prescribing system. • The trust will consider electronic discharge in maternity. • The trust will implement a process that will ensure surgical patients have the regular medications prescribed	• Implementation of EPMA system in ED • Evidence of review • Implementation of Chemotherapy system • Evidence of review • Audit of patients	Chief Pharmacist Associate Medical Director, Surgery Business Group	Dec 2018 Mar 2019 Mar 2019 Mar 2019 Mar 2019	Safe Medicines Group	Medicines Optimisation Group	Quality Committee	
The trust must ensure that governance processes are sufficient to mitigate identified clinical risks.	• The trust will assess the progress against risk management framework (RMF) • The trust will identify a process for sharing of risks • The trust will review the current risks by business group and ensure visibility to others • The trust will complete a training needs analysis and deliver training on risk management to all staff identified	• Completed assessment against RMF • Audit of process • Review complete and spot audit completed • TNA completed and training programme commenced	Deputy Director of Quality Governance	Apr 2019	Safety & Risk Group	Quality Governance Group	Quality Committee	
Regulation 18 HSCA (RA) Regulations 2014 Staffing								
The trust must take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times	• The trust will work as part of the NHSI collaborative. • The trust will deliver actions outlined in the recruitment and retention strategy. • The trust will monitor progress in	• Progress will be monitored through the IPR at People & Performance Committee • Strategic staffing	Deputy Chief Nurse	Jun 2019	Temporary Staffing Group Business Group monthly Performance meetings	Workforce & Education Group	People & Performance Committee Board of Directors	

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	reducing the vacancy numbers for RN's. • The trust will monitor agency and NHSP usage. • The trust will report the NHSP usage to Board of Directors via the IPR. • The trust will continue to deliver the actions relating to recruitment and retention with the GM partnership. • The trust will assist in the delivery of the people strategy in specific relation to the objective - creating a workplace that attracts and retains people with the right skills and commitment to providing high quality, safe care. • The trust will triangulate temporary staffing fill rate against agreed establishment. • The trust will undertake daily assessments of staffing levels.	review twice yearly • Monthly temporary staffing data • Audit of policies						

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The trust must ensure that compliance with mandatory training is increased, including safeguarding training, particularly for medical staff.	• The trust will proactively identify areas/subjects of low compliance for mandatory training. • The trust will review the provision of mandatory training in areas identified and work with teams/staff groups to develop a trajectory for improved compliance levels. • The trust will develop a targeted approach for medical staff.	• Mandatory training compliance audit • Integrated Performance Report includes compliance against targets	Deputy Director of Workforce and OD Deputy Chief Nurse	Mar 2019	Education Governance Group Business Group monthly Performance meetings	Workforce & Education Group	People & Performance Committee Board of Directors	
SHOULD								
The trust should consider developing a documented talent map or succession plan	• The trust will develop a strategy for talent management and succession planning arrangements as part of its People Strategy. • The trust will implement the strategy and associated actions.	• Strategy developed and approved • Audit of outcomes	Deputy Director of Workforce and OD	Mar 2019 Jun 2019	Culture and Engagement Group	People & Performance Committee	Board of Directors	
The trust should move at pace to implement the medium term financial strategy	• The trust will consider the control total for 2019/20 and agree the overall target • The trust will agree the Cost Improvement Target for 2019/2020 • The trust will develop and implement the clinical services efficiency programme for 2019/20	• Monthly monitoring of financial performance • Execution of the performance management framework	Deputy Director of Finance	Mar 2020	Business Group monthly Performance meetings	Finance & Performance Committee	Board of Directors	
The trust should consider involving patients in the development of the patient experience strategy.	• The trust will share the strategy with patient and the carer representative • The trust will assess any changes required following feedback	• Evidence of the sharing of information via the Patient Experience Action Group minutes	Deputy Chief Nurse	Mar 2019	Patient Experience Action Group	Patient Experience Group	Quality Committee	
The trust should consider improving the quality of appraisals	• The trust will implement a task and finish group to review the appraisal process, documentation	• Terms of reference of task and finish group	Deputy Director of Workforce and OD	Mar 2019	Culture & Engagement Group	People & Performance Committee	Board of Directors	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
	and training. • The trust will develop an action plan to ensure steps are taken to improve the experience of appraisal for staff.	• Action plan delivery • Increase of staff satisfaction in annual staff survey.		Jun 2019				

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust should consider embracing the spirit of duty of candour in all applicable incident investigations	• The trust will review process when including patients and their relatives in the investigation of serious incidents • The trust will ensure new template includes section and guidance on patient engagement • The trust will review process to include a patient liaison contact	• Bi-annual audit of Serious Incident panel hearings • Bi-annual audit of patient input into investigations	Deputy Director of Quality Governance	Jan 2019	Safety & Risk Group	Quality Governance Group	Quality Committee	
The trust should consider board level clinical staff sign off of all clinical serious incidents.	• The trust will ensure that all clinical Serious Incidents panels to be chaired by a clinical executive	• Bi- annual audit of Serious Incident panel hearings	Deputy Director of Quality Governance	Dec 2018	Safety & Risk Group	Quality Governance Group	Quality Committee	
The trust should consider auditing all areas for medicines reconciliation	• The trust will commence monthly audits in surgery business group in addition to the existing medicine business group medicines reconciliation audits • The trust will undertake a review of all the areas where medicines reconciliation does not take place and a risk assessment will be completed to ensure all areas are appropriately managed	• Monthly audit • Risk assessment	Chief Pharmacist	Dec 2018 Jan 2019	Senior Pharmacy Management Group	Medicines Optimisation Group	Quality Committee	
The trust should strengthen performance management arrangements for the business units.	• The trust will put in place monthly performance management meetings with each business group, covering key indicators in quality, operational performance, finance and workforce.	• Key issue reports to EMG and Finance & Performance Committee	Director of Strategy and Planning	Dec 2018	Executive Management Group	Executive Team	Finance & Performance Committee	
The trust should consider improving governor's understanding of the trust's strategic direction	• The trust will deliver a workshop to facilitate Governor understanding of new strategy following Board approval in January 2019. • The trust will include strategic development as a standing	• Record of Workshop • Agendas and minutes of meetings.	Associate Director of strategy & Planning Head of communications	Mar 2019 Mar 2020	Strategy & Planning Oversight Group	Council of Governors Governance Committee	Board of Directors	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
	agenda item at Council of Governors meetings.							

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust should ensure the ambient temperature of the medicines storage room is monitored to make sure medicines are stored within their accepted temperature range	• The trust will introduce a temperature monitoring scheme across all clinical areas (treatment rooms and drug fridges) in the hospital. • The trust will undertake a continuous rolling programme of monitoring of treatment rooms until the Estates work is completed. • The trust will manage the medicine stock expiry dates according to the temperatures reported.	• Monthly audit	Chief Pharmacist	Mar 2019	Safe Medicines Group	Medicines Optimisation Group	Quality Committee	
The trust should take appropriate actions so that staff competency records are reviewed, maintained and kept up to date.	• The trust will implement a task and finish group to design a system for mapping competency requirements • The trust will develop a system for accurately recording and updating compliance against competency of staff.	• Terms of reference of the task and finish group • Bi-annual audit of records	Deputy Director of Workforce and OD Deputy Chief Nurse	Jun 2019	Task and Finish Group	Education Governance Group	People & Performance Committee	
Medicine								
The trust should take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times. (In addition see actions under regulation 18)	• The business group will review staffing numbers to ensure safety on each shift across the business group on a daily basis. • The business group will create a retention plan specific to the needs of the business group and implement the actions.	• Reduction in turnover figures • Improved vacancy figures	Associate Nursing Director, Medicine	Mar 2019	Ward Managers Forum Medical Governance Board	Medicine & CS Business Group Quality Governance Board	People & Performance Committee	
The trust should take appropriate actions so that acute non-invasive ventilation patients receive care and treatment in line with British Thoracic Society	• The trust will establish a task and finish group that will ensure that staff on duty have the appropriate training to care for patients who are being treated with non-invasive ventilation in accordance to BTS quality standards	• Quarterly report from task and finish group	Associate Nursing Director, Medicine	July 2019	Task and Finish Group	Medicine & CS Business Group Quality Governance Board Quality Governance Group	Quality Committee	

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(BTS) Quality Standards. (Adults)								
The trust should take appropriate actions to improve staff mandatory training and appraisal process compliance	• The trust will review mandatory training provision in the unit; with provision of dedicated support to resolving access issues. • The trust will develop a trajectory to ensure delivery of the required compliance levels.	• Compliance with mandatory training figures • Agreed improvement trajectory achieved	Business Group Director, Medicine Deputy Director of Workforce and OD	Mar 2019	Ward Managers Forum	Medicine and CS Business Group Quality Governance Board Education Governance Group	People & Performance Committee	
The trust should take appropriate actions to improve staff compliance in fluid balance monitoring and the management of patients with sepsis	• The trust will ensure that all staff have appropriate training and knowledge about fluid balance monitoring • The trust will ensure that all staff have appropriate training and knowledge about manging patients with sepsis • The trust will ensure each ward review sepsis alerts on a daily basis.	• Compliance with training • Monthly audit of compliance with fluid balance monitoring standard • Monthly compliance with NEWS 2 standards • Monthly compliance with sepsis bundle	Associate Nursing Director, Medicine	Jun 2019	Medicine & CS Business Group Quality Governance Board Sepsis Steering Group Quality, Safety Improvement Strategy group	Quality Governance Group	Quality Committee	
The trust should take appropriate actions to reduce patient moves to other beds and wards during the night	• The trust will define and implement agreed standards for moving patients within appropriate timescales. • The trust will develop a database and establish a baseline audit of patients who are moved out of hours. • The trust will agree a target reduction of the number of patients who are moved out of hours • The trust will ensure that Clinical Site Co-ordinators support the	• Audit of compliance against agreed trajectory • Audit of transfer guidance	Lead Nurse for patient flow	Mar 2019	Deteriorating Patient Group (under development)	Quality Governance Group	Quality Committee	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
	movement of patients earlier in the day							
The trust should take appropriate actions to improve the average length of patient stay for non-elective patients in geriatric medicine and cardiology specialties.	• The trust will improve length of stay for geriatric and cardiology wards. Actions to progress this will be: • The trust will redesign cardiology pathways. • The trust will implement a consultant of the week model. • The trust will develop transfer to assess model. • The trust will embed SAFER principles on the wards. • The trust will develop pathways with community services to improve LOS.	• LOS metric • Readmission rate metric	Business Group Director, Medicine	Sept 2019	Cardiology and DMOP Clinical Governance meetings	Operational Board for Medicine & CS Business Group	Operational Performance Group	
The trust should take appropriate actions so that records are maintained for medicines returned to pharmacy for disposal.	• The trust will review best practice and national standards to ensure records, when appropriate, are maintained for medicines returned to pharmacy for disposal. • The trust will benchmark against other trusts to identify how recording of medicines disposal is managed elsewhere. • The trust will continue to document controlled drug returns • The trust will complete a risk assessment of medicines not recorded • The trust will ensure drug recycling continues and the stock is entered onto the pharmacy system	• Monthly recycling figure • Audit of records in CD book • Annual review of the risk	Chief Pharmacist	Mar 2019 Jan 2019 Dec 2018 Jan 2019 Dec 2018	Senior Pharmacy Management Group	Medicines Optimisation Group	Quality Committee	

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

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Service for community adults								
The trust should consider reviewing the security arrangements at Kingsgate House	• The trust will review security arrangements at Kingsgate House to prevent unsupervised patient access to clinical rooms on floor 2 • The trust will implement new security arrangements / complete Risk Assessment	• Evidence of decision making and risk assessment	Director of Estates and Facilities	Jan 2019 Mar 2019	Integrated Care BG Quality & Performance Board	Operational Performance Group	Finance & Performance Committee	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust should ensure that the crisis response team carry out the expected nursing assessments based on the acuity and referral criteria of the patient	• The trust will produce a new Standard Operating Procedure. • The Crisis Response Team will undertake appropriate nursing assessments in line with the new Standard Operating Procedure on clinical documentation.	• Monthly audit of clinical records against SOP standards	Associate Nurse Director Community	Jan 2019 Feb 2019	Neighbourhood Care Quality Assurance Group	Integrated Care Quality Assurance Board Quality Governance Group	Quality Committee	
The trust should ensure the crisis response team review their terms of reference and key performance indicators	• The trust will review Crisis Response service criteria and KPIs with CCG and other key stakeholders. • The trust will implement the agreed KPI's in line with community contract.	• New KPI's in place • Monthly monitoring of KPI's	Business Group Director, Integrated Care	Jan 2019	Integrated Care Operational Group	Operational Performance Group	Urgent Care Delivery Board	
The trust should improve arrangements for meeting individual patient needs and access to information	• The trust will clarify the process for managing the trust internet • The trust will work with Healthwatch to seek feedback about the appropriateness of public information. • The trust will review the community services information on the trust internet. • The trust will add a question regarding the trust internet to the community services' annual patient surveys.	• A quarterly patient report collating responses by service	Associate Nurse Director Community	Jun 2019	Neighbourhood Care Quality Assurance Group	Integrated Care Quality Assurance Board Quality Governance Group	Quality Committee	
The trust should consider reviewing targets for referral to treatment times.	• The trust will review services' targets for referral and treatment times with the CCG. • The trust will update the service specifications as required. • The trust will incorporate the updated referral and treatment times into the performance monitoring process.	• Monthly performance report	Business Group Director, Integrated Care	Mar 2019	Integrated Care Operational Group	Community Services Quality and Performance Forum	Business Group monthly Performance meeting	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
Devonshire								
The trust should take appropriate action so staff can access all mandatory training.	• The trust will undertake a review of mandatory training provision in the unit; with provision of dedicated support to resolving access issues. • The trust will develop a trajectory to ensure deliver of the required compliance levels.	• Compliance with mandatory training figures • Agreed improvement trajectory achieved.	Associate Nursing Director, Medicine Deputy Director of Workforce and OD	Mar 2019	Medicine Business Group Quality Board	Education Governance Group	People & Performance Committee	
The trust should secure patient records at all times	• The trust will ensure lockable medical records trollies are in use at the Devonshire Unit. • The trust will ensure that patient records are kept in a locked office at all times when not in the possession of a healthcare professional.	• Monthly audit of record security.	Associate Nursing Director, Medicine	Feb 2019	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance Board	Quality Governance Group	
The trust should secure the doors leading to the ward area at all times	• The trust will review the security of the Devonshire Unit to ensure compliance.	• Monthly audit of compliance to agreed standard	Associate Nursing Director, Medicine	Mar 2019	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance Board	Business Group monthly Performance Meeting	
The trust should consider introducing regular engagement with patients and their families to identify areas requiring improvement that will improve care and experience.	• The trust will promote the use of the patient and visitor suggestion box. • The trust will work with the patient experience matron and communications lead to develop further opportunities for patient engagement • The trust will encourage families to meet with the MDT team weekly to ensure close involvement in care	• FFT results • Patient survey focussed on engagement	Associate Nursing Director, Medicine	Mar 2019	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance Board Patient Experience Group	Quality Committee	
The trust should take appropriate actions so patients have access to	• The trust will continue to work with Pennine Care NHS Foundation Trust to develop a	• Audit of timeliness of access for patients requiring	Business Group Director, Medicine	Jun 2019	Operational Safeguarding Group	Safeguarding Group	Quality Committee	

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psychiatric support.	memorandum of understanding /service level agreement in the development of the Core 24 service.	mental health support						
The trust should take action so that patients have regular access to an activity co-ordinator	• The trust will publicise a calendar of activities for patients. • The trust will consider the use of activity coordinator role.	• FFT and patient/ relative complaints and feedback • Bi-monthly report of activities at the Devonshire Unit	Associate Nursing Director, Medicine	Mar 2019	Neuro Rehabilitation Governance Group	Medicine and CS Business Group Quality Governance Board Patient Experience Group	Quality Committee	
The trust should provide appraisals to all members of staff	• The trust will ensure that all staff have appraisals in a timely manner	• Compliance report	Associate Nursing Director, Medicine	Completed	Neuro Rehabilitation Governance Group	Education Governance Group	People & Performance Committee	
Maternity								
The trust should consider installing neonatal resuscitation equipment in all birthing areas to prevent separation of mum and baby in an emergency	• The trust will obtain costings for wall mounted/ freestanding resuscitation equipment to be placed in all birth rooms on the Birth Centre. • The trust will add the equipment to the capital programme list • The trust will purchase and install the equipment	• Evidence of equipment installed	Head of Midwifery	Apr 2019	Women's' Children's & Diagnostics Governance and Risk Group	Women's' Children's & Diagnostics Quality Board	Quality Governance Group	
The trust should continue to work towards staffing the unit to full establishment for safety of women and babies, to improve the access and flow for women and to optimise their choices of place of birth	• The trust will resubmit the outline business case for additional registered midwifery staffing to the Executive Management Group for approval and onward escalation when ratified • The trust will clearly articulate the staffing deficit on the risk register and review every three months. • The trust will ensure timely	• Audit of staffing incidents • Evidence of risk review	Head of Midwifery	Apr 2019	Women's' Children's & Diagnostics Governance and Risk Group	Women's' Children's & Diagnostics Quality Board	People & Performance Committee	

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	reporting of staffing related risks on the incident reporting system.							
The trust should consider redesign of the birthing room where the toilet is behind a curtain	• The trust will take the birthing room out of use following a review by the Estates Team. • The trust will undertake a review of the birthing rooms and collate plans for redesign of the birth environment to meet current standards • The trust will assess the cost for the works to be undertaken to birthing rooms and submit an outline business case.	• Work Completed	Head of Capital Projects	May 2019	Estates Capital Group	Capital Programme Development Group	Finance & Performance Committee	
Urgent and Emergency Services								

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust should ensure patient records evidence capacity and delirium assessments	• The trust will ensure that staff document mental capacity assessments. • The capacity assessment tool will be incorporated into Advantis ED as a mandatory field.	• Quarterly audit against standards	Associate Nurse Director Urgent care	Mar 2019	Operational Safeguarding Group	Safeguarding Group	Quality Committee	
The trust should ensure a review of the staffing model in the paediatric department is completed to ensure staffing complies with the Royal College of Paediatrics and Children's Health standards	• The trust will ensure that the paediatric emergency department model is compliant with the RCPCH standards. • The trust will arrange for an external peer review to be undertaken. • The trust will review the findings of the external report and implement actions to meet standard.	• A report following the review	Associate Nurse Director Urgent care	Mar 2019	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	
The trust should ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department	• The trust will review the current pathways to improve performance against national standards. • The trust will reconfigure the urgent care estate, completing the work on the 'front door' • The trust will continue to monitor daily performance of admitted and non-admitted pathways.	• A weekly compliance report	Associate Director Urgent care	Jan 2019	Urgent Care Quality Assurance meeting	Operational Performance Group	Urgent Care Delivery Board	
The trust should ensure that all patients receive an initial assessment within 15 minutes of arrival, in line with the Royal College of Emergency Medicine standards	• The trust will develop a triage plan to achieve the 15 minute standard, which will include actions around training, competencies for diagnostic ordering and response to surge / increase in patient demand. • The trust will implement the actions of the plan and monitor progress.	• A weekly compliance report	Associate Director Urgent care	Jan 2019	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board Quality Governance Group	Quality Committee	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
The trust should ensure that plans for a new room for mental health assessments are completed	• The trust will complete the estate work for additional major assessment areas, designed and planned in partnership with Pennine Care NHS Foundation Trust.	• A monthly utilisation report	Associate Director Urgent care	Mar 2019	Urgent Care Operations Group	Operational Performance Group	Urgent Care Delivery Board	
The trust should ensure staff follow national guidance and patient pathways to ensure patients receive treatment that meets best practice	• The trust will review and update the clinical pathways / national guidance available on the intranet. • The trust will revise the emergency department induction programme, to ensure all staff are able to access clinical pathways / national guidance on the intranet. • The trust will develop an urgent care clinical pathway audit programme for 2019/20.	• Audit patient records to ensure pathways used when applicable • Induction compliance figures	Clinical Director Urgent Care	Mar 2019	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	Quality Governance Group	
The trust should continue to develop the number of substantive medical staff	• The trust will improve the number of substantive staff in place to meet Royal College guidance. • The trust will develop and implement a workforce strategy, addressing the recruitment of Physician Associates, Acute Care practitioners and international recruitment.	• Monthly update on progress	Clinical Director Urgent Care	Mar 2019	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	
The trust should ensure that privacy and dignity of patients is always maintained	• The trust will ensure that patients are being cared for and treatment is being delivered with dignity and compassion in suitable environments. • The trust will adopt a zero tolerance approach regarding examinations performed outside of cubicle space. • The trust will implement the	• Monthly audits against standard	Associate Nurse Director Urgent care	Mar 2019	Integrated Care Quality Assurance Board	Patient Experience Group	Quality Committee	

Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	How we will measure the action	Responsible Lead	Timescale (by end of)	1st Line Responsible Group	2nd Line Responsible Group	3rd Line Responsible Committee	Initial RAG Rating
	emergency department safety checklist. • The trust will implement an escalation process in the event that standards are not maintained.							
The trust should take action to promote a positive culture within the emergency department.	• The trust will assess the culture in the department and develop an action plan based on the results, in conjunction with the team	• Staff surveys	Associate Director Clinical Director Associate Nurse Director Urgent care	Mar 2019	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	

Appendix 1

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

Trust standard template completed by identified lead

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

Implementations and timescales monitored by the named committee/group

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

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

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

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

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NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Adult Safeguarding – Update		
Report of:	Chief Nurse and Director of Quality Governance	**Prepared by:**	Trust Safeguarding Advisor

REPORT FOR ASSURANCE

Corporate objective ref:	2a,b
Board Assurance Framework ref:	2.4.5.6.7
CQC Registration Standards ref:	Regulation 9,10,12,13,17
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report
Identify key facts, risks and implications associated with the report content.
This report provides an update relating to:

- Adult Safeguarding activity
- Assurance to address those areas of development and improvement in line with the CQC report
- Compliance with legislation and guidance in protecting vulnerable persons in the care of the Trust.
- Adoption of best practice and continued positive development of the safeguarding provision toward delivering shared care and partnership working.
- Assurance, reporting and adherence to local safeguarding agreements

Adult and children's safeguarding teams work closely together and share responsibility for providing assurance to the Board of Directors, however this report contains an additional layer of assurance relating to adults. This is in response to concerns raised through regulators reports about adult safeguarding.

Attachments: Nil

This subject has previously been reported to:

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

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1.	**INTRODUCTION**
1.1	This report provides an update relating to activity in Adult Safeguarding since April 2018. It intends to provide assurance of the progress to date in addressing areas of developments and improvements since the launch of the new Quality Governance Framework, and the CQC findings in their reports published 2016, 2017 and 2018. The report discusses Trust compliance with the legislation and guidance in protecting vulnerable adults in the care of the Trust. An update to the Trust's adoption of best practice and continued positive development of the safeguarding provision in delivering shared care and partnership working. In addition, the report is intending to provide assurance to reporting and adherence to local safeguarding agreements. Adult and children's safeguarding teams work closely together and share responsibility for providing assurance to the Board of Directors, however this report contains an additional layer of assurance relating to adults. This is in response to concerns raised through regulators reports about adult safeguarding. Therefore this report solely concentrates on adult safeguarding.
2.	**BACKGROUND**
2.1	In April 2018 the Trust introduced the Quality Governance Framework (2018 -2020), which saw the profile of adult safeguarding rise within the organisation. The Trust continues to progress in meeting the national and local safeguarding agenda's as further guidance and legislation is adopted in meeting the Care Act of 2015.
2.2	The Trust Adult Safeguarding team (consisting of 2 members of staff) has been in place since 2008, and our response to the Act has developed since this time. In particular, the development has been enhanced further throughout 2018 in relation to key developments in personalised care: Making Safeguarding Personal (MSP). In addition, the developments have including the requirement to work collaboratively with multi agency colleagues and adopt learning from notifiable deaths and subsequent reviews. There is no doubt that raising the profile of adult safeguarding through the Quality Governance Framework has impacted the capacity of the team as they work towards making improvements.
2.3	In the context of adult safeguarding, challenges continue to arise given increasing complexity of needs and acuity of patients, particularly with those patients who have mental ill health or learning disabilities. The Quality Governance Framework has provided the infrastructure in which the adult safeguarding structure fits, allowing improved reporting to the Board of Directors. With the support of the Quality Committee, the Trusts ownership and integration of best practice has begun to emerge with notable areas of good practice, however there are areas where improvements are required. This was recognised by the Trust, and also by the CQC in their report of December 2018.
3.	**CURRENT SITUATION**
3.1	The CQC report published in December 2018, following their unannounced core inspection visit, highlighted a number of areas where improvement was required under Regulation 9 of the Health and Social Care Act (2014). These are in line with the requirements the Trust had already recognised. The CQC reported that the Trust must: • Ensure that care and treatment meets individual needs of patients including those with learning disabilities and mental capacity concerns • Ensure that the best interests' decision making is documented within patient records

	• Ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs • Take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs
3.2	**Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) - Assessment and Application**
3.2.1	The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards set out a process that hospitals and care homes must follow if they believe that, in order to provide treatment or care to a person that in the best interests, they may need to be deprived of their liberty. In the first instance, the Trust can urgently deprive someone of their liberty for seven days during which time the responsible body which is Stockport Adult Social Care Team at the local authority, must assess the application and ultimately approve that the deprivation of liberty is in the persons best interest. Whether someone is deprived of their liberty depends on the person's specific circumstances. A large restriction may sometimes in itself be a deprivation of liberty or sometimes a number of small restrictions added together will amount to a deprivation of liberty. What needs to be assessed by the Local Authority is the amount of control that the Trust has over the person, ensuring that: • the arrangements are in the person's best interest • the person is appointed someone to represent them • the person is given a legal right of appeal over the arrangements • the arrangements are reviewed and continue for no longer than necessary The Trust safeguarding team are responsible for reporting a range of information about DoLS applications to the Trust Safeguarding Group. Reporting includes the quality assurance process in place by the Safeguarding Team, whereby they review all applications made and offer guidance to all clinical areas in conjunction with senior clinical staff in the business groups. At the point that the CQC visited the Trust in September 2018, they noted that although the Trust had made applications to the Local Authority this had not always resulted in an assessment by the Local Authority within the appropriate time frame of seven days. Due to their own capacity, the Local Authority is not always able to provide an assessor within this time due to their own capacity, potentially meaning that the Trust was depriving patients of their liberty out-with the requirements of the Mental Capacity Act. It is important to note that this situation is not unique to Stockport Local Authority or the Trust. Together the Trust and Local Authority had recognised this previously and agreed that in order to ensure that our patients continue receive their treatment plans, we would legally provide this care in the patients 'best interest' under the Mental Capacity Act. The CQC noted that there was insufficient evidence within patient records that this process was in place. At any time, around 90 patients in the Trust are subject to DoLS.

3.2.2	The agreed process in place is as follows: The DoLS application is completed by a registered nurse at the Trust using Association of Directors of Adult Social Services (ADASS) guidance using an agreed standardised form, the following steps will take place: • The form is quality assured by the Safeguarding Team • The form is emailed to the responsible body by the Safeguarding Team to Stockport Local Authority • The application is triaged by the Local Authority team on a low, medium or high basis In response to our emailed application, the Trust receives the following information: • An email confirming the level of triage • Instructions to care for the patient under the Mental Capacity Act 2005 pending (attached at appendix 2) – stating *'whilst awaiting assessment, you are able to continue giving necessary care under Section 5 and 6 of the Mental Capacity Act 2005 – i.e. in 'Best Interests'.* Since September 2018 in relation to caring for patients '*under Section 5 and 6 of the Mental Capacity Act 2005 – i.e. in 'Best Interests',* the Trust developed the existing care plan to include: • Information of the patients short term goals, ensuring that: o all care is given in patients best interest o the patient is treated with dignity and respect within a safe and appropriate environment o the patient and family are involved in decision making as far as practicably possible: if the patient has no one other than paid carers and no family consider referral to IMCA services o as far as possible that care is delivered in the least restrictive way The care plans are in place across the Trust, and are reviewed by the Safeguarding Team. During Q3 2018/19 the Safeguarding Team developed a robust process to ensure that documentation is clear within the case notes that patients are being treated in their best interests. The care plans have been shared with other Trusts as an example of best practice. Advice on the matter that the Trust was an outlier in its position with the Local Authority and potentially working outside the MCA was sought from GM Partnership Safeguarding Lead, Stockport CCG Designated Nurse, and the Local Authority Head of Safeguarding. The Trust considered the position carefully, and took legal advice. As explained, we are aware that the national situation is similar. The option of applying to the Court of Protection, the Trust understands that this is not routinely undertaken in cases where authorisation has not yet been granted. If this were necessary, in any urgent case, then the Trust would undertake to apply. The Safeguarding Group received assurance through a written report describing the improvements made in this area during Q3 2017/18. Improved understanding and compliance with the national standards was evident, and areas for further improvement were outlined. Additionally the Trust continues to work closely with the LA in relation to the developments that will be required to introduce Liberty Protection Safeguards (LiPS), which has been developed to replace DoLS but which is not yet legislated.

	These developments will see a change in the MCA to potentially transfer the responsibility for assessment to hospitals.
3.3	**Building blocks action plan – a focus for safeguarding work** Throughout Q2 and Q3 2018/19 significant work has been undertaken to build on staff understanding and application of the required standards, driven by a 'Building Blocks Action Plan'. This plan developed as a focus for the safeguarding teams' everyday work. The plan also forms the basis of the work for the Safeguarding Adult Operational Group, which was developed in Q2 18/19 as a group reporting to the Safeguarding Group. Through the plan, the Trust developed, and delivered, a series of awareness raising streams to support staff understanding in this area, and to augment the training provided was been developed. These were as follows: • DoLS 7 minute briefings – delivered throughout the Trust by the Safeguarding Team. • Safeguarding Seven Minute Briefings' have been taking place monthly. The first event took place in July 2018, as a roadshow visiting all the wards and departments across the Trust sharing the briefings. During the briefing, staff made pledges as to how their practice has changed or will change as a result of the learning. • Development of a suite of five Always Events as part of our Quality Improvement Indicators to be reported through the Quality Account, due to be published in May 2019. In relation to safeguarding, the Always Events include aspects of mental health assessment. • Quality, Safety and Leadership (QSL) meetings were introduced in April 2018, which met in addition to our already well-established weekly Patient Quality Summit and weekly Patient Safety Summits. The QSL meetings are held three times a week for half an hour, where a focus on improving understanding by engaging/deploying our senior nursing teams to the front-line. This included a specific focus on DoLS applications, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and capacity assessment. By having this focus, the senior nurses are empowered to provide challenge and support based on the best practice identified and distributed. • A forum to deliver training to band 6 nurses and allied health professionals, to include safeguarding was established. The training consisted of 15 minute time slots, delivered over 90 minutes, sharing the 7 minute briefings on MCA, Learning Disability and DoLS. We plan to deliver these sessions bi-annually; they were well evaluated by staff and have contributed to the improvements we have seen. • Band 7 forums. This forum is held monthly and chaired by the Deputy Chief Nurse. It is attended by junior and senior ward sisters, specialist nurses, allied health professional and managers. The Adult safeguarding team has had the opportunity to share with the staff the improvement journey, ensuring that the required standards are embedded in practice and the information is cascaded through the nursing teams via this meeting. The most recent of these meetings, held on 3 January 2019 saw 30 band 7 staff trained in PREVENT, for example. • Sample documentation has been developed of the MCA assessment form and DoLS application, to help guide staff through assessment and completion of the forms. These sample documents are accessed through the Trusts Adult Safeguarding microsite. A review of the statistics that are generated each time a staff member accesses the microsite demonstrates a sustained high number of staff (around 650 per month on average) since July 2018 to today's date. • In July 2018, each member of clinical staff (nursing, medical, allied health professional) and our support staff such as porters, domestics, and security received a pocket card explaining the concepts of the Mental Capacity Act

	and the DoLS application process. • During informal but regular senior visits to the ward, both medical and nursing staff report that these are regularly used when developing plans for vulnerable patients. • The Trust Safeguarding Advisor was invited to the Clinical Directors forum to deliver further training in September 2018 as part of the Building Blocks action plan. This focused on mental health and learning disability pathways and required intervention under agreed shared care protocols. This will be followed by focused learning sets on MCA, DoLS application into practice and Mental Health Awareness during January and February 2019.
3.4	**Safeguarding Training**
	Since the CQC visits, training to front-line staff increased the Trusts position to satisfactory levels although with a target to increase, at the end Q3 2018/19 at 90.93% for Level 1 and 88.61% for Level 2 training. The training was delivered via e-learning, face to face in the classroom, and by 'tool box' approach directly in clinical areas. Mental Capacity Act training analysis in the last six months shows that the training was fit for purpose. A national e-learning tool is in place, as is both face to face and 'toolbox' training. The toolbox training contains a very useful Five Point reminder, which has been highly effective in engaging staff. Toolbox training was delivered at ward level and above and also to the Board of Directors in November 2018. The aim of the training was to concentrate on the key issues of the Mental Capacity Act and assessment, with the toolbox produced to offer underpinning information for staff when assessing the needs of their patient should a cognitive impairment be suspected. Priority training for Q4 2018/19 and Q1 2019/20 are as follows : • Level 3 Adult Safeguarding training in line with intercollegiate guidelines training being established for quarter Q1 2019/20 via an e learning package with focused training in priority areas in the Business groups. • PREVENT – training in recognising and understanding of the prevention of vulnerable people being radicalized and exploited. Current figures show an increase in this training toward achieving 85% by March 2019. • 'Safe holding' training to be delivered, which is the effective de-escalation and physical intervention for people likely to be disturbed in their behavior • Mental Health Awareness, including Mental Health Act application and Mental Capacity Act application. All security staff are trained at Level 1, throughout Q4 2018/19 and Q1 2019/20 this will be delivered to senior nurses, matrons and senior managers.
3.5	**Ward Accreditation Scheme- Accreditation for Continued Excellence (ACE)**
	In Q4 2017/18 the Trust developed and piloted our ward accreditation scheme, ACE, which was then launched in April 2018. Safeguarding is one of the 14 standards that make up the accreditation process. All wards will go through the accreditation process by March 2019. Other clinical areas, such as theatres, community, maternity and ED are developing their tools for 2019, and will include safeguarding adults and children as standard.
3.6	**Additional Audits** A monthly audit takes place in the clinical areas, undertaken by the matrons and was launched in August 2018. Our aim is to reach to above 90% and reset our target. The questions asked are:

	1. *Have all the patients that you suspect to have an impairment of the mind or brain had a mental capacity assessment around the question of discharge?* Overall compliance to date is 85% 2. *Have all the patients that you suspect to have an impairment of the mind or brain had a mental capacity assessment around any aspect of medical treatment?* Overall compliance to date is 84% 3. *Have all the patients that you suspect to have an impairment of the mind or brain had a mental capacity assessment around the question of consenting to stay in the care environment?* Overall compliance to date is 88%
3.7	**Security and responding well to people likely to be disturbed in their behaviour.**
	Concern around responding well to people likely to be disturbed in their behaviour was heightened in June 2018 following incidents which included the security team and restraint. A focus was placed on the work being undertaken, not only in responding to those particular concerns, but in ensuring we maintained the focus of the safeguarding team on raising awareness. The Trust received from a letter from the CQC, written under Section 64/65 of the Health and Social Care Act outlining their concerns in relation to safeguarding, restraint and security. An action plan has been completed to address the required improvements. The action plan is reviewed and monitored through the Safeguarding Group to the Quality Committee. Actions include: • A weekly review of all security incidents by a panel of both security and safeguarding leads with a reporting process and action log of outcomes to the Safety Summit on a weekly basis, to achieve the effective review, learning and changes in practice. • Urgent training of all security staff in mental health awareness and ensuring that national security standards are met both in practice and training. • Establishment of pre and post guidelines for all staff when calling for assistance from security • A review of the use of agency security staffing in 'bed watching' and adoption of best practice in relation to using healthcare support workers • The development of a 'safe holding' training programme that is to be launched at the end of January 2019 for all clinical and security staff with emphasis on de-escalation techniques and non-violent resilience (NVR). • Joint working with Business groups in learning from incidents with the Safeguarding team working directly with practitioners in de-escalating incidents and leading on intervention in clinical areas. The interim chief executive requested an external review be undertaken specifically focusing on operational oversight of multiple incidents. The terms of reference for this review, which commenced on 24 December 2018 are: • In the context of individual incidents that were potentially connected, how was oversight of the operational and HR issues maintained. • Recommend any amendments or additions required to existing policies and procedures to ensure sufficient oversight. The review is expected to complete during February 2019 and will provide an additional layer of assurance that systems and processes in place are fit for purpose.

3.8	**Patients Detained under the Mental Health Act: Governance and Monitoring**
	Since June 2018, the Trust has had 22 cases of application of the Act or patients detained and transferred to our services. In all cases the appropriate actions were followed. 'Receipt of recommendations' was completed and copies of the section papers retained in the repository in the safeguarding department, demonstrating compliance with the Act.
3.9	**Reasonable Adjustments for people with a diagnosis of learning disability**
	All known Stockport patients who have a learning disability have an alert set on Advantis. Patient data provided by Stockport GP's, Learning Disability registers or Continuing Healthcare (CHC) funded care registers, has enabled the trust to add the alert against patients. This alert generates automatic IT server notifications of all patients admitted with a learning disability where this is known. The Trust has introduced the following clinical guidelines, demonstrating assurance and compliance with national standards: • Out of area patients have an alert added to Advantis on confirmation of a learning disability diagnosis (the alert is added manually). • We liaise with the community LD teams for all admissions, to ensure effective partnership working in meeting the complex needs of patients. • A daily Advantis ward alerts email is sent to the Business Group Associate Nurse Directors. This provides a current position on learning disability in-patients within their business groups to enable the matrons to support their teams. • With support of the Safeguarding team the wards are empowered to: o *Place the Blue Butterfly symbol above the patients bed* o *There is a visual symbol on ward whiteboards and ED whiteboard of a Blue Butterfly – this denotes the person has a learning disability.* o *Check that the patient has their Hospital Passport* o *Complete the reasonable adjustment care plan using information in the passport and from the patient / family / carers* o *Share 'my carers passport' with NOK / carer* o *Follow the principles in the MCA – presume capacity unless there is a reason to doubt* o *Complete MCA assessment – are they able to consent for being here for care and treatment , do they meet the "acid test " for DoLS* o *Consider DoLs application following the MCA* o *Ensure that their documentation aligns with the care plan and reflects any reasonable adjustment* o *Family/cares/NOK are actively encouraged to be part of the care delivery* o *Consider the need for IMCA (independent mental Capacity Advocate* • Patients are reviewed daily by the Adult Safeguarding Team Following a well-received training session on the care of patients with learning disabilities a programme of training has been launched. The dates run from Jan-March 2019 and will be facilitated by the Specialist Community Learning Disability Nurse.
3.10	**Compliance with Learning Disabilities Mortality Review (LeDeR) programme**
	The LeDeR programme, commissioned by NHS England, is in place to support local areas in England to review the deaths of people with a learning disability in order to Identify common themes and learning points and to provide support to local areas in the development of action plans to take forward the lessons learned. The Trust has reported seven cases to the programme since April 2017. The Organisation is

	compliant with national criteria and has two registered assessors within the Safeguarding Team. The CQC, in their September unannounced visit found the following: • All cases had been referred for a learning from death review, although this was not always immediately evident from the records. • All patients had had a LeDeR referral. However, five out of six records did not clearly evidence this. In one case, where the referral was evident, it did not outline the nature of the person's learning disabilities • All patients had a 'hospital passport' or other key information. However, this information was not readily available within files. • Whilst five of six patients had a reasonable adjustments care plan, care documented in records did not reflect the adjustments made. • All patients had do not attempt cardio-pulmonary resuscitation (DNACPR) orders in place, but these were not consistently completed • There was a lack of evidence that capacity assessments had been completed in reference to care and treatment decisions. This included three occasions where Deprivation of Liberty Safeguards were in place The CQC escalated their concerns at the time of the well-led inspection and sought immediate assurance regarding patient safety, which the Chief Nurse was able to provide. The Trust explained to the CQC that, at the time, there were four patients in hospital with learning disabilities, and an immediate review of all these patients was undertaken. Three patients required minor amendments to their care plans and the fourth had more significant adjustments. The Safeguarding Team undertook an immediate and full review of the seven cases and put in place an action plan which has progressed.
3.9	**Memorandum of Understanding with Pennine Care NHS Foundation Trust (Core 24)**
	In order to comply with the 2017 national enquiry 'Treat as One' which focused on addressing the needs of people with mental ill health in a general hospital setting, the Trust has led a task and finish group with Pennine Care NHS Foundation Trust to establish a Memorandum of Understanding (MoU) in the delivery of Core 24. Core 24 is the Pennine Care service provision of Liaison Psychiatry for all age groups which includes intervention for people likely to self-harm where emphasis is placed on shared care and improved guidance and liaison. Additionally, targets have been agreed to improve patient experience, appropriate assessment and intervention under shared care protocols, this supports the need to enhance current working relationships (including those with the police and the Ambulance services). Priority areas identified: • Revision of the care pathway for people detained under the mental health act. • Development and enhancement of the community pathway for patients placed under section 136 to be transferred when there is no medical emergency to mental health providers' assessment provision. • Review of Crisis concordat – mental health street and care triage (Police and mental health provision) • 72 hours assessment of any patient detained under the act by Core 24. • Effective liaison and assessment of patients requiring medical review in mental health services setting on site. • Rapid Assessment Interface and Discharge (RAID) provision across all clinical areas

	• Improved working with the Multi-Agency Safeguarding and Support Hub **(**MASSH**)** provision and development of pathway model under care in the community • Working with Multi-agency partners in reviewing Multi Agency Risk Assessment Conference (MARAC) and the required 'working together' in line with the Stockport Domestic Abuse Policy. It is important to note that the work described above has been driven by the Trust Safeguarding Advisor with his expertise being key to changes in development.
4.0	**REVISED SAFEGUARDING STRUCTURE**
	It is proposed to develop the current structure so that the Safeguarding Team becomes a modern flexible resource to the Trust. The proposal, which is due to be received by the Executive Management Group in late January, describes the structure required to ensure proactive and responsive working in four key ways (to be fully operational by April 2019 if agreed) • Integrated clinical safeguarding champions in each clinical area underpinned by Specialist safeguarding practitioners and the Named Nurse via a virtual team structure working within the Business groups. • A robust direct safeguarding advisory and consultancy role • Integration and close working with specialist areas of practice including Independent Domestic Violence Advisor (IDVA) MARAC ,Dementia care, MASSH and a DoLS Gatekeeper • Continuous training and development of safeguarding knowledge and application into practice
4.1	**Safeguarding Leadership**
	Currently the Trust has employed a Safeguarding Advisor on an interim basis. The post-holder has provided the Trust with a much needed senior level of safeguarding expertise. The Safeguarding Advisor has been in post since August 2018 and has provided seniority in key areas of leadership, supervision, consultative advice and service development. He has provided clarity of what is required of a flexible safeguarding team in the modern NHS. The interim post was agreed with the Interim Chief Executive to be an essential way of developing safeguarding at the Trust. The Trust was also supported by NHS Improvement in this interim role. Working alongside the named and designate nurse and doctor roles there is evidence of partnership working at multi agency platforms. The post-holder reports to the Deputy Chief Nurse, and is professionally responsible to the executive safeguarding lead, the Chief Nurse. The Medical Director and Chief Nurse work closely together in ensuring delivery of improvements for our vulnerable patients. As part of the Building Blocks work described above, the clinical director's forum in July and August, the Medical Director and the Chief Nurse delivered a series of 7 minute briefings to the consultants who are identified as leads in their specialty area.
5.0	**BENCHMARKING WITH OTHER TRUSTS**
	In October 2018, the safeguarding team visited Salford Royal NHS Foundation Trust. The visit provided assurance team that the work the adult safeguarding team are undertaking to make improvements is appropriate. Salford Royal NHSFT discussed the benefits that the EPR system has brought to their Trust and we are exploring how those benefits can currently be utilised within the Safeguarding team and across the wider organisation in the streamlining of forms, documents and

	templates. The Trust has adopted the NHS England Safeguarding Application, which has been added to the Trust Applications site and following support of our communications team, is accessible to all staff is the trust intranet. Whilst we cannot provide information as to the number of 'hits' to this app, we are anecdotally informed that it is in use and that the teams find it useful.
6.0	**RISK & ASSURANCE**
6.1	The Trust has improved reporting through its safeguarding structure through the Quality Governance Framework, from operational groups through to an executive led group reporting to a sub-committee of the Trust Board through appropriate leadership. The Trust is well supported by the Clinical Commissioning Group and the Local Authority Safeguarding Adults Board in adult safeguarding work. As described in this report, developments have happened at pace; there were a number of platforms from which to do this: • Recognition of the position that adult safeguarding had prior to 2018 within the Trust by new leadership team, and a subsequent change in culture • Findings from the CQC reports of 2017 and 2018 • Areas within the GM Assurance Framework failing to provide the assurance required • CQC Section 64/65 letter following concerns raised by a whistleblower. • Increasing system complexities relating to patients presenting with physical and mental health problems. The new infrastructure has been able to provide assurance through the use of the ACE programme in conjunction with using survey monkeys, audits and self-assessment tolls such as the GM Assessment and Assurance Framework. However, it is recognised that there is more to do to provide further assurance.
6.2	Whilst there has been significant progress since April 2018 and a level of assurance provided, this paper offers an understanding of where further improvements are required. It also describes the need to develop the service and current practice and understanding across the business groups. Emphasis has to be placed on the required developments: • Progressing the proposal to change the Safeguarding Structure • Consistently delivering safe personalised care • Addressing the needs of the vulnerable group where there is evidence of specific complex multiple diagnosis that require shared care; people with learning disability or mental ill health • Training and educating staff in the application of safeguarding procedures governed by national legislation • Policies and procedures based on national guidance
7.	**RECOMMENDATIONS**
7.1	The Board of Directors is recommended to: • Note the assurance the report provides relating to the significant developments since April 2018 in adult safeguarding across the Trust • Significant work that the Safeguarding Team has undertaken • Support the areas identified for further development and priority areas for training.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Learning from Deaths		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR ASSURANCE

Corporate objective ref:	S04, C9, C10
Board Assurance Framework ref:	n/a
CQC Registration Standards ref:	13, 17, 20
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

Regular Board updates are mandated by the national 'learning from deaths' program.

This report offers our agreed bi-annual update on progress against the National Quality Board standards on 'learning from deaths'.

This report was previously reviewed by the Quality Committee on 22 January 2019.

The Board is advised to be assured of progress against this national agenda.

Attachments:

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 This paper summarises progress against national standards for 'learning from deaths' (LFD).

Based upon the national guidance, our LFD policy recommends that the board;

- Understand the (LFD) process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.
- Champion and support learning and quality improvement
- Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges,

Following previous board discussion, it was agreed that the Quality committee would review this topic quarterly, and that a bi-annual summary paper would be included in our public board meetings.

Reports are submitted to the quality governance group and quality committee four times per year (Jan, April, July, Oct). Two reports per year being presented to the Board of Directors (Jan, July).

2. BACKGROUND

2.1 In March 2017, the National Guidance on learning from deaths (LFD) was published. The key requirements for *Learning from Deaths* to be effective were defined, including:

1. Clinical governance structures and processes should be in place to ensure that appropriate reporting, review and investigation of patient deaths occurs, particularly those deaths where problems in clinical care may have caused or contributed to death.

2. Structures and processes should also be in place to ensure that relevant lessons are learned by identification of deaths, reporting, investigation and sharing of the conclusions /recommendations so that lessons are acted upon.

3. Particular deaths that should always be reviewed, including as a minimum:
    a. All deaths where bereaved families, carers or staff have raised significant concerns about the quality of care.
    b. All deaths in patients with learning disabilities or severe mental illness.
    c. All deaths in a patient group (eg a particular diagnosis or treatment) where an "alarm" has been previously raised by the Trust.
    d. All deaths where patients are not normally expected to die, eg elective surgery.
    e. A random sample of other deaths.

4. There should be a clear policy of engagement with bereaved families.

3. CURRENT SITUATION

3.1 Mortality review group

The mortality review group continues to meet on a bimonthly basis to oversee the establishment of this process. It is chaired by the Medical Director. The Mortality review group submits a Key Issues Report to the Quality Governance Committee.

3.2 Clinical Governance and the LFD policy.

Our policy is published on our trust internet site and is managed by the Mortality review group. LFD reviews grade the clinical care evident in the case notes using a 1-4 scale.

Outcome 1 Evidence of **serious failings** in clinical management.

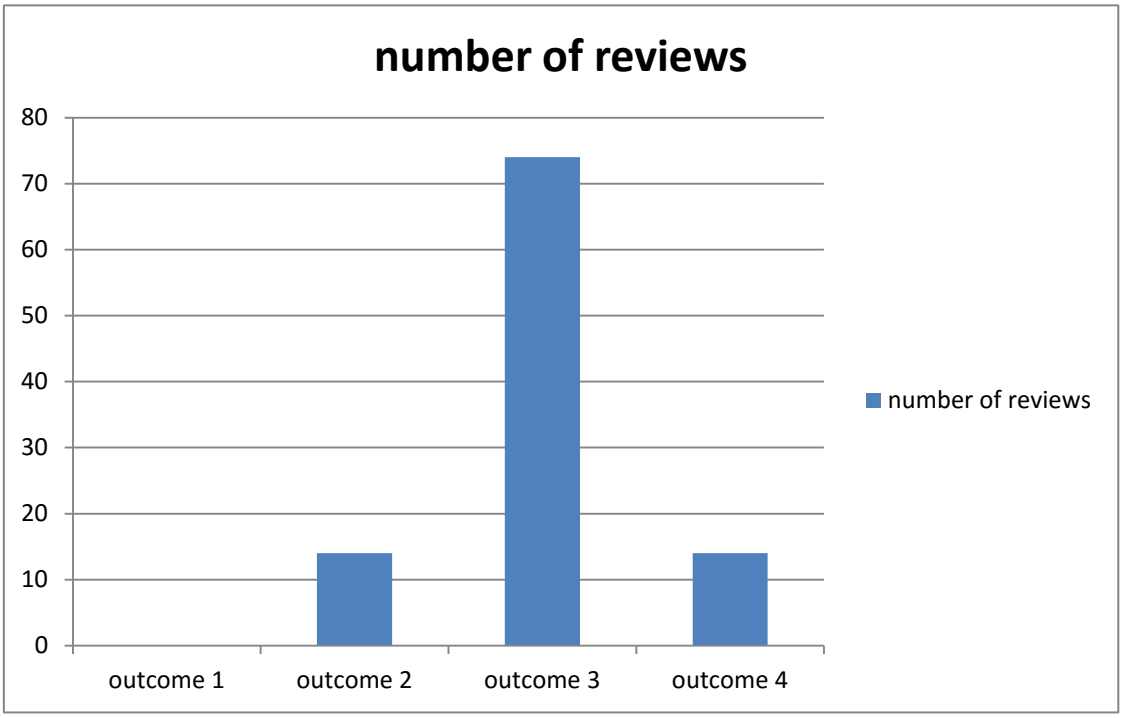
Outcome 2 Evidence of **suboptimal management**.

Outcome 3 Patient was generally managed to a **satisfactory** level.

Outcome 4 Evidence of **exemplar clinical management**.

This quarter, several cases have been referred for a second opinion from the LFD lead, but no cases have been graded as outcome 1.

Where cases are graded outcome 2 or outcome 4, they are referred to the relevant directorates for formal peer review in the morbidity and mortality (M&M) meetings. The graph shown below summarises the outcome conclusions for the past quarter of data.



3.3 Morbidity and Mortality (M&M) meetings.

To facilitate discussion of all outcome 2 (suboptimal) and outcome 4 (exemplar) cases, patient facing clinical teams are mandated to meet regularly to discuss and learn from these cases.

Agreed some minimum standards for these meetings;

- Be held at least quarterly
- Have a documented attendance register
- Document action points or minutes.

All major patient facing specialties are expected to meet these standards. Establishment of M&M meetings is a fundamental requirement of the LFD process but also facilitates an opportunity for learning from all adverse incidents Minutes or action notes are to be retained on the trust shared drive for future reference..

Integrated care
ED
Acute Medicine
Surgery
Anaesthesia
Obstetric anaesthesia
Endoscopy
ENT
Gastroenterology
ICU
Trauma and orthopaedics
Urology
General Surgery
Specialty Medicine
Cardiology
Endocrine
Ophthalmology
Respiratory
Stroke
Elderly care
Haematology
Womens and Childrens
Breast
Obstetrics and Gynaecology
Paediatrics.

Results for Jan 2018
Standard: M&M documentation submitted to the shared drive for the third quarter

In response to these results, the January Quality Governance Group meeting has requested a 'deep dive' into learning from deaths and adverse incidents in ophthalmology and respiratory medicine. This will be presented to the February Quality Governance Group meeting, and a summary shared with the Quality committee.

Learning from deaths newsletter.

3.4

The primary goal of the 'learning from deaths' process is to facilitate learning and assist with improving the care of future patients. In addition to discussion at departmental M&M meetings, a summary of pertinent cases is shared in a quarterly 'learning from deaths' newsletter. The December newsletter was shared with the Quality Committee.

In addition to the oversight newsletter, each business group produces a separate newsletter relating to cases pertinent to their clinical practice;

- Medicine
- Surgery
- ICU
- ED

Key themes raised in this quarters report were;

- **Sepsis - query cause is an unsatisfactory diagnosis**. If other common causes of sepsis have been reasonably excluded (chest, urinary tract, soft tissue/joints etc) consideration should be given to a possible abdominal/pelvic cause, acknowledging that symptoms/clinical signs suggestive of such may not be evident, particularly in elderly and confused patients. This may require an early CT scan to confirm/refute the diagnosis. Once severe sepsis secondary to an intra-abdominal catastrophe develops a few days later the prognosis is very much poorer.

- **Opportunities for palliation and a "good death" should not be unduly delayed,** recognising that this can be a difficult decision (to accept failure of medical intervention, to acknowledge the patient is dying and to switch from active to passive clinical management). This always requires senior decision-making and involvement of patients and their families.

- **High EWS scores must be actioned by appropriate timely medical review and involvement of a consultant,** as per Trust guidelines, to consider the direction of further clinical management – active (escalation to critical care) versus intermediate (ward-based ceiling of care) versus passive (palliation). It is appropriate to consider DNACPR status for all three of these directions.

3.5 **Addressing concerns raised in LFD reviews.**

The role of the LFD reviewers is to identify areas of concern, and opportunities for learning. It is not their role to address or correct all issues identified. Enacting change in response to LFD findings is managed by;

Cases graded as outcome 1, 'serious failings' in clinical management, are escalated to a serious incident review. Any required actions are managed through this process.

Cases graded as outcome 2, evidence of suboptimal management, are reviewed at directorate level in their M&M meeting, and actions put in place through that process.

Additional learning is gained from an oversight of consistent themes from the LFD reviews. These themes are pulled out in the quarterly newsletter. This newsletter is presented to the quality governance group for review.

To assist the quality committee and board of directors in gaining assurance that the themes arising in the LFD newsletters are addressed, a new 'deteriorating patient group' has been established. This group will be chaired by the Medical Director, supported by the Chief Nurse, with representation from Critical Care, Acute Medicine, Medicine and supported by our Governance Team. The group will review the quarterly LFD data, and ensure that appropriate actions are agreed, and specific projects initiated as required.

3.6 **Using LFD reviews to investigate areas of excess mortality**

The CQC raised concerns relating to excess deaths coded as resulting from 'acute or unspecified renal failure'. Our LFD process was used to investigate 30 of the 31 patients that had died in one year with this diagnosis recorded as the cause of their illness. This comprehensive review reached the following conclusions;

- In no case was acute renal failure found to be the primary cause of death. It was an associated marker of global systemic dysfunction or secondary to dehydration from poor oral intake during concurrent severe illness.

- A significant majority of the patients coded as dying from acute and unspecified renal failure were found to be approaching end of life due to other causes. A significant number were receiving palliative care, but were not coded as such.

- In all cases that might have been considered appropriate for escalation to critical care, this did occur. 3 of the 6 patients who may have been considered for ICU were admitted. A further two were appropriately reviewed and considered not appropriate for escalation. One last patient died after an unexpected and unheralded cardiac arrest, so not offering the opportunity for escalation.

- Stockport has an elderly population, and a disproportionate number of in hospital deaths.

- Treatment of Acute Kidney Injury has been a subject of considerable local focus.

This method of undertaking a 'deep dive' into a highlighted area of potential 'excess mortality' offered robust intelligence relating to the care that these patients received, and considerable assurance that this did not represent an area of low standards of care.

3.7 **Family involvement**

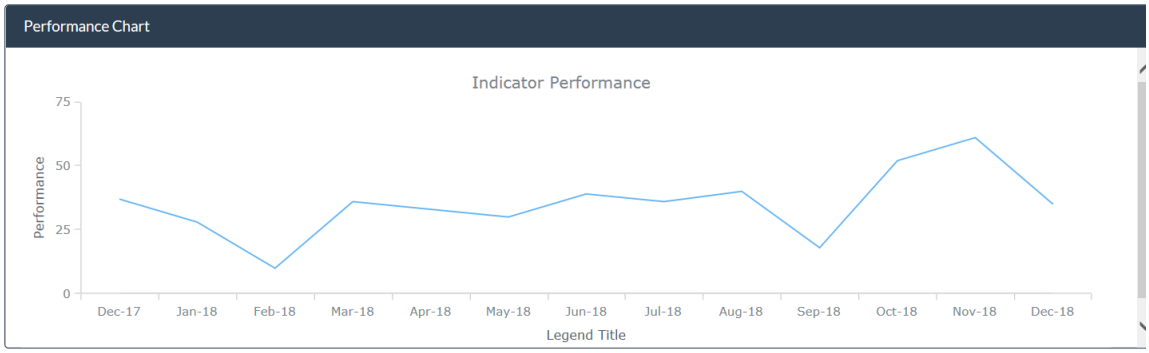
Improved family involvement will be one of our key goals over the coming year. A standard format letter is now given to all bereaved families, offering bereavement support, and inviting them to submit any feedback relating to the death of their relatives. Any feedback containing significant concerns about quality of care triggers an LFD review. This process is still under initial pilot, and likely to require further work. The feedback gained with a successful process will be extremely powerful in assisting how we shape future service provision.

3.8 **Involvement of the wider clinical teams.**

We have established the LFD process largely using consultant reviewers. Over the coming year we plan to augment this by establishing senior nursing LFD reviews. Our Chief Nurse and Medical Director have both committed to undertaking regular LFD reviews.

3.9 **Board oversight**

The board of directors receive a monthly update at our public board meeting, relating to the numbers of LFD reviews undertaken. We have set a goal of undertaking a review of 30% of all in patient deaths. We have approximately 110 deaths per month, so aim for 33 LFD reviews each month.



Performance Data Table

Indicator Name	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality: Case Note Reviews	2017/18									37	28	10	36
Mortality: Case Note Reviews	2018/19	33	30	39	36	40	18	52	61	35			

A significant peak of reviews over October and November represented the 30 additional reviews undertaken as part of the review into the 'acute and unspecified renal failure' mortality alert.

4. RISK & ASSURANCE

4.1 The transparent review of our own care will improve patient care. Identification of unrecognised failings in patient care is the key goal of this process. In combination with our duty of candour obligations, this may result in litigation or complaints. This risk is easily justified, by the benefits to future care offered by this process.

5. CONCLUSION

5.1 Progress establishing the LFD process is maintained.

6. RECOMMENDATIONS

6.1 This report is provided for information, and recommends that the Board of Directors be assured that progress against the national standards is being made.

NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Medium Term Financial Strategy		
Report of:	Director of Finance	**Prepared by:**	Director of Finance

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** Following discussion at the Board of Directors in November 2018 regarding the associated delivery plan of the Medium Term Financial Strategy, this report proposes the governance and monitoring arrangement for 2019/20 and beyond.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:

This subject has previously been reported to:

- ☐ Board of Directors
- ☐ Council of Governors
- ☐ Audit Committee
- ☐ Executive Team
- ☐ Quality Committee
- ☐ 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 Medium Term Financial Strategy (MTFS) was presented to the Board of Directors in November 2018, that illustrated the five key opportunities and objectives that the Trust needs to purse to deliver sustainability over the next five years. At the meeting, Directors requested the associated delivery mechanism to review and monitor progress against each of the five objectives.

1.2 Since presenting the MTFS, there has been a significant change to the financial framework for NHS Providers for 2019/20, which will be presented through the Draft Operational Plan and has a significant change to the five year plan. NHSI will be providing support over the coming weeks to review the extent and depth of the Trust's approach to achieve medium term financial sustainability. Recommendations from this review may alter the proposed governance and monitoring arrangements.

2. BACKGROUND

2.1 The Medium Term Financial Strategy described five key objectives and opportunities to deliver medium term financial sustainability:

1. Significantly reduce workforce costs and reliance upon non-substantive staff;
2. Drive all available opportunities in Model Hospital, CHKS and Reference Costs
3. Deliver the Stockport Together Benefits
4. Increase income opportunities through repatriation of planned day case and elective activities, increase births and contract discussion
5. Exploit opportunities arising from Greater Manchester development and / or neighbouring Trusts

2.2 This report summarises the governance and monitoring arrangements for 2019/20.

3. MONITORING ARRANGEMENTS

3.1 The five key objectives can be grouped into three major programmes:

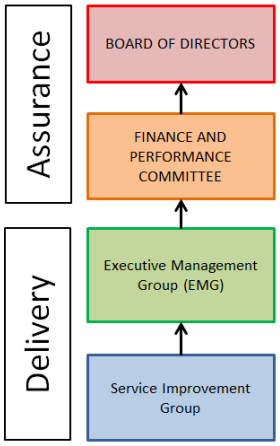
1. The Clinical Services Efficiency Programme;
2. Stockport Together;
3. Partnerships and Federation.

The Clinical Services Efficiency Programme

3.2 As presented to the Finance and Performance Committee and the Board of Directors, the Clinical Services Efficiency Programme (CSEP) brings together clinical and operational management teams to review all aspects of performance, workforce and efficiency benchmarks for each specialty and Business Group. Using the AQUA Quality Improvement methodology, the CSEP will be implementing a number of projects to deliver efficiency across all services in the Trust.

3.3 The Trust's 2019/20 Operational Plan and medium term sustainability requires the CSEP to develop and deliver objectives 1, 2 and 4 and continue to be reported and monitored through the Finance and Performance Committee. Some aspects of the workforce objectives may also need to be reported to the People Performance Committee.

3.4 The diagram below illustrates the governance arrangements for CSEP.

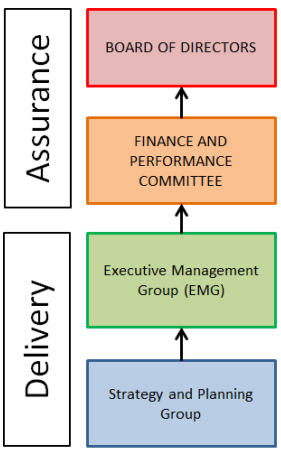


Stockport Together

3.5 Due to the ongoing dialogue across the Health Economy with regarding to the governance arrangements for Stockport Together, proposed monitoring arrangements have not been able to be formalised. It is expected however, that the financial framework for 2019/20 that will form part of the Trust's Operational Plan will be presented to the Finance and Performance Committee.

Partnerships and Federation

3.6 This programme brings together all aspects of developments with other providers in Greater Manchester and East Cheshire. The Director of Strategy, Planning and Partnerships chairs the bi-monthly Strategy and Planning Group where key developments are reported. Key issues and decisions are reviewed by the Executive Management Group. Financial and performance implications are reported through the Finance and Performance Committee.



4. RISK & ASSURANCE

4.1 The Trust is embarking on a considerable sustainability programme. In order for the Trust to meet the plans, it is crucial and engagement occurs at all levels in the Trust specifically clinical engagement on the Trust's Strategy.

4.2 The Trust has resources for strategy, planning and transformation however, the key risk is the capacity of the clinical and operational management teams to plan, develop and deliver the objectives.

4.3 These risks will be actively managed and monitored by the Executive Team

5. RECOMMENDATIONS

6.1 The Board of Directors is asked to note the contents of the report. An updated MTFS will be presented to the Board of Directors following the update to the 2019/20 Operational plan and the review by NHSI.

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NHS
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Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Corporate Trustee Approval of the Charitable Funds Annual Accounts and Report 2017-2018		
Report of:	Director of Finance	**Prepared by:**	Lisa Byers, Chief Financial Accountant

REPORT FOR APPROVAL

Corporate objective ref:		**Summary of Report** This paper presents the Board of Directors, sitting as the Corporate Trustee, the Charitable Funds Annual Accounts and Report for 2017-2018 together with the Deloitte external audit opinion for approval.
Board Assurance Framework ref:		
CQC Registration Standards ref:		
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	Charitable Funds Annual Accounts and Report 2017-2018 , Deloitte External Audit Report 2017-2018 and Letter of Representation.

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

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1. INTRODUCTION

1.1 The financial statements for Stockport NHS Charitable Funds in 2017-2018 are prepared under FRS 102 effective from January 2016 and the Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2015), the Charities Act 2011 and the Charities (Accounts and Reports) Regulations 2008.

1.2 Sitting as the Corporate Trustee of the Charity, the Board of Directors are required to approve the Charitable Funds Accounts and Annual Report for submission to the Charity Commission on the 31st January 2019.

1.3 The external auditor, Deloitte, have issued the ISA 260 report on the 2017-2018 Accounts. This report is attached along with the Accounts and Annual Report, the Statement of Trustee Responsibilities and the Letter of Representation.

2. Background

2.1 In 2017-2018 the Charity has net income of £253,000 having spent significantly less in 2017-2018 than in the previous financial year (2016-2017 net expenditure of £436,000). The Charity received income of £320,000 from donations, legacies, fundraising and investment income (2016-2017: £438,000). Expenditure of £89,000 in 2017-2018 (2016-2017: £1,057,000) was largely spent on smaller items to benefit patient and staff welfare. In comparison in 2016-2017 the Charity utilised £936,000 of the Evelyn Wood legacy to purchase theatre capital equipment.

2.2 The Charitable Funds Accounts are split between unrestricted, restricted and endowment funds. The Charity currently has one unrestricted fund of £272,000, one small endowment fund of £10,000 with the remaining funds of £1,677,000 restricted based on the wishes of the donor. These funds are organised into fifteen smaller restricted subsidiary funds under the one Charity Commission registration.

2.3 The external audit opinion has now been issued with an unqualified audit opinion on the financial statements. There are no adjustments requested in the financial results and presentational and disclosure amendments have been updated where agreed.

3. Recommendation

3.1 The Board of Directors, as Corporate Trustee, is asked to approve the Charitable Funds Annual Accounts and Report for 2017-2018. The Trustee is also asked to sign the Statement of Trustee Responsibilities, the Balance Sheet and Letter of Representation on the Accounts to the external auditor, Deloitte. The Accounts and Report will be submitted to the Charity Commission by the 31st January 2019 in accordance with the Charity's statutory duties.

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Stockport NHS Foundation Trust
General Fund

Annual Report & Financial Statements 2017- 2018

Stockport NHS Foundation Trust General Fund
Charity Commission Registration number 1048661

Contents **Page**

Stockport NHS Foundation Trust General Fund
Annual Report & Accounts 2017-18
Charity Commission Registration Number: 1048661

Who we are

Welcome to our annual report for 2017-18. Stockport NHS Foundation Trust General Fund is a public benefit entity and registered charity with the Charity Commission under the registration number 1048661. It has as its Corporate Trustee Stockport NHS Foundation Trust (SNHSFT). We work for the benefit of NHS patients and their families from Stockport and the surrounding area. The Charity is an umbrella charity, split between an unrestricted fund and 15 restricted funds.

What we aim to do: our objectives and activities for the public benefit

The objectives of the charity, as laid out in its governing document, are:

- To provide funds for any charitable purpose, or purposes relating to the National Health Service;
- For the relief of sickness by promoting the efficient performance of their duties by staff;
- For the relief of patients treated by Stockport NHS Foundation Trust;
- For any other charitable purpose which will further the aim of advancing scientific, or medical research; and
- To support staff training, development and improvement of staff welfare.

We exist to raise funds and receive donations for the benefit of patients and staff at Stockport NHS Foundation Trust. With careful management of existing funds and the receipt of new donations and legacies the Charity provides a public benefit by making grants to Stockport NHS Foundation Trust.

Grants are made in accordance with charity law, our constitution as laid out in our governing document and the wishes and directions of donors. When considering where to focus the Charity's activities the Corporate Trustee Board and, particularly, the Charitable Funds Committee, have complied with the duty in Section 4 of the Charities Act 2011 to have due regard to the Charity Commission's guidance on public benefit.

What we have achieved in 2017-18: highlights from the activities undertaken in the year

Our key aim is to serve the NHS patients of the Trust, their visitors and staff for the public benefit. By funding services and equipment the Charity is able to help the Trust to provide care to its patients over and above that which it is funded by central government to provide. We help patients from throughout the local community and wider area irrespective of race, creed, ethnicity or personal or family circumstances. We put this into practice by helping patients, families, visitors and staff by:

- Enhancing the care the Trust can offer through new equipment and building improvements to deliver better facilities;
- Investment in the people who work at the Hospital to create a caring environment for the patients receiving care; and
- Providing direct support to patients by way of information, support and better facilities.

We do this through a whole range of activities funded by our generous supporters. Highlights from this programme are detailed below:

Patient Welfare Expenditure

Unrestricted charitable funds have been utilised throughout 2017-18 to purchase items for the benefit of the Trust's staff, patients and visitors. This includes:

- £1,604 on Christmas decorations, used to enhance the appearance of various departments across the site over the festive period;
- £3,040 on Christmas gifts for patients in Stepping Hill Hospital.

Medicine Funds

- £1,000 on information leaflets for patients and relatives from the Stroke Association. £1,600 from the Respiratory Care Fund on smaller revenue equipment items including two pulse oximeters for the Chest Clinic.

Critical Care Fund

A number of improvements have been made to the patient environment in the intensive care and high dependency unit:

- £1,000 on eight televisions for patient beds in the high dependency unit.
- £800 on mobile TV stands for televisions within the unit.
- £1,000 on the introduction of the Sound Ear noise system to the intensive care and high dependency units to promote a peaceful and quiet night time environment for patients.
- £200 for a guest bed.

Child and Family Funds – including:

Neonatal Fund

- £1,000 on the Neonatal Christmas party for relatives and staff on the unit during the Christmas period.
- £1,375 on the provision of cuski clinical nests for premature babies. These are designed to keep babies snug and enhance their sleep patterns and have been specifically designed for neonatal use within hospital units.
- £754 for seven meeting chairs and notice board to upgrade the staff working environment.

Maternity and Delivery Suite Fund

- £4,880 was spent purchasing seven new manual recliner chairs for the delivery suite rooms.
- £1,700 was spent on a cuddle cot and was purchased from monies donated by the Isabella Rose Foundation in memory of Isabella Rose Parr. The cuddle cot system assists parents in dealing with the loss of a baby by allowing parents to spend time with their baby following stillbirth or the loss of a baby at birth.
- £659 was used to supply new blinds to the Sandalwood Bereavement Suite.

Swanbourne Gardens/Children's Disabilities

The Swanbourne Gardens Children's Respite Care Unit has used funds to purchase vital equipment to the benefits of patients and staff:

- £5,900 on a manual hoist for use in the Jungle, Seaside and Space rooms
- £2,970 on a hydrotilt system
- £2,418 on a Airvo Optiflow Humidifier system

In addition donations are used to fund activities for the children throughout the year. In 2017-2018 this has included visits to sensory play and sea life centres, Lego Land and a children's animal farm.

Staff Education and Welfare Expenditure

Overall the Charity spent £27,976 on initiatives to support staff that work at the Trust. Ensuring staff are well trained and supported benefits the quality of care they provide. In addition to the essential training that the Trust provides as its duty as an employer the Charity adds extra amenities and supports additional training.

Education

The Charity spent £5,694 supporting staff on training courses across its restricted funds. This included £2,133 for staff from the Critical Care department, £800 for the Palliative Care team, £1,160 for Pharmacy staff and £974 for the community nursing team.

It also spent £918 on a training simulator for staff education on the Jasmine Suite.

Staff Welfare

Charitable funds were used to support staff and improve their working environment in the following areas:

Hospital General Fund

- £7,049 on retirement gifts to award staff for their long service.

Older People Fund

- The fund has spent £1,600 on upgrading a kitchen area within the department to improve the staff environment.

Haematology Fund

- 8 operator chairs for the department.

National Awards

The Charity funded tables at the Nursing Times, Patient Safety and HFMA Award events to recognise staff achievement and represent the Trust at a cost of £2,382.

Pharmacy Fund

- £1,595 on IT equipment for staff in the department.

Staff Amenities Fund

The Staff Amenities Fund receives donations from the Trust Staff Lottery to support staff welfare which is mainly spent on items for staff rest rooms and kitchens. In 2017-18 £6,308 was spent replacing white goods and purchasing armchairs.

How we funded our work - our achievements and performance

The following figures are taken from the audited 2017-18 financial statements for the year ended 31st March 2018 which carry an unqualified audit report. A full copy can be viewed on the Charity Commission's website or is available from the Finance Department, Aspen House, Stepping Hill Hospital, Hazel Grove, Stockport, Cheshire SK2 7JE. This part of the report comments on key features of these accounts.

The Charitable Fund can only continue to support the work of Stockport NHS Foundation Trust for as long as we receive the money needed. Almost all our income comes from the voluntary efforts of the public and staff and generous bequests.

Overall during 2017-18 the Charity received £320,000 (2016-2017: £438,000) income from donations, legacies, investment income and fundraising events. Expenditure over the same period amounted to £89,000 (2016-2017: £1,057,000).

Money Received – Sources of Funds

The total income received in year of £320,000 can be analysed as follows:

Donations: £84,000 (£282,000 in 2016-17) – The individual ward funds receive many donations specifically given to improve the hospital and ward environment for patients. These and other contributions are in recognition of the hard work and commitment from Stockport NHS Foundation Trust staff.

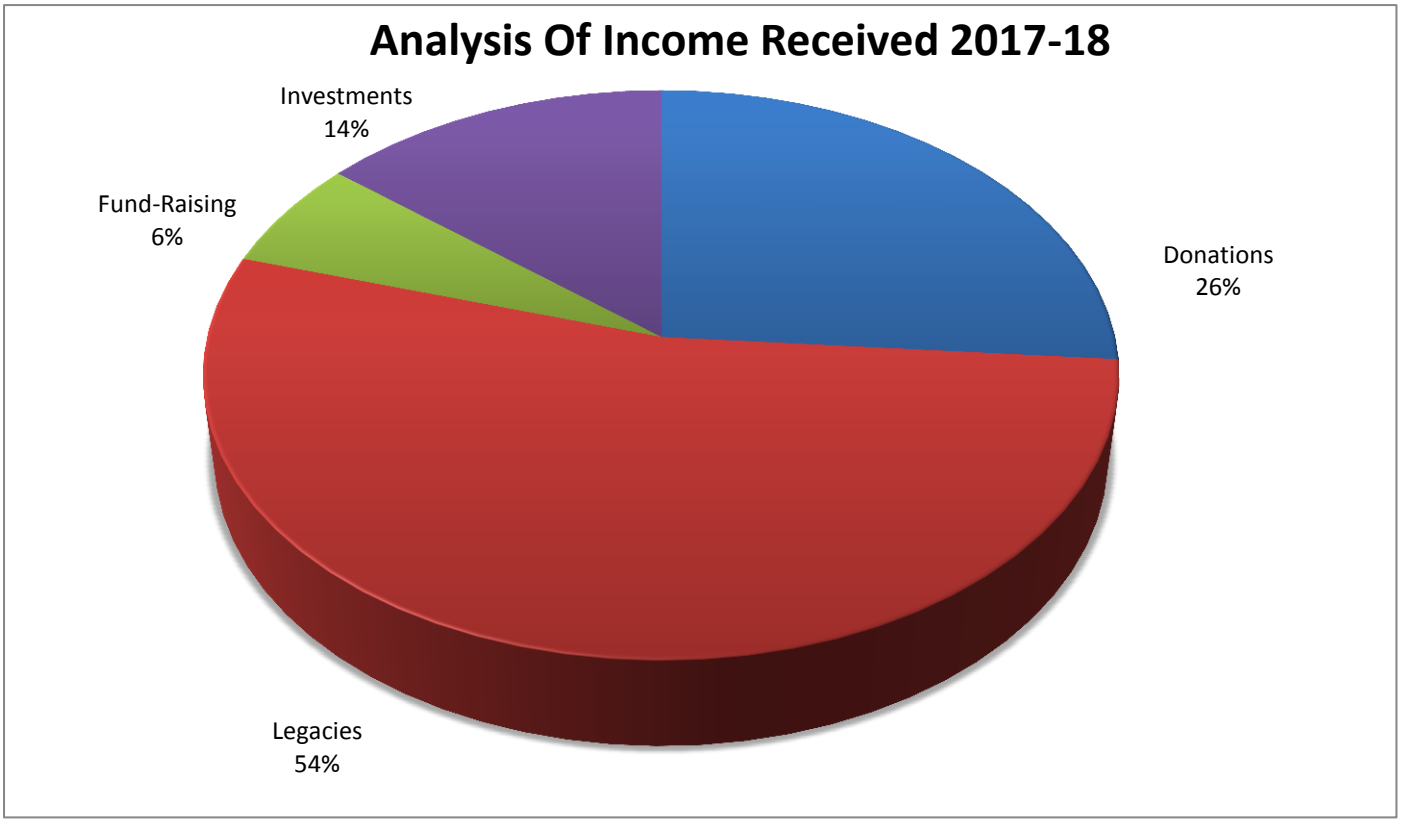
Legacies: £171,000 (£78,000 in 2016-2017) – The Charity is fortunate that patients or their relatives remember us in their will. During 2017-18 the Trust Charity has received £31,000 to its unrestricted General Fund and one legacy for £140,000 split equally between the Prostate Cancer Fund and Coronary Care.

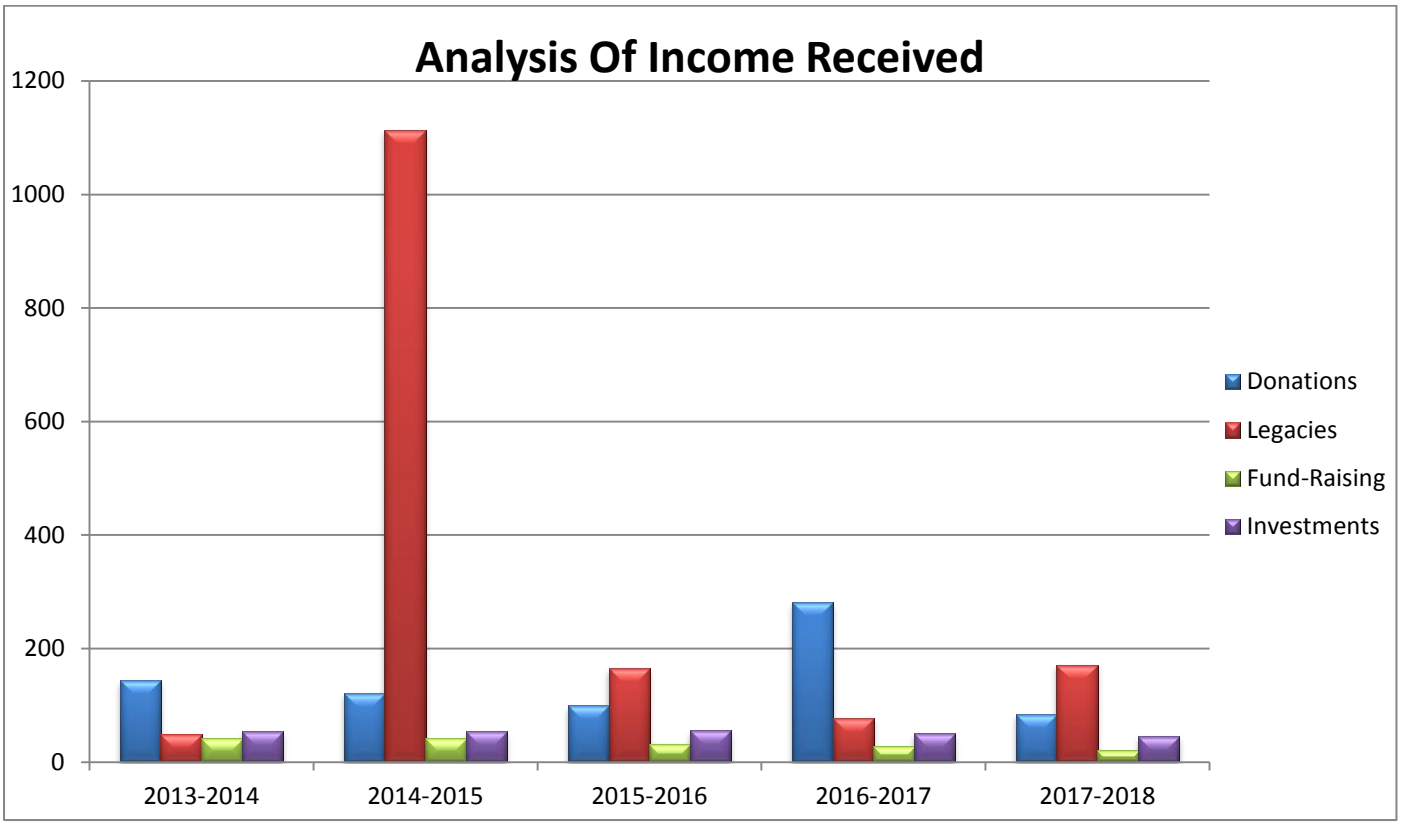
Charitable Activities: Fundraising: £20,000 (£28,000 in 2016-2017) – This income is generated by staff, patients and families fundraising on behalf of the Trust Charity. Many small events were undertaken by our supporters on a voluntary basis. The Charity does not employ professional fundraisers. In 2017-2018 fundraising has benefitted the Radiology department, cancer patients, a new appeal for an Endoscopy Scope Guide and improvements to Swanbourne Gardens Children's Respite unit.

In addition to the main sources of income outlined above, the Charity received investment income of £45,000 (£50,000 in 2016-2017), relating to the dividend earned during the financial year 2017-18. This dividend income is generated from prudently investing funds not needed for immediate use with CCLA Investment Management Ltd on behalf of the Charity.

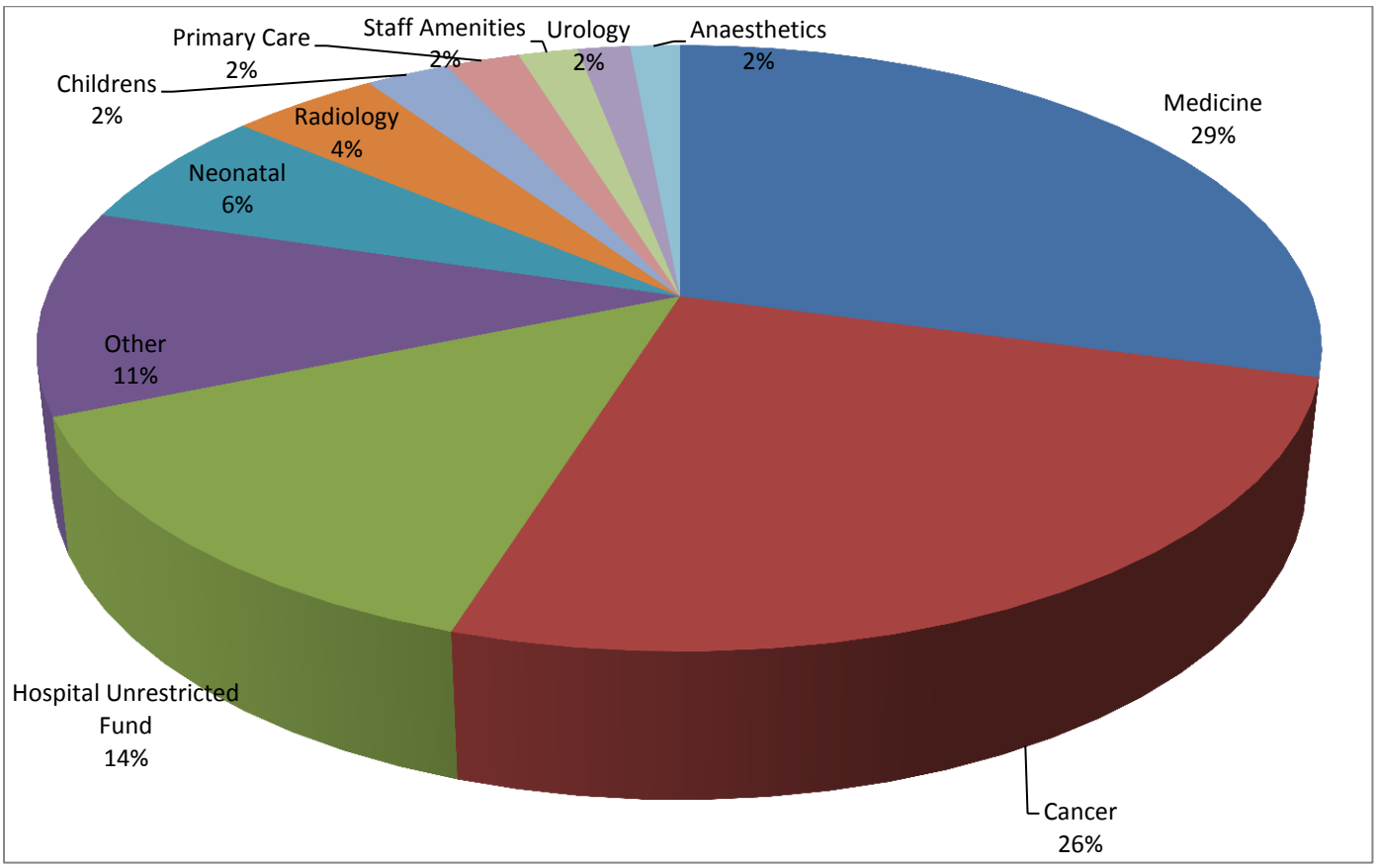
Analysis of Income Received

Overall income received during 2017-2018 fell by £118,000 to £320,000 (£438,000 in 2016-2017). This is predominantly due to the large donation made from the Stockport NHS Staff Supporters Lottery of £100,000 in 2016-2017.





Income by Fund



The above pie chart displays the donations, legacies and fundraising income received according to the restricted charitable fund area. It can be seen that the Hospital Unrestricted Fund, Cancer Fund and Medicine Funds account for

69% of incoming resources in 2017-2018 (48% in 2016-2017). The Coronary Care Fund within the Medicine Funds is 22% of the income received in year.

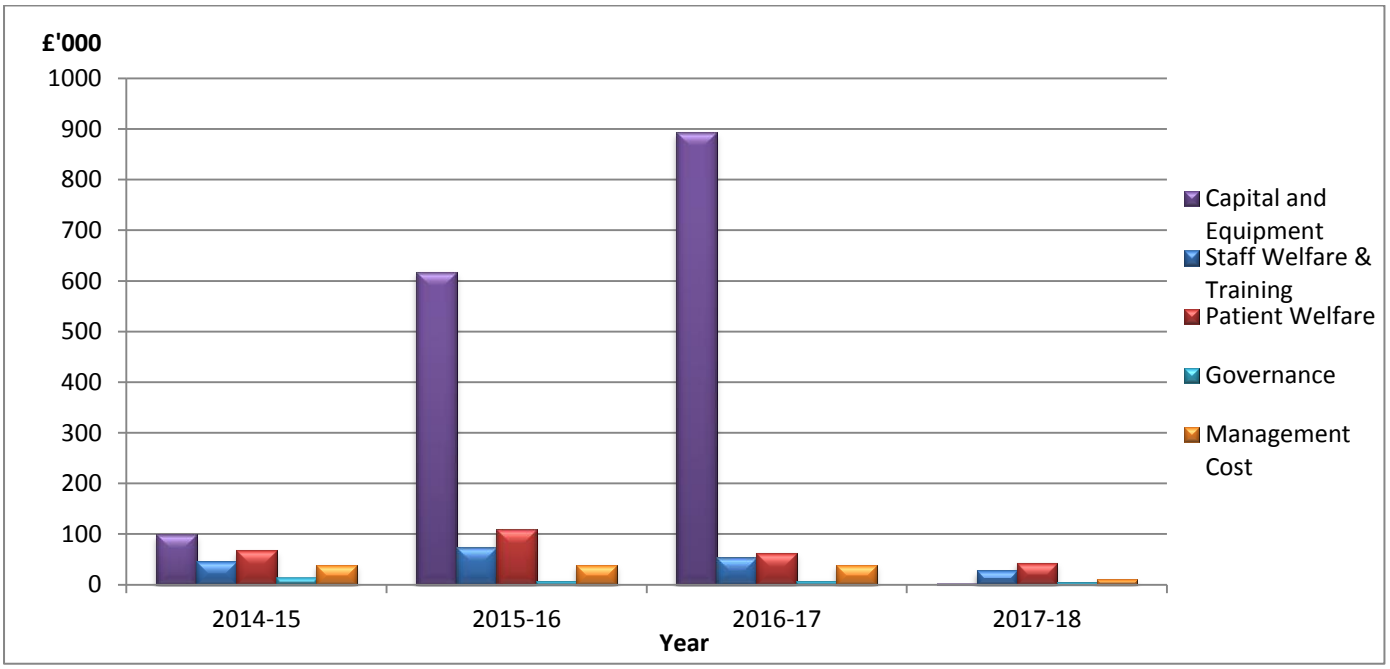
Areas with income described as 'Other' include smaller Surgery, Orthopaedic and Maternity Funds.

Expenditure

Total charitable expenditure in year decreased from £1,057,000 to £89,000.

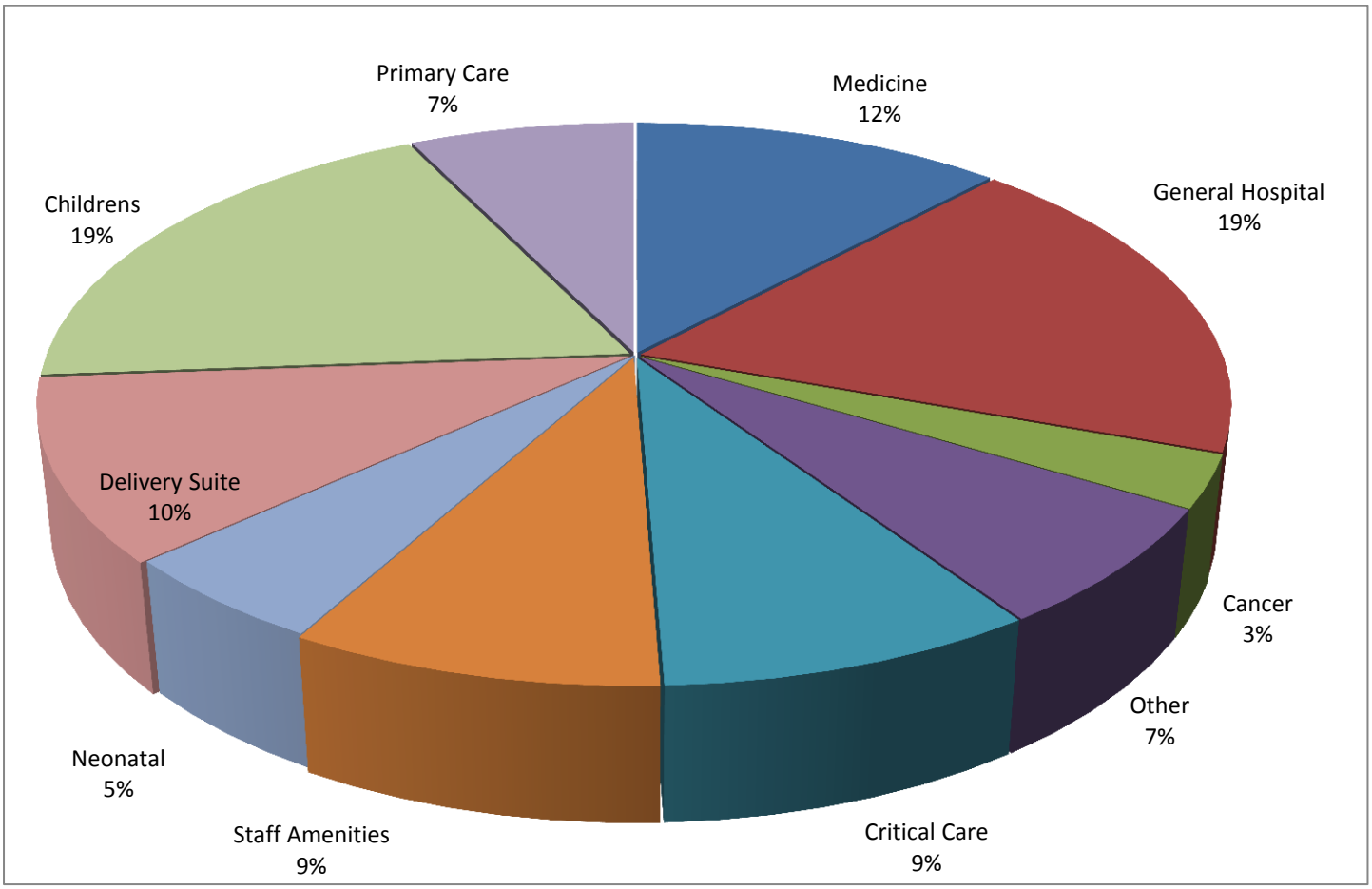
Details of the main areas of expenditure are listed from page three to five within the Achievements and Performance section. The decrease in the expenditure on capital equipment is directly related to the utilisation of the £1 million legacy received in 2014-2015 that was utilised to buy equipment for the new Surgical and Medical Centre in the previous financial year 2016-2017.

Analysis of Expenditure



Expenditure by Fund

The chart below shows a breakdown of the expenditure according to spend by restricted charitable fund. All areas with expenditure for the year shown on the chart as 'Other' include areas of expenditure in the Surgery and Maternity Funds.



Governance and Risk Management

The Charitable Funds are governed by a set of Trust Deeds which state clearly the objectives of each fund. Trustees for the fund operate as a Corporate Trustee Board, the membership of which is detailed on page 12 of this report. The governance and operation of the Charitable Fund forms part of the induction program for new Trustees, thereby ensuring sufficient knowledge is maintained within the governing body to mitigate risks and implement procedures to identify and manage risk at a strategic level. In addition the Charitable Fund benefits from the risk and control framework in place at the Trust, owing to the close working relationship of the two entities. Decisions relating to the operation of the funds are delegated to a number of fund holders who are responsible for each fund. Fund holders are nominated senior managers from within each specific fund area who have the required knowledge and skills to manage the individual funds effectively.

The Charitable Funds are further governed by a Charitable Funds Committee with powers delegated by the Trust Board of Directors to oversee all matters in relation to its registered charity. The Committee includes executive and non-executive membership and has formally approved terms of reference and a work plan to cover all key issues relevant to the sound governance of the funds. In 2017-18 this has included the approval of the annual grants.

The major risks to which the Charity has been exposed have been identified and considered. The Corporate Trustee is confident that reliance can be placed on the management arrangements in place, which include internal and external audit services, to minimise any risk to funds. The most significant risks identified are the possible losses from a fall in the value of investments and these are considered below on page ten.

Procedures are in place to ensure that both spending and financial commitments remain in line with income through the grant setting process. Income is covered by Standing Financial Instructions and there is an agreed boundary for the receipt of donations. There is an agreed expenditure and reserves policy with an approval procedure which gives the Corporate Trustee confidence that the expenditure will remain within the limits of the Charity's resources.

The Corporate Trustee approach to risk management in relation to its reserve policy and investment of cash surpluses are detailed on pages ten to eleven.

Overall the Corporate Trustee has considered all the key risks of the Charity and it has assessed that the Charity has mitigated risk in the following ways:

- No risk to income as active fund raising is low;
- No risk to service and going concern as the Charity operates through annual one-off grants with no dependent operational service;
- No risk to staff redundancies as there are no staff employed by the Charity or reliant on its continued funding; and
- Investment risk is managed through quarterly performance reports and meetings with the Charity's Investment Manager.

Grants

In 2017-2018 the Charity has continued to plan to meet its objectives through the setting of annual grants with individual fund holders. In setting objectives and planning activities, the Corporate Trustee gives careful consideration to the Charity Commission's public benefit guidance. The grant setting process is based on fundholders expectations of their required spend in the forthcoming financial year and presented to the Charitable Funds Committee for final approval. Where there are specific plans in place the Charitable Funds Committee considers these alongside the overall grant setting process.

Stockport NHS Foundation Trust General Fund makes grants from both the unrestricted and restricted funds.

- **Unrestricted funds -** the general fund managed by the Trustees. Applications are submitted from members of the hospital and the Trustees agree funding priorities.

- **Restricted funds** - these usually contain amounts from individuals or groups who want to donate to a specific department or activity. Restricted fund expenditure is limited to activities as instructed by the donor. Fund holders make recommendations on how to spend the money within their designated area. Each fund holders' proposals are usually agreed, with a general rule that funds are spent within a three year period.

- **Graham Riley fund** – a separate endowment fund. A covenant dictates the capital in this fund cannot be spent. However the interest received from the investment of the capital sum can be used. This interest is treated as income and benefit's the Treehouse Unit within the Child and Family Business Group.

Reserve Policy

Stockport NHS Foundation Trust General Fund is an unrestricted 'umbrella' income fund linked to 15 subsidiary restricted income funds and one restricted endowment fund. Stockport NHS Foundation Trust, as Corporate Trustee for the funds has established a general reserves policy for all of the charitable funds it administers.

The Corporate Trustee is very aware of the legal duty to apply charitable funds within a reasonable time of receiving them and actively encourages delegated staff to spend funds on charitable purposes within their charitable objectives and in a manner that as far as possible meets the donor's wishes.

The following procedure applies to the retention of funds within a charitable fund held by the Trust Charity:

1. As part of the yearly grant discussions with fund holders, reserves will be agreed and explained for a report to the Charitable Funds Committee. Factors taken into account include the need to cover fluctuations in income (principally donations and legacies). Each fund holder must consider the necessity and benefit of holding reserves and set an acceptable level of reserves. Reserves held are, in effect, the remaining fund balances once the annual grant has been set.

2. Where possible, funds must be only retained in respect of a specific project – for example to maintain equipment.

Funds that are reserved for a specific purpose such as the purchase and maintenance of equipment have been donated for that purpose.

3. The projects for which the funds have been reserved must be identified during the expenditure planning process. The full cost of the project must be indicated and the length of time for which it will be necessary to reserve funds. Unless funds have been donated specifically for this via an appeal the maximum amount of time the funds are to be reserved is three years.

4. Where funds are reserved for more than three years a cashflow forecast must be prepared to ascertain whether the amount reserved is surplus to the requirements to meet the needs of the appeal.

5. The Corporate Trustee board or delegated staff will, annually, review and approve the level and projects for which funds have been reserved.

6. The Corporate Trustee will, annually, approve the disbursement of surplus funds where applicable.

7. The delegated staff will be required to report to the Corporate Trustee on a bi-annual basis or at any time when requested with a summary of the charitable fund reserves and accounts.

8. Monies not needed for immediate use (reserved) will be invested in line with the agreed investment policy.

9. The day to day monitoring of this policy will be the responsibility of the delegated staff who will be expected to bring any issues to the immediate attention of the Corporate Trustee.

10. The Corporate Trustee considers it prudent that the target range of unrestricted reserves is within the range £100,000 to £400,000 in order to ensure that the charity can function efficiently and meet the needs of its beneficiaries. The Balance Sheet shows that the unrestricted reserves of £272,000 at the end of the financial year are within the range required by the policy (£242,000 at the 31st March 2017).

Investment Policy and Performance

The Funds are pooled together and held within the following investment funds:-

- Charities Official Investment Fund (COIF) Fixed Interest Fund
- COIF Equity Investment Fund
- COIF Deposit Fund

The Charity has a formal investment policy that is reviewed periodically. The purpose of investment is to safeguard against inflation and to yield a reasonable level of income. The Charity's strategy is to invest for the long term benefit rather than for any short term gain. In order to maximise the returns, investments are made in market linked non cash assets. The valuation of these will vary over the term of the investment in line with short term fluctuations of the market.

In assessing performance against investment objectives income in 2017-18 has slightly decreased its level at £45,000 for the year (£50,000 in 2016-2017). This is due to the sale of the Fixed Interest Common Investment Fund part way through 2016-2017. The COIF Investment Fund has increased in value in year by £22,000 with a 3.8% return from the total portfolio invested by CCLA Investment Management Limited on behalf of the Trust including the Deposit Fund. In monetary terms this represents total asset carrying value of £1.2m as at the 31st March 2018. Income and investment performance is monitored quarterly by the finance department, via regular reports from the Investment Management Company, CCLA Investment Management Ltd.

Gains will be distributed to individual charitable funds in proportion to the average balance over the period. Losses will similarly be shared between funds in proportion to the average balance over the period.

In order to minimise the effect on individual funds the Charity keeps gains and losses in an unrealised reserve and apportions when gains are realised. This is reviewed on an annual basis and unrealised losses may be apportioned across to funds in loss making periods. In such periods any investment income that is made is first offset against losses.

Corporate Trustee and Charitable Funds Committee.

Stockport NHS Foundation Trust is a Corporate Trustee of its charitable funds and as such the Trust's Board of Directors acts as the controlling body .Therefore, there are not individuals named as trustees of the Charity. New appointments of the Board include responsibilities to the Charity in their induction and training for their roles as executive or non-executive directors.

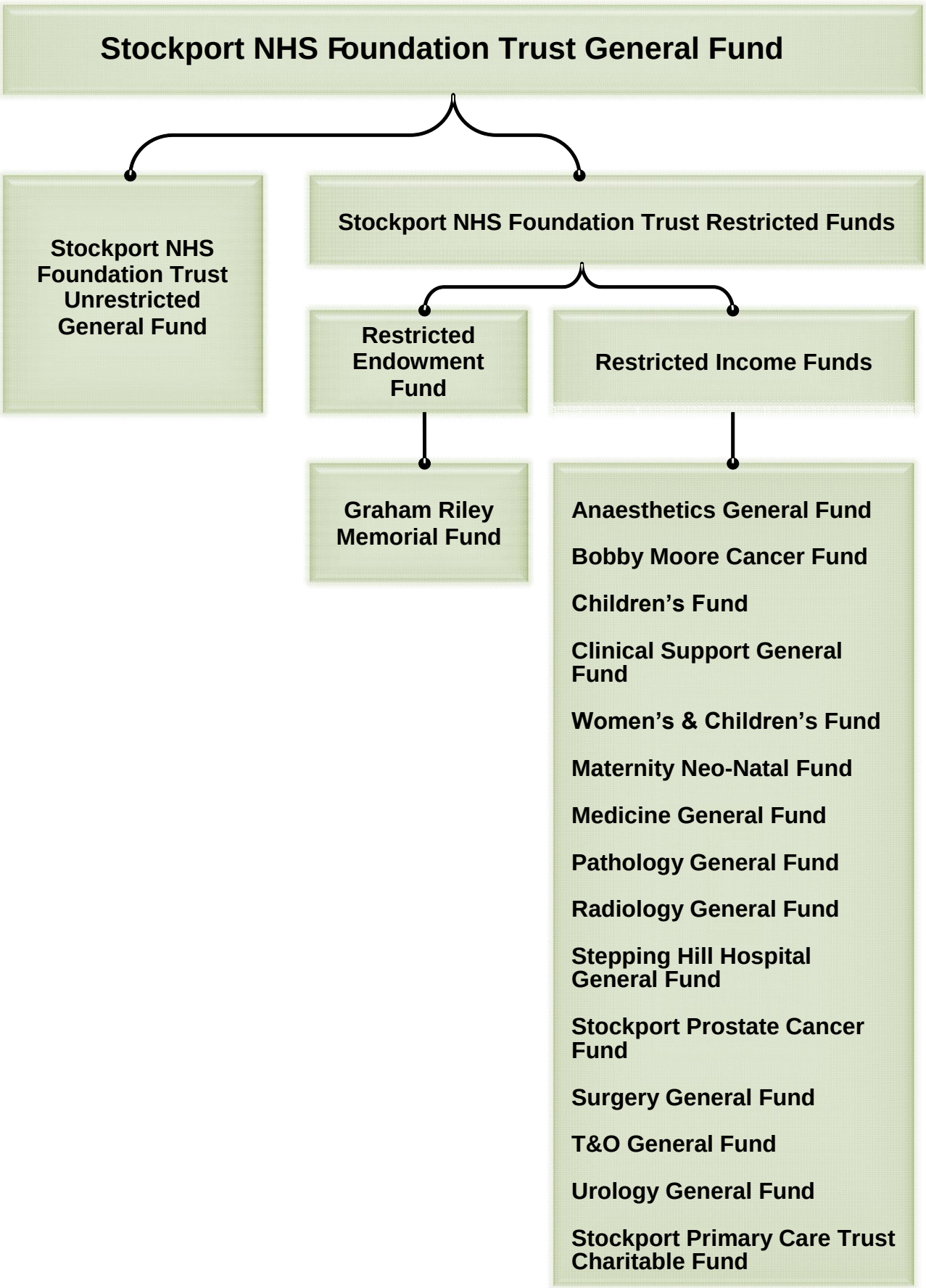
The Board of Directors of Stockport NHS Foundation Trust has established a Remuneration and Terms of Service Committee. Its responsibilities include the review and consideration of remuneration and conditions of service of the executive directors. The Council of Governors of the Trust is responsible for the appointment of the Chairman and other non-executive directors, approval of their remuneration, allowances and terms and condition.

The Charitable Funds Committee acts as the delegated Committee of the Board to oversee the Charity. Membership of the Committee comprises of two executive directors: the Director of Finance and Director of Nursing and Midwifery), two non-executive directors: the Trust Chair and the Chair of the Audit Committee and the Deputy Director of Finance.

As Stockport NHS Foundation Trust General Fund has a corporate trustee it is, in accounting terms, controlled by Stockport NHS FT and is therefore its subsidiary. Financially it is consolidated into the Group Accounts of the Trust.

Executive Directors	**Non-Executive Directors**
Mrs A Barnes - Chief Executive (left 31st December 2017)	Mrs G Easson – Chair (left 31st May 2017)
Mrs H Thomson (Interim Chief Executive from 1st January 2018)	Mrs A Belton – Chair (from 1st June 2017)
Mr F Patel – Director of Finance	Mr J Sandford
Mrs J Shaw – Director of Workforce and Operational Development (left 31st March 2018)	Mr M Sugden
Dr C Wasson - Medical Director	Mrs C Anderson
Mrs A Lynch – Chief Nurse and Director of Quality (from 23rd October 2017)	Mrs C Barber-Brown
Mrs S Toal – Chief Operating Officer	Dr M Cheshire
Mr H Mullen – Director of Support Services (from 1st November 2017)	Mrs A Smith
Mr P Buckingham – Director of Corporate Affairs.	
Mrs J Morris – Director of Nursing and Midwifery (left 31st December 2017)	

Organisational Fund Structure



Address Information

Registered Office Address:

Stepping Hill Hospital
Aspen House
Poplar Grove
Stockport
Cheshire
SK2 7JE

Investment Manager:

Charities Official Investment Funds (COIF)
Managed by:
CCLA Investment Management Ltd
COIF Charity Funds
80 Cheapside
London
EC2V 6DZ

Bank:

Barclays Bank Plc
Barclays Corporate Division
PO Box 190
2nd Floor
1 Park Row
Leeds
LS1 5WU

Finance Office:

Finance Department
Aspen House
Stepping Hill Hospital
Stockport
Cheshire
SK2 7JE

Auditor:

Deloitte LLP
Statutory Auditor
2 Hardman Street
Manchester
United Kingdom
M3 3HF

Stockport NHS
NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST GENERAL FUND
ANNUAL ACCOUNTS 2017-18

FOREWORD

Stockport NHS Foundation Trust General Fund is a registered charity with the Charity Commission, reference number 1048661, and are funds held in respect of Stockport NHS Foundation Trust which is a Corporate Trustee of the Charity.

The financial statements for the year ended the 31st March 2018 have been prepared in accordance with the requirements of the Charities Act 2011 and the Charities Statement of Recommended Practice 2015.

STOCKPORT NHS FOUNDATION TRUST GENERAL FUND - 2017-18: CHARITY COMMISSION REG NUMBER 1048661

Statement of Trustees' Responsibilities in respect of the Trustees' Annual Report and the financial statements

The Corporate Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kimgdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) including FRS 102 " The Financial Reporting Standard applicable in the UK and Republic of Ireland."

The law applicable to charities in England and Wales requires the Corporate Trustee to prepare financial statements for each financial year which give a true and fair view of the state of the affairs of the Charity and of the incoming resources and the application of resources of the entity for that period. The Corporate Trustee has elected to prepare the financial statements in accordance with the law and United Kingdom Accounting Standards, including FRS 102.

In preparing these financial statements, generally accepted accounting practice entails that the Corporate Trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- observe the methods and principles in the Charities SORP;
- follow all applicable accounting standards; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Corporate Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Report) Regulations 2008 and the provision of the trust deed.They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Corporate Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The Corporate Trustee confirms that it has met the responsibilities set out above and compiled with the requirements for preparing the accounts.

The financial statements set out on pages 1 to 12 attached have been compiled from and in accordance with the financial records maintained by the Corporate Trustee.

These financial statements were approved by the Board of Directors sitting as the Corporate Trustee on the 31st January 2019 and were signed on its behalf by:

David Hopewell, Non Executive Director, Stockport NHS Foundation Trust and Chair of Audit Committee

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Feroz Patel, Director of Finance, Stockport NHS Foundation Trust

Statement of Financial Activities for the year ended 31 March 2018

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Income and endowments from:						
Donations and Legacies		37	218	-	**255**	360
Investments	4.3	7	38	-	**45**	50
Other trading activities:						
Income from Fundraising Events		-	20	-	**20**	28
Total Income		**44**	**276**	**-**	**320**	438
Expenditure on:						
Charitable Activities - grant funding:	2					
Capital and Revenue Equipment Purchased		-	2		**2**	936
Staff training & Welfare		11	23	-	**34**	56
Patient Welfare		6	47	-	**53**	65
Total Expenditure		**17**	**72**	**-**	**89**	1,057
Net Gains on Investments		**3**	**19**	-	**22**	183
Net Income/(Expenditure)		**30**	**223**	**-**	**253**	(436)
Net Income/(Expenditure) before other gains and losses		**30**	**223**	**-**	**253**	(436)
Net movement in funds		**30**	**223**	**-**	**253**	(436)
Reconciliation of Funds						
Total Funds brought forward	9	242	1,454	10	**1,706**	2,142
Total Funds Carried forward		**272**	**1,677**	**10**	**1,959**	1,706

There were no other recognised gains and losses other than those listed above and the net income for the year.

All income and activity derives from continuing activities.

Statement of Financial Activities for the year ended 31 March 2017

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	2016-17 Total Funds £000	2015-16 Total Funds £000
Income and endowments from:						
Donations and Legacies		35	325	-	**360**	265
Investments	4.3	6	44	-	**50**	55
Income from Fundraising Events		1	27	-	**28**	32
Total Income		**42**	**396**	**-**	**438**	352
Expenditure on:						
Charitable Activities - grant funding:	2					
Capital and Revenue Equipment Purchased		6	930	-	**936**	654
Staff training & Welfare		28	28	-	**56**	79
Patient Welfare		5	60	-	**65**	116
Total Expenditure		**39**	**1,018**	**-**	**1,057**	849
Net Gains/(Losses) on Investments		**23**	**160**	-	**183**	(51)
Net Income/(Expenditure)		**26**	**(462)**	**-**	**(436)**	(548)
Net Income/(Expenditure) before other gains and losses		**26**	**(462)**	**-**	**(436)**	(548)
Net movement in funds		**26**	**(462)**	**-**	**(436)**	(548)
Reconciliation of Funds						
Total Funds brought forward	10	216	1,916	10	**2,142**	2,690
Total Funds Carried forward		**242**	**1,454**	**10**	**1,706**	2,142

There were no other recognised gains and losses other than those listed above and the net income for the year.

All income and activity derives from continuing activities.

Balance Sheet as at 31 March 2018

	Notes	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total at 31 March 2018 £000**	Total at 31 March 2017 £000
Fixed Assets						
Investments	4.1 / 4.2	171	1,054	10	**1,235**	1,213
Total Fixed Assets		**171**	**1,054**	**10**	**1,235**	1,213
Current Assets						
Debtors	5	5	-	-	**5**	46
Cash at bank and in hand		109	683	-	**792**	879
Total Current Assets		**114**	**683**	**-**	**797**	925
Creditors: Amounts falling due within one year	6	13	60	-	**73**	432
Net Current Assets		101	623	-	**724**	493
Total Assets less Current Liabilities		**272**	**1,677**	**10**	**1,959**	1,706
Total Net Assets		**272**	**1,677**	**10**	**1,959**	1,706
Funds of the Charity						
Capital Funds:						
Endowment Funds	9.1 / 9.2	-	-	10	**10**	10
Income Funds:						
Restricted	9.3 / 9.4	-	1,677	-	**1,677**	1,454
Unrestricted	9.5	272	-	-	**272**	242
Total Funds		**272**	**1,677**	**10**	**1,959**	1,706

The notes on pages 6 to 12 form part of these financial statements.

Approved and authorised for issue by the Trustee on the 31st January 2019 and signed on their behalf by:

David Hopewell,
Non-Executive Director, Stockport Foundation Trust and
Chair of Audit Committee

Balance Sheet as at 31 March 2017

	Notes	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total at 31 March 2017 £000**	Total at 31 March 2016 £000
Fixed Assets						
Investments	4.1 / 4.2	72	1,131	10	**1,213**	1,289
Total Fixed Assets		**72**	**1,131**	**10**	**1,213**	1,289
Current Assets						
Debtors	5	46	-	-	**46**	46
Cash at bank and in hand		124	755	-	**879**	1,656
Total Current Assets		**170**	**755**	**-**	**925**	1,702
Creditors: Amounts falling due within one year	6	-	432	-	**432**	849
Net Current Assets		170	323	-	**493**	853
Total Assets less Current Liabilities		**242**	**1,454**	**10**	**1,706**	2,142
Total Net Assets		**242**	**1,454**	**10**	**1,706**	2,142
Funds of the Charity						
Capital Funds:						
Endowment Funds	10.1 / 10.2	-	-	10	**10**	10
Income Funds:						
Restricted	10.3 / 10.4	-	1,454	-	**1,454**	1,916
Unrestricted	10.5	242	-	-	**242**	216
Total Funds		**242**	**1,454**	**10**	**1,706**	2,142

Cash Flow Statement for the year ended 31 March 2018

	Notes	**Total at 31 March 2018 £000**	Total at 31 March 2017 £000
Reconciliation of net income/(expenditure) to net cash flow from operating activities		**253**	(436)
Net Income/(expenditure) for the reporting period (as per the statement of financial activities)		**253**	(436)
Adjustments for:			
(Gains)/Losses on investments	4.1	(22)	(159)
Dividends and interests from investments		(45)	(73)
Decrease in debtors	5	41	-
(Decrease) in creditors	6	(359)	(417)
Net cash (used in) operating activities		**(385)**	(649)
Cash flows from investing activities			
Dividends and interest from investments	4.3	45	50
Proceeds from sale of investments		-	258
Net cash provided by investing activities		**45**	308
Change in cash and cash equivalents in the reporting period		**(87)**	**(777)**
Cash and cash equivalents at 1st April	7	**879**	1,656
Cash and cash equivalents at 31st March		**792**	879
Analysis of Cash and cash equivalents			
Cash in hand	7	**212**	343
Notice Deposits (less than three months)		**580**	536
Total Cash and cash equivalents		**792**	879

1 Notes to the Financial Statements

1.1 Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments. The financial statements have been prepared in accordance with the Financial Reporting Standard applicable in the UK (FRS102) effective from the 1st January 2016 and the Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2015), the Charities Act 2011 and the Charities (Accounts and Reports) Regulations 2008.

The principle accounting policies are set out below.

1.2 Income

a) All income is included in full in the Statement of Financial Activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii) probability - when the income is probable to be received; and

iii) measurement - when the monetary value of the income can be measured with sufficient reliability.

b) Gifts in kind

i) Assets given for distribution by the funds are included in the Statement of Financial Activities only when distributed.

ii) Assets given for use by the funds (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.

iii) Gifts made in kind but on trust for conversion into cash and subsequent application by the funds are included in the accounting period in which the gift is sold.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised. The basis of the valuation is disclosed in the annual report.

c) Legacies

Legacies, being either Pecuniary or Residuary in nature, are accounted for as income upon receipt or where the receipt of the legacy is probable. This will be once confirmation has been received from the representatives of the estate that probate has been granted, the executors have established that there are sufficient assets in the estate to pay the legacy and all conditions attached to the legacy have been fulfilled or are within the Charity's control.

1.3 Expenditure

a) Raising Funds

The cost of raising funds, if applicable, are the costs associated with generating income for the funds held on trust.

b) Charitable activities

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs include an apportionment of support costs and are apportioned by average fund balance charged to the specific funds.

Grants are payments, made to third parties (including NHS bodies) in the furtherance on the funds held on Trust's charitable objectives to relieve those who are sick. They are accounted for on an accruals basis where the conditions for their payment have been met or where there is a constructive obligation to make a payment or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

1.3 Expenditure continued

The Trustee has control over the amount and timing of grant payments and consequently where approval as been given by the Trustee then a liability is recognised.

Irrecoverable VAT is charged against the category of expenditure for which it was incurred.

c) Support and Governance costs

i) Support costs relate to apportioned recharges from Stockport NHS Foundation Trust in relation to salaries, investment management fees and other running costs. They are split across each fund in direct relation to the end of year balance for each fund and are accounted for on an accruals basis.

ii) Governance costs relate to apportioned recharges from Stockport NHS Foundation Trust in relation to audit fees and strategic level salary costs. They too are split across each fund in direct relation to the end of year balance for each fund and are accounted for on an accruals basis.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Corporate Trustee has chosen to earmark for set purposes are classified funds. The major funds held within these categories are disclosed on notes 9.1 to 10.5.

1.5 Fixed Assets

There are no fixed assets held by Stockport NHS Foundation Trust Charitable Funds other than investment assets.

1.6 Investment Fixed Assets

Investment fixed assets are shown at market value. Quoted stocks, shares and common investment funds are included in the balance sheet at the closing dealing price at the 31st March 2018.

1.7 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.8 Cash at bank and at hand

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. The bank accounts held by the Charity both fall within this definition, and no other type of account is held.

1.9 Pooling Scheme

Investments relating to Stockport NHS Foundation Trust General Fund are held within the CCLA COIF Equity Investment Fund.

1.10 Reserves Policy

Stockport NHS Foundation Trust General Fund is an unrestricted 'umbrella' income fund linked to 15 subsidiary restricted income funds and 1 restricted endowment fund. Stockport NHS Foundation Trust, as Corporate Trustee for its charitable funds has decided to establish a general reserves policy for all of the charitable funds it administers.

1.10 Reserves Policy continued

Monies not needed for immediate use (reserved) will be invested in line with the agreed investment policy.

The Corporate Trustee considers it prudent that the target range of unrestricted reserves is within the range £100,000 to £400,000 in order to ensure that the charity can function efficiently and meet the needs of its beneficiaries. The Balance Sheet shows that the unrestricted reserves of £272,000 at the end of the financial year are within the range required by the policy (£242,000 at the 31st March 2017).

1.11 Going Concern

The Charitable Fund Financial Statements for 2017-18 have been prepared under the going concern basis. The Corporate Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern for at least the next twelve months.

1.12 Post Balance Sheet Events

There are no post balance sheet events in 2017-2018.

1.13 Financial Instruments

Financial assets and financial liabilities are recognised when the Charity becomes a party to the contractual provisions of the instrument. All financial assets and liabilities are initially measured at transaction price (including transaction costs), except for those financial assets classified as at fair value through profit or loss, which are initially measured at fair value (which is normally the transaction price excluding transaction costs), unless the arrangement constitutes a financing transaction. If an arrangement constitutes a finance transaction, the financial asset or financial liability is measured at the present value of the future payments discounted at a market rate of interest for a similar debt instrument.

The charity only holds financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value.

Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due. Cash at bank and cash in hand includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account. Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due.

1.14 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity’s accounting policies, which are described in notes 1.1 to 1.14, the Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

There are no critical accounting judgements or estimates outside of the accounting policies at notes 1.1 to 1.14.

Details of Charitable Expenditure - Grant Funding 2017-2018 — **2 / 2.1**

	Grant Funding: Unrestricted Funds	Grant Funding: Restricted Funds	Support Cost (Note 3)	**Total 31 March 2018 Funds**	Total 31 March 2017 Funds
Charitable Activities:	£000	£000	£000	**£000**	£000
Capital & Rev Equipment	0	2	0	**2**	936
Staff Training & Welfare	9	19	6	**34**	56
Patient Welfare	5	38	10	**53**	65
	14	**59**	**16**	**89**	1,057

All grants were made to Stockport NHS Foundation Trust. No grants were made to individuals.

2016-2017 — **2.2**

	Grant Funding: Unrestricted Funds	Grant Funding: Restricted Funds	Support Cost (Note 3)	**Total 31 March 2017 Funds**	Total 31 March 2016 Funds
Charitable Activities:	£000	£000	£000	**£000**	£000
Capital & Rev Equipment	4	889	43	**936**	654
Staff Training & Welfare	26	28	2	**56**	79
Patient Welfare	3	60	2	**65**	116
	33	**977**	**47**	**1,057**	849

Support Costs — **3**

	Total 31 March 2018 Funds	Total 31 March 2017 Funds
	£000	£000
Finance & Procurement	**11**	39
External Audit fee	**5**	5
	16	44

Analysis of Fixed Asset Investments — **4 / 4.1**

Fixed Asset Investments:	**2017-18 £000**	2016-17 £000
Market value at 1 April	**1,213**	1,289
Less: Disposals at carrying value	-	(258)
Realised gain on revaluation		23
Unrealised gain on revaluation	**22**	159
Market value at 31 March	**1,235**	1,213
Historic cost at 31 March	**939**	939

4.2 Market value at 1 April :

	Held in UK £000	**2017-18 Total £000**	2016-17 Total £000
Investments in a Common Investment Fund	1,235	**1,235**	1,213
	1,235	**1,235**	1,213

Analysis of gross income from investments — **4.3 Total gross income**

	Held in UK £000	**2017-18 Total £000**	2016-17 Total £000
Investments in a Common Deposit Fund	45	**45**	50
	45	**45**	50

Analysis of Debtors 5

	2017-18 £000	2016-17 £000
Total debtors falling due within one year	**5**	46
Total debtors	**5**	46

Analysis of Creditors 6

Amounts falling due within one year:	2017-18 £000	2016-17 £000
Other creditors	**73**	432
Total creditors falling due within one year	**73**	432
Total creditors	**73**	432

Other creditors represents the sum owed to a related party, Stockport NHS Foundation Trust, for costs incurred by the Trust as grants payable on behalf of the Charity in the furtherance of the Charity's objects.

Analysis of Cash at Bank and in hand 7 **Cash and Cash Equivalents**

	2017-18 £000	2016-17 £000
COIF Charities Deposit Fund	**580**	536
Barclays Current Account	**212**	343
	792	879

Related party transactions 8 Stockport NHS Foundation Trust is a Corporate Trustee to Stockport NHS Foundation Trust Charitable Fund (Registered Charity Number 1048661). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary due to the way in which its financial and operating policies are discharged so as to obtain benefits from its activities for itself, its patients or its staff. In accordance with IFRS 10 Consolidated Financial Statements, the Trust has prepared 2017-2018 Group financial statements that include the Charitable Fund. These are available from:

Stockport NHS Foundation Trust
Stepping Hill Hospital
Poplar Grove
Hazel Grove
Stockport
SK2 7JE

The Trust Charity operates through a grant setting process of which the expenditure is transacted by Stockport NHS Foundation Trust and reimbursed at a later date. At the 31st March 2018 the Charity has a creditor balance of £73,000 with Stockport NHS Foundation Trust (£432,000) at the 31st March 2017).

The Trust's Charitable Fund statutory accounts have continued to be prepared at the 31st March 2018 in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting principles (UK GAAP).

During the year none of the Trustees or members of the key management staff or parties related to them has under-taken any material transactions with Stockport NHS Foundation Trust General Fund.

The Charitable Fund has made revenue payments to Stockport NHS Foundation Trust where the Trustees (whose names are listed in the Annual Report) are also members of the Board of Directors.

Analysis of Funds 2017-2018 — **9 9.1**

		Opening Balance 1 April 2017 £000	Income £000	Expenditure £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2018 £000**
A	Graham Riley Fund	10	-	-	-	-	**10**
Total		**10**	-	-	-	-	**10**

Details of material funds - endowment funds — **9.2**

	Name of Fund	**Description of the nature and purpose of each fund**
A	Graham Riley Fund	To provide income for midwifery training

Details of material funds - restricted funds 2017-2018 — **9.3**

	Material funds	Opening Balance 1 April 2017 £000	Income £000	Expenditure £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2018 £000**
A	Medical Equipment	138	3	-	-	2	**143**
B	Medicine	293	94	(12)	48	4	**427**
C	Bobby Moore Unit	152	82	(3)	-	2	**233**
D	Radiology	126	14	(1)	-	1	**140**
E	Staff Amenities	219	5	(8)	(10)	3	**209**
F	Primary & Public Health	73	7	(6)	-	1	**75**
G	Neonatal	72	21	(5)	-	1	**89**
H	Surgery	28	6	-	-	-	**34**
I	Anaesthetics	50	5	(7)	-	1	**49**
J	Urology/Prostate Cancer Fund	87	5	(1)	-	1	**92**
K	Research & Development	16	-	-	-	-	**16**
L	Children's	38	8	(14)	-	-	**32**
	Others	162	26	(15)	(38)	3	**138**
	Total	**1,454**	**276**	**(72)**	**-**	**19**	**1,677**

9.4

	Name of fund	**Description of the nature and purpose of each fund**
A	Medical Equipment	For patient & staff welfare, research & other charitable purposes
B	Medicine	For patient & staff welfare, research & other charitable purposes
C	Bobby Moore Unit	For patient & staff welfare, research & other charitable purposes
D	Radiology	For patient & staff welfare, research & other charitable purposes
E	Staff Amenities	For staff welfare & amenities
F	Primary & Public Health	For patient & staff welfare, research & other charitable purposes
G	Neonatal	For patient & staff welfare, research & other charitable purposes
H	Surgery	For patient & staff welfare, research & other charitable purposes
I	Anaesthetics	For patient & staff welfare, research & other charitable purposes
J	Urology/Prostate Cancer Fund	For patient & staff welfare, research & other charitable purposes
K	Research & Development	Research & other charitable purposes
L	Children's	For patient & staff welfare, research & other charitable purposes
	Others	For patient & staff welfare, research & other charitable purposes

Details of material funds - unrestricted funds 2017-2018 — **9.5**

		Opening Balance 1 April 2017 £000	Income £000	Expenditure £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2018 £000**
	Stockport NHSFT General Fund	242	44	(17)	0	3	**272**
	Total	**242**	**44**	**(17)**	**0**	**3**	**272**

	Name of fund	**Description of the nature and purpose of each fund**
A	Stockport NHS FT General Fund	For patient & staff welfare, research & other charitable purposes

Analysis of Funds 2016-2017 — **10 10.1**

		Opening Balance 1 April 2016 £000	Income £000	Expenditure £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2017 £000**
A	Graham Riley Fund	10	-	-	-	-	**10**
Total		**10**	-	-	-	-	**10**

Details of material funds - endowment funds — **10.2**

		Name of Fund	**Description of the nature and purpose of each fund**
A	Graham Riley Fund		To provide income for midwifery training

Details of material funds - restricted funds 2016-2017 — **10.3**

		Opening Balance 1 April 2016 £000	Income £000	Expenditure £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2017 £000**
Material funds							
A	Medical Equipment	744	13	(668)	-	49	**138**
B	Medicine	316	121	(172)	(2)	30	**293**
C	Bobby Moore Unit	158	45	(63)	-	12	**152**
D	Radiology	123	15	(23)	-	11	**126**
E	Staff Amenities	115	104	(15)	-	15	**219**
F	Primary & Public Health	62	9	(6)	2	6	**73**
G	Neonatal	64	12	(11)	-	7	**72**
H	Surgery	40	2	(14)	-	0	**28**
I	Anaesthetics	40	6	(2)	-	5	**49**
J	Urology/Prostate Cancer Fund	43	39	(2)	-	7	**87**
K	Research & Development	15	1	-	-	-	**16**
L	Childrens	33	12	(10)	-	3	**38**
Others		163	17	(32)	-	15	**163**
Total		**1,916**	**396**	**(1,018)**	**0**	**160**	**1,454**

10.4

		Name of fund	**Description of the nature and purpose of each fund**
A	Medical Equipment		For patient & staff welfare, research & other charitable purposes
B	Medicine		For patient & staff welfare, research & other charitable purposes
C	Bobby Moore Unit		For patient & staff welfare, research & other charitable purposes
D	Radiology		For patient & staff welfare, research & other charitable purposes
E	Staff Amenities		For staff welfare & amenities
F	Primary & Public Health		For patient & staff welfare, research & other charitable purposes
G	Neonatal		For patient & staff welfare, research & other charitable purposes
H	Surgery		For patient & staff welfare, research & other charitable purposes
I	Anaesthetics		For patient & staff welfare, research & other charitable purposes
J	Urology/Prostate Cancer Fund		For patient & staff welfare, research & other charitable purposes
K	Research & Development		Research & other charitable purposes
L	Childrens		For patient & staff welfare, research & other charitable purposes
Others			For patient & staff welfare, research & other charitable purposes

Details of material funds - unrestricted funds 2016-2017 — **10.5**

	Opening Balance 1 April 2016 £000	Incoming Resources £000	Resources Expended £000	Transfers £000	Gains and Losses £000	**Closing Balance 31 March 2017 £000**
Stockport NHSFT General Fund	216	42	(39)	-	23	**242**
Total	**216**	**42**	**(39)**	**-**	**23**	**242**

	Name of fund	**Description of the nature and purpose of each fund**
A	Stockport NHS FT General Fund	For patient & staff welfare, research & other charitable purposes

Deloitte.

NHS
Stockport
NHS Foundation Trust

Stockport NHS Foundation Trust General Fund

Final report to the Charitable Funds Committee on the 31 March 2018 audit

Issued Date: 21 January 2019 **Meeting Date:** 31 January 2019

Contents

Our final report

Appendices

Introduction

The key messages in this report:

- Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit: A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our final report to the Charitable Fund Committee ("The Committee"), of Stockport NHS Foundation Trust General Fund ("The Charity") for the 2018 audit.

I would like to draw your attention to the key messages of this paper:

Work performed on significant risk areas

The significant risks were communicated at the planning meeting. There have been no changes to the principle significant risks identified. We have not identified any issues from our testing of significant audit risks to date including no unadjusted misstatements.

The significant risks have been summarised on page 5.

Further details on the significant risks identified, our procedures performed and conclusions given can be found on pages 6-8.

Conclusion from our testing

Based on the work completed to date, we plan to issue an unmodified audit opinion on the financial statements.

There are no corrected or uncorrected misstatements.

Insights

From our audit, we have found the controls to be appropriately designed and implemented and we have not identified any material deficiencies. However, we have identified two control insights, as detailed on page 10.

Status of audit

The status of the audit is as expected at this stage. The main items that we are waiting for include:

- Post balance sheet events review and receipt of signed letter of representation;
- Receipt of updated accounts; and
- Clearance of our internal reviews.

Sarah Anderson
Charity Engagement Lead

Our audit explained

We tailor our audit to your business and your strategy

Identify changes in your business and environment

Stockport NHS Foundation Trust Charitable Fund has remained stable with no significant changes to operations or funding.

Scoping

We have conducted our audit in accordance with International Standards on Auditing (UK) as adopted by the UK Auditing Practices Board.

Our audit objectives are set out in our "Briefing on audit matters" document which has been provided separately.

In addition, the audit opinion we intend to issue will reflect the financial reporting framework applicable in the UK relating to Charities.

Other findings

As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. Based on our testing completed to date, we have noted one finding for the financial year in relation to management override of control.

Determine materiality

We have set our materiality at £16,000 (2017: £17,700), based on 5% of income. We have completed our audit to this materiality and report to you in this report all misstatements above £800 (2017: £885).

Significant risk assessment

Our risk assessment process includes consideration of changes in your activities and operations, critical judgements, accounting estimates and discussions with management. Our risk assessment is unchanged from last year, given the stable nature of the Charity.

Conclude on significant risk areas

Our work has not highlighted any specific concerns surrounding the significant risks that we wish to draw to your attention. We have reported on each risk on the following pages (pages 5-8).

Our audit report

On satisfactory completion of our audit, we anticipate issuing an unmodified audit report.

Significant audit risks

Significant risk dashboard

	Fraud risk	Planned controls testing approach	Controls conclusion	Consistency of judgements with Deloitte's expectations	Page reference
Revenue recognition – Legacies and Donations	✓	Design and implementation	Satisfactory	●	6
Application of Funds	✗	Design and implementation	Satisfactory	●	7
Management override of controls	✓	Design and implementation	Satisfactory	●	8

Overly prudent, likely to lead to future credit — Overly optimistic, likely to lead to future debit.

Significant audit risks

Revenue Recognition – Legacies and donations

Risk identified

International Standard on Auditing (UK) 240 The auditor's responsibility to consider fraud in an audit of financial statements requires us to presume a risk of fraud in relation to income recognition. We consider that the key risks for the Charity are whether income has been recorded in the appropriate period and whether income is complete.

Practice Note 11 The Audit of Charities in the United Kingdom issued by the APB and revised in November 2017 identifies that "Whilst it is the trustees' responsibility to safeguard the assets and income of the charity, the voluntary nature of some elements of its income may restrict the methods available to trustees to ensure that all income to which the charity is entitled are correctly accounted for."

Key judgements

We consider that the key risks for the Charity are whether income is complete and recognised in the correct period.

Procedures performed and our conclusion

We have focused specifically on completeness of income. Completeness of income is a risk associated with charities given the level of donations received through the post and other predominantly cash-based income streams. We have identified a significant risk given the guidance in Practice Note 11.

In addition to the above, we have focused upon the risk of incorrect cut off of income at the period end, whether due to error or otherwise

To address the significant risk identified, we have performed the following procedures:

- tested the design and implementation of key controls that address the identified risks around the main income streams of the Charity, legacies and donations;
- carried out detailed cut-off testing of income through a sample of items selected from pre- and post-year end bank statements and agreeing to supporting documentation to confirm inclusion in the correct period; and
- carried out detailed testing of income through a sample of items selected from bank statements, legacy documentation, official receipts or other source documentation from throughout the financial year and tracing through to the ledger to confirm recognition and completeness of income.

We are satisfied that legacy and donation income disclosed is not materially misstated.

Significant audit risks

Application of Funds

Risk identified

Practice Note 11 The Audit of Charities in the United Kingdom (revised November 2017) issued by the Auditing Practices Board ("APB") requires the auditor to fully understand and assess risks associated with restricted funds, including disclosure, cost allocation, deficit balances and transfers.

Key judgements

The Charity must ensure that income is recorded correctly between restricted and unrestricted funds and expenditure is incurred in accordance with relevant charities legislation, the objects of the Charity and the specific fund balances.

Procedures performed and our conclusion

We have performed tests of design and implementation of key controls around the application of funds, specifically the recognition of income and the utilisation of restricted funds. In addition, we have:

- Tested a sample of income receipts to assess whether initial classification is in accordance with donor wishes;
- Tested a sample of expenditure from restricted funds in the year to assess whether the expense is in line with donor wishes; and
- Reviewed any other movements to/ from restricted funds (e.g. transfers) and obtain supporting documentation to confirm the validity of the movement.

During our testing of income and expenditure, we found no instances of items being allocated to, or expended from funds that were not aligned to the wishes of the donor.

Significant audit risks

Management override of controls

Risk identified

In accordance with ISA (UK) 240 The auditor's responsibilities relating to fraud in an audit of financial statements, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

Although the level of this risk will vary from entity to entity, the risk is nevertheless present in all entities and therefore a presumed risk for all our audits.

Key judgements and our challenge of them

Specific areas of consideration for potential management override are controls surrounding journal entries since these are often one-off manual adjustments. We have used data analytic tools to identify unusual entries or outliers and test identified entries to ensure that they are within the normal course of business.

Management override of controls is a pervasive matter which we have considered throughout our work on the above significant risks with a focus on reviewing accounting estimates for biases that could result in material misstatement due to fraud. We have also performed a retrospective review of management's judgements and assumptions relating to significant estimates reflected in last year's financial statements.

Procedures performed and our conclusion

We have performed audit procedures to respond to the risk of management's override of control, which included:

- An assessment of the design and implementation of the controls in place around key accounting cycles and areas of management judgement;
- A review of accounting estimates for bias that could result in material misstatement due to fraud including whether any differences between estimates best supported by evidence and those in the financial statements, even if individually reasonable, indicate a possible bias on the part of management;
- Testing a sample of journals which exhibit indicators of risk or fraud to assess whether they are appropriate and supportable; and
- Enquiring about transactions outside the normal course of business. We understand there were none in 2017/18.

We have not identified any significant bias in the key judgements made by management.

No evidence of management override of controls was noted during the course of our audit work.

During our review of journals it was noted that signed and hard copy journals are not produced for all transactions, which could lead to transactions being processed without approval. Therefore we have raised an insight, please refer to page 10.

Other accounting judgements

At the planning stage of the audit, we identified a number of other accounting judgements which we did not identify as a significant risk. Our conclusions on these are outlined below:

Key judgements and our challenge of them
The Charity has a significant investment portfolio. As at 31 March 2018 the value of the fixed assets investments was £1,235k (2017: £1,213k), representing 63% of total Charity funds. There is a potential risk that the carrying value of investments held at fair value in the financial statements does not reflect the actual value, and that any downward movements in value post year-end could be indicative of a permanent diminution in value, which should be recognised as an impairment. Given the nature of the investments, the carrying value can be readily determined by reference to market information. As such, we have not identified a significant audit risk of material misstatement in relation to the balance but agreed in our planning report to report separately on this to you.
Our response
Specifically, we have: • Agreed the values of the investments per the balance sheet to confirmations from the Charity's fund managers; • Independently checked the market value of investments using publicly available market data; • Asked our internal financial instrument specialists to conduct a review of the work performed by the audit team; and • Reviewed post year end valuations to assess whether there is no indication of a permanent diminution in value.

Insights

Internal control and risk management observations

We identified the following observations from our audit testing, a follow up is detailed below.

	Observation	Deloitte recommendation	Management response
Authorisation of Journals	Deloitte noted that journals posted to the charitable funds codes during the year were not consistently signed off by management.	All journals posted to charitable fund codes should be approved by Lisa Byers or a member of management before posting, as this will avoid any expenditure being charged to the charity/charitable funds that are not in accordance with fund objectives/charity objectives.	Agree that all charitable funds journals to be signed as evidence of review by management. Procedures have been updated to reflect this. To add these journals are to update the Charity Accounts for the Charity creditor to the Trust. They are not initial postings of expenditure to the Charity funds. This has already occurred with the appropriate authorisation to the Trust revenue Charity financial codes.
January 2018 charitable funds committee meeting not documented	PDW Lisa Byers, the June and November meetings were cancelled at short notice. The January 2018 meeting did take place but there are no minutes as Paul Buckingham (Director of corporate affairs) was not present. An insight has been raised.	To ensure all charitable funds committee meetings are documented and recorded.	Noted and accepted.

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Committee discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA 260 (UK) to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:

- Results of our work on key audit judgements.
- Our internal control observations.

What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to the Committee.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

We welcome the opportunity to discuss our report with you and receive your feedback.

The scope of our work

Our observations are developed in the context of our audit of the financial statements.

This report has been prepared for the Charitable Funds Committee, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Sarah Anderson

for and on behalf of Deloitte LLP

Leeds | 21 January 2019

Appendices

Appendix 1: Fraud responsibilities and representations

Responsibilities explained

Your Responsibilities:

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations.

Our responsibilities:

- We are required to obtain representations from your management regarding internal controls, assessment of risk and any known or suspected fraud or misstatement.
- As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.
- As set out in the significant risks section of this document, we have identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for the Charity.

Fraud Characteristics:

- Misstatements in the financial statements can arise from either fraud or error. The distinguishing factor between fraud and error is whether the underlying action that results in the misstatement of the financial statements is intentional or unintentional.
- Two types of intentional misstatements are relevant to us as auditors – misstatements resulting from fraudulent financial reporting and misstatements resulting from misappropriation of assets.

We have requested the following to be stated in the representation letter signed on behalf of the Trustees:

- We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error.
- We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- We are not aware of any fraud or suspected fraud / We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the entity or group and involves:
  (i) management;
  (ii) employees who have significant roles in internal control; or
  (iii) others where the fraud could have a material effect on the financial statements.
- We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Appendix 1: Fraud responsibilities and representations

Inquiries

We made the following inquiries regarding fraud:

Management:

- Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments.
- Management's process for identifying and responding to the risks of fraud in the entity.
- Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity.
- Management's communication, if any, to employees regarding its views on business practices and ethical behaviour.
- Whether management has knowledge of any actual, suspected or alleged fraud affecting the entity.

Those charged with governance

- How those charged with governance exercise oversight of management's processes for identifying and responding to the risks of fraud in the entity and the internal control that management has established to mitigate these risks.
- Whether those charged with governance have knowledge of any actual, suspected or alleged fraud affecting the entity.
- The views of those charged with governance on the most significant fraud risk factors affecting the entity.

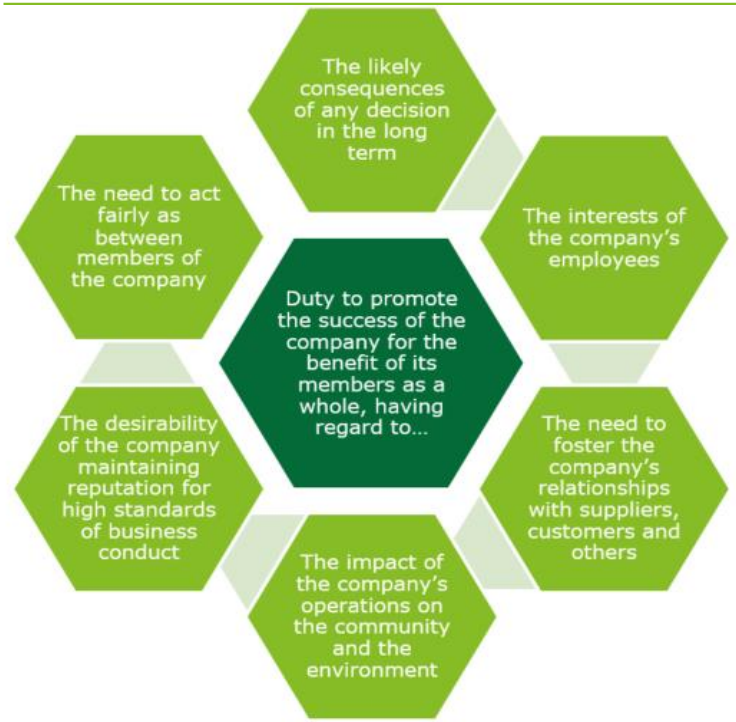
Appendix 2: Independence and fees

As part of our obligations under International Standards on Auditing (UK & Ireland), we are required to report to you on the matters listed below:

Independence confirmation	We confirm the audit engagement team, and others in the firm as appropriate, Deloitte LLP and, where applicable, all Deloitte network firms are independent of the Charity.
Fees	The fee for the audit of Stockport NHS Foundation Trust General Fund £3,920 (2017: 4,000).
Non-audit services	In our opinion there are no inconsistencies between the FRC's Ethical Standard and the Charity's policy for the supply of non-audit services or any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary.

Sector Developments

Sector developments



Section 172 and revised reporting requirements

New BEIS (the Department for Business, Energy and Industrial Strategy) Reporting Regulations now require a new, separately identifiable Section 172(1) statement to be included in the Strategic Report and on a website.

Section 172 is the duty to promote the success of the company and it sets out a number of factors the directors should consider.

The new statement must cover:

–the issues, factors and stakeholders relevant in complying with s172 and why;
–engagement methods; and
–impact on decisions and strategies during the year.

These new regulations are applicable for all large companies (not just listed companies) and are applicable for financial years beginning on or after 1 January 2019.

There are also additional requirements for the Directors' Report for large companies on business relationships, where those matters have not been covered in the Strategic Report, and on employee engagement for UK registered companies with more than 250 staff.

Charitable companies are not however included in the new requirements for private companies of a significant size to make a statement on their corporate governance arrangements.

Sector developments

SORP Bulletin 2

On 5 October 2018 the Charity Commission issued the final SORP Bulletin 2. The bulletin sets out the proposed amendments in three parts:

- those changes which are required to ensure that the SORP is consistent with the existing requirements of FRS 102 – these amendments are applicable to reporting periods beginning on or after the date of the publication of the bulletin;
- those changes which are significant and likely to have an impact on the accounts; and
- those amendments which are considered less significant and editorial in nature.

The key changes to be applied in the next reporting period relate to:

- the disclosure of comparative information;
- removal of undue cost or effort exemption for depreciating assets with major components with significantly different lives; and
- providing more clarity on the treatment of gift aid payments and the impact on the tax treatment.

The last change means that only gift aid payments which are legal obligations should be accrued for at the year end - constructive obligations are no longer included in the list of examples of adjusting events occurring after the end of the reporting period.

Other significant proposals, for periods beginning on or after 1 January 2019, reflect those requirements of the FRS 102 triennial review and include:

- Permitting charities that rent investment property to another group entity to measure the investment property either at cost (less depreciation and impairment) or at fair value;
- Removing the undue cost or effort exemption for the investment property component of mixed use property to require measurement at fair value;
- Removing the disclosure of stock recognised as an expense;
- Requiring a reconciliation of net debt as a note to the statement of cash flows; and
- Including the transfer of activities to a subsidiary undertaking as an example of charity reconstruction that should be accounted for as a merger.

Sector developments

A new Code of Ethics

The Code of Ethics has been development by the National Council for Voluntary Organisations (NCVO) for consultation. The code is intended to be complementary to existing sector codes such as the Charity Governance Code, as well as individual charities' codes or policies. It is not intended to replace their own definitions of values and codes of conduct. It is hoped that the code will make charities more relevant and accessible for beneficiaries.

The principles of the draft code are:

- Beneficiaries first
- Integrity
- Openness
- Right to be safe

The principles are straightforward and the challenge for charities will come in assessing how they uphold those principles and how procedures and policies are embedded into the culture and ethos of the organisation. The Code also challenges charities to make public, not only their annual accounts, but also their approach to safeguarding, bullying and harassment, and the complaints procedure. It will be important that procedures are in plan to action and monitor these public policies.

Sector developments

Trust in Charities 2018

The Charity Commission asked Populus to update their research into Trust in Charities. The last report was issued in 2016. The headline is that public trust and confidence in charities has continued to decline (though only slightly) from the prior year and stands at 5.5/10. The most significant fall was between the 2014 survey where trust was at a high of 6.7/10 and the 2016 survey where the impact of the various fundraising scandals meant public trust and confidence had dipped to 5.7/10. However, it is clear that charities still need to rebuild and manage their reputation and impact. The Charity Commissions conclusions are clear it is not just transparency (although that is still important) but authenticity.

> "It's about organisational values and ethos. The public want to know that charities are what they say they are. "

Some of the key findings from the survey include:

- Trust matters to donation behaviour and those who feel their trust in charities has decreased (4 in 10 of the population) are giving less.
- In both years of the survey scandals in the media involving major humanitarian charities occurred just before polling took place.
- Only Doctors, the Police and the Man/woman in the street are trusted more than charities.
- Transparency still rates highest when people are deciding whether to trust a charity.
- 62% of respondents said that their trust had decreased due to media stories and 60% due to too much money spent on advertising, wages and admin.
- The regulator has an important role in increasing trust.

Indirect Taxes

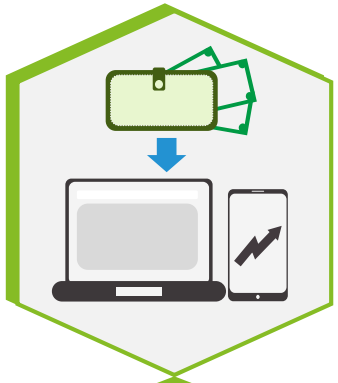
VAT

HMRC’s ambition is to become one of the

“most digitally advanced tax administrations in the world”

Making Tax Digital – what does it mean?

Three key areas



Making Tax Digital for VAT

HMRC Priority

- Digital submission by April 2019
- Digital records by April 2019
- Digital links by April 2020

Making Tax Digital for Individuals

Deferred

- Individual information in one online place
- Access from a digital device
- Register for new services, update information and see how much tax you need to pay

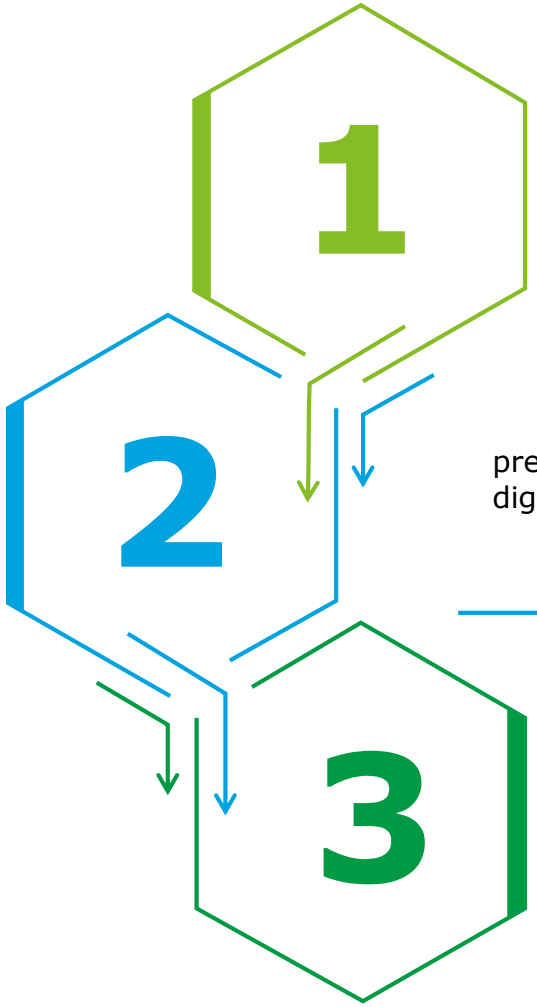
Making Tax Digital for Business

Progressing

- Quarterly summaries of gross income and expenses to HMRC via software
- VAT only until system has been shown to work well, and not before April 2020 at the earliest

Making Tax Digital for VAT

Software which businesses use to keep digital records must be capable of:



keeping and maintaining the records specified in the regulations;

preparing VAT Returns using the information maintained in those digital records; and

communicating with HMRC digitally via their Application Programming Interface (API) platform.

Changes from April 2019: Digital Submission

- Most businesses submit their VAT returns by manually re-keying into HMRC's online portal
- The online portal will close from April 2019
- All submissions must be done digitally via HMRC's Making Tax Digital API
- Software must be approved by HMRC
- "Off-the-shelf" solutions available
- Deloitte's digital submission solution is myInsight VAT Return Filer

www.deloitte.co.uk/makingtaxdigital

Changes from April 2019: Digital Records

Designatory data

- your business name
- the address of your principal place of business
- your VAT registration number
- any VAT accounting schemes that you use

Supplies

AP and AR transactions:

- time of supply (tax point)
- value of the supply (net value excluding VAT)
- rate of VAT charged

Summary data

- the total output tax
- the total tax you owe on acquisitions from other EU member states
- the total tax you are required to pay under a reverse charge procedure
- the total input tax you are entitled to claim on business purchases
- the total input tax allowable on acquisitions from other EU member states
- the total tax that needs to be paid or you are entitled to reclaim following a correction or error adjustment, and
- any other adjustment allowed or required by VAT rules

- Digital records can be maintained across different software (it will all need to be "digitally linked" from April 2020
- Total value of adjustments must be stored electronically
- Optional supplementary information (transactional data) can be submitted to HMRC

Changes from April 2020: Digital Links

"A transfer or exchange of data is made electronically between software without the need for manual transcription, i.e. copying over of information by hand".

- Mandatory digital link: the API submission to HMRC via "bridging software" must be in place for VAT periods after April 2019.
- Digital link: there will be an additional 12 month in order to ensure all other digital links are in place – this is the "soft landing period". Fines and penalties to apply for non-compliance after April 2020.

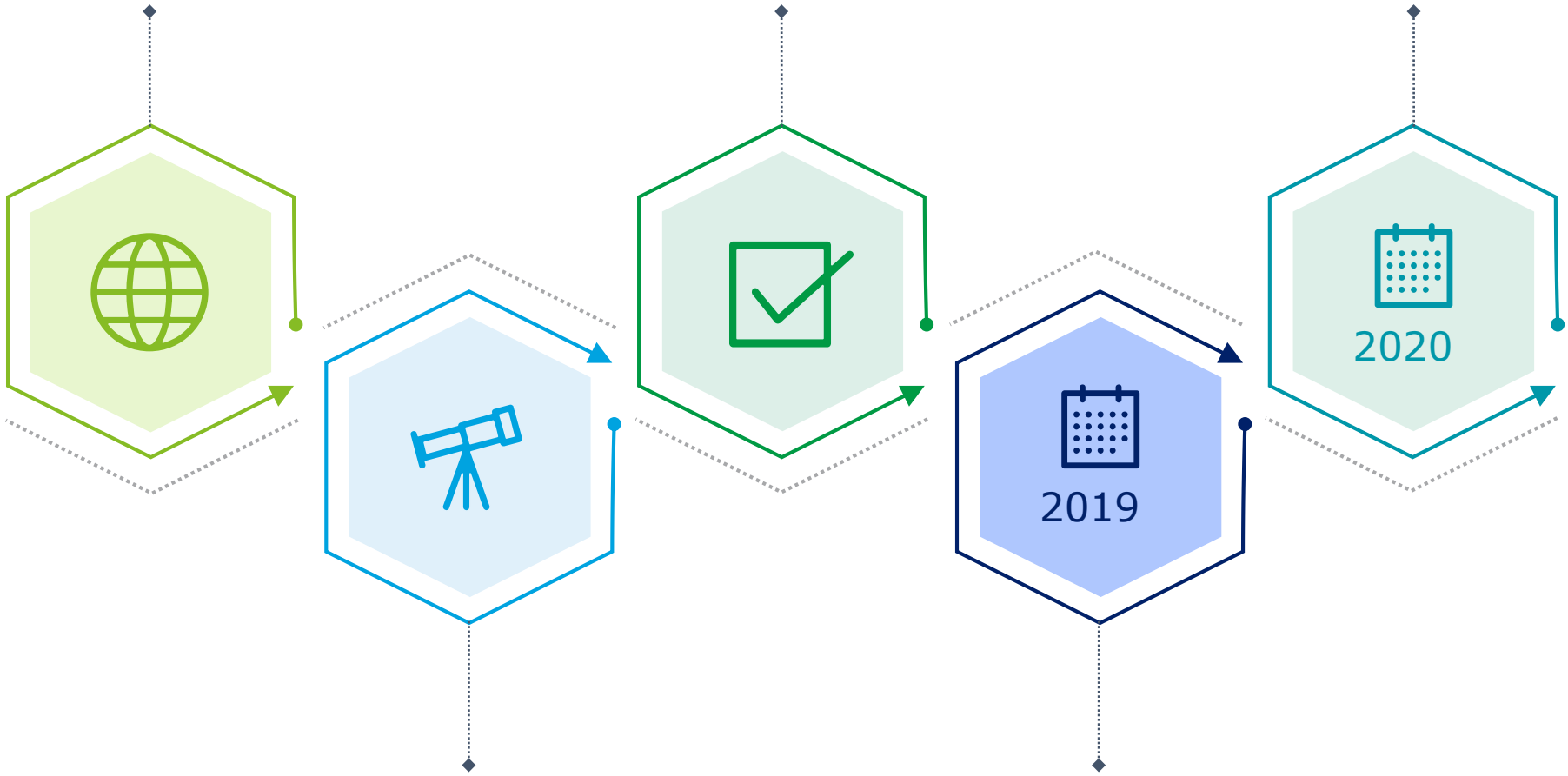
Acceptable links

- Linked cells and macros in spreadsheets
- Emailing of spreadsheets with digital records, e.g. to an agent
- Interfaces and middleware
- XML import and export
- Running reports and downloading information
- Transferring information on portable devices
- Manual adjustments into the VAT return – totals required only when the financial system has closed, e.g. accrued input VAT
- Standard templates to collect information from other entities

Unacceptable links

- Transferring data between different parts of an accounting system by hand – no materiality threshold for this
- Cutting and pasting of information between functional compatible software
- Re-keying large amounts of information
- Stand-alone spreadsheets
- Stand-alone API software
- Adjustments not reflected back in the system of record
- Re-keying of data supplied in email or word documents

Your Approach to VAT Compliance



Deloitte.

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Stockport NHS Foundation Trust General Fund

Charity Commission Registration Number: 1048661

David Hopewell
Non Executive Officer
Trust HQ
Oak House
Stockport NHS Foundation Trust
Poplar Grove
Stockport
SK2 7JE

FAO Sarah Anderson
Deloitte LLP
1 City Square
Leeds
LS1 2AL

31 January 2019

Our Ref: SA/HT/StockportFT

Dear Sirs

This representation letter is provided in connection with your audit of the financial statements of Stockport NHS Foundation Trust General Fund for the year ended 31st March 2018 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Stockport NHS Foundation Trust General Fund as of 31 March 2018 and of the results of its operations, other recognised gains and losses and its cash flows for the year then ended in accordance with the applicable accounting framework and the Charities Act 2011.

We acknowledge as trustees our responsibilities for preparing financial statements for the charity which give a true and fair view and for making accurate representations to you.

We confirm, to the best of our knowledge and belief, the following representations.

Financial statements

1. We understand and have fulfilled our responsibilities for the preparation of the financial statements in accordance with the applicable financial reporting framework and the Charities Act 2011 which give a true and fair view, as set out in the terms of the audit engagement letter.

2. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

3. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of FRS102 Section 33 “Related party disclosures”.

4. All events subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment of or disclosure have been adjusted or disclosed.

5. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements and disclosure deficiencies is detailed in the appendix to this letter.

6. We confirm that the financial statements have been prepared on the going concern basis. We do not intend to liquidate the charity or cease trading as we consider we have realistic alternatives to doing so. We are not aware of any material uncertainties related to events or conditions that may cast significant doubt upon the charity's ability to continue as a going concern. We confirm the completeness of the information provided regarding events and conditions relating to going concern at the date of approval of the financial statements, including our plans for future actions.

7. Having considered our income streams and based on management's close monitoring of donations, response rates and appeals for funds we are satisfied that the total value of income as reported is not materially misstated.

8. All grants, donations and other incoming resources, the receipt of which is subject to specific restrictions, terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such incoming resources. We have given particular consideration regarding the Harding legacy in determining the level of income recognition and followed legal advice regarding the likelihood of receipt and associated costs in this judgement.

9. All constructive obligations for grants meeting the conditions set out in FRS 102 Section 21 "Provisions and Contingencies" and the Charities SORP have been recognised in the financial statements.

10. We have drawn to your attention all correspondence and notes of meetings with regulators, including any serious incident reports.

11. The disclosures given in the financial statements regarding control of the entity are correct.

12. We are not aware of events or changes in circumstances occurring during the period which indicate that the carrying amount of fixed asset investments may not be recoverable.

Information provided

13. We have provided you with:
    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
    - Additional information that you have requested from us for the purpose of the audit; and
    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

14. All transactions have been recorded and are reflected in the financial statements and the underlying accounting records.

15. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

16. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

17. We are not aware of any fraud or suspected fraud that affects the entity or group and involves:

    (i) management;
    (ii) employees who have significant roles in internal control; or
    (iii) others where the fraud could have a material effect on the financial statements.

18. We are not aware of any deficiencies in internal control.

19. All minutes of Charitable Fund Committee meetings during and since the financial year have been made available to you.

20. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

21. We are not aware of any instances of non-compliance, or suspected non-compliance, with laws, regulations and contractual agreements whose effects should be considered when preparing financial statements

22. We have disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.

23. No claims in connection with litigation have been or are expected to be received.

24. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities reflected in the financial statements.

25. We have drawn to your attention all correspondence and notes of meetings with regulators, including, any serious incident reports.

26. All trades in complex financial instruments are in accordance with our risk management policies, have been conducted on an arm's length basis and have been appropriately recorded in the accounting records, including consideration of whether the complex financial instruments are held for hedging, asset/ liability management or investment purposes. None of the terms of the trades have been amended by any side agreement and no documentation relating to complex financial instruments (including any embedded derivatives and written options) and other financial instruments has been withheld.

We confirm that the above representations are made on the basis of adequate enquiries of management and staff (and where appropriate, inspection of evidence) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

Yours faithfully

David Hopewell , Non-Executive Director, Signed on behalf of the Corporate Trustee

Appendix 1

Schedule of Uncorrected Misstatements

Description	Assets DR / (CR) £	Liabilities DR / CR) £	Equity DR / (CR) £	Income Statement DR / (CR) £
None				

Disclosure deficiencies:

#	Disclosure title	Description of the deficiency and explanation of why not adjusted
	None noted.	

NHS
Stockport
NHS Foundation Trust

Report to:	Board Of Directors	**Date:**	31 January 2019
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR APPROVAL

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

Summary of Report

The data for this report was collated on the 3 January 2018
This paper provides an overview of the current Trust Risk Register.

This report includes all current risks of 15 and above for the members to review that have been approved to go onto the trust risk register.
There are currently 379 live risks recorded on the Risk Register systems

There are 38 risks rated 15 or above on the Trust Risk Register with corporate approval. This is a decrease of 2 compared to last month.
Across the 38 risks rated 15 or higher that have been corporately approved;

- 15 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 618, 686, 457, 825, 869)
- 8 risks are associated with capacity issues or increase in demand (130, 400, 586, 183, 429, 407,576, 315)
- 6 risks associated with statutory or regulatory activity (134, 135, 513, 476, 499, 638)
- 4 risks are associated with financial issues (469, 127, 461, 466)
- 4 risks are associated with equipment / facilities (46, 819, 765, 816)
- 1 risk associated with delivery of a contract. (652)

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

Attachments:

This subject has previously been reported to:

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

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1. Introduction

1.1 There are 379 live risks recorded on the risk register system. In addition there are 2 risks awaiting corporate approval

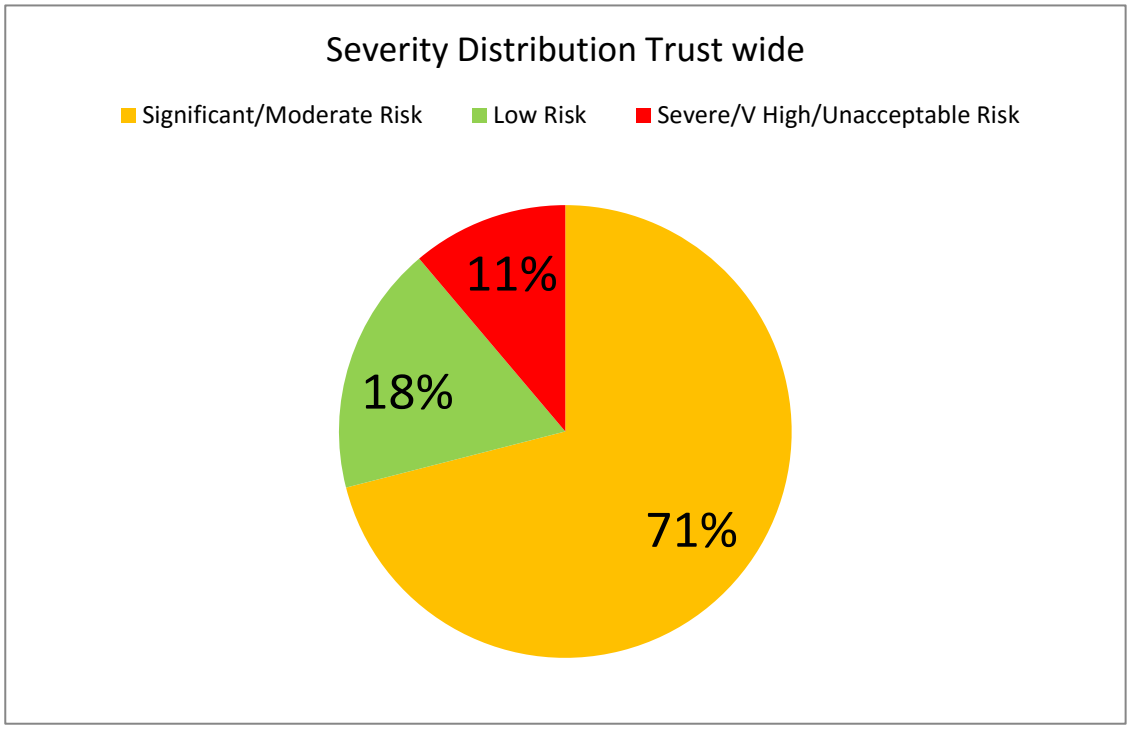
1.2 There are 47 risks awaiting business group approval. There are 77 general hazard inventory assessments awaiting approval.

2. Risk Profile

2.1 The trust wide distribution of risks is shown below

	Low				Significant			High			Very High		Severe	Unacceptable
Rating	**1**	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
Number of risks	**3**	**4**	**11**	**49**	**2**	**48**	**43**	**58**	**18**	**98**	**16**	**18**	**12**	**0**

2.2 The severity distribution is shown below



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

Business Group	Risk Score 15	Risk Score 16	Risk Score 20	Risk Score 25	Total
Corporate	4	4	6	0	14
Integrated Care	0	3	1	0	4
Medicine and Clinical Support	4	3	0	0	7
Surgery, GI and Critical Care	2	1	0	0	3
Women's and Children and Diagnostic	1	6	3	0	10

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

Risk number	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19		Feb 19	Mar 19
46	20	20	20	20	20	20	20	20	20	20	↔		
130	20	20	20	20	20	20	20	20	20	20	↔		
134	20	20	20	20	20	20	20	20	20	20	↔		
135	20	20	20	20	20	20	20	20	20	20	↔		
124							20	20	20	20	↔		
231	20	20	20	20	20	20	20	20	20	20	↔		
400						15	20	20	20	20	↔		
469			20	20	20	20	20	20	20	20	↔		
505						16	16	16	**20**	20	↔		
586							20	20	20	20	↔		
686									16	16	↔		
765									16	16	↔		
816										16	N		
618									16	16	↔		
869										16	N		
125						16	16	16	16	16	↔		
127	16	16	16	16	16	16	16	16	16	16	↔		
429		20	20	20	16	16	16	16	16	16	↔		
457									16	16	↔		
461		16	16	16	16	16	16	16	16	16	↔		
466			16	16	16	16	16	16	16	16	↔		
183	16	16	16	16	16	16	16	16	16	16	↔		
50					16	16	16	16	16	16	↔		
67			16	16	16	16	16	16	16	16	↔		
75	16	16	16	16	16	16	16	16	16	16	↔		
78	20	20	20	16	16	16	16	16	16	16	↔		
355	15	15	12	12	12	12	12	12	15	15	↔		
638							15	15	15	15	↔		
819									15	15	↔		
825										15	N		
587						15	15	15	15	15	↔		
513					15	15	15	15	15	15	↔		
576					15	15	15	15	15	15	↔		
476							15	15	15	15	↔		
499									15	15	↔		
407					15	15	15	15	15	15	↔		
408		15	15	15	15	15	15	15	15	15	↔		

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

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

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

3. Risk Movement

3.1 There are 38 risks on the trust risk register, a decrease of 2 since last month.

3.2 The Safety and Risk Group approved three new risks at the January meeting (816, 825 and 869).

3.3 Four risks were reduced to a risk rating of 12 and therefore removed from the Trust risk register (96, 162, 624 and 627).

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

4. Trends

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

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

- 15 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 618, 686, 457, 825, 869)
- 8 risks are associated with capacity issues or increase in demand (130, 400, 586, 183, 429, 407,576, 315)
- 6 risks associated with statutory or regulatory activity (134, 135, 513, 476, 499, 638)
- 4 risks are associated with financial issues (469, 127, 461, 466)
- 4 risks are associated with equipment / facilities (46, 819, 765, 816)
- 1 risk associated with delivery of a contract.

4.3 A review of the controls of the risks that have remained the same for over 6 months will be undertaken in the next month.

5. Summary

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

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

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

The risk factor = severity x likelihood

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

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

QUALITATIVE MEASURE OF CONSEQUENCE

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

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Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	46	Smethurst, Mr Richard	Women Children and Diagnostics Business Group	There is a risk that the Telepath Server will Fail	16	To have contingency plans in place and documented. To put in place a new system that would mitigate the risk of the system failing and not being retrievable.	5	4	20	Replacement Telepath Server	16/01/2019	5
Trust Risk	130		Integrated Care Business	There is a risk that the ED 4 Hour Target will not be met	20	Existing internal escalation processes	4	5	20	High Impact Priority Action Plans	31/01/2019	10
Strategic Risk	134	Kershaw, Helen	Corporate Nursing	There is a risk that the statutory requirements and billing will not be met due to lack of capacity in the medico-legal team	20	Extra hours available for staff in department Clear prioritization and support from senior staff Use of volunteers and other available staff Bank staff being utilized to cover vacancy Vacancy advertised	4	5	20	Continue Weekly updates from Team	28/02/2019	8
										Continue weekly monitoring of situation for a month	28/02/2019	
										Use volunteers and bank staff to increase throughput	28/02/2019	
Strategic Risk	135	Lehnert, Mrs Jean	Information and IT	There is a risk that Subject Access Provisionis not adequate to meet GDPR requirements	20	1. Medico Legal Team adhere closely to guidance (see earlier risk re pressures) 2. There is a clear process (doesn't include all areas)	4	5	20	Determination of requirements to meet legislation post review	31/03/2019	8
										Changes to Screening	31/03/2019	
										Improve on Packaging	31/03/2019	
Strategic Risk	124	Stimpson, Emma	Human Resources	This is a risk of increased use of Temporary Staffing and failure to achieve the agency ceiling	25	Further actions in place include recruitment at international and national events to attract doctors to join teams where we have hard to fill vacancies. Reduced internal rates for medical bank shifts. Exercise with procurement team to agree reduced commission rates with agencies on a tiering system. Significant challenge on all agency requests to ensure doctors are only	4	5	20	International & Domestic Recruitment - Medical Staff	31/01/2019	12
										Internal rates (bank) for medical staff	28/02/2019	
										Challenge of Rates and Improved Negotiations	31/03/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
						booked when absolutely essential and that rates are negotiated to within an acceptable range.				Negotiation of rates – training for relevant individuals	31/01/2019	
Trust Risk	231	Glynn, Marie	Corporate Nursing	lack of medical and nursing staff resulting in mandatory work only being undertaken resulting in an inefficient IP service.	20	To review all options for an interim and long term solution	4	5	20	review long term option for IV service	28/02/2019	8
										review BG for wider IP team	31/01/2019	
										review links with sepsis agenda	28/02/2019	
										Current work load undertaken by the IP service team	31/01/2019	
										To produce a gap analysis against the Health & Social Care Act	31/01/2019	
										present compliance data against the H&SC act	28/02/2019	
Trust Risk	400	Sperring, Mrs Carol	Women Children and Diagnostics	There is a risk to 18 week targets and compliance with NICE guidance.	15	1) Local offer defines the limitations on the provision for different parts of the service 2) The service has requested a review by the CCG to re-define priorities and	4	5	20	LOCAL OFFER DEFINED FOR 2018	31/03/2019	8
										Selective Mutism bid to increase capacity	31/03/2019	
Trust Risk	469	Wiss, Kay	Finance	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	There are a number of meetings in place to manage the overall financial performance of the organization led by the executive management team.	5	4	20	Ensure that the Business Groups are held to account on the delivery of their respective operational	29/03/2019	10
										Develop a demand and capacity model	31/03/2019	
										Preparation of a workforce plan	01/03/2019	
										To regularly report the key issues facing the Trust as part of the Stockport Together Programme	29/03/2019	
										Grip and Control Meetings	31/03/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	505	May, Mr David	Women and Children	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	16	Escalation spreadsheet on shared drive to monitor progress of urgent cancer cases.	4	5	20	Recruit to vacant histopathologist posts	31/01/2019	4
Trust Risk	586	Statham, Mr David	Estates and Facilities	There is a risk due to the significant Estate Backlog Maintenance Increase	20	Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised. Planned Preventative Maintenance (PPM) schedule of works. Regular walkrounds/visual checks undertaken by Estates Staff. Estates Helpdesk: Facility to report jobs. On-going review & monitoring of DATIX Incidents & appropriate remedial action.	4	5	20	Prioritise Identified High Risks	01/07/2019	8
Business Group Risk	686	Hancock, Susan	Integrated Care Business Group	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	20	NHSP working to fill shifts through bank and agencies via the trust agreed agency cascade. AMU currently has an agreed uplift on rate, RN04 rate. Continued recruitment to vacancies	4	4	16	Commencement of recruited staff	29/03/2019	9

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Business Group Risk	765	Jones, Mr David	Women Children and Diagnostics Business Group	There is a risk to the delivery of the CT service and patient safety due to a delay in installing 3rd CT scanner	16	Mobile CT scanner being used to maintain the service at present and extra sessions booked to backfill our CT breakdowns. Mobile MR scanner will be used during down time for install of replacement MR Estates and procurement involved along with Radiology and the capital team in planning this large project	4	4	16	CT/MR Repacement Programme	29/03/2019	4
Business Group Risk	816	Lee, Mr James	Estates and Facilities	There is a risk of injury/death due to loose cladding on DMOP building	20	Survey of cladding condition. Repairs/Remedial works to be undertaken (pending outcome of survey) Estates Team undertaking regular monitoring of cladding condition. Harris fencing in situ around DMOP building.	4	4	16	Survey of Cladding Condition	25/01/2019	8
										Repairs / Remedial Works to be undertaken	25/01/2019	
										Monitoring of cladding condition	28/02/2019	
Trust Risk	618	Featherstone, Nesta	Corporate Nursing	This is a risk of a failure to recognise and adequately treat sepsis within our organisation	12	sepsis screening tool and rolling audit. Introduction of NEWS 2 and quality improvement project	4	4	16	A review is required of the sepsis steering group terms of reference	31/12/2019	8
										Following a none compliance of the sepsis screening tool, an email will be sent to the clinical director of that business group for an investigation	31/01/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
										Business group sepsis leads will prodcue an action plan against their sepsis screening compliance which will be presented to the steering group on a monthly basis	24/12/2019	
										To produce a guidance document for sepsis triggers and completion of screening tool	24/12/2019	
Risk Assessment	869	Heal, Dr Carrie	Women Children and Diagnostics Business Group	There is a risk of harm to patients with current medical staffing levels and threat to sustainability of Neonatal Unit	20	Review of rota and informal support at Consultant level	4	4	16	Business Case to be developed	29/03/2019	8
Trust Risk	125	MR1	Integrated Care Business Group	Reduced Emergency Department Medical Staffing	12	Dependant on internal cover and locum bookings	4	4	16	Persue international recruitment with Edge Hill	31/01/2019	8
										Review consultant rota for 2019	04/02/2019	
										Tracking of temporary staffing use	12/02/2019	
Trust Risk	127	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the M&CS BG overspends due to agency costs	16	Monthly reporting of finance and performance Weekly agency meeting with medical staffing, finance and operational team Regular reviews of nurse eroster rota Ward monthly finance and HR reviews Monthly budget reviews with directorate budget holders	4	4	16	Introduction of medical e-rostering	11/01/2019	12
										Junior Ward Staffing Standard	29/03/2019	
										Review SCF Rota	29/03/2019	
										Review JCF Rota	29/03/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
						Tier 2 authorization of nursing shifts ECP process to approve all agency spend Nursing workforce plan led by corporate nursing team				Review job plans for locum consultants	31/01/2019	
										CD escalation process for locums above cap	28/02/2019	
Trust Risk	429	Curtis, Mrs Kelly	Women Children and Diagnostics Business Group	Inadequate capacity to meet demand in Paediatric ADHD Services	20	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	4	4	16	Advertise additional consultant PA's to provide ADHD Service	29/03/2019	8
										Additional Consultant PA's in post to provide ADHD service	29/03/2019	
										Review pathway for ADHD service	29/03/2019	
										Representation of Business Case	28/02/2019	
Trust Risk	457	Ms. Raisa	ess Group	There is a risk to patient safety due to a lack of Haematology/TransfusionSt	12	In the process to get trained staff in post ASAP. BMS currently in post to join out of hours rota. 1 locum	4	4	16	recruitment of BMS posts	31/01/2019	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
		Zaman,	Women Children and Diagnostics Busine	aff in Post		obtained 06/08/18 T295A however he left due to stress in the middle of October and new locum obtained on 01/11/18 thus we had to again train another member of new staff which still is not sufficient to cover shifts. 2nd locum post for out of hours shift cover advert placed on Tempre-T2P1S and appointed in Aug 2018 . They have been trained in Blood bank in Oct 2018 however due to lack of staff he has not been signed off in Haematology to work OOH so we are still short.Still recruiting via NHS jobs.				Recruitment for Training Lead Bank Post	31/01/2019	
Trust Risk	461	Hatchell, Karen	Surgery GI and Critical Care	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19 including CIP	16	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment eg, physician associates, ANP's etc Validation of all activity with a view to alternativer modes of delivery eg., virtual clinics Robust financial controls in place across the Business Group	4	4	16	Management of Elective Plan	28/02/2019	12
										Support patient flow to ensure surgical admissions are not compromised	28/02/2019	
										Review all the spend across budgets to stop the run rate of spend	28/02/2019	
										Review agency locums and implement 3rd sign off models where necessary	28/02/2019	
										Review of coding to ensure the trust are receiving appropriate income	31/01/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
										Review the efficiency of clinic and theatre utilisation	31/01/2019	
										Work closely with finance dept to ensure supply chain products are appropriately masked	31/01/2019	
										Business Manager to attend budget scrutiny meetings on a bi-weekly basis	31/01/2019	
										Ensure BG representation at weekly CIP executive meeting	31/01/2019	
Trust Risk	466	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the BG will fail to deliver the CIP Target	16	Financial monitoring within BG occurs monthly Financial reports to monitor CIP schemes Tactical CIP schemes developed for the BG Improving patient flow work stream with metrics and governance arrangements Reporting of CIP savings, progress and escalation via Finance Improvement Group	4	4	16	Establish monthly budget review meetings with budget holders	31/01/2019	8
										Establishe exception reporting for ward budget meetings	31/01/2019	
										Introduce new WLI process in BG	29/03/2019	
										Identify first tranche of CIP schemes for 19/20	31/01/2019	
										Establish escalation process for budget holders	28/02/2019	
Strategic Risk	183	KEH	Executive teams	Failure to meet the 62 day Cancer target standards	12	Monthly Cancer Board. Tracking team review all patients on pathway. Cancer Services Manager reviews patients using "Predictor" tool. Patients discussed at weekly tumour specific PTL meetings, Business Group meetings and Trust-wide PTL. Escalation policy in use	4	4	16	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	01/04/2019	8
										Action plan being created with input from Business Groups to ensure sustained performance	01/03/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
										Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	01/04/2019	
Trust Risk	50	Cotton, Mrs Janet	Children and Diagnostics Business Group	Risk to maternity service continuity and safety due to midwifery staffing levels	16	- Birth Rate Plus staffing review undertaken June 2017 - Business case collated and submitted August 2017 - additional staff recruited. - Midwife to Birth Ratio reviewed on a monthly basis and reported on dashboard - Evaluation of maternity service diverts undertaken June 2018 - Escalation of concern reports formally submitted to Quality Board, Quality Governance Committee and	4	4	16	Resubmit outline business case	21/01/2019	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
			Women			People and Performance Committee as appropriate (see documents) - Ongoing recruitment taking place to address any long term deficits. - Maternity leave tracked and recorded to highlight staffing deficit. - RM staff 8.0wte employed in excess of funded establishment to cover maternity leave and deficit highlighted by Birth Rate Plus review following submission of a business case in August 2017.						
Trust Risk	67	Drury, Mrs Margaret	Women Children and Diagnostics Business Group	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	20	Temporary staffing processes in place which is not sustainable. OH support to staff where necessary.	4	4	16	Continuity for locum cover	11/01/2019	8
Trust Risk	75	Waterman, David	Integrated Care Business Group	There is a risk that there could be management of palliative atients due to lack of Specialist Palliative Care Medical Cover	20	During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. Clinical Nurse Specialists attend some cancer MDT's if they have capacity Current Consultant is available for telephone advise in own personal time	4	4	16	There is a risk that Macmillan will not fund ongoing costs of new recruitment in palliative care	31/01/2019	9

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk	78	Ingleby, Mrs Sarah	Medicine and Clinical Support	There is a risk to patient safety and BG finances due to the excessive registered nursing staffing deficit within Medicine & CS	20	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment	4	4	16	Reference to the Minimum safe staffing escalation policy	08/02/2019	8
										Local recruitment	08/02/2019	
										Supporting the retention of staff	08/02/2019	
Business Group Risk	355	Hatchell, Karen	Surgery GI and Critical Care	There is a risk of cancelling elective activity due to bed and patient flow pressures, particularly during the winter months	15	Start the day meetings to assess the position and prioritise patients. In response to NHSI guidance, cease operating on routine procedures. Screened trauma patients to enable the elective orthopaedic units to admit these patients. Elective programme to re-commence on 9th April. Plan in place to de-escalate B3 (discharge or repatriate patients into Medical wards) and deep clean ward, repatriate patients from D2 to B3 and deep clean D2 in preparation for 9th April. Plan in place to maximise opportunity to	3	5	15	Medical involvement in decision making	29/03/2019	6
										Use decision matrix to determine which elective surgery cases are appropriate to cancel during periods of extreme bed capacity and patient flow pressures	29/03/2019	
										Monitor impact of lost activity	29/03/2019	
										Weekly monitoring of activity v plan	31/01/2019	
Trust Risk	638	Catherine	Idren and Business Group	There is a risk to non compliant with HSE guidleines due to CL3 room	15	Report any issues with the digital lock system with estates for immediate review and repair if required	3	5	15	Awaiting a quote for the new CL3 swipe card access	31/01/2019	9

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
		Hatch, Mrs	Women Chi Diagnostics	access and sealing		Report the leaks identified in the report to estates for repair, ensure the leaks are repaired according to the report				Sealing of CL3 ROOM LEAKS	29/03/2019	
Business Group Risk	819	Ryan, Mr Joseph	Estates and Facilities	There is a risk of patients absconding undetected via Ripley Ave due to broken CCTV equipment.	15	View CCTV footage of other areas to ascertain patient location (process of elimination). Security routine search of Ripley Ave when notified of patient absconding.	3	5	15	Arrange Replace CCTV Equipment	31/01/2019	9
										Replacement of CCTV equipment	31/01/2019	
Risk Assessment	825	Hatchell, Karen	Surgery GI and Critical Care	There is a risk to loss of activity due to staffing levels in theatre	15	Sporadic cover depending on who can volunteer for the shifts. Short term sickness and childcare issues cause a deficit due to WTE shortage.	3	5	15	Options appraisal to be drafted to assess the	31/01/2019	6
										Full workforce action plan to be drafted to mitigate the risk	29/03/2019	
Trust Risk	587	Fox, Mrs Paddy	Informa tion and IT	There is a risk to the operation of the Trust electronic syst/ntwrk due	15	Advertising 2 key post; in interim attempting to recruit agency to be in place until substantive recruitment	5	3	15	Recruit to 2 senior IT posts	31/01/2019	10
Trust Risk	513	Statham, Mr David	Estates and Facilities	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards.	15	Survey Specification	3	5	15	Review cleaning programme for Ward Kitchens	31/01/2019	9
										Programme of Food Safety Training for Ward Based Staff	22/02/2019	
Trust Risk	576	Barrett, Mrs Angela	Medicine and Clinical Support	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	- - ring-fenced capacity for 2ww and Cancer upgrade patients - clinical triage of all referrals - patients booked into clinic by clinical urgency / longest wait - monitoring of wait times in Trust performance meetings.	3	5	15	Business Case for expansion to be developed	22/02/2019	6
										Service Review	22/02/2019	
										Additional Clinics	22/02/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
						- Capacity and Demand work completed.				Review of Lung function provision	22/02/2019	
Trust Risk	476	damant, Mrs gillian	Medicine and Clinical Support	There is a risk of not achieving the empiric review of antibiotic prescriptions &reduction in	15	Guidelines on reviewing antibiotics exist and should be embedded in practice already. Antibiotic stewardship ward rounds	3	5	15	Consider additional antibiotic pharmacist post	07/01/2019	6
Trust Risk	499	Buckley, Lisa	Corporate Nursing	There is a risk that complaints responses are not being completed within Trust timescales	15	Action Plan Reports	3	5	15	weekly monitoring of complaints that are overdue	31/01/2019	4
Trust Risk	407	Barrett, Mrs Angela	Medicine and Clinical Support	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed	12	- Urgent OWL codes used to identify patients who need to be prioritised for urgent Follow Up. - Consultants doing some validation of longest waiting patients to see if	3	5	15	Locum (Resp Medicine) to perform WLI	22/02/2019	6
Trust Risk	408	damant, Mrs gillian	Medicine and Clinical Support	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	Staff resources allocated to prioritise patient needs however this can impact on staff wellbeing and cause delays for other work commitments.	3	5	15	electronic prescribing system	01/04/2019	3

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Board Assurance Framework		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR APPROVAL

Corporate objective ref:	N/A
Board Assurance Framework ref:	SO 2
CQC Registration Standards ref:	10,17,18
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

The purpose of this report is to present the Quarter 3 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

The risk rating against 1 principle risk has decreased. All the others remain unchanged.

Work to refine the presentation of the Board Assurance Framework continues.

The Board of Directors is recommended to:

- Approve the Board Assurance Framework for Quarter 3.

Attachments: Annex A – Board Assurance Framework

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Quarter 3 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

2. BACKGROUND

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

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

3. CURRENT SITUATION

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

- Risk 1: Failure to implement the Trust's refreshed strategy – decrease from 12 to 8

3.2 With regard to Risk 1, failure to implement the Trust's refreshed strategy, the decreased risk rating is based on progress made an the comprehensive engagement process and the feedback received from staff.

4. NEXT STEPS

4.1 Work to refine the presentation of the Board Assurance Framework continues. This includes striking a balance of content across the strategic objectives.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the Board Assurance Framework for Quarter 3.

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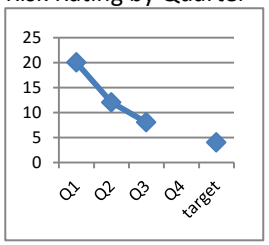
Strategic Objective 1:
To achieve full implementation of the Trusts refreshed strategy

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
11 June 2018	July 2018	October 2018	Well Led NHSI – Use of Resources	Deputy Chief Executive & Director of Support Services	Board of Directors	Finance and Performance

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Target Date**
4	5	20	4	2	8	4	1	4	March 19

Executive commentary for the Current Risk Score

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

Corporate objectives

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

Links to other Strategic Objectives:	SO2, SO3, SO4, SO5, SO6, SO7
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	Partial
Quarter 1 Commentary:	Strategy has not been finalised and embedded. Trust has sought external support from ATTAIN to assist with final product
Quarter 2 Commentary:	The draft refreshed trust strategy was approved at the Board in September 2018 and agreed to go out a three month consultation with staff and stakeholders.
Quarter 3 Commentary:	Consultation is in progress. Approximately 40 meetings with staff and stakeholders have been undertaken and more are planned in

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

	January. There have been face to face discussions with over 600 staff and as a result of their feedback, changes will be made. The revised strategy will be taken to the Board of Directors in February.
Quarter 4 Commentary:	

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

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

SO2

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

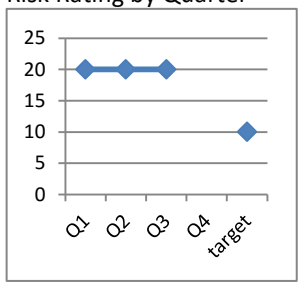
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

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

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

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	2	10	March 2019

Executive commentary for the Current Risk Score

The mitigated risk score is 20 which relates to early improved engagement internally and externally. Strengthening is required of the current action plans, the risk management strategy and framework, and the quality governance framework in order to provide sustained demonstrable improvements and associated assurances at ward, department and business group levels

Corporate objectives

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

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

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

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

	commenced. Walk rounds by senior teams and governors have given positive assurance about patient experience.
Quarter 2 Commentary:	CQC unannounced inspection has been undertaken. Feedback has been mainly positive. Review and progress update has been undertaken on the Quality Governance Framework and Risk Management Framework and been viewed by sub-board committees. Review demonstrated partial assurance with both frameworks with further work to be undertaken
Quarter 3 Commentary:	CQC Well-led inspection has been undertaken. The final report was received in December. Significant improvements in core services with removal of inadequate ratingsin safe and well-led. 12 "must dos" and 45 "should dos" in HSCA regulations; 5, 9, 15, 17 and 18. QIP on track to deliver
Quarter 4 Commentary:	

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
46	There is a risk that the telepath server will fail	20	06/04/2018				
130	Failure to deliver the 4 hour target	20	01/09/2017				
231	Lack of consultant microbiologists and nursing team in IP service	20	02/10/2017				
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	16	02/07/2018		Approved		
183	Failure to meet the 62 day Cancer target standards	20	20/04/2010		16 ↓		
618	There is a risk of a failure to recognise and adequately treat sepsis within our organisation	16	14/08/2018			↑16 from 12	
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	14/02/2018				
506	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	11/06/2018			Closed	
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017		Closed		
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
75	Lack of consultant in palliative care team	16	02/11/2016				
78	Registered Nurse Vacancies	16	21/11/2016	↓ from 20			
96	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	23/03/2017			12↓	
457	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	16	19/04/2018			↑16 from 12	
765	There is a risk to the delivery of the CT service and patient safety due to a	16	25/10/2018			Approved	

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

	delay in installing 3rd CT scanner						
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	05/10/2018			Approved	
476	There is a risk of not achieving empiric review of antibiotic prescriptions and reduction in antibiotics CQUIN 18/19	15	09/05/2018		approved		
286	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	15	22/11/2017			Closed	
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
576	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	01/06/2018				
499	There is a risk that complaints responses are not being completed within Trust timescales	15	07/06/2018				
126	Surges in demand in the Emergency Department	16	11/05/2016	↓ to 12			
137	Pressure ulcers	16	01/09/2016	↓ to 9			
160	Policies and procedures	15	17/11/2011	↓ to 8			
288	Central Venous Access Device Service	15	27/11/2017	↓ to 9			
362	Ketone Testing	15	04/02/2018	↓ to 9			
296	Blood Pressure monitors	15	06/12/2017	Closed			
358	Location of the AI unit	15	26/01/2018	↓ to 9			
346	Use of escalation beds	15	09/01/2018	Closed			

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

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

1	Quality Governance & Risk Management Frameworks in place 2018/2020	• Revised monthly governance reports • Revised quarterly risk register reports at business group/corporate level in development. • Well-Led / Use of Resources initial review required (NHSI Framework).	• 1:1 Meetings • Team Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings • Patient Quality Summit	• Quality Governance Group • QG and sub-groups key issues reports (KIR) • Quality Committee • QC KIR • Integrated Performance Report • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Review *(Please note the above oversight structure will be referred to as Quality Governance oversight throughout the document)*	• Quality Account • CQC rating RI in October 2017 • NHSI Improvement Board • Annual Governance Statement-April 2018 • Quarterly Review Meetings with NHSI • MIAA Review of Committees Report: Partial Assurance • CQC insights report • Internal Audit Programme • MIAA Risk Management & Corporate Governance Report: Partial Assurance	Mock CQC inspection June 2018 Externally facilitated Developmental Review NHSI Well Led Framework required in 2018	Reports to Quality Committee from December 2017 with quarterly monitoring Well-Led / Use of Resources Initial Review April 2018
2	Governance Teams in place	• Review of Governance Team					• Complete and progress Governance Team review
3	Systems in place to address external clinical alerts						
4	Infection Prevention & Control (IPC) Team and supporting strategies & policies	• MRSA Bacteraemia x 2 • Business case relating to IPC Service	• 1:1 / Team Meetings • Harm Free Care Panels • Monthly Business Group Quality Boards • Quarterly	• Infection Prevention and Control Group • IPCG KIR • Monthly MESS data return • Account-April 2018	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • NHSE/NHSI Feedback • Single Oversight		• Business Case being progressed

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

			Performance Meetings	• *Quality Governance oversight*	Framework Segmentation • Quality Account-April 2019		
5	Maternity Dashboard	• MMBRACE	• Maternity champion meetings • 1:1 meetings • Labour ward forum • Maternity Performance meeting • Women's and Children's Quality Board	• *Quality Governance oversight*	• GM Maternity transformation Board • Board of Directors		Bi-monthly maternity champions meetings
6	Quality Improvement Strategy 2018/2019 implementation	• Data access & collective intelligence • Quarterly CQUIN reports	• 1:1 Meetings • Monthly Business Group Quality Boards • Monthly CQUIN report • Quarterly Performance Meetings	• Professional Advisory Group • Quality Safety and Improvement Strategy Group • *Quality Governance oversight*	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • NHSI Improvement Board • Monthly QIS reports • CQC Inpatient Survey-March		• Quarterly review to commence June 2018 • Development of reports / data collection in progress including Model Hospital data.
7	Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence Quarterly CQUIN reports					

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

8	Safety Team established with objectives and associated policies & procedures	• Data access & collective intelligence. • Dashboards by CQC Domains • Accreditation for Continued Excellence (ACE) • Quarterly Quality Reviews • Business Case to support Quality improvements completed •			2019 • Internal Audit Programme • Quality Account-April 2019		• Progress Business Case
9	Patient & Public Involvement Strategy implementation	• PPI Strategy • Patient Experience Strategy • Carers Strategy • Equality and Diversity Strategy	• 1:1 / Team Meetings	• Patient Experience Action Group • Patient Experience Group • People and Performance Committee • PPC KIR • Alliance Provider Board • *Quality Governance oversight*	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019 •	• There is no current PPI, Patient Experience or Carers Strategy • An E&D strategy is in place	• Strategies to be developed and in place by Q4 2018/19
10	Quality Impact Assessment (QIA) Process	• QIA process in place – requires overarching document from May 2018.	• Programme/ Project Team in place	• Medical Director & Chief Nurse reviews • Finance Improvement Group • FIG KIR • Finance and Performance Committee	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating-January 2015 • CQC RI rating-October 2017	• Strengthen reporting and monitoring of QIA process	• Revised QIA Procedure to be implemented

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

				• F&P KIR • *Quality Governance oversight*	• Quality Account- April 2019 • Quarterly Review Meetings with NHSI		
11	Adult & Child Safeguarding Team & policies & procedures.		• 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Safeguarding Group • SG KIR • *Quality Governance oversight*	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		
12	Nursing, Midwifery and Allied Health Professionals Strategy	• Annual Strategic Staffing Reviews	• 1:1 Meetings	• Nurse Leadership walkarounds • Professional Advisory Group • *Quality Governance oversight*	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating- January 2015 • CQC RI rating- October 2017 • Quality Account- April 2019 • Quarterly Review Meetings with NHSI		
13	Learning from Deaths Policy & Mortality Review Process	Report to Quality Committee	• Mortality and Morbidity Reviews • Learning from	• Trust Mortality Reduction Group • CHKS and BIU data & reports	• CQC RI rating- October 2017 • NHS Improvement data	• Mortality data / reporting systems • Lack of triangulation	• Triangulated learning from deaths report • Mortality review structured assessment process

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

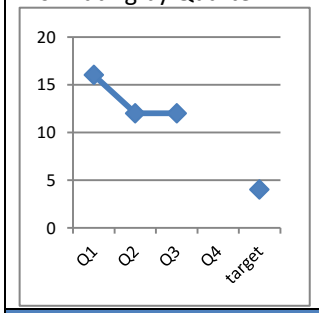
			Deaths Process • 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• *Quality Governance oversight* • Quarterly Learning from Deaths Report from December 2017 • Quality Account- April 2019	• CCG Contract meetings monthly • CCG Quality Visits • CQC Outlier Alert process • Nationally benchmarked mortality data • Advancing Quality Quarterly Safety Reports • Internal Audit Programme:		• Deteriorating Patient Safety Collaborative April 2018
13	7 Day Clinical Services	Clinical Directors Forum	1:1 / Team meetings Business Group Quality Boards Quarterly Performance Meetings	• Quality Governance Group			

Strategic Objective 3:
To strive to achieve financial sustainability

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

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

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	3	12	4	1	4	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score relates to urgent actions that the Trust must enact in order to deliver the financial plan. The Trust has delivered the financial plan at the end of quarter 2. Whilst the Trust delivered the CIP plan to the end of September, there remains a significant shortfall for the financial year.
If the action come within the planned parameters then the risk will reduce to a likelihood of 1

Corporate objectives

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

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

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

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

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

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

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

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

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

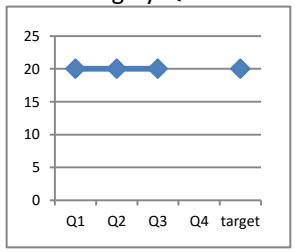
			Group Accountants 1:1s • Weekly CIP development meetings chaired by COO • Operational performance group to hold Business Group directors to account				

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

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

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

Risk Rating by Quarter



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

Executive commentary for the Current Risk Score

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

Corporate objectives

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

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

Quarter 2 Commentary:	The governance arrangements have been reviewed a revised provider board is in place; however there is still ongoing delay with implementing the new models of care within the neighbourhoods and within outpatients. There is also the need to review progress with the ambulatory care model.
Quarter 3 Commentary:	The provider board has been unable to meet in the later part of Q3, thus resulting in little progress. Leadership and governance arrangements are being reviewed by Stockport System Senior Leadership (CEOs) in January to refocus priorities.
Quarter 4 Commentary:	

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

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

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Engagement in Stockport Provider Alliance Board	• Trust Strategy	• 1:1's • Team meetings	• Executive Management Group • Board of Directors	Greater Manchester Combined Authority	• Scale & pace of change • Relationship building with key partners • Governance Arrangements	

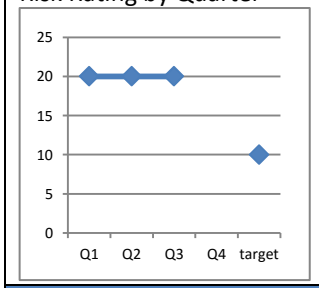
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

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

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

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	2	10	31/10/2018

Executive commentary for the Current Risk Score

Concerns around emergency Department performance, cancer waits and RTT. Plans are in place to enable improve the position recovery by end of Quarter 3

Corporate objectives

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

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

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

	patients requires a system wide solution. Diagnostics is compliant. Improvement trajectories for cancer are in place for Q3. The area of concern would be breast 2WW and this has been escalated to GM and NHSI for partner support and resolution. The RTT recovery plan has been complied in partnership with colleagues from the CCG based in the reduction of GP referred activity through CCG-led referral management schemes. Comprehensive data validation. A clinical review of discharge criteria and clinical management. We have commenced a review of inpatient medical ward management. The delivery director has commenced and has undertaken a full review of flow across the organisation and implemented a robust monitoring system to meet expected standards. Well led review in October.
Quarter 3 Commentary:	Benefit realisation of system wide plans have not come to fruition. Performance regarding the 4 hour target remains under trajectory. This is unacceptable. System wide stranded patient board is reviewing in-hospital, out of hospital and out of areas drivers. Winter plans have not been able to be fully implemented due to staffing constraints. Cancer performance has seen a significant improvement in the later part pf Q3 with an expected continued improvement on Q4. Breast 2 week wait is now compliant. Focus has been on reducing the RTT waiting list size to March 18 levels. The trust remains at a 4%behind improvement trajectory but has seen an increase in GP referrals of 4.5%.
Quarter 4 Commentary:	

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

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	16	02/07/2018		Approved		
130	Non delivery of ED 4 hour performance	20	01/09/2017				
183	Failure to meet the 62 day cancer target standards	20	20/04/2010		↓16		
506	There is a risk that winter pressure son ED, patient flow and capacity will affect the delivery of the 2018 – 19 elective plan in ortho	16	11/06/2018			Closed	
96	There is a risk of lack of capacity for timely outpatient reviews in the ophthalmology department	16	23/03/2017			12↓	
286	There is a risk to patient experience due to Endoscopy capacity and demand	15	22/11/2017			Closed	
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
162	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, quality experience and Trust reputation	15	06/07/2017			12 ↓	

SO2				
Key Controls / Influences Established (What are we currently	**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**	**Gaps in Assurance on Controls / Influences (What additional**	**Agreed Actions for Gaps in Controls / Influences or Assurances**

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

doing about the risk?)			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Bi- Monthly Performance Reports	• External influences on medically fit for discharge patients • Insufficient community capacity • Failure to deliver sustainable Stockport Together programme •	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Bi-Monthly Performance Management Group Meetings • Operational Performance Group • OPG minutes and KIR	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors • Executive Management Group	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • Urgent and Emergency Care Delivery Board • Internal Audit Programme:	•	
2	Improving patient flow programme	• Staff engagement • Transformation support • Finance support • Winning hearts and Minds • Changing culture • Embedded new practice	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Bi-Monthly Performance Management Group Meetings • Finance improvement Group	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors • Executive Management Group	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • Urgent and Emergency Care Delivery Board • Internal Audit Programme:		

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

			• Operational Performance Group • OPG minutes and KIR				
3	Quality Impact Assessment Process	• Development of overarching document • Completing the Quality Impact Assessments •	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Bi-Monthly Performance Management Group Meetings • Financial Improvement Group (FIG)	• Medical Director and Chief Nurse & Director of Quality Governance approval of QIAs • F&P Committee • Board of Directors	• CQC rating Monthly CCG meetings • NHSI Oversight	• Strengthen reporting and monitoring of QIA process	
4	Emergency Planning (EP) & Business Continuity	•	• 1:1 meetings • Desktop exercises	• Emergency Planning Group • Board of Directors • NHSE Emergency Preparedness, Resilience and Response Self-Assessment Substantial Assurance Return-October 2017 – did that go in	• Emergency Preparedness, Resilience and Response NHS England submitted-when did we submit?		
5	Non elective performance	Capacity and demand oversight Analysis reports	• Urgent care operational	• Urgent care delivery Board	• CQC • NHSI		

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

		Data and KPI Performance monitoring	group • Programme development group	• Executive management Group • Finance and performance committee	• GMCA		
6	Elective performance	Business Group PTL's Trust wide PTL's RTT and Cancer Monitoring OWL Clinical pathways Staff training	• Operational performance group • Cancer Board	• Executive management Group • Finance and performance committee	• CQC • NHSI • GMCA		

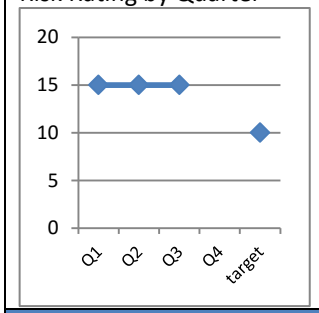
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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

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

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

Risk Rating by Quarter



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

Executive commentary for the Current Risk Score

Current mitigation includes recruitment and retention strategy. Comprehensive 3-5 year People Strategy approved at September Board. Comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work using the NHSi Culture Programme. Ongoing challenges are national recruitment situation and the improvement required on staff retention

Corporate objectives

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

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

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

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

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

Quarter 2 Commentary:	Key workforce KPIs remain stable. Recruitment to key medical posts. Agencies spend above cap. Enhanced retention strategy and culture plan.
Quarter 3 Commentary:	Progress continues on KPI performance and recruitment strategies that have been implemented have started to reduce agency spend. Culture programme has been launched. Enhanced retention strategy continues to be a priority.
Quarter 4 Commentary:	

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

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

SO2

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

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

1	Recruitment and retention strategy: Building line manager capability Using reward in recruitment and retention Targeted recruitment campaigns	• GM theme 3 – employer banding and streamlining • Develop guidance on job design for managers • Undertake a review of all vacancies that are not filled and those that are vacated in a year to ensure jobs are designed well • Include benefit and reward information in recruitment campaign for applicants and the induction process for new starters • Implement 'refer a friend' scheme for difficult to fill posts • Benchmark with other Trusts in Greater Manchester and identify associated costs - Prepare proposal paper. • Run focussed campaigns for areas with high vacancy rate to include: • National advertising • Development of recruitment microsite • Vacancy and business group specific recruitment literature • Ensuring a Trust presence at	• WEG • CEG • Staff survey • Workforce reports • Staff friends and family • Workforce KPI's • Temporary staff meetings • JLMC • JNC • Training needs analysis • Schwartz rounds	• People and performance Committee • Executive management board • Trust Board	• Greater Manchester Combined authority • NHSI • CQC	• Employment market – key skills shortage • Building leadership skills to support change and improvement	• Workforce remodelling • Proactive workforce plan • Just culture programme

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

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

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

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

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

3	People strategy:	• Signed off strategy					

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

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

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

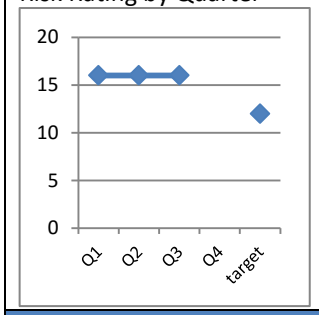
		consistent use of all functions • Implementation of the 'Just Culture' approach to restorative practice, learning and support					
4	Operational plan	• Delivery of plan					

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

Principal risk	There is a risk in not delivering the trust capital programme in a planned and efficient manner

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

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	3	12	4	4	16	4	3	12	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score is 16 which relates to a reduced planned spend, agreed capital programme against risk assessed concerns. Benefits of EPR have not yet been realised and there is a delay in go live. In addition, significant capital investment is required which has not yet been secure.

Corporate objectives

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

I. Medical equipment
II. IT
III. Estates

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

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

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

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

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

SO2

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

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

1	Risk assessment for each area	Further review on all risks	• CPDG	• Executive management Group • Finance and performance committee	• Greater Manchester CA		
2	Signed off capital programme for 18/19 operational plan	Review when changed information	• CPDG	• Executive management Group • Finance and performance committee	• Greater Manchester CA		

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

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 January 2019
Subject:	Remuneration 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 Remuneration Committee's Terms of Reference for approval following periodic review.

Attachments: Annex A – Draft Remuneration Committee Terms of Reference

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Remuneration Committee's Terms of Reference for approval following periodic review.

2. BACKGROUND

2.1 Terms of Reference for the Remuneration Committee were last reviewed and approved by the Board of Directors on 27 October 2016. Consequently, the Terms of Reference are now due for periodic review. The Terms of Reference were reviewed by the Remuneration Committee during a meeting held on 29 November 2018.

3. CURRENT SITUATION

3.1 Current Terms of Reference for the Remuneration Committee are included for reference at Annex A to this report. The content of the Terms of Reference is based on a best practice model included in an NHS Providers publication *The foundations of good governance: A compendium of best practice*. The content clearly defines the Committee's functions relating to both Remuneration and Appointments and reflects the relevant requirements set out in the NHS Foundation Trust Code of Governance.

3.2 The review completed by the Remuneration Committee did not result in any proposed amendments to the current Terms of Reference and a recommendation was made to the Board of Directors for approval.

4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications arising out of the subject matter of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the Terms of Reference for the Remuneration & Appointments Committee included at Annex A of the report.

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REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee, to be known as the Remuneration and Appointments Development Committee *(hereinafter referred to as 'the Committee')*. The Committee has no executive powers, other than those specifically delegated within these terms of reference.

2. MAIN PURPOSE

2.1 To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2.2 When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act.

3. APPOINTMENTS ROLE

3.1 The Committee will:

i. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board, and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.

ii. Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

iii. Keep the leadership needs of the Trust under review at Executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

iv. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

v. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria.

vi. Ensure that a proposed Executive Director's other significant commitments, if applicable, are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

vii. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

viii. Ensure that proposed appointees satisfy the relevant Fit and Proper Person requirements.

ix. Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

4. REMUNERATION ROLE

4.1 The Committee will:

i. Establish and keep under review a remuneration policy in respect of Executive Directors and senior managers on locally-determined pay (VSM).

ii. Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

iii. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors, and senior managers on locally determined pay, including:

- salary, including any performance-related pay;
- provisions for other benefits, including pensions and cars;

- allowances;
- payable expenses; and
- compensation payments

iv. Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

v. Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, and senior managers on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them.

vi. Be sensitive to pay and employment conditions elsewhere in the Trust.

vii. Monitor and assess the output of the evaluation of the performance of individual Executive Directors and consider this output when reviewing changes to remuneration levels.

viii. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments to avoid rewarding poor performance.

5. COMPOSITION AND CONDUCT OF THE GROUP

5.1 The Committee shall comprise the following membership:

- Trust Chairman (Chair)
- Non-Executive Directors
- Chief Executive (when appointing Executive Directors other than the Chief Executive)

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.

5.2 The following post-holders shall routinely attend meetings of the Committee in an advisory capacity:

- Director of Workforce & Organisational Development

5.3 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.

5.4 Any non-member, including the Secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

5.5 ***Quorum***. No business shall be transacted unless at least four members, to include either the Chairman or Deputy Chairman, are present.

5.6 ***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.

5.7 ***Frequency of meetings***. The Committee will, as a minimum, meet on a six-monthly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 5.6 above.

5.8 ***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.

5.9 ***Administration***. The Committee shall be supported administratively by the Company Secretary, 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.

6. DELEGATED AUTHORITY

6.1 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.

7. RELATIONSHIP WITH THE BOARD OF DIRECTORS

7.1 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.

8. REVIEW

8.1 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.

8.2 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 s8.1 will include a summary on compliance with the Terms of Reference.

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