NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

31 JULY 2019

Your Health. Our Priority.

Board of Directors bundle- PUBLIC MEETING - 31 July 2019 - FINAL

This page has been left blank

NHS Stockport NHS Foundation Trust

Board of Directors Meeting
Wednesday, 31 July 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		**C Wasson**
0950	**5.**	Minutes of Previous Meeting: 27 June 2019	✓	**A Belton**
0955	**6.**	Chair's Report	✓	**A Belton**
1000	**7.**	Chief Executive's Report	✓	**L Robson**
	8.	**FOR ASSURANCE**		
1010	8.1	Performance Report	✓	**H Mullen**
1040	8.2	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee • Audit Committee	✓	**Committee Chairs**
1050	8.3	Quality Improvement Plan Update	✓	**A Lynch**
1100	8.4	Learning from Deaths Report	✓	**C Wasson**
	9.	**FOR DECISION / APPROVAL**		
1110	9.1	Constitution Report	✓	**C Parnell**
	10.	**FOR NOTING**		
1120	10.1	Implementation of NHS Long Term Plan (Presentation)		**H Mullen / J Graham**
	11.	**CONSENT AGENDA**		
1130	11.1	EPRR Annual Report	✓	
	12.	**DATE, TIME & VENUE OF NEXT MEETING**		
	12.1	Thursday, 26 September 2019, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.		

This page has been left blank

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
Tuesday, 27 June 2019
9.30am in Lecture Theatre B, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Mr G Moores	Director of Workforce and Organisation Development
Dr M Cheshire	Non-Executive Director
Mr J Graham	Director of Finance
Mr D Hopewell	Non-Executive Director
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mr H Mullen	Director of Strategy, Planning & Partnerships
Mrs L Robson	Chief Executive
Mr M Sugden	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

In attendance:

Mrs S Katema	Committee Secretary
Mrs C Woodford	Director for Women, Children and Radiology Business Group
Ms LJ Woodward	Locality Lead (Health & Early Intervention)
Ms R Lee	Parent for Patient Story

ACTION

151/19 Apologies for Absence

The Board noted apologies for absence from Mrs C Parnell.

152/19 Declarations of Interests

There were no declarations in relation to the agenda items.

153/19 Opening Remarks by the Chair

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

154/19 Patient Story

Ms Lee, Mrs Woodford and Ms Woodward joined the meeting.

Mr Mullen informed the Board that the patient story focused on the Stockport Family Service Pilot, led by the Integrated Early Year's team which comprised of colleagues from Stockport local authority and the Trust. He invited the team to deliver their presentation.

Ms Woodward advised that the Early Years team operated in Brinnington, one of the most deprived areas within Stockport. Commissioners had analysed the 2015 entry data of preschool children and identified developmental delays in 2year olds as well as the increasing levels of need and risks within families. Several referrals had also been made to both educational psychologists and Speech and

Language therapists due to the high proportion of preschool children with significant delays with communication and language development as well as personal and social development.

Ms Woodward outlined that there was a greater understanding across the workforce and partner agencies regarding the impact of integrated working. The team established a place based approach to improve school readiness in Brinnington and piloted new ways of working which in turn, improved outcomes for children and their families.

In relaying her experience of the Early Years' Service, Ms Lee advised that she was a single mother of two children that had lived, worked, and volunteered in Brinnington. Ms Lee outlined the support she had received which enabled her to retrain and ultimately secure employment with Ladybird Nursery in Brinnington. In addition, she had completed the Empowering Parents, Empowering Community (EPEC) training programme and was now delivering the programme to fellow parents. The EPEC programme sought to engage with parents and promoting focus on the parent/child interaction as well as supporting child and school readiness through different home learning techniques.

The Board viewed a video which emphasised the need for good links and relationships within the community. It provided an overview of the work of the Early Years Team and the need for consistency and continuity of care when working with children and families. The team acknowledged the important role that parents played in the development of their children. It was expected that programmes such as EPEC would empower parents to train so they could also deliver the programme to other parents. This shared vision and learning from the work in Brinnington had influenced the development of the Start Well Early Years Integrated Strategy. Mrs Woodford outlined that Start Well Early Years Integrated Strategy provided innumerable benefits to the community as the team could offer and monitor vaccinations, child development, emerging health and mental health issues. She added that promoting the restratification in the Early Years Strategy would enable the measurement of child level data and improved outcomes for children.

In response to Mr Moores' observation regarding integrated working, Ms Woodward stated that what made it work well was a combination of the right culture, a shared understanding, mutual respect and opportunities to trial new ways of working. Mrs Woodford highlighted the need for investment in the workforce advising that every single member of the team had received relationship building training.

Dr Cheshire asked if consideration had been given to other population groups that could benefit from a similar type of fully integrated key worker approach. Mrs Woodford advised that the programme was being scaled up and had already spread to five boroughs of Greater Manchester. Mr Belton thanked the team for attending and delivering their presentation. It was agreed that this would be a good story to share with external system partners such as the Health and Wellbeing Board as it demonstrated the best practice model for the system.

Ms Lee, Mrs Woodford and Ms Woodward left the meeting.

The Board of Directors:

- Received and noted the Patient Story.

155/19 Minutes of the previous meeting

The minutes of the previous meeting held on 28 May 2019 were agreed as a true and accurate record of proceedings subject to amending minute reference 140/19 to reflect Baroness Dido Harding's title.

The action log was reviewed and annotated accordingly.

156/19 Chair's Report

Mr Belton presented a report informing the Board of the activities undertaken since the previous meeting. He informed the Board that the winter period had been the toughest on record with regards to Emergency Department (ED) performance and formally thanked all members of staff for their hard work in spite of the sustained amount of pressure.

Mr Belton advised that following the appointment of Cllr McGee as Deputy Leader of Stockport Council, Cllr Jude Wells had been appointed to the combined health and adult social care portfolio. He advised that Cllr Wells would be joining the Trust as an appointed governor and formally thanked Cllr McGee for his contribution to the Council of Governors.

Mr Belton drew attention to the following key points:

- The Trust's achievement of the Veteran Aware Trust accreditation.
- The progress with the recruitment of a non-executive director following the interview process.
- The appointment of Andrea Green as Accountable Officer for Stockport Clinical Commissioning Group (CCG).
- The Board Schedule of business would be added to the agenda for future meetings.

The Board of Directors:

- Received and noted the Chair's Report.

157/19 Report of the Chief Executive

Mrs Robson presented her report outlining national and local, strategic and operational developments. She drew attention to the following key points:

- The Trust had experienced the highest ever recorded ED attendance rate despite being in summer adding that there was a huge focus on ED performance nationally. A particular challenge for the Trust was the non-admitted patients breaching the four hour standard, overnight performance, and keeping patient flow moving at weekends.
- The One Year On event had been held the previous day and had seen attendance by the Governors and non-executive directors. The event showcased the amount of hard work undertaken across the Trust by teams on agreed standards.
- Her delivery of an introductory speech at the Orthopaedic Fractured Neck of Femur event which was hosted by the Trust on behalf of the GM Orthopaedic Network. The event was attended by clinicians from all trust in GM and was led by Prof David Johnson.
- Engagement events such as Meet the Execs sessions had now been

introduced and provided an appropriate vehicle for improving communication and engagement with all members of staff.

- Reiterated the importance of having the right staff with the right skills in the right place and welcomed the publication of the interim NHS People Plan. This aligned with the Trust's People Strategy and provided an opportunity to review Vision, values, and behaviours within the Trust. Engagement sessions with internal and external stakeholders and the Council of Governors would be taking place in the next few weeks.

Mrs Robson commended all members of staff for their hardwork and commitment acknowledging that there was still a lot more work to do.

In addition, Mrs Robson referred to the chair's report which mentioned partnership working advising that all members of the Executive Team continued to work closely with their respective peers across Stockport, Greater Manchester and East Cheshire.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

158/19 Performance Report – Month 2

Mr Mullen presented the Trust Performance Report for Month 2 which provided a summary of performance against key performance indicators. The Board briefly discussed the IPR and agreed that the narrative needed to be more forward looking.

Chief Operating Officer

Ms Toal outlined the key issues and performance against indicators for June 2019. She advised that:

- The Trust did not achieve the 1% Diagnostic standard in month due to capacity within Echocardiography; however, a small number of breaches occurred, which impacted on outpatient activity, due to the CT scanners breaking down and the service having to prioritise.
- The Trust achieved the improvement trajectory milestone set for May on the Cancer 62 day performance.
- Orthodontics demand increased threefold due to increased demand as a result of surrounding providers closing services. This was being closely monitored and series of weekly discussions with NHSE were taking place.
- One patient commenced treatment beyond day 104 of their pathway in May. The patient was a late transfer from another hospital requiring further diagnosis and treatment at Stockport.
- Clinical correspondence performance improved overall in May.
- Good progress was noted regarding the number of overnight breaches on Medical wards.
- Ed 4-hour standard and overnight breeches

Mrs Robinson advised that the Trust had faced exceptional circumstances following the breakdown of 2 CT scanners. She commended the team for the rapid and robust response applauding their excellent performance in recovering the time lost during the breakdown. Mrs Robson outlined that staff had come in to help outside of their normally working hours and thanked them for their efforts and dedication in ensuring the continued delivery of safe patient care.

Dr Wasson queried if there was an improvement in performance against the Stranded indicator. Ms Toal responded that this required tracking carefully as it was measured at point of discharge.

In response to Ms Lynch query regarding headlines stemming from the 104 Day breaches, Ms Toal outlined that no emerging trends or initial issues identified following initial Root Cause Analysis (RCA).

Medical Director

Dr Wasson presented the update in relation to the below indicators:

- 12-hour trolley wait remained a cause for concern. There was assurance that patients were kept safe and have been well looked after.
- Diabetes reviews
- Timely identification and treatment of Sepsis
- The number of medication errors increased from 3.62 to 4.00 per 1000 bed days
- There was good improvement in performance of the Discharge summaries
- A total of 13 incidents that were reported on the Strategic Executive Information System (StEIS). This was an decrease of 5, compared to last month. The incidents reported on StEIS were:
    - 6 reported 12 hour ED breach incidents
    - 3 maternity diverts
    - 1 safeguarding incident
    - 1 missed diagnosis
    - 1 instance where a patient had a fall that resulted in a fractured neck of femur
    - 1 incident where both CT scanners failed causing service disruption diverts

Chief Nurse and Director of Quality Governance

Ms Lynch provided an update on the following Quality and Safety indicators:

- 5 C.Diff infection cases were recorded in April and there were zero cases of MRSA.
- 1 fall was recorded in month which resulted in a fractured neck of femur adding that investigations were underway
- Complaints rates were continuing to improve
- 6 patients had been reported to be beyond the 52 week Referral to Treatment standard. Weekly reviews and escalations of any patient waiting beyond 38 weeks were continuing. It was noted that two of the cases related to patient choice

Ms Lynch outlined that she had attended the Trusts' Pressure Ulcer Collaborative event. She commended teams that had been presented with awards for having gone 190days and 600 days without a pressure ulcer incident.

In response to Dr Cheshire query regarding a coordinated approach to CDiff cases and antibiotic stewardship, Miss Lynch responded whilst there was ongoing work at the CCG regarding this, the Trust had now recruited a Consultant Microbiologist, Dr Ibrahim Hassan who would also be looking into this.

Dr Cheshire queried if norovirus incidents were captured anyway as it could result in ward closures and how the Board would be alerted of any incidents. Ms Lynch responded that incidents would be reported through exception reports to the Board. Dr Wasson advised that he was not aware of outbreaks in the residential home or of any cases that had spread to the hospital. It was agreed that Dr Cheshire and Ms Lynch could follow up discussions regarding norovirus offline and report back to Quality Committee.

Mr Graham commended the Trust performance regarding pressure ulcers and asked if there were areas where the learning could be spread. Ms Lynch responded that the safety collaborative had been used to educate and train staff adding that other areas were continuing to join the pilot.

Director of Finance

Mr Graham presented an update regarding the financial position for May. The following key points were noted:

- The financial position was in line with the overall plan; the Trust has delivered a deficit against the NHSI control total of £3.8m as planned. However, in achieving this, the Trust delivered less activity and income than plan and also spent less than plan.
- The Trust borrowed £1.6m in May
- An informal request had been received from NHSI/NHSE regarding the level of capital expenditure due to the over-commitment on the capital expenditure.
- The Trust was £0.3m favourable to the profiled CIP plan to date.

Mr Graham outlined that there was a significant risk to the delivery of the total CIP programme in 2019/20. At month 2 the Trust identified £9.1m of schemes and was working to identify schemes in order to bridge the £5.1m gap to the £14.2m requirement for 2019/20. Mr Graham added that external support had been sought with regards to improving the CIP position and therefore providing additional areas of focus. They would be providing support for a 6 to 7 week period.

Mr Sugden highlighted that the Finance and Performance Committee took significant assurance on Q1 and Q2 performance and took limited assurance regarding the delivery of CIP programmes for the year.

Responding to Mrs Anderson's question regarding any opportunity to push back on the proposals, Mr Graham outlined that this related to the Department of Health and Social Care (DHSC) capital. He outlined that the expectation was that Greater Manchester would be given the overall figure for the system.

Mr Sugden observed that the Trust Capital programme was relatively small and asked if there was a mechanism to look at the scale of capital programmes in comparison with the size of the Trust. Mr Mullen advised that it was highly likely that the focus of the reduction in capital spend would be the Stockport Healthier Together Programme.

Director of Workforce and Organisational Development

Mr Moores presented the Workforce report and drew attention to the following

- Sickness levels had increased. It was expected that the new managing sickness absence policy would enable the Trust to be more proactive and robust against managing absence.
- The rolling 12-month permanent headcount unadjusted turnover figure at the end of May was 13.87% which was below the Trust target.
- Appraisal rates for non-medical staff was below the trajectory of 95%. Reporting arrangements were continuing with support being given to managers to enable them to focus efforts on areas of non-compliance.
- Total spend on bank and agency costs was 11.5% of the total pay spend. Mr Moores outlined that work to re-profile agency spend was ongoing and this included increased use of Bank staff.

Ms Lynch provided a brief overview of the Safer Staffing Report. She reassured the Board that staffing levels in Ward D4, a short stay ward, had not gone below the required standard. The Matron was very supportive as this was a difficult situation for the ward manager.

The Board of Directors:

- Received and noted the Integrated Performance Reports.

159/19 Key Issues Reports from Assurance Committees

The Assurance Committee chairs presented their reports to the Board. It was agreed that issues detailed in the reports, were consistent with those discussed during the Integrated Performance Reports presentation.

The Board took assurance from the Key Issues Reports from the following committees:

- Quality Committee
- Finance and Performance Committee
- People Performance Committee

The Board of Directors:

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

160/19 Inpatient Survey Results

Ms Lynch and Mrs Howard delivered the presentation which provided an overview of the results for the Inpatient Survey 2018.

Mrs Howard outlined that the presentation would provide a high level analysis which summarised the comparison to the 2017 survey and the comparison to external trusts. The following key points were noted:

- The survey had been conducted by Quality Health, marking a change from Picker
- The survey had nine sections which were designed to mirror the service user journey.
- There was an improvement in the response rate from 40.9% in 2017 to 46%.
- The next steps would include a review of the areas for improvement including sections and individual questions
- Business groups would be notified of their top 5 worst performing

questions following completion of monthly patient satisfaction surveys. The progress would be monitored by the Patient Experience Group.

Mrs Howard outlined that the new Inpatient Survey would be launched in July and would continue throughout July across the hospital. She outlined that her team would continue the drive to improve positive patient response rate

The Board:

- Received and noted the Inpatient Survey Results.

161/19 Mortality Data Review

Dr Wasson presented the report which provided an update on the Trust's mortality data. He outlined that there was a divergence between the way the Trust monitored outcomes using the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality (SHMI) indicators.

Dr Wasson outlined the main difference between HSMR and SHMI indicators which was that:

- whilst HSMR excludes deaths with a specialist palliative care code, SMHI did not
- HSMR looked only at in hospital death whilst SHMI included death within 30 days of discharge.

Dr Wasson provided an overview of the areas of focus and highlighted the trends over the previous six months. A key area was ensuring the accuracy of clinical coding as this impacted the mortality index. Poor coding of diagnosis would often reduce the expected risk of mortality thus worsening the result. In terms of benchmarking against peers, Dr Wasson advised that whilst the Palliative care coding rate increased, the Trust was 50% lower than its North West peers.

Dr Wasson outlined that it was widely recognised that patients died and the role of the hospital was to ensure the death was managed effectively. He outlined that many patients preferred to die supported in their own homes and listed some of the incentives the Trust was looking at in order to improve the facilitation of dying patients in their preferred place of death. These included:

- Earlier identification of palliative care needs and deterioration both in community and acute sectors
- Future care planning discussions with patients and their families
- Sharing of this key information, with the patient's consent, with other professionals

The Board agreed with Dr Wasson's request for the Mortality Dashboard to be included to the Board Schedule of Business as a biannual agenda item.

Mr Graham added that Mersey Internal Audit Agency (MIAA) was currently conducting a review on Clinical Coding and had noted the good data on mortality and outcomes.

Action: The Mortality Dashboard to be included to the Board Schedule of Business as a biannual agenda item. **Governance Team**

The Board of Directors:

- Received and noted the Mortality Data Review Update

162/19 Fit and Proper Persons Test Report

Mr Moores presented the Fit and Proper Person's Test (FPPT) Report which provided assurance that the Trust continued to meet its Governance requirements as well as promoting an open and honest culture.

The Board agreed with the recommendation that all individuals falling within scope of the FPPT, needed to register with the update service. This would provide the Trust with continual assurance and immediate notification of any change in the individual check status.

The Board of Directors:

- Received and noted the Fit and Proper Person's report noting the progress against CQC actions.
- Approved that all directors within scope of the FPPT should register with the DBS update service and that FPPT checks be included in the director appraisal process.
- Approved that core competencies should be embedded in all role descriptions, selection processes and development plans on completion of the consultation on competencies led by Baroness Dido Harding.

163/19 Seven Day Services Report

Dr Wasson presented the Seven Day Service report which provided assurance and outlined the progress against the 7 day National standards.

Dr Wasson outlined that the mandated report was a national directive and included a self-assessment template that was set nationally. He provided an overview of the Trust's self-assessment against the Clinical Standards. The following key points were noted:

- The Trust was not compliant against Clinical Standard 5 as there were no Echocardiography or MRI tests at the weekend. .
- The Trust was not compliant against Clinical Standard 6 for weekdays in Interventional Endoscopy as this was only available through informal arrangement

ACTION: The Seven Day Services Update to be included on Board Schedule of Business in the next six months. **Governance Team**

The Board of Directors:

- Received and noted the Seven Day Services Update
- Approved the national submission of the report by the 28th June 2019 (deadline for submission).

164/19 Primary Care Networks – Update on the impact on community services

Mrs Malkin joined the meeting

Mrs Malkin provided the Board with an update on the Trust's response to the establishment of seven Stockport Primary Care Networks (PCNs). It was noted that there was a need for clarity around the intentions of the Local Authority in

order to ensure the success of the PCNs as the Adult Social Care Services were undergoing a service review which could result in further changes to their current structures and configurations.

Mrs Malkin outlined that initially, Stockport CCG had presented a strategy document around primary care network governance advising of the processes in place. These included eight neighbourhoods that were working together very well. However, issues regarding the splitting of Stepping Hill Locality had highlighted the need to consider the impact on community services. She provided an overview of the options for the Trust community services which would ensure the proposed seven PCNs were supported in a coordinated and cohesive manner.

The Board discussed the proposals and in particular, considered whether to contest the decision as across the wider North West, as some patches had also contested. It was noted that the mechanism for highlighting the concerns would be the Stockport Healthcare Partnership Board. The Board expressed concern regarding the decision being taken without an impact assessment. It was noted that there was a danger to patients and the coordination of their care which risked being compromised. It was noted that there was a need for a better approach to governance and building on what worked and in order to ensure there was coterminosity across partnership organisations.

The Board noted the potential risks that the new networks could pose to current community services and the work being undertaken to explore how the Trust's community services could support the establishment of PCNs. It was agreed that given the strength of feeling around the Board, a response to the decision would be made on behalf of the Trust Board.

The Board of Directors:

- Received and noted the Primary Care Networks report.
- Approved that the Trust should issue a response on behalf of the Board of Directors.

165/19 Governance Declarations

The Board received the draft Governance Declarations for consideration.

The Board of Directors:

- Considered and approved the draft declarations included at Appendix 1 to the report.

166/19 Closing remarks and feedback

In his closing remarks, the Chair thanked all members and observers for attending. A member in attendance queried why the Trust had changed from Picker for the Inpatient Survey and asked why this had only just been presented. Ms Lynch responded that this was a national survey conducted by Quality Health who also conducted surveys for other trusts. She added that the survey results had been embargoed until June.

Ms Lynch outlined that the Council of Governors would be able to see the IPR

and specific themes outlined at the Safety Collaborative.

167/19 Date, time and venue of next meeting

There being no further business, the Chair brought the meeting to a close at 1215

Mr Belton advised that the next public meeting of the Board of Directors would be held on Wednesday, 31 July 2019, commencing at 9.30am in Lecture Theatre A, Pinewood House.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
37/18	29 Nov 18	280/18	Medium Term Financial Strategy	The Board approved the Medium Term Financial Strategy and agreed that the Strategy would be reviewed in March 2019. **Update 28 Mar 2019:** The action would be put on hold until the incoming Director of Finance is in a positon to review. An update to be provided at the June meeting. **Update 27 June 2019:** Mr Graham outlined that NHSI and NHSE were expected to issue planning guidance later in the day. He would provide an update in July.	Mr F Patel (Director of Finance)
01/19	31 Jan 19	09/19	Trust Performance Report – Month 9	In response to a comment from the Chair, it was agreed that Urgent & Emergency Care system resilience should be incorporated in the Winter Plan review in April 2019. **Update 28 Mar 2019:** This would be reviewed at the April Board meeting. **Update 29 May 2019 –** Ms Toal advised that this would come through in the next meeting. **Update 27 June 2019:** Deferred to July meeting.	S Toal (Chief Operating Officer)
04/19	28 Feb 19	30/19	Quality Committee Key Issues Report	In response to comments from a number of Board members, who endorsed and commended the safety collaborative method, it was agreed to invite the Matron of Tissue Viability to deliver the Pressure Ulcer presentation at a future Board meeting. **Update 28 Mar 2019:** Action carried forward. **Update 25 April 2019:** The action was ongoing with the expectation that this would be presented as a patient story in September. **Update 27 June 2019**: Following the Pressure Ulcer collaborative event, the Tissue viability nurse had been invited to present in **September.**	A Lynch (Chief Nurse)

05/19	28 Mar 19	54/19	Performance Report – Month 11	The Chief Nurse to provide report in **July** highlighting the implications and a gap analysis following publication of the National Patient Safety Strategy. **Update 27 June 2019**: An update would be provided in line with normal processes. **Action complete.**	Ms Lynch (Chief Nurse)
06/19	28 Mar 19	54/19	Performance Report – Month 11	The Chief Operating Officer to facilitate a Winter Evaluation Workshop. **Update 25 April 2019**: Ms Toal to confirm date for Workshop for Board. **Update 27 June 2019**: The workshop took place on 26 June. **Action Completed.**	Ms Toal
08/19	27 June 19	161/19	Mortality Data Review	The Mortality Dashboard to be included on the Board Schedule of Business as a biannual agenda item. **Update 31 July** – Completed. **Action closed**	Governance Team
09/19	27 June 19	163/19	Seven Day Services Report	The Seven Day Services Update to be included on Board Schedule of Business in the next six months. **Update 31 July** – Completed. **Action closed**	Governance Team

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 July 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mrs C Parnell

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

This report advises the Board of Directors of the Chair's activities over the last month in relation to:

- Values, behaviours and culture
- Governance
- Board development
- External visitors

Attachments:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of the Chair's recent activities in relation to:

- Values, behaviours and culture
- Governance
- Board development
- External visitors.

2. VALUES, BEHAVIOURS AND CULTURE

In recent months the Trust has been refreshing its strategy to reflect key changes in the health and care system nationally, regionally and locally. The Board of Directors has spent a considerable amount of time thinking about how it sees the future of the Trust and the role it will play in our health and care system.

It was good to share some of our thinking on our strategy with the Council of Governors last week, and we will be doing further work over the summer to align our strategy with those emerging from some of our partner organisations. The development of our strategy is a key role for the Board of Directors and indeed everyone with a leadership role in the Trust, from ward managers to clinicians, community services leads to corporate services managers.

But the Board also has a crucial role to play in helping to shape the right environment for our colleagues in every part of the organisation to effectively deliver the final agreed strategy. Having values that reflect our aspirations for the organisation, as well as what is important to our staff, patients and partners, are the very foundations of an effective strategy.

We need to recruit colleagues who reflect those values, we should reward those staff who live our values on a daily basis, and challenge those who do not behave in a way that encompasses our values. As the Trust Chair I positively welcome challenge and I know my Board colleagues share in my desire to receive feedback and have the opportunity to positively act on that feedback in an open and honest way. It is by doing this that as a Board we help to shape a culture that will support the effective delivery of our strategy, and make the Trust a great place to work and be cared for.

It has been a number of years since the Trust considered its values and, in the last couple of weeks as part of NHS Values Week, people working in a range of NHS services nationally were encouraged to think about what the NHS values mean to them and how they demonstrate those values of:

- Working together for patients
- Compassion
- Respect and dignity
- Improving lives
- Commitment to quality of care
- Everyone counts.

Therefore the timing seems right to look at our own values and we are launching a programme of engagement work over the next two months to refresh the Trust's values. We will test out whether people recognise our existing values and identify what is important to our colleagues, patients and their families. I very much welcomed the opportunity to begin this process with our Governors last week and with the Board later today.

Over the coming weeks members of our senior leadership team will meet with teams and groups of colleagues across the Trust to identify the values that make up a good day at work, as well as what a good day feels like for patients. That work will be reported back to the Board in the Autumn, and we will then start to identify and distil down the key values that reflect what makes this Trust so special to colleagues, patients and their families and our aspirations for the future.

Our intention is to use the final values as part of a "compact" we will agree with colleagues setting out the behaviours we expect to see in line with our values, and what the Trust will do to support colleagues in consistently behaving in that way. This is an exciting opportunity to work with colleagues across the Trust and one that I hope represents a more engaging way of operating than we have perhaps operated in the past.

3. GOVERNANCE

Creating the right culture to deliver the Trust strategy is a key role for the Board to play, as is making sure we have the right governance systems and processes in place to ensure we have an organisation that is operating effectively.

Over the last couple of years we have been working hard not only on improving the quality of our services, but also our governance arrangements. The Trust's Constitution is a key governance document for the organisation, and a number of changes are being proposed to the Constitution at today's meeting.

These proposals were also put before our Council of Governors last week, and it was good to see the governors recognising the importance of improving our governance arrangements. One of the key proposals they agreed was the ability to flex the make-up of our Board to ensure that we have the right people with the right skills in place now and in the future.

Another important change governors have supported is the re-introduction of a maximum tenure of office for governors, ensuring that our Council can demonstrate its independence and also that the membership of this key Trust body is regularly refreshed with individuals with new ideas and experiences. This was unanimously supported by the Board of Directors and by the majority of governors as the right thing to do in terms of our governance, but it does mean that over the next couple of years we will lose at least five long standing governors who have given so much time, commitment and enthusiasm to the organisation. We are now looking at how we can continue to benefit from their knowledge of our services and passion for the Trust.

Over the last couple of years we have had a number of organisations and individuals supporting us in looking at various aspects of our governance and offering their advice and expertise. It is good practice to carry out a full review of our governance arrangements at least every three years, and some issues that have surfaced through our existing internally processes recently have prompted us to look for some external support to carry out a deep dive into our governance. The aim will be able

to identify how we track issues from our frontline hospital and community services through the organisation and ultimately to the Board, identifying areas for further improvement, and looking for ways we can refine our current systems and processes.

4. **BOARD DEVELOPMENT**

Over the last couple of months the Nominations Committee has been focused on appointing a new Non-Executive Director to join our Board. I would like to take this opportunity to thank all Board members, governors and colleagues for their involvement in the rigorous appointment process.

We had such an excellent field of candidates that we felt that we should take the opportunity of further broadening the skills and experiences of our Board of Directors by recommending to the Council of Governors that we should actually appoint two of the candidates, subject to their agreement and the Board's support for the relevant Constitution change.

Our governors were whole heartedly in support of their appointment and, subject to the Board's Constitution discussion today, I hope to be able to officially welcome the two new Non-Executive Directors to the organisation from tomorrow.

They are Marisa Logan-Ward, who was mostly recently Group Pathology Director with BMI Healthcare, and Mark Beaton, who was most recently Senior Managing Director with Accenture.

Following an independent review the Board agreed to create a new role – Director of Communications & Corporate Affairs, which will be a non-voting member of the Board in the future. The advertisement for the role closes today, and we are hoping to interview for this key position early in September.

5. **EXTERNAL VISTORS**

It is always good to welcome external visitors to the Trust to see our services and hear about the improvements we are making, but I was particularly pleased to welcome Peter Wyman, Chair of the Care Quality Commission (CQC), on a visit to Stepping Hill Hospital recently.

I invited Peter to visit the Trust after our last CQC inspection and he spent the majority of a day with us, touring the hospital and meeting some of our senior leadership team for a presentation about the improvements we have made over the last two years, and our aspirations for the future.

Listening to colleagues describe that improvement journey made me feel immensely proud of what we and our teams have achieved, and their passion and commitment to the Trust shone through in all they talked about. He also had the opportunity to meet with some of our system partners to hear about how we are working together to support the health and care of the people of Stockport.

More recently Andy Burnham, Mayor of Greater Manchester, visited the hospital to meet some of our recently graduated nurse associates, who are now working across a range of services at Stepping Hill as well as in our community services. He heard about the differences these new roles are making to our services, and also our plans to grow our nursing associates with a further 30 due to start their training later in the year.

6. OUT AND ABOUT

It is always a pleasure to visit our hospital and community services, and meet colleagues in their roles in a wide variety of services. Our emergency department, like many others across the country, is often in the spotlight for performance issues so I was particularly pleased to recently visit the team, and hear about some of the improvements they have been making to appropriately stream patients as they come through the front door of A&E ensuring patients more quickly receive the right level of care to meet their needs.

Emergency performance has been a challenge across the region for a considerable period of time, so it was good to see how this initiative and others throughout the Trust are having a positive impact on patient flow and the care patients receive.

7. RECOMMENDATIONS

The Board of Directors is recommended to receive this report.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 July 2019
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

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

Attachments:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

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

2. GENERAL SUMMARY

The Board of Directors and our staff regularly talk about our improvement journey and the progress we have made in strengthening the quality and safety of our services over the last couple of years.

That journey continues and the work we are doing to improve the care of our local population cannot be done alone, so it was great to see Stockport Clinical Commissioning Group retain its overall rating of "good" in NHS England's annual assessment of its performance. The CCG was also amongst the top performers in the country for ten different elements of its performance. This coupled, with the recent acknowledgement of the improvements Stockport Metropolitan Borough Council has also made to its performance, demonstrates that the local system is really starting to make progress.

The Care Quality Commission (CQC) is likely to return to the Trust in 2020 as part of its regular programme of assessments, and this as a real opportunity to highlight all the progress our staff and services have made, as well as our aspirations for the future of the Trust and the local health and care system.

We are all committed to moving the organisation from the current "requires improvement" to "good" and ultimately an "outstanding" rating, as these ratings demonstrate that trusts are doing the right thing for their patients and staff. The Board of Directors will be spending some time on our plans for the inspection over the coming months, but it is important that what we tell the CQC about our services and plans for the future reflects the experience of our patients and staff. So as part of our focus on consistently doing the right thing for patients, we recently held a clinical services review that involved teams of staff and colleagues from other organisations acting as peer reviewers.

This was a great day and it was really heartening to hear from the reviewers about the many good things they found during the visits to clinical areas. The open and welcoming attitude of staff was a stand-out positive for me, and certainly reflected my experience of visiting our hospital and community services. The reviewers also commented on about how honest staff were about the issues facing them, as well as being positive about the opportunity to share what they are doing and learn from others. These are attributes we all want to encourage.

However, there were also some areas where we could do even better, and disappointingly some of those were amongst the basics of good care, such "bare below the elbow", which should be the norm across all of our services but we did find pockets where it, and other elements of good care, was not consistently or fully embedded.

The CQC inspection is a great opportunity for our staff and services to get the recognition they deserve for the improvements they have made, and over the coming months we will be focusing on the areas we have identified where we could do better. This focus will not be because we are expecting a CQC inspection, but because they are the right things to do for patients and they

should be the things we do as a matter of course.

I firmly believe in the power of focusing on the right things and making small incremental changes that together build up to major improvements. In the last couple of weeks we've seen a real example of that in the impact of the whole organisation focusing on improving the flow of patients through the hospital and reducing bed occupancy rates. As a direct result we had a number of days in the last month where the performance of our emergency department against the four hour standard was consistently in the range of 90%, and making us the top performer in Greater Manchester despite high levels of activity. Conversely, when our focus on flow and bed occupancy dips so does our emergency department performance, so we have to maintain the emphasis on the importance of flow, not just to meet our agreed standards but also because it is the right thing to do for patients.

How we use our resources is one area that the CQC will look at during our next inspection, and our financial position has been under the spotlight for some time with regulators. This year is crucial for the organisation in moving towards a more sustainable position, and until recently our progress against our financial plan as well as our quality improvements have been the subject of monthly external monitoring.

We have made such good progress on our quality improvement journey that those monthly meetings were recently stood down, and we have now moved towards quarterly monitoring of our financial position. This is a positive move as instead of just monitoring our position these meetings are now focused on the financial position of the Stockport health and care system, emphasising the importance of partnership working. While this is a welcome change we must not be complacent – the financial position we and our health and care partners face this year is extremely difficult and delivering our plan for the year will take consistent focus from everyone in the organisation.

Our staff regularly demonstrate that when they focus on a task they can make hugely positive changes – the improvements in patient flow is just one example. In the last month we have also seen a large number of frontline and support staff focus on upgrading our PAS and Patient Centre systems. I have often seen similar processes fail despite the best planning, but our staff should be congratulated for the highly effective way they worked together to deliver this upgrade with the minimum of disruption.

I also want to congratulate our school nursing immunisation team, who have achieved a vaccination rate of over 90% for year 8 and 9 vaccinations – this is a great performance and more importantly a great step forward in protecting the health of Stockport's young people

3. NEWS AND EVENTS

- **Finance award** – congratulations to our finance and procurement department on winning the Healthcare Financial Management Association's North West Great Place to Work Award.
- **Veterans** – Greater Manchester and Lancashire Royal British Legion has nominated the Trust for a Royal British Legion Public Sector Partner Award for the work we have done to recognise and support the individual needs of patients who are veterans.
- **This is Me** – was the theme of a host of events in the Trust earlier this month to mark Disability Awareness Week. A powerful feature of the week was a number of staff sharing their experiences of living with a hidden disability.

- **Frailty, dementia and end of life care** – I was delighted to introduce a workshop session at an event in the Trust focused on the work we are doing with partners around improving frailty, dementia and end of life care. There was a huge amount of energy and enthusiasm in the room and I am excited about the improvements we will see from this important programme of work.
- **Public Health** – the Trust played host to a public health conference earlier this month and it was a pleasure to open the event that focussed on the importance of healthy lifestyles and ill health prevent, the impact on health services, and the responsibilities of health professionals to make every contact count.
- **Hello my name** – the Trust marked Hello My Name Is Day last week. Set up in memory of Dr Kate Grainger the aim of the day was to remind staff of how small, simple acts can improve the lives of patients.
- **Swanbourne Gardens** – thank you to volunteers from Network Rail who recently gave up their free time to spruce up the outside space at Swanbourne Gardens, which provides important respite care for children and young people.

4. VISITS

- **Marbury House** - I had the pleasure of visiting this excellent residential care facility, of which the Trust delivers services in partnership with Stockport Metropolitan Borough Council and Borough Care Limited. This was a great example of working together to support people in the community to recover after a hospital stay – and also an opportunity for further joint working.
- **Catering** – providing good quality food is so important to our patients and staff so I was keen to visit out catering team, who has done so much to improve the quality of the service it offers. It was a really interesting visit that culminated in presenting the team with very well deserved Proud to Care certificates.

5. RECOMMENDATION

The Board of Directors is recommended to receive this report.

This page has been left blank

Report To:	Trust Board	**Date:**	31 Jul 2019
Subject:	Integrated Performance Report		
Report of:	Director of Strategy & Planning	**Prepared by:**	B.I & Performance Team

REPORT FOR ASSURANCE

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

Summary of Report

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

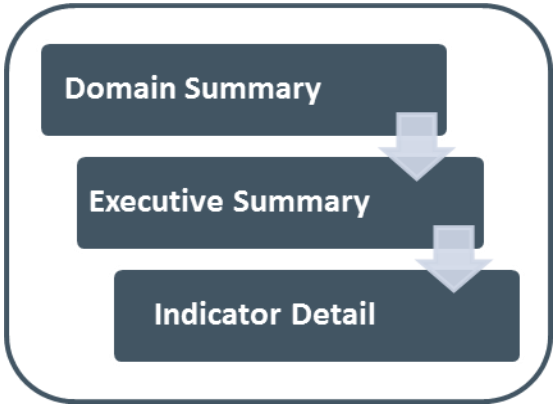
Attachments:

This subject has previously been reported to:

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

Introduction

The Board report layout consists of three sections:



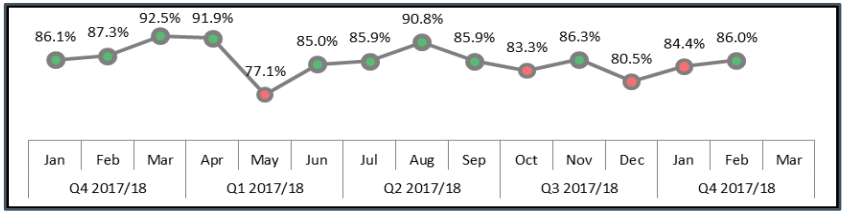
Domain Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

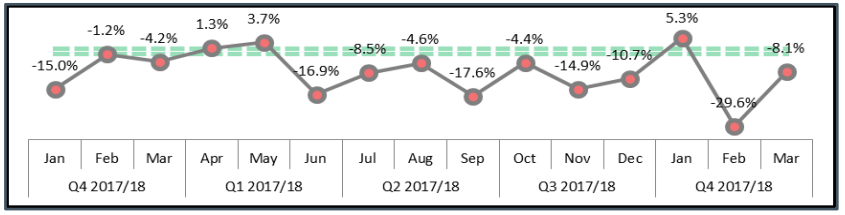
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

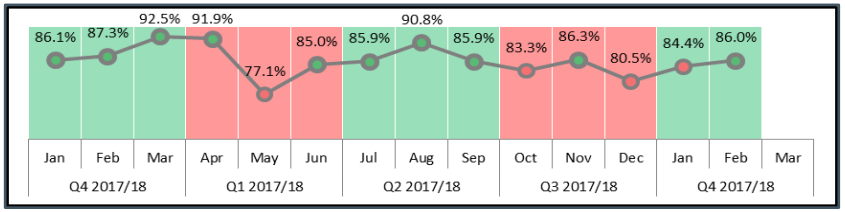
The following chart types are in use throughout the report:



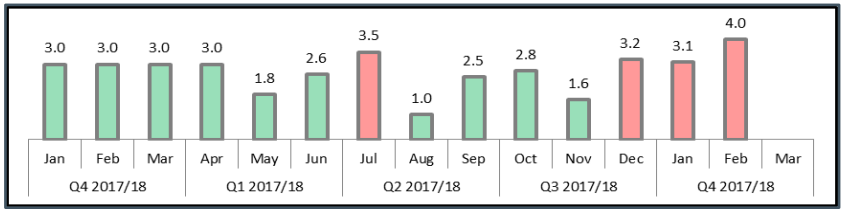
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



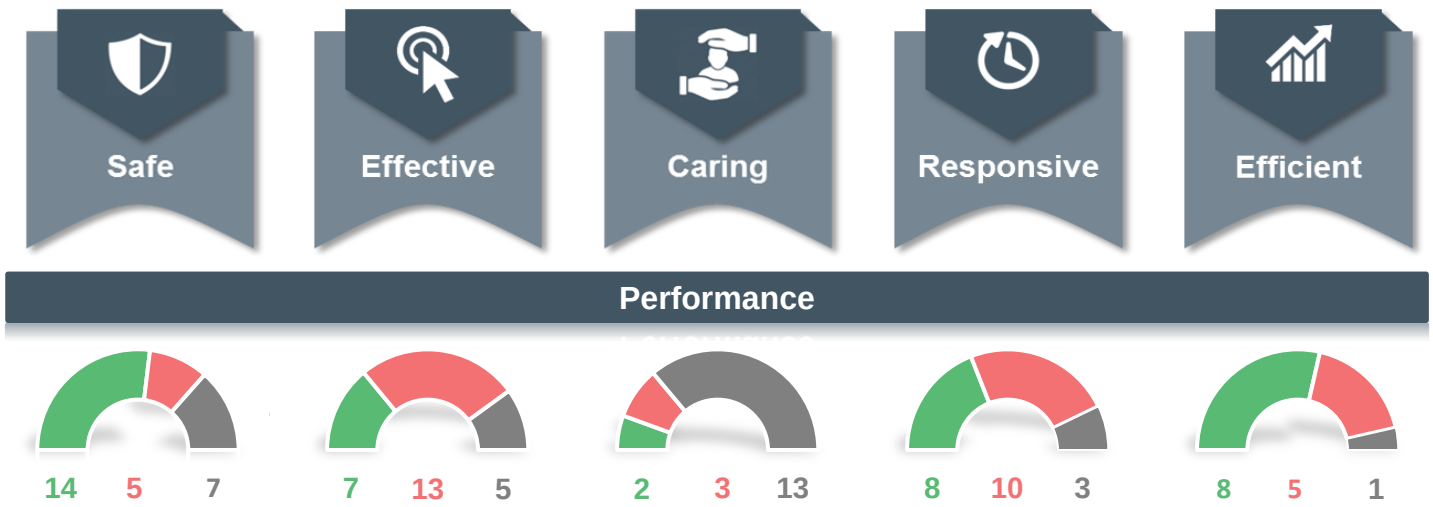
Where applicable, quarterly performance is indicated as coloured columns behind the main trend line.



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

Domain Summary

Stockport NHS Foundation Trust



Key Changes to the indicators in this period are:

Metrics changing from green to red in month:
- RTT Incomplete pathways
- Workforce Turnover

Metrics changing from red to green in month:
- Diagnostic 6 wk standard
- Diabetes reviews
- Pressure Ulcers: Community Cat 4
- Induction of Labour

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Operating Officer													
Diagnostics: 6 Week Standard	Responsive	Jun-19	<= 1%	0.6%							1.2%		12
Cancer: 62 Day Standard	Responsive	Jun-19	>= 74.2%	77.0%							78.7%		12
Cancer: 104 Day Breaches	Responsive	May-19	<= 0	6.0							7.0		13
Referral to Treatment: Incomplete Pathways	Responsive	Jun-19	>= 85.6%	84.2%							84.1%		13
Referral to Treatment: Incomplete Waiting List Size	Responsive	Jun-19	<= 24391	24154									14
Clinical Correspondence	Safe	Jun-19	>= 95%	88.5%							65.8%		14
Outpatient Hospital Cancellation Rate (UoR)	Responsive	Jun-19	<= 9%	10.7%							11.0%		15
Outpatient DNA rate (UoR)	Effective	Jun-19	<= 7.4%	6.5%							6.5%		15
Outpatient Clinic Utilisation (UoR)	Effective	Jun-19	>= 90%	82.7%							82.8%		16
Outpatient New to Follow-up Ratio (UoR)	Effective	Jun-19	<= 1.77	2.26							2.20		16
Theatres: Delivered Sessions vs. Plan	Effective	Jun-19	>= 100%	90.2%							94.3%		17
Theatres: Overall Touch-time Utilisation (UoR)	Effective	Jun-19	>= 85%	78.5%							79.9%		17
Theatres: In-Session Touch-time Utilisation (UoR)	Effective	Jun-19	>= 85%	70.0%									18

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Operating Officer													
Elective Day Case Activity vs. Plan	Responsive	Jun-19	>= *0%*	0.6%							0.6%		18
Elective Day Case Income vs. Plan	Responsive	Jun-19	>= *0%*	3.1%							3.1%		19
Elective Inpatient Activity vs. Plan	Responsive	Jun-19	>= *0%*	-2.7%							-2.7%		19
Elective Inpatient Income vs. Plan	Responsive	Jun-19	>= *0%*	-4.9%							-4.9%		20
Outpatient Activity vs. Plan	Responsive	Jun-19	>= *0%*	-0.9%							-0.9%		20
Outpatient Income vs. Plan	Responsive	Jun-19	>= *0%*	-4.7%							-4.7%		21
Length of Stay: Non-Elective (UoR)	Effective	Jun-19	<= *9*	10.37							10.81		21
Length of Stay: Elective (UoR)	Effective	Jun-19	<= *2.6*	2.04							2.43		22
Stranded Patient Count (UoR)	Effective	Jun-19	<= *304*	290									22
Super-Stranded Patient Count (UoR)	Effective	Jun-19	<= *144*	132									23
Delayed Transfers of Care (DTOC) (UoR)	Effective	Jun-19	<= *3.3%*	3.6%							4.0%		23
Medical Optimised Awaiting Transfer (MOAT)	Effective	Jun-19	<= *40*	87							267		24
Discharges by Midday	Effective	Jun-19	>= *33%*	16.2%							16.3%		24

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
A&E: 12hr Trolley Wait	Responsive	Jun-19	<= 0	18							72		26
Emergency Readmission Rate (UoR)	Effective	Apr-19	<= 7.9%	8.3%							8.3%		26
Diabetes Reviews	Caring	May-19	>= 90%	95.8%							87.9%		27
VTE Risk Assessment	Safe	May-19	>= 95%	97.0%							97.1%		27
Sepsis: Timely Identification	Safe	Jun-19		81.1%							84.1%		28
Sepsis: Timely Treatment	Safe	Jun-19	>= 90%	42.9%							45.6%		28
Medication Errors: Rate	Safe	Jun-19		4.16									29
Discharge Summaries	Safe	Jun-19	>= 95%	91.7%							91.2%		29
Mortality: Deaths in ED or as Inpatient	Effective	Jun-19		121							360		30
Mortality: Case Note Review Rate	Effective	Jun-19		33.9%							34.4%		30
Mortality: Specialist Palliative Care Length of Stay	Caring	Jun-19		17.84							20.52		31
Mortality: HSMR	Effective	Mar-19	<= 1	1.05									31
Mortality: SHMI	Effective	Dec-18	<= 1	0.96									32

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
Never Event: Incidence	Effective	Jun-19	<= 0	0							0		32
Duty of Candour Breaches	Effective	Jun-19		0							1		33
Serious Incidents: STEIS Reportable	Responsive	Jun-19		19							50		33

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
C.Diff Infection Rate	Safe	May-19		18.44							17.55		34
C.Diff Infection Count	Safe	May-19	<= 8 *	5							10		34
MRSA Infection Rate	Safe	May-19		0.00							0.00		35
MSSA Infection Rate	Safe	May-19		4.61							4.62		35
E.Coli Infection Rate	Safe	May-19		18.44							18.02		36
E.Coli Infection Count	Safe	May-19		5							7		36
Falls: Total Incidence of Inpatient Falls	Safe	Jun-19	<= 275 *	81							248		37
Falls: Causing Moderate Harm and Above	Safe	Jun-19	<= 6 *	3							6		37
Pressure Ulcers: Hospital, Category 2	Safe	May-19	<= 15 *	6							13		38
Pressure Ulcers: Hospital, Category 3	Safe	May-19	<= 3 *	0							3		38
Pressure Ulcers: Hospital, Category 4	Safe	May-19	<= 0 *	0							0		39
Pressure Ulcers: Community, Category 2	Safe	May-19	<= 32 *	13							26		39
Pressure Ulcers: Community, Category 3	Safe	May-19	<= 7 *	3							6		40

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Pressure Ulcers: Community, Category 4	Safe	May-19	<= 1 *	0							1		40
Pressure Ulcers: Device Related, Category 2	Safe	May-19	<= 5 *	4							9		41
Pressure Ulcers: Device Related, Category 3	Safe	May-19	<= 1 *	0							0		41
Pressure Ulcers: Device Related, Category 4	Safe	May-19	<= 0 *	0							0		42
Safety Thermometer: Hospital	Safe	Jun-19	>= 95%	96.4%							96.8%		42
Safety Thermometer: Community	Safe	Jun-19	>= 95%	96.5%							97.7%		43
Patient Safety Incident Rate	Effective	Jun-19		53.22									43
Patient Safety Alerts: Completion	Caring	Jun-19	>= 100%	88.9%							90.5%		44
Emergency C-Section Rate	Effective	Jun-19	<= 15.4%	16.7%							17.0%		44
Term Babies Admitted to the Neonatal Unit	Effective	Jun-19	<= 5	0									45
Dementia: Finding Question	Responsive	May-19	>= 90%	92.4%							93.9%		45
Dementia: Assessment	Responsive	May-19	>= 90%	100.0%							100.0%		46
Dementia: Referral	Responsive	May-19	>= 90%	100.0%							100.0%		46

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Friends & Family Test: Response Rate	Caring	May-19		20.8%		↑					20.4%		47
Friends & Family Test: Inpatient	Caring	May-19		95.9%		↑					95.3%		47
Friends & Family Test: A&E	Caring	May-19		88.4%		↑					87.8%		48
Friends & Family Test: Maternity	Caring	May-19		93.9%		↓					94.1%		48
DSSA (mixed sex)	Caring	Jun-19	<= 0	0		→					0	△	49
Learning Disability: Adjusted Care Plans	Caring	Mar-19	>= 100%	78.9%		↓						△	49
Compliments	Caring	Jun-19		165		↑					456	△	50
Complaints Rate	Caring	Jun-19		0.5%		↓					0.8%	△	50
Complaints: Response Rate 45	Caring	Jun-19	>= 95%	90.9%		↓					84.1%	△	51
Complaints: Parliamentary & Health Service Ombudsman Cases	Caring	Jun-19		0		↓					1	△	51
Complaints Closed: Overall	Caring	Jun-19		33		↓					126	△	52
Complaints Closed: Upheld	Caring	Jun-19		11		↑					27	△	52
Complaints Closed: Partially Upheld	Caring	Jun-19		11		↓					48	△	53

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Complaints Closed: Not Upheld	Caring	Jun-19		11		↓					51	Δ	53
Litigation: Claims Opened	Responsive	Jun-19		5		↑					15	Δ	54
Litigation: Claims Closed	Responsive	Jun-19		6		↑					13	Δ	54
Referral to Treatment: 52 Week Breaches	Responsive	Jun-19	<= 0	5		↓					15		55

Executive Summary

NHS Stockport NHS Foundation Trust

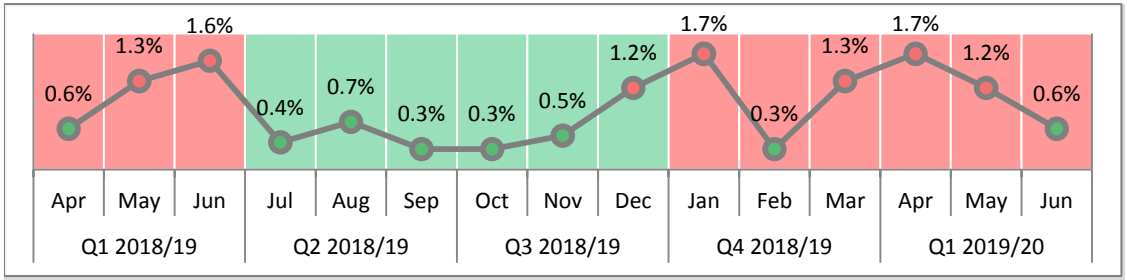
Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Director of Finance													
Financial Controls: I&E Position	Well-Led / Efficient	Jun-19	>= 0%	1.3%									55
Cash	Well-Led / Efficient	Jun-19	<= 0%	-10.2%									56
Financial Use of Resources	Well-Led / Efficient	Jun-19	<= 3	3									56
CIP Cumulative Achievement	Well-Led / Efficient	Jun-19	>= 0%	61.0%									57
Capital Expenditure	Well-Led / Efficient	Jun-19	+/- 10%	-21.9%									57

Domain Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Director of Workforce & Organisational Development													
Staff in Post	Well-Led / Efficient	Jun-19	>= 90%	91.4%							91.4%		58
Sickness Absence Rate (UoR)	Well-Led / Efficient	Jun-19	<= 3.5%	4.6%							4.6%		58
Workforce Turnover (UoR)	Well-Led / Efficient	Jun-19	<= 13.94%	14.2%									59
Staff Friends & Family Test: Recommend for Work	Well-Led / Efficient	Mar-19		53.9%							55.1%		59
Appraisal Rate: Medical	Well-Led / Efficient	Jun-19	>= 95%	96.6%							96.9%		60
Appraisal Rate: Non-medical	Well-Led / Efficient	Jun-19	>= 95%	91.9%							92.3%		60
Statutory & Mandatory Training	Well-Led / Efficient	Jun-19	>= 90%	91.0%							90.3%		61
Bank & Agency Costs	Effective	Jun-19	<= 5%	11.1%							11.1%		61
Agency Shifts Above Capped Rates	Well-Led / Efficient	Jun-19	<= 0	653							1907		62
Agency Spend: Distance From Ceiling (UoR)	Well-Led / Efficient	Jun-19	<= 3%	-13.8%							-13.8%		62
Flu Vacination Uptake	Safe	Feb-19	>= 75%	75.3%									63
Staff Friends & Family Test: Recommend for Care	Caring	Mar-19		71.9%							71.6%		63

Indicator Detail

Jun-19	Diagnostics: 6 Week Standard
0.6%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The diagnostic standard was achieved in June.
<= 1%	



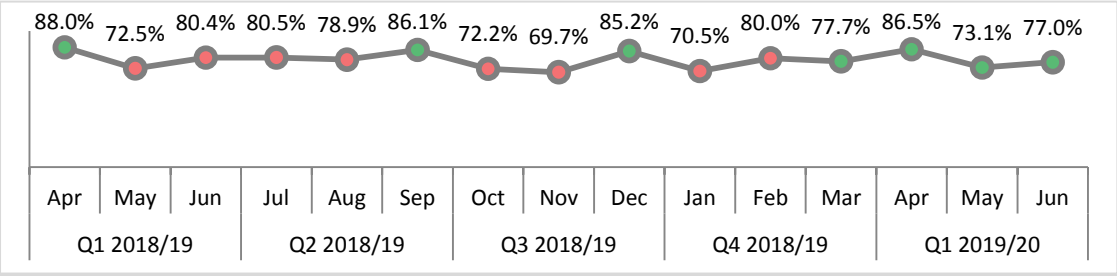
Actions

Continue to commission additional mobile CT capacity.
It is anticipated that the 2 new CT platforms, due to become available at the end of August, will also mitigate the lost activity once building work commences for the 3rd and 4th CT scanners.

Monitor the continued availability of contrast for MR examinations.

Monitor the overdue planned Endoscopy patients and mitigate the impact on the 6 week diagnostic standard.

Jun-19	Cancer: 62 Day Standard
77.0%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	The latest position indicates the Trust will achieve its improvement trajectory for 62 day referral to treatment in June.
>= 74.2%	



Actions

The straight to test lung pathway is due to commence in July.

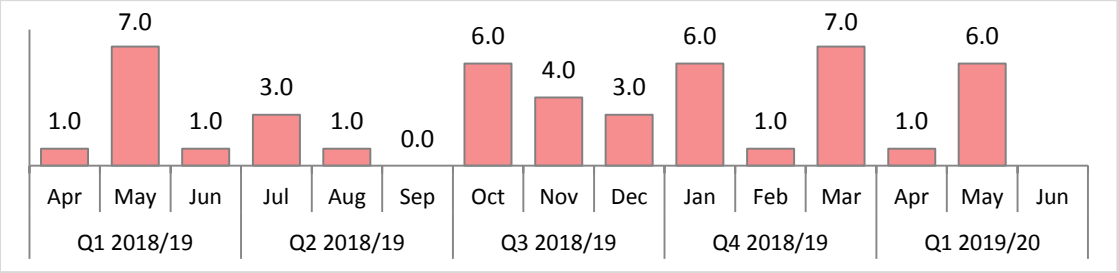
The straight to MR pathway for prostate patients is due to commence in August.

An additional TRUSS machine has been purchased and will be commissioned for use end of July. This will increase biopsy capacity for prostate patients.

A Trust wide deep dive of patients treated beyond day 62 has been arranged with Senior Managers and Directors.

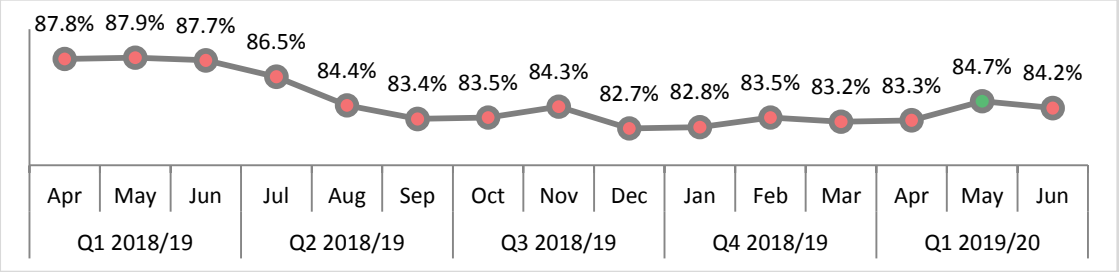
Indicator Detail

May-19	Cancer: 104 Day Breaches
6.0	The number of patients that have pathway length of 104 days or more at the point of treatment.
Target	6 patients commenced treatment beyond day 104 of their pathway in June. 2 x Urology; 2 x Lung; 1 x H&N and 1 x colorectal. Themes included patient DNAs and cancellations, a patient changing their mind over their choice of treatment, OP capacity and delays to diagnostics both within and external to the Trust.
<= 0	



Actions
Actions: Nil specific but learning from 104 days being shared across BGs and pathways under review. All cancer patients are tracked and pathway delays are escalated to ensure patients are treated as soon as possible. A serious untoward incident review is undertaken for any patient breaching and findings are shared as part of the Trusts' Cancer Quality & Service Improvement group.

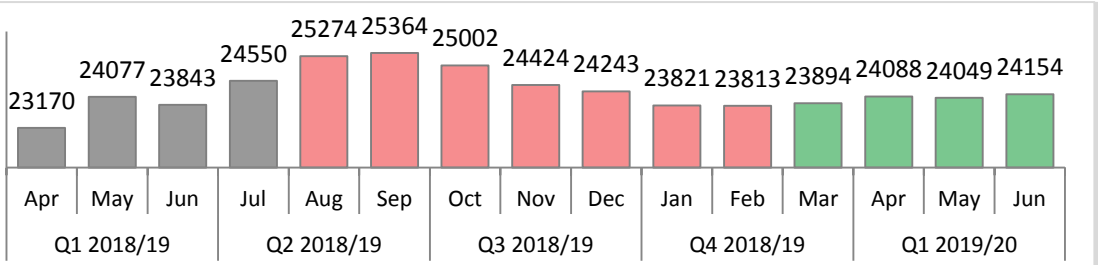
Jun-19	Referral to Treatment: Incomplete Pathways
84.2%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	Performance is behind trajectory in month. This is due in the main to an increasing number of patients awaiting treatment beyond 18 weeks within Oral Surgery and Orthodontics.
>= 85.6%	



Actions
An options paper is being prepared for Oral Surgery. Discussions are ongoing with NHSE regarding Orthodontic demand. It is anticipated that the waiting list will continue to grow despite the mitigation actions that have been taken.

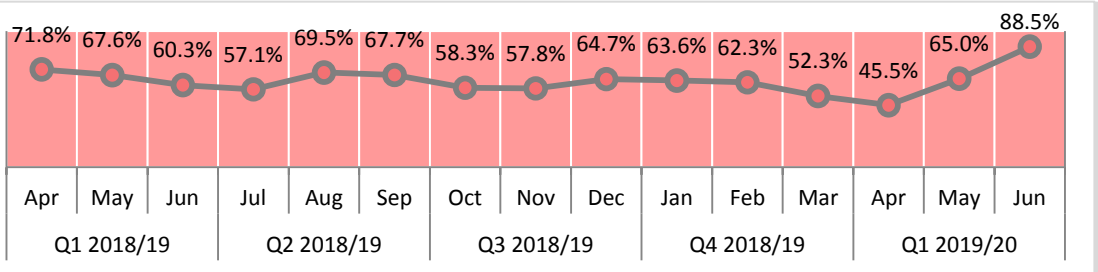
Indicator Detail

Jun-19	Referral to Treatment: Incomplete Waiting List Size
24154	The total number of patients on an open pathway. Please note: This indicator is measured against an agreed improvement trajectory.
Target	The waiting list size has slightly increased from the May position, however, is still ahead of trajectory.
<= 24391	



Actions
The main driver for the increase is Oral Surgery and Orthodontics. Demand for the latter is the subject of an on-going discussion with NHSE. Specialties with a waiting list backlog that are also behind activity plan are undertaking a recovery and forecast trajectory which will positively impact the waiting list size.

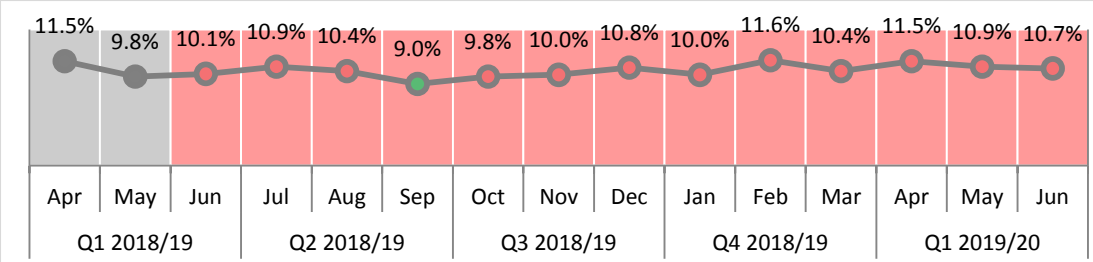
Jun-19	Clinical Correspondence
88.5%	The percentage of clinical correspondence typed within 7 days.
Target	The expected improvement in performance is now being realised.
>= 95%	



Actions
Outsourcing continues to be used flexibly as required. Currently a proportion of Haematology letters are being outsourced to cover annual leave with the secretarial team. Moving forward, the aim is to achieve clinic attendance to distribution within 7 days. To support this, the Clinical Directors have agreed a set of internal timescales for completing dictation, transcription and clinical sign-off. At the time of writing, July's performance is 95.6%.

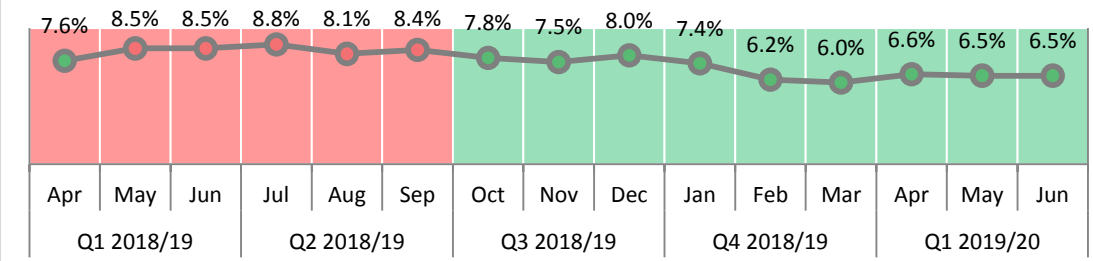
Indicator Detail

Jun-19	Outpatient Hospital Cancellation Rate (UoR)
10.7%	The percentage of outpatient appointments where the hospital has cancelled the appointment. This indicator combines new and follow-up appointment types.
Target	The Hospital cancellation rate improved slightly in month.
<= 9%	



Actions
The Outpatient improvement work continues to support efficient ways of working to minimise cancellations.

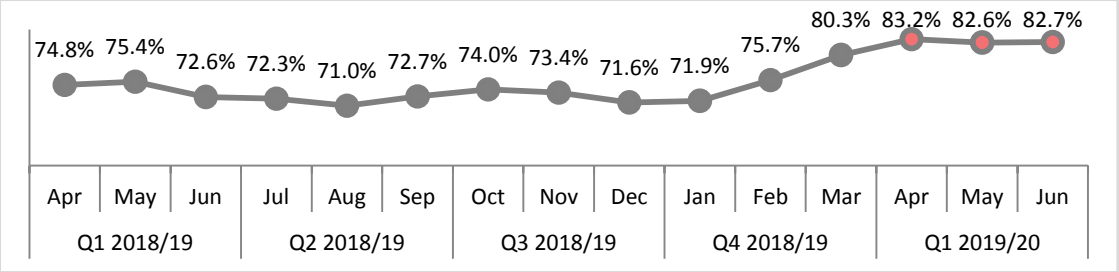
Jun-19	Outpatient DNA rate (UoR)
6.5%	The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types.
Target	The DNA rate remains below peer group average.
<= 7.4%	



Actions
Continue to develop the appointment reminder system as required.

Indicator Detail

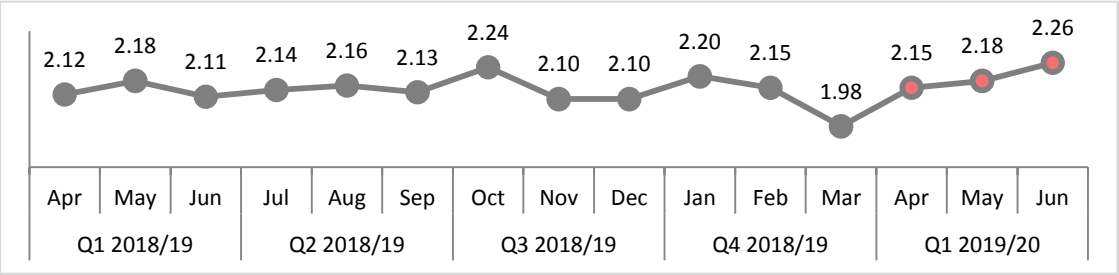
Jun-19	Outpatient Clinic Utilisation (UoR)
82.7%	The percentage of planned clinic appointment slots that were booked. Planned slots include all appointment slots on clinic templates that went ahead - cancelled clinic templates are excluded.
Target	Utilisation in June was similar to that reported in May
>= 90%	



Actions

The Outpatient improvement work will include a focus on clinic templates and utilistation.

Jun-19	Outpatient New to Follow-up Ratio (UoR)
2.26	The number of outpatient follow-up attendances that took place for every one outpatient new attendance.
Target	The new to follow-up rate has increased in month. This in part will be due to the reduction of new attendances within the Breast service.
<= 1.77	

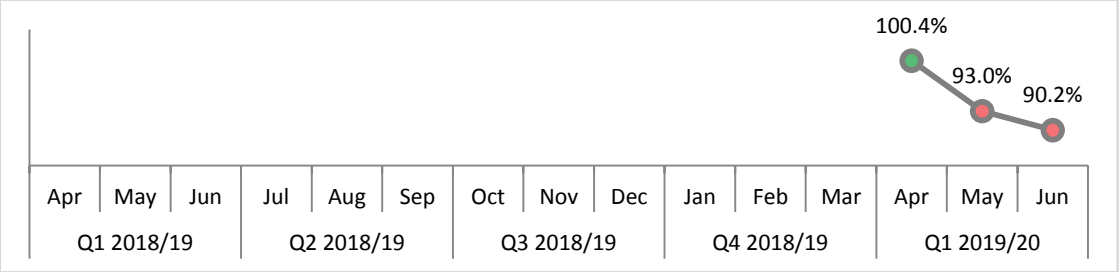


Actions

Patient Initiated Follow-up (PIFU) continues to be embedded across appropriate specialties.

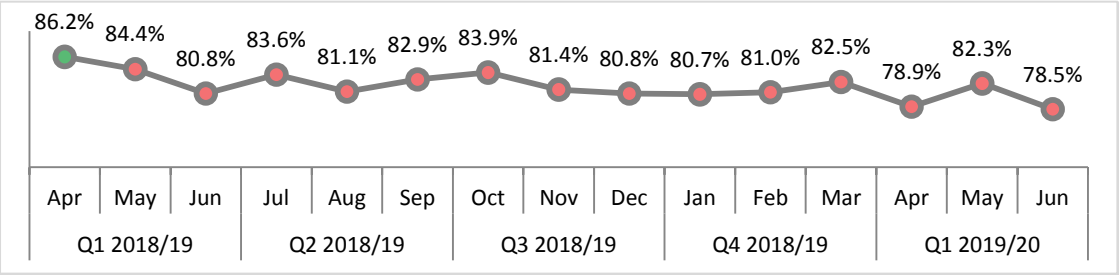
Indicator Detail

Jun-19	Theatres: Delivered Sessions vs. Plan
90.2%	The number of delivered sessions, as a percentage of the required sessions to deliver the activity plan. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	The Trust delivered fewer planned theatre session than required in month as the impact of vacancies within the Anaesthetic team and annual leave was felt.
>= 100%	



Actions
A risk assessment relating to the vacancies is in place and the Trust has approved to over-recruit to Consultant Anaesthetists at risk. Work undertaken to allocate theatre lists to specialties based on their plan requirements should start to take effect in July. Performance and improvement continues to be tracked via the monthly Theatre productivity meeting.

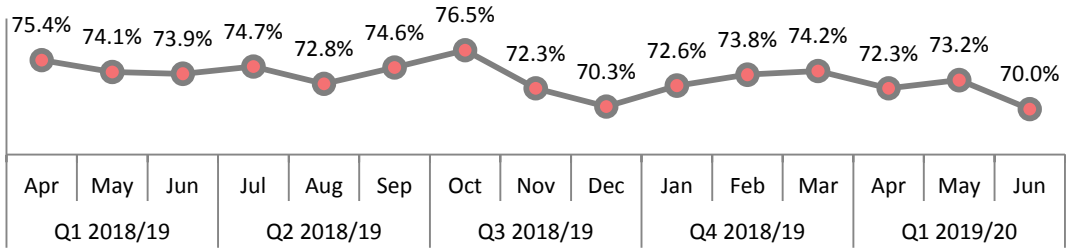
Jun-19	Theatres: Overall Touch-time Utilisation (UoR)
78.5%	The overall time spent operating, calculated as a percentage of the overall planned session time. Touch-time will include any case overlap time and session over-run time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	Utilisation down on last month.
>= 85%	



Actions
Monthly specific theatre meetings are in place and a new suite of metrics is being developed to support monitoring of theatre efficiency and elective activity.

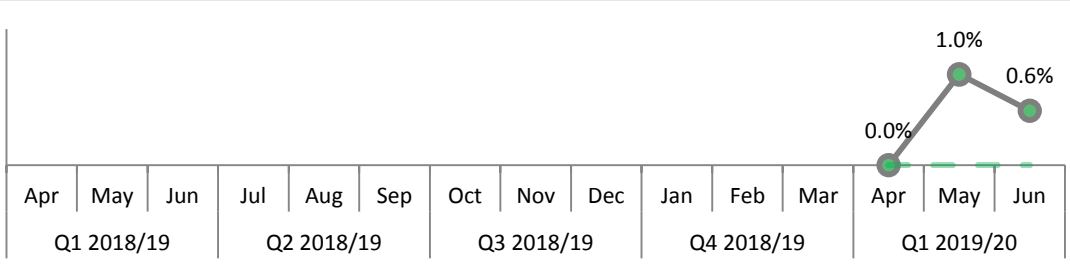
Indicator Detail

Jun-19	Theatres: In-Session Touch-time Utilisation (UoR)
70.0%	The overall time spent operating within the planned hours of the session, calculated as a percentage of the overall planned session time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	Utilisation deteriorated slightly in month.
>= 85%	



Actions
A new suite of metrics is being developed to support monitoring of elective activity and theatre efficiency. These will form the basis of the monthly theatre specific meetings.

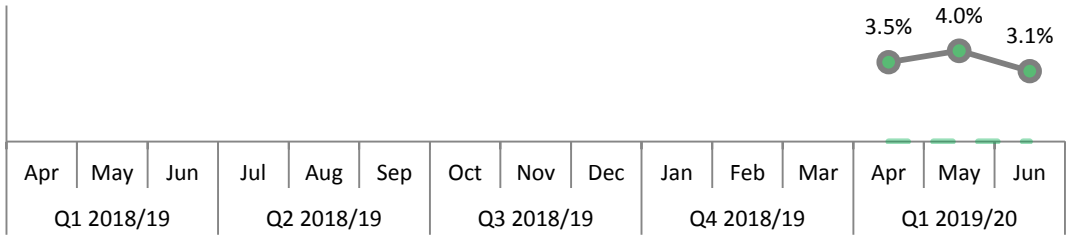
Jun-19	Elective Day Case Activity vs. Plan
0.6%	The percentage variance between planned elective day case activity and actual elective day case activity.
Target	Day-case activity is ahead of plan by 48 cases to the end of Q1.
>= 0%	



Actions
Weekly monitoring at the Executive start of the week meeting continues.

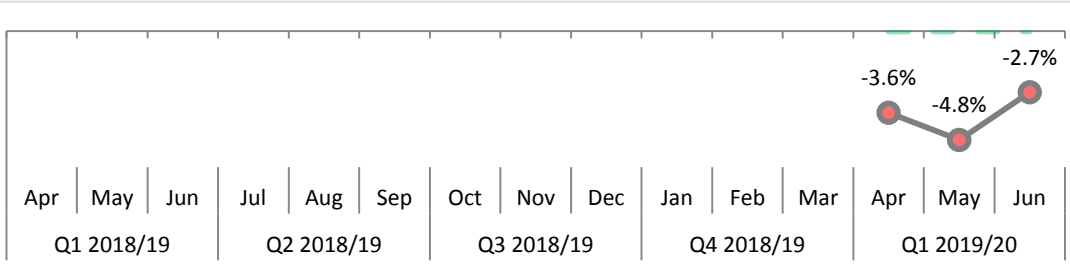
Indicator Detail

Jun-19	Elective Day Case Income vs. Plan
3.1%	The percentage variance between planned elective day case income and actual elective day case income.
Target	Day-case income remains ahead of plan in line with activity delivered.
>= 0%	



Actions
Weekly monitoring at the Executive start of the week meeting continues.

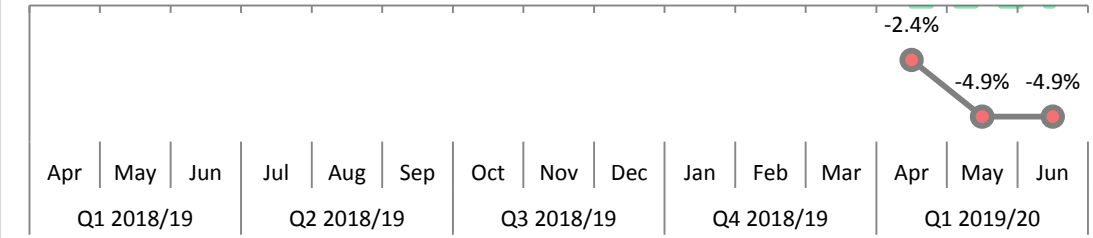
Jun-19	Elective Inpatient Activity vs. Plan
-2.7%	The percentage variance between planned elective inpatient activity and actual elective inpatient activity.
Target	Elective activity is 39 cases adverse to plan at the end of Q1. Due to a reduction in Orthopaedic referrals, a risk to delivering the elective plan has been raised.
>= 0%	



Actions
Considering offering Orthopaedic capacity to other GM providers due to our strong position on access position and comparatively short waiting times.

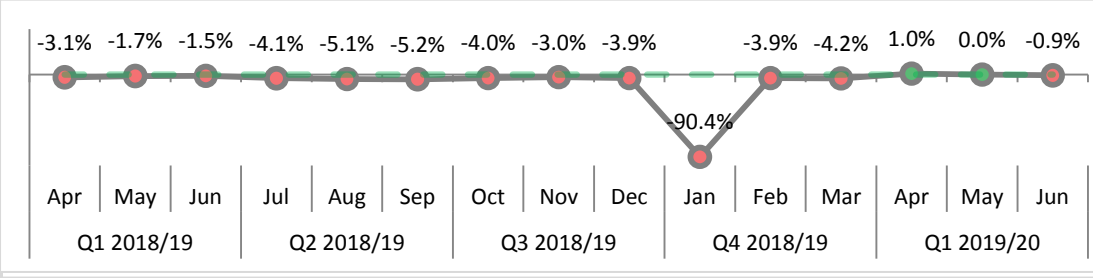
Indicator Detail

Jun-19	Elective Inpatient Income vs. Plan
-4.9%	The percentage variance between planned elective inpatient income and actual elective inpatient income.
Target	Elective income is behind plan in-line with the adverse activity position.
>= 0%	



Actions
Continue weekly monitoring of activity at the Executive start of the week meeting.

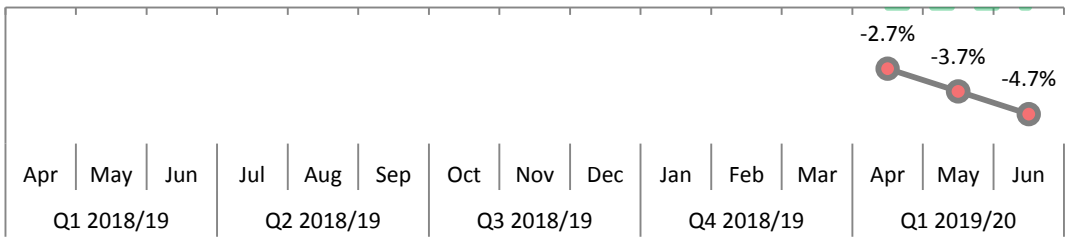
Jun-19	Outpatient Activity vs. Plan
-0.9%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Outpatient activity is 740 spells behind plan at the end of Q1.
>= 0%	1st attendances are significantly behind plan which is being offset by an over-performance on follow-ups and Outpatient procedures.



Actions
Suspension of referrals to the Breast Service accounts for a proportion of the activity behind plan. ENT has re-aligned job plans to clinic capacity to facilitate increasing OP activity and reduce the variance to plan. Paternity leave in Gastroenterology has impacted on activity due to a gap in locum cover.

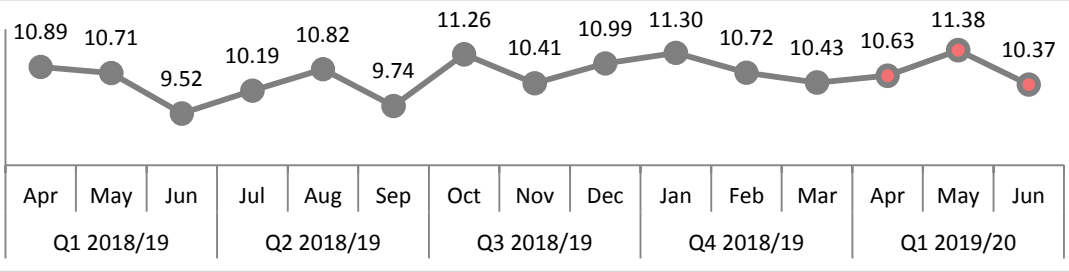
Indicator Detail

Jun-19	Outpatient Income vs. Plan
-4.7%	The percentage variance between planned outpatient income and actual outpatient income.
Target	Outpatient income is £0.4m behind plan to the end of Q1.
>= 0%	



Actions
Action plans to recoup 1st attendances within ENT and Gastroenterology. Continue to cash up clinic outcomes in a timely way.

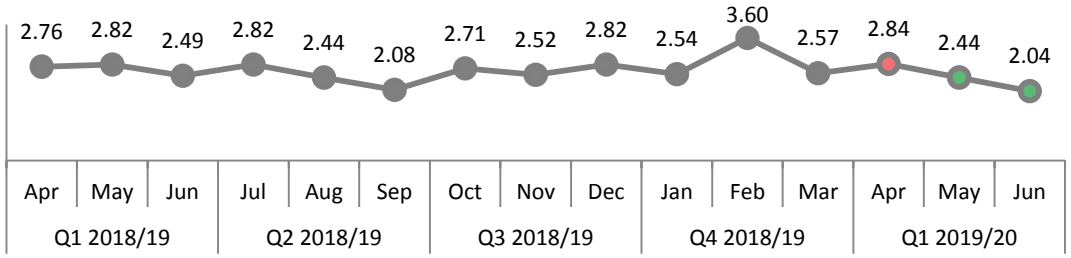
Jun-19	Length of Stay: Non-Elective (UoR)
10.37	The average length of a patient spell, from admission to discharge. Calculated using non-elective admissions only. Excludes Obstetrics/Maternity. Excludes admissions of 0 and 1 days length of stay. Reported by month of discharge.
Target	The average length of patient spell decreased in June.
<= 9	



Actions
Improvement actions are related to the programme of work on reducing stranded patient numbers.

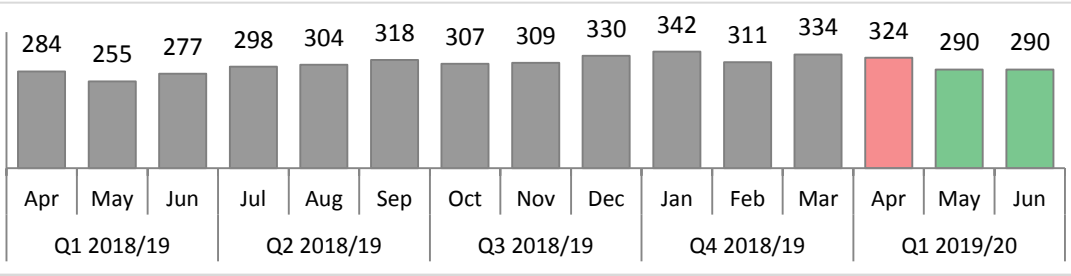
Indicator Detail

Jun-19	Length of Stay: Elective (UoR)
2.04	The average length of a patient spell, from admission to discharge. Calculated using elective admissions only. Excludes day case admissions with length of stay of 0 days. Excludes Obstetrics/Maternity. Reported by month of discharge.
Target	The elective length of stay target was met in month, correlating to the increase in day-case activity.
<= 2.6	



Actions
Work is focusing on discharging patients by mid-day and improving use of the discharge lounge.

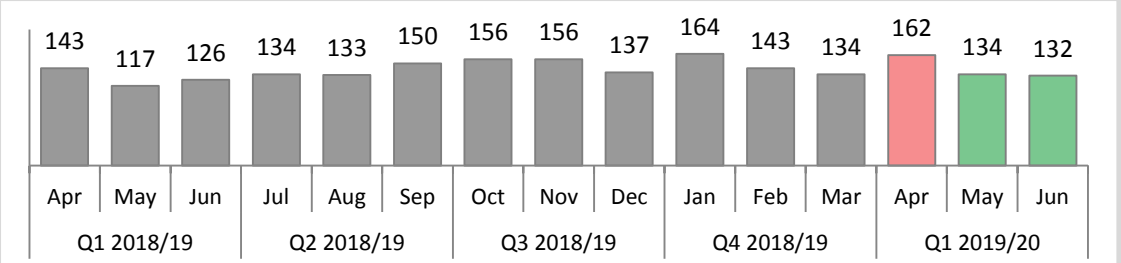
Jun-19	Stranded Patient Count (UoR)
290	The total number of patients with a length of stay of 7 days or more. Performance based on a snapshot taken on the last Monday of the reporting month. Please note: This indicator is measured against an agreed improvement trajectory.
Target	Longer length of stay (Stranded) patient numbers have reduced in month and the Trust is meeting the agreed trajectory.
<= 304	Further improvement continues in July.



Actions
Improvement actions continue within the ITT with a weekly meeting with ITT Manager/Clinical Nurse Lead for CSC and the Delivery Director. Weekly monitoring which focuses not only on patients with lengths of stay of +21 days but the +14 and +7 to reduce the number of patients who will then flip into the +21 day LOS is in place. SRO's for Stay Well, Home First, Patient Flow and Discharge to continue with the workgroups to improve flow to reduce the number of admissions and increase the number of discharges in a timely manner.

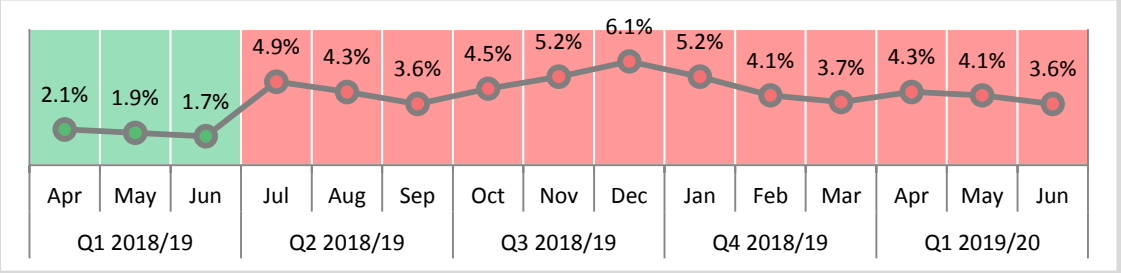
Indicator Detail

Jun-19	Super-Stranded Patient Count (UoR)
132	The total number of patients with a length of stay of 21 days or more. Performance based on a snapshot taken on the last Monday of the reporting month. Please note: This indicator is measured against an agreed improvement trajectory.
Target	The number of longer length of spay patients reduced in June in line with the Trust's trajectory.
<= 144	



Actions
Improvement actions continue within the ITT with a weekly meeting with ITT Manager/Clinical Nurse Lead for CSC and the Delivery Director. Weekly monitoring of not only of patients with lengths of stay of +21 days but the +14 and +7 to reduce the number of patients who will then flip into the +21 day is in place. SRO's for Stay Well, Home First, Patient Flow and Discharge to continue with the workgroups to improve flow to reduce the number of admissions and increase the number of discharges in a timely manner.

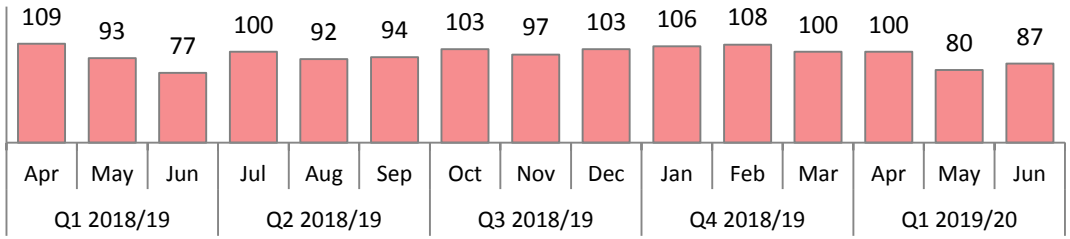
Jun-19	Delayed Transfers of Care (DTOC) (UoR)
3.6%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	Delayed transfers of care reduced in month but remains slightly above target.
<= 3.3%	



Actions
Actions being implemented to reduce longer lengths of stay will positively impact on DTOC rates

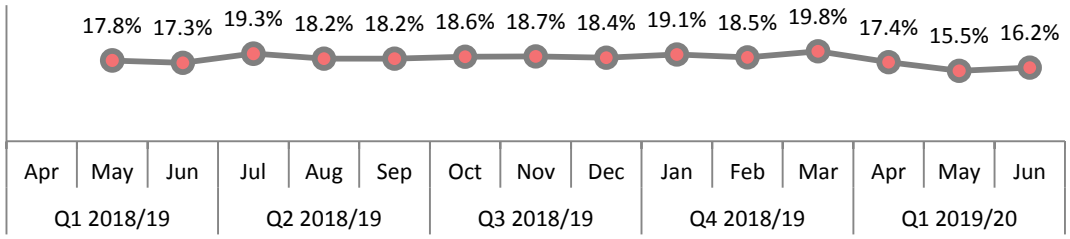
Indicator Detail

Jun-19	Medical Optimised Awaiting Transfer (MOAT)
87	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 MOAT patients increased slightly in month.
<= 40	



Actions
Significant progress has been made more recently in reducing the Longer Length of Stay numbers. Actions within this work stream will have a positive impact on the number of MOAT patients. From 1st August a dedicated ward for MOAT patients will be operational that will actively focus on facilitated discharge. From 1st October, Bluebell as a Transfer to Assess Unit will become operational thus enabling earlier discharge from an acute bed.

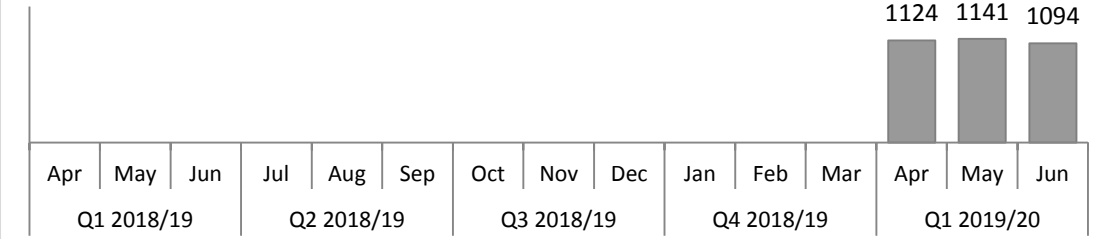
Jun-19	Discharges by Midday
16.2%	The total number of patients discharged by midday, calculated as a percentage of the total number of discharges for the period. Includes SAFER wards only.
Target	Performance improved slightly in June but is still considerably below the >33% target the Trust aspires to achieve.
>= 33%	



Actions
Use of the Discharge Lounge has been promoted and the new coordinator is actively visiting wards to identify patients suitable to move. The 'New World Metrics' are displayed on the 'Executive Wall' and subject to review at the 'Start of the Week' meeting. Particular focus on earlier Surgical discharges, inclusive of Gastroenterology.

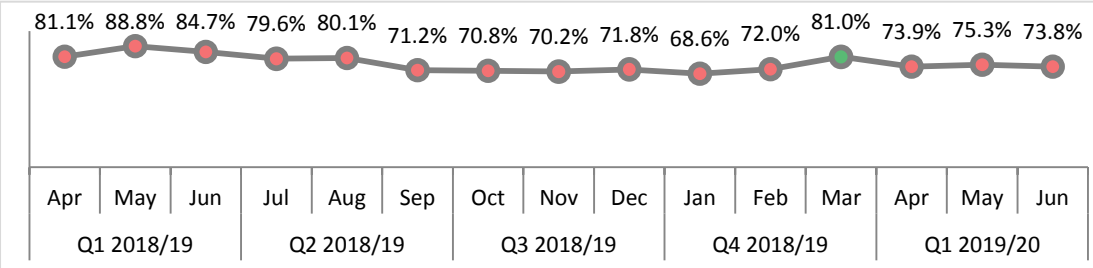
Indicator Detail

Jun-19	A&E: Overnight Breaches
1094	The total of patients who were admitted, discharged, or leave A&E over 4 hours after their arrival between 20:00 and 07:59.
Target	The number of overnight breaches reduced in June.



Actions
Actions put in place include: - Focusing on earlier discharges from AMU - Having a consultant presence in ED until midnight - Maintaining a sub 1.5hr wait to be seen in ED into the evening handover. - waiting room Doctor - Navigator at the front door

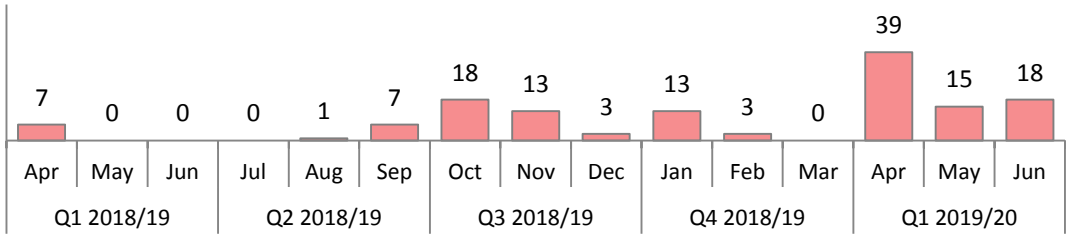
Jun-19	A&E: 4hr Standard
73.8%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target >= 80%	The 4hr improvement trajectory standard was not achieved in June. Overall attendances in June were less than predicted yet still higher than last year. Unprecedented levels of attendance were experienced on some days, the highest being 399.



Actions
Short –term action plans being enacted include: - Reduction in overnight non-admitted breaches - Increased senior management presence in the department later in the day - ED Consultant presence until midnight - A 'waiting room' doctor - Reviewing ACU operating model to avoid early closure. Additionally, weekend planning meetings have been re-instituted with a revised agenda to ensure weekend staff are fully briefed.

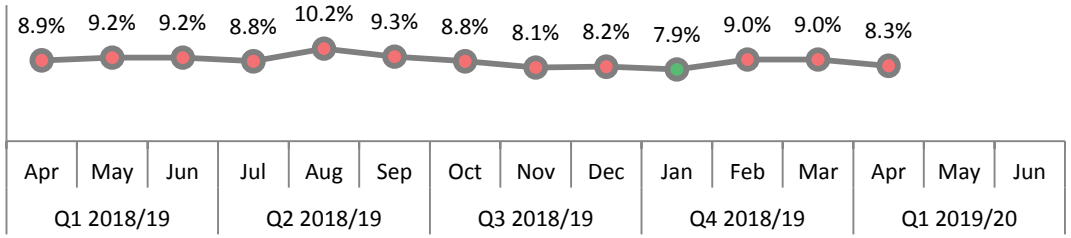
Indicator Detail

Jun-19	A&E: 12hr Trolley Wait
18	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	The number of 12 hour trolley waits increased in June and remains a cause for concern.
<= 0	



Actions
Patients who reach 10 hours following a decision to admit who do not have a plan are escalated to the Delivery Director and Director of the day and are the subject of a meeting which includes the key business group personnel.

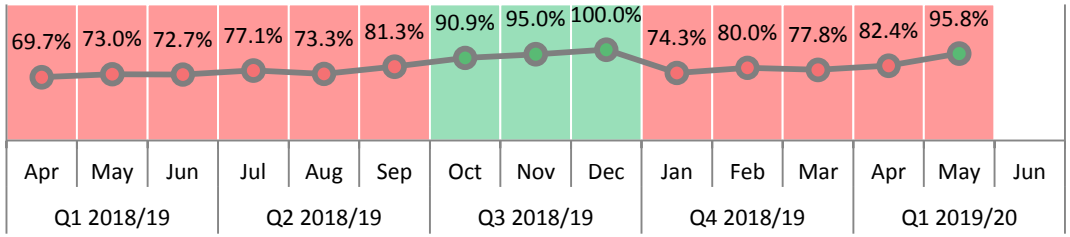
Apr-19	Emergency Readmission Rate (UoR)
8.3%	The percentage of emergency re-admissions within 28 days following an inpatient discharge. This indicator includes admissions for all conditions, and is not restricted to re-admissions for the same condition as the original admission.
Target	
<= 7.9%	



Actions

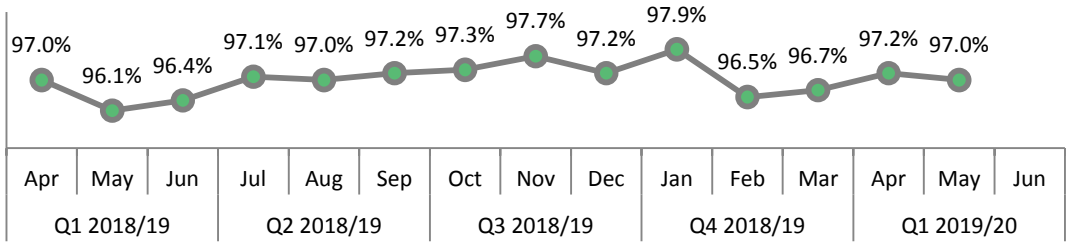
Indicator Detail

May-19	Diabetes Reviews
95.8%	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 in month
>= 90%	



Actions

May-19	VTE Risk Assessment
97.0%	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%	

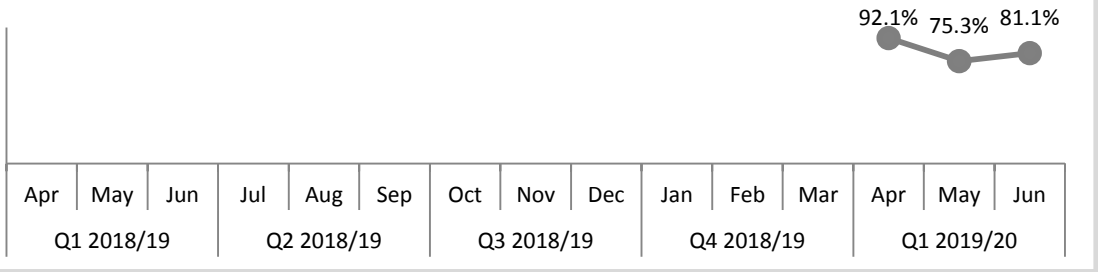


Actions

The target has been achieved in month.

Indicator Detail

Jun-19	Sepsis: Timely Identification
81.1%	The number of patients who are screened for sepsis, as a percentage of all eligible patients who meet the criteria .
Target	Percentage of inpatients that have undergone a sepsis screening



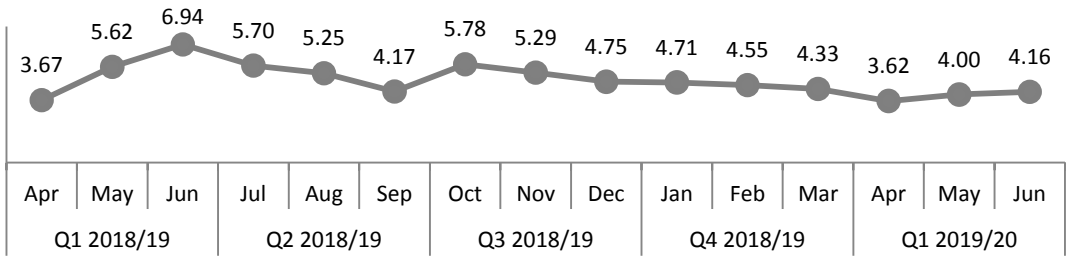
Actions
During June a total of:- 644 patients triggered on the NEWS2 as a possible sepsis 275 patients were reviewed by the IP&C service team after the exclusion criteria was applied 234 patients were escalated by nursing staff to the medical teams for review 223 patients were reviewed and screened for sepsis by the medical team 21 patients following review were recording as having sepsis During July we are reviewing an electronic sepsis screening system to aid the screening process

Jun-19	Sepsis: Timely Treatment
42.9%	The number of patients who received IV antibiotics within 1 hour, as a percentage of all eligible patients found to have sepsis.
Target	Percentage of inpatients clinically found to be septic and who received their antibiotics within an hour of the diagnosis
>= 90%	

Actions
During June:- 9 of the 21 patients were given antibiotics within the hour of diagnosis. 9 of the 21 patients were reviewed within the hour of diagnosis Only 5 of the 21 patients were reviewed and given antibiotics within an hour of diagnosis From July the Business Groups are undertaking a review of all cases where sepsis was identified where antibiotics were not given with one hour.

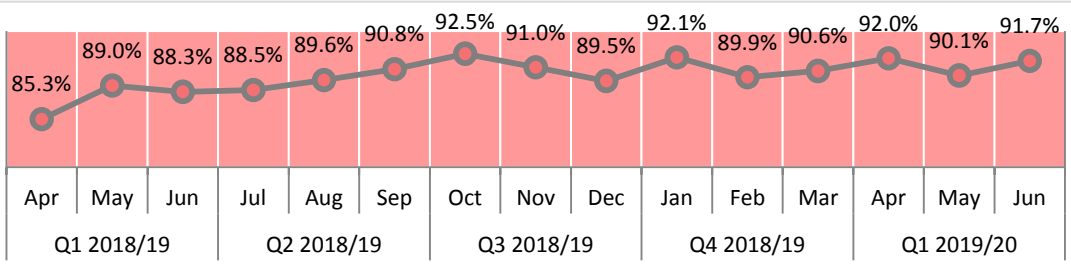
Indicator Detail

Jun-19	Medication Errors: Rate
4.16	Rate of medication errors, calculated as incidence per 1000 bed days.
Target	In June, the medication error rate was 4.16. This is the second month that there has been an increase in the rate. A number of the incidents relate to neonatal staff giving babies antibiotics intravenously on the delivery suite. There was 1 moderate incident reported; this was an extravastion injury.



Actions
Medication errors are reviewed each week at the patient safety summit. In June, reminders were sent to staff, via the patient safety summit update, regarding the following: Expired medication Prescribing of first doses of medication but no follow up medication prescribed Labelling of intravenous medication The importance of the second staff member of checking intravenous medication throughout the whole process

Jun-19	Discharge Summaries
91.7%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	In June the Surgery, GI & CC BG achieved the 95% target. The greatest challenges remain in high turnover assessment areas, but as effective communication with primary care after such discharges is of critical importance, the focus will remain until the target is reached.
>= 95%	

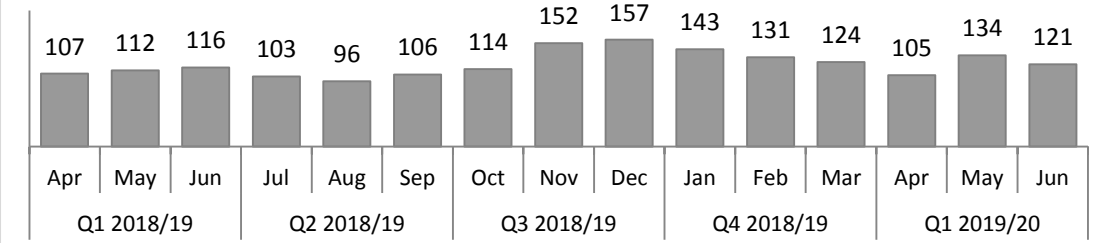


Actions
Business Groups are challenged as to how they will maintain a focus on meeting the 95% target at the monthly performance review meetings.

Indicator Detail

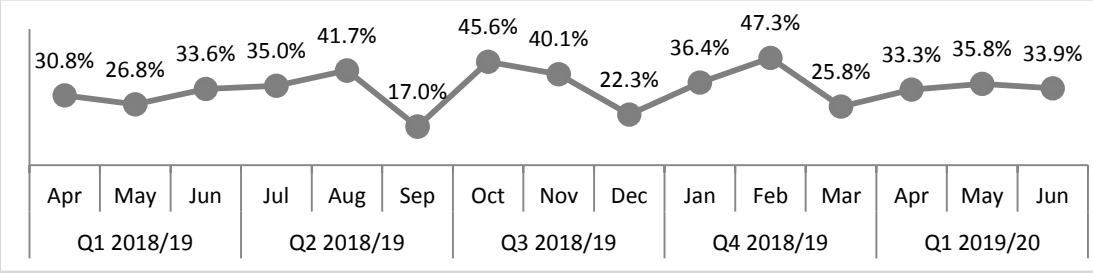
Jun-19	Mortality: Deaths in ED or as Inpatient
121	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	In June there were 121 deaths recorded in the Emergency Department or as an inpatient. This is a decrease from last month.

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

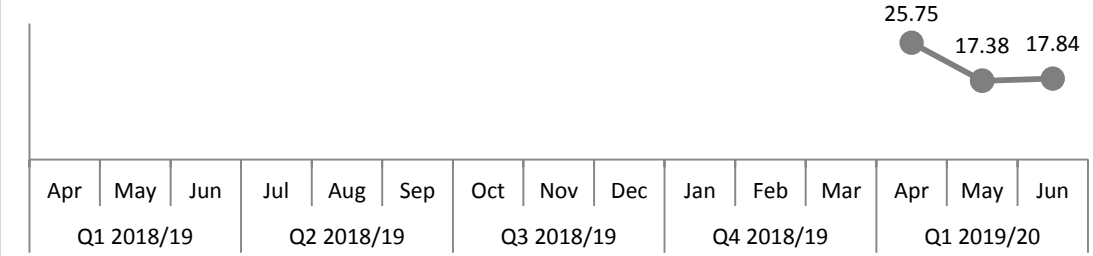


Jun-19	Mortality: Case Note Review Rate
33.9%	The number of case note reviews that taking place in month, as a percentage of all patient deaths while patient was in the emergency department or as an inpatient.
Target	40 learning from death reviews were undertaken in June. There are several recurring themes that are identified through the reviews. These will be shared with appropriate groups to action.

Actions
The quarterly newsletter detailing the key themes identified through the reviews, will be circulated by the Medical Director in July. All LFD reviews are now completed using standardised methodology and available for scrutiny in the centralised Datix reporting platform.

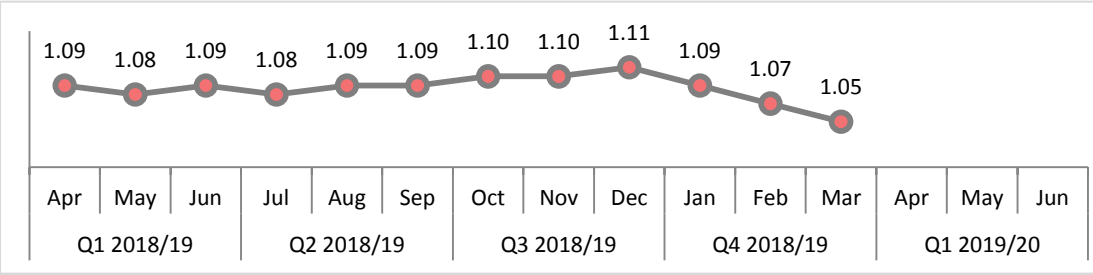


Jun-19	Mortality: Specialist Palliative Care Length of Stay
17.84	The average length of a patient spell, from admission to death. Includes specialist palliative patients who die in hospital only. Reported by month of discharge/death.
Target	The positive reduction in the length of stay was reported in May has been maintained in June.



Actions

Mar-19	Mortality: HSMR
1.05	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	A non significant improvement for the third consecutive month.
<= 1	



Actions

Mortality actions include an AQUA quality improvement project, improvements in the palliative care team, work on improved integration with primary care, Enhanced case management and crisis response.

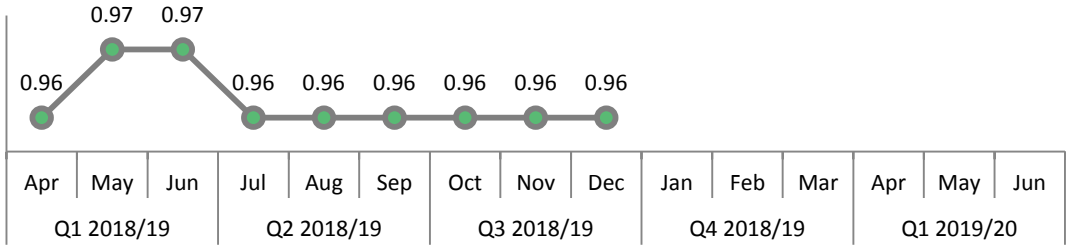
Giving patients little choice but to die in hospital increases the mortality statistic, but more importantly for many fails to meet their wishes relating to preferred place of death.

Improving outcomes requires a close analysis of all diagnoses with excess deaths, optimising treatment of sepsis, reducing in patient falls and pressure ulcers, as well as a focus upon nutrition and hydration all have a part to play.

A bi-annual report on mortality is submitted to the Quality Committee.

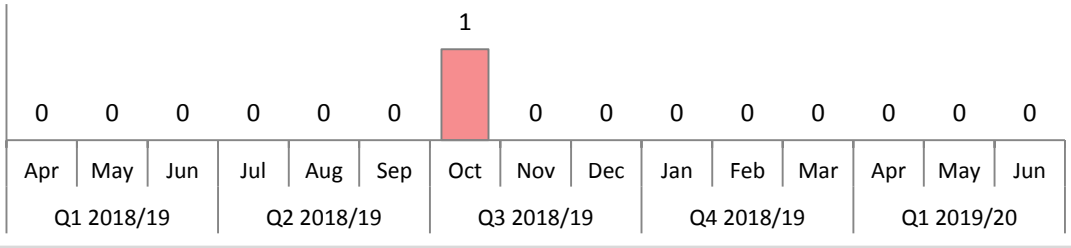
Indicator Detail

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



Actions

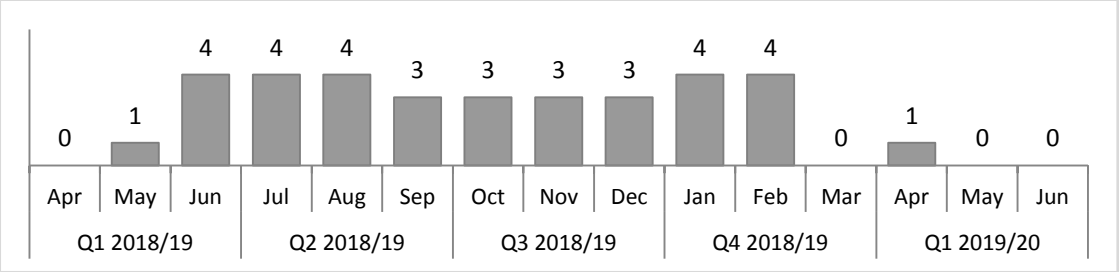
Jun-19	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	In June, there were no never events recorded.
<= 0	



Actions

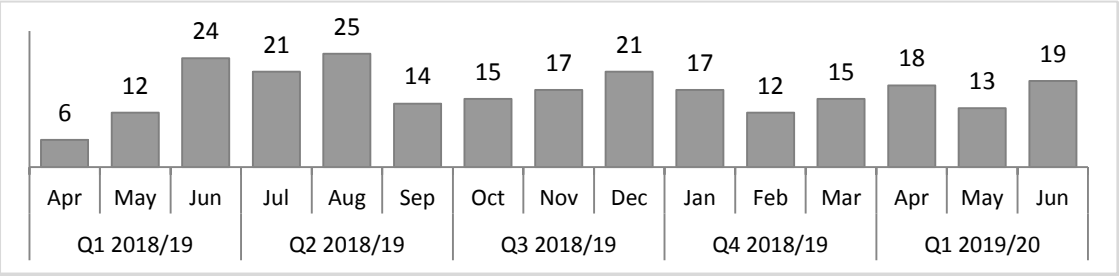
The last never event in the organisation occurred in October 2018.

Jun-19	Duty of Candour Breaches
0	Total number of duty of candour breaches of regulation in month.
Target	In June, there were no Duty of Candour breaches.



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

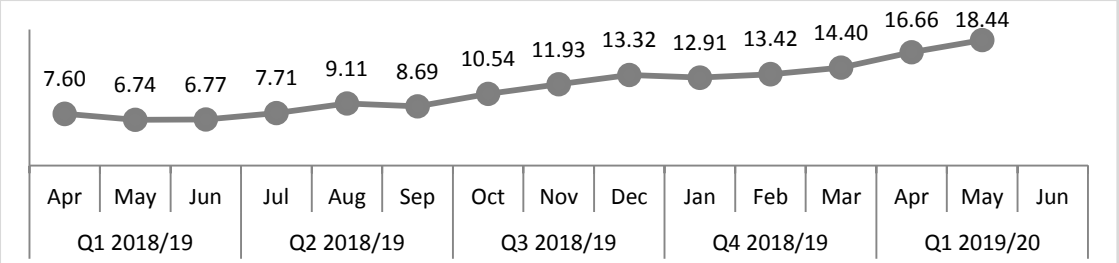
Jun-19	Serious Incidents: STEIS Reportable
19	The total number of STEIS reportable incidents.
Target	In June 2019 there were 19 incidents that were reported on the Strategic Executive Information System (StEIS). This was an increase of 6, compared to last month.



Actions
The incidents reported on StEIS were: - 8 pressure ulcers including seven category 3 and one category 4. - 5 instances where patients waited more than 12 hours in the emergency department and met the criteria for a 12 hour trolley wait. - 3 incidents where the delivery suite was placed on divert - 2 incidents where a patient had a fall that resulted in a fractured neck of femur - 1 incident where a patient was transfused the incorrect blood product

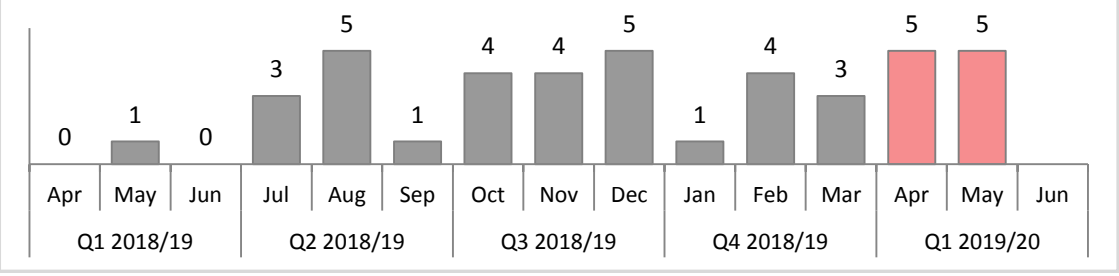
Indicator Detail

May-19	C.Diff Infection Rate
18.44	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
The target rate is monitored through the infection prevention & Control group Due to the increase in cases over the last few months, NHS improvement are supporting us in different ways of working to reduce number of cases

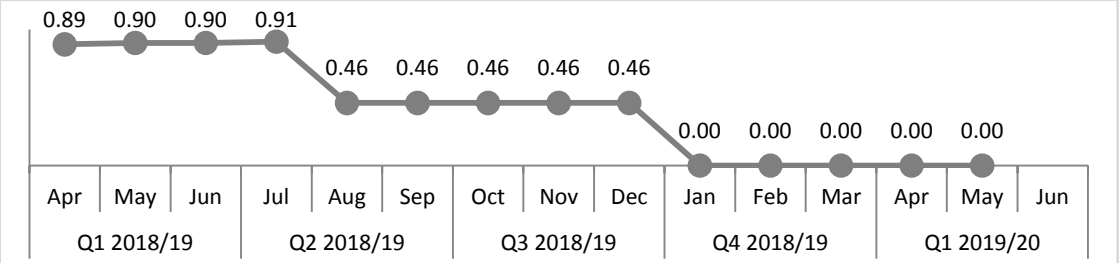
May-19	C.Diff Infection Count
5	Total number of C.Diff infections.
Target	The 2019-20 target set by the Department of Health for hospital acquired Clostridium difficile toxin positive cases is 51
<= 8 *	



Actions
During May there were 5 cases of Clostridium difficile Each CDI case will require investigating within 14 days Bi-weekly Healthcare Acquired Infection (HCAI) panels have been introduced that are separate from Harm Free Care Panels. These are chaired by the Director of Infection Prevention & Control, with attendance from the microbiologist with lead responsibility for infection prevention and control, and the matron for infection prevention and control. This approach is aimed at ensuring that C-Diff infection incidents are investigated within 14 days and presented at the panel within 2 weeks. A composite action plan will then be developed by mid August 2019 to address the increase in cases seen.

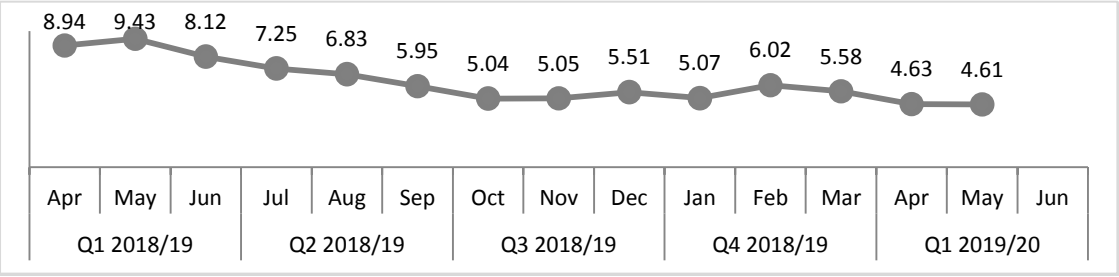
Indicator Detail

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



Actions
The MRSA target set by the Department of Health remains zero for2019-20. In May there were zero cases of MRSA The target is monitored through the infection prevention & control group

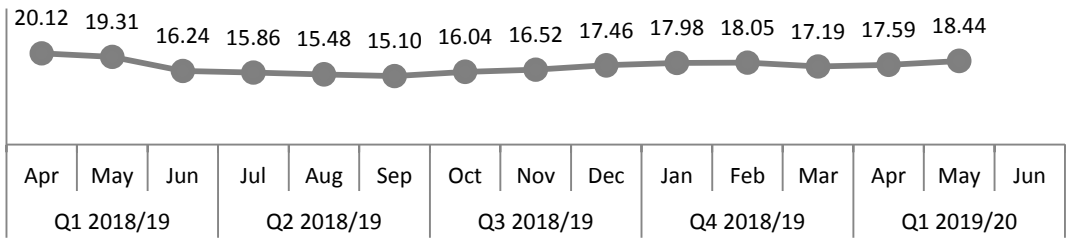
May-19	MSSA Infection Rate
4.61	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections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



Actions
The MSSA infection rate is monitored as a whole health economy. The figures represented within this report are Trust acquired cases This is monitored through the Infection prevention & control group Discussions have taken place with the CCG to agree a quarterly target tolerance for the Trust in relation to MSSA infections. Concurrent to this agreement is the development of a proforma to undertake concise investigations which will be heard during the bi-weekly HCAI Panels from Q3.

Indicator Detail

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



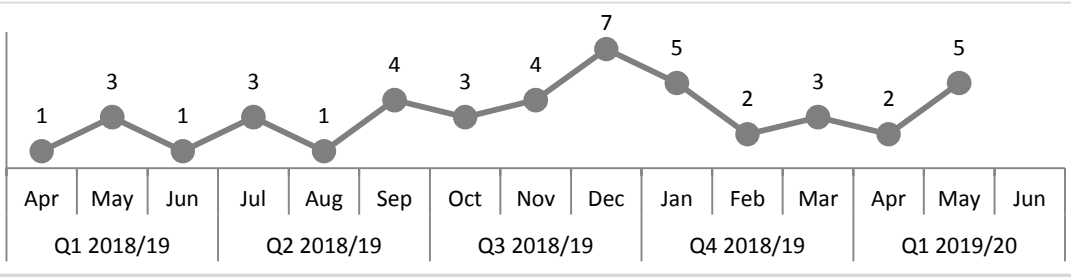
Actions

Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups. The figures represented within this report are trust acquired cases.

A reduction plan owned by the CCG has been developed collaboratively between the Trust, Health protection nurses and CCG.

This plan is monitored through the infection prevention & control group

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



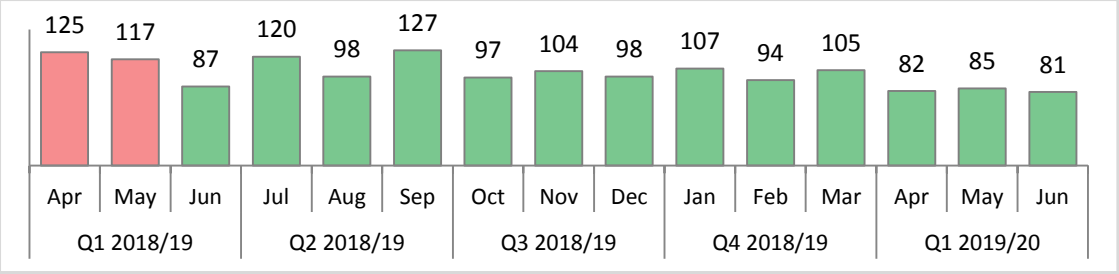
Actions

This is monitored through the Infection prevention & control group

Discussions have taken place with the CCG to agree a target tolerance for the Trust in relation to E-coli infections. Concurrent to this agreement is the development of a proforma to undertake concise investigations which will be heard during the bi-weekly HCAI Panels from Q3.

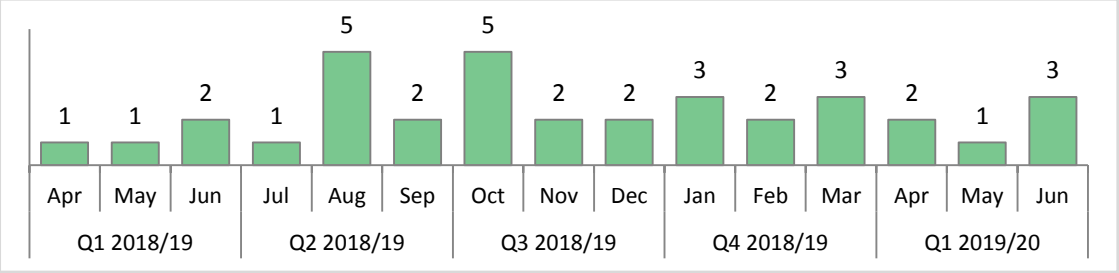
Indicator Detail

Jun-19	Falls: Total Incidence of Inpatient Falls
81	Total number of Inpatient falls
Target	The Trust has set a target of 10% reduction in in-patient falls for 2019/20 in comparison to 2018/19.
<= 275 *	This will be < 1100



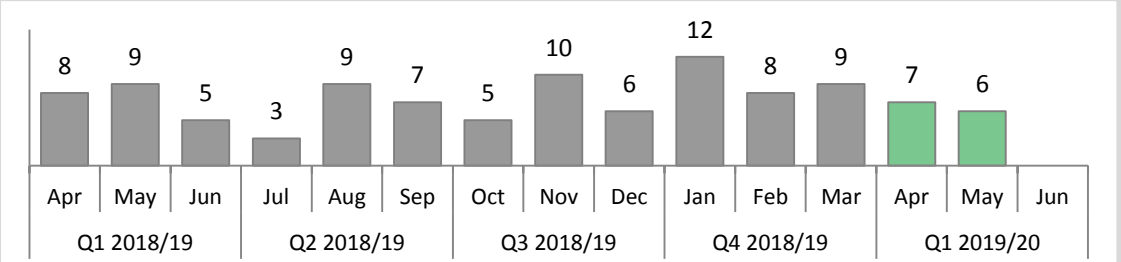
Actions
There have been a total of 81 in-patient falls during the month. June 19 continues the trend noted since December 18 with a month on month reduction in comparative data from the previous year (June 19- 81 falls; June 18- 83 falls equating to a 2.5% reduction). Running total for the year to date is 249

Jun-19	Falls: Causing Moderate Harm and Above
3	Total number of falls causing moderate harm and above.
Target	The Trust has set a target of 10% reduction of in-patient falls resulting in moderate or above harm level for 2019/20 in comparison to 2018/19.
<= 6 *	This will be <26 falls with harm.



Actions
There has been 3 falls in month resulting in Moderate or above harm, resulting in a fractured cheekbone and 2 fractured neck of femurs. These investigations are currently on-going. The 3 falls with moderate or above harm were within Surgery, GI and Critical Care Business Group Running total for the year to date is 6

May-19	Pressure Ulcers: Hospital, Category 2
6	Total number of category 2 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (May data) we have had 6 Category 2 PU reported
<= 15 *	



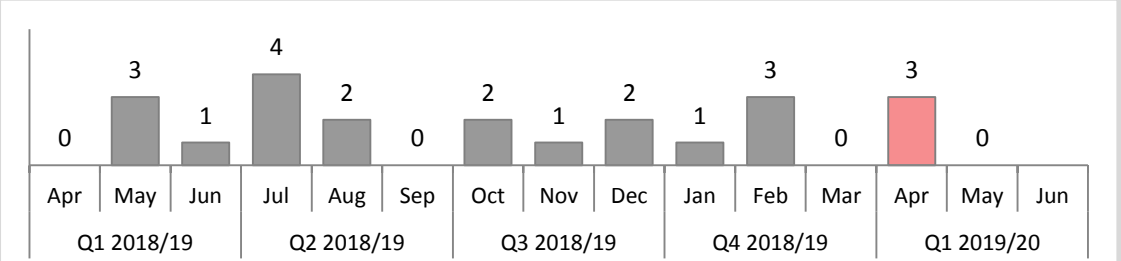
Actions

The Trust held a successful Pressure Ulcer Collaborative event on 26th June 2019. The themes and ideas raised at this event will be analysed and developed as the basis for our Trust wide PU improvement strategy over the next 12 months. Specifically:

A task and finish group focusing on variations in the provision and standards relating to pressure relieving equipment is to be established.

A new type of cross over replacement pressure relieving mattress is to be evaluated which has the potential to minimise delays in both equipment upgrade and downgrade when appropriate.

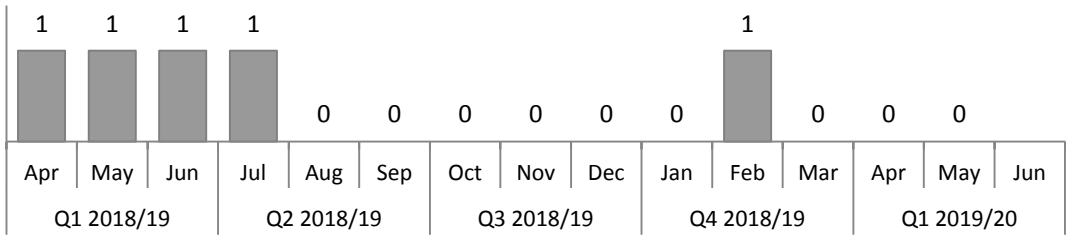
May-19	Pressure Ulcers: Hospital, Category 3
0	Total number of category 3 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (May data) we have had no category 3 PU reported
<= 3 *	



Actions

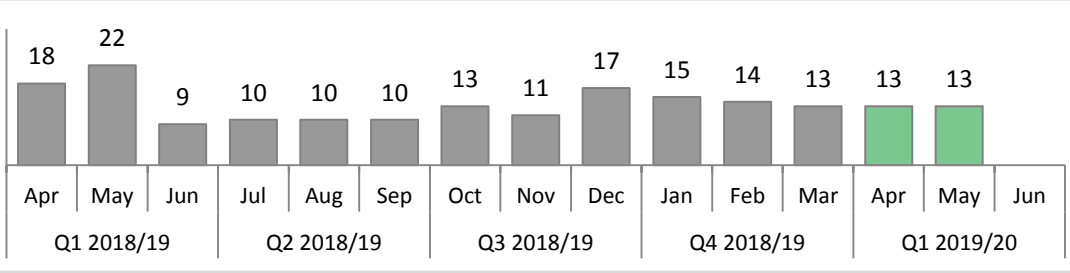
No actions required.

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



Actions
No actions required.

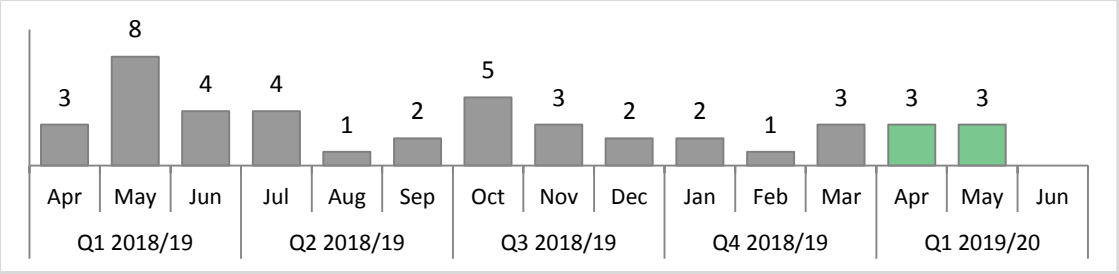
May-19	Pressure Ulcers: Community, Category 2
13	Total number of category 2 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired pressure ulcers (p u) by 10% over the next 12 months. This month (May data) we have had 13 Category 2 PU reported
<= 32 *	



Actions
The Trust held a successful Pressure Ulcer Collaborative event on 26th June 2019. The themes and ideas raised at this event will be analysed and developed as the basis for our Trust wide PU improvement strategy over the next 12 months. Specifically: A task and finish group focusing on variations in the provision and standards relating to pressure relieving equipment is to be established. A new type of cross over replacement pressure relieving mattress is to be evaluated which has the potential to minimise delays in both equipment upgrade and downgrade when appropriate.

Indicator Detail

May-19	Pressure Ulcers: Community, Category 3
3	Total number of category 3 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired pressure ulcers (p u) by 10% over the next 12 months. This month (May data) we have had 3 x Category 3 PU reported
<= 7 *	



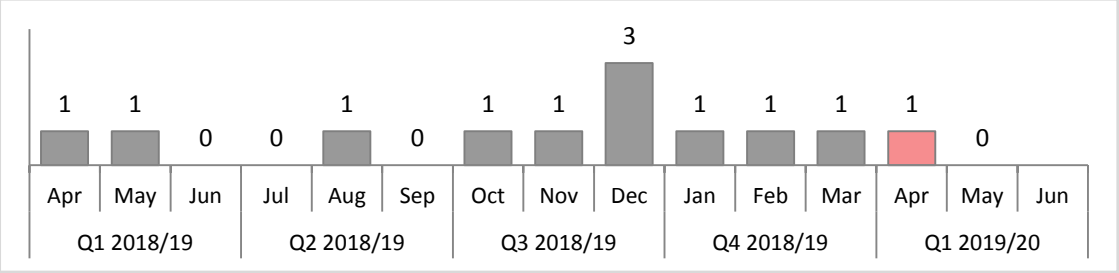
Actions

The Trust held a successful Pressure Ulcer Collaborative event on 26th June 2019. The themes and ideas raised at this event will be analysed and developed as the basis for our Trust wide PU improvement strategy over the next 12 months. Specifically:

A task and finish group focusing on variations in the provision and standards relating to pressure relieving equipment is to be established.

A new type of cross over replacement pressure relieving mattress is to be evaluated which has the potential to minimise delays in both equipment upgrade and downgrade when appropriate.

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

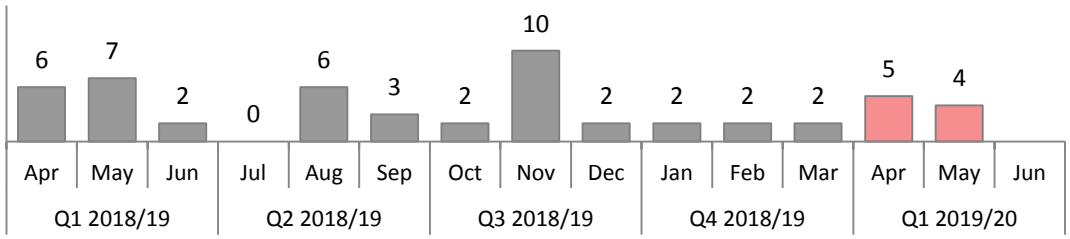


Actions

No actions required.

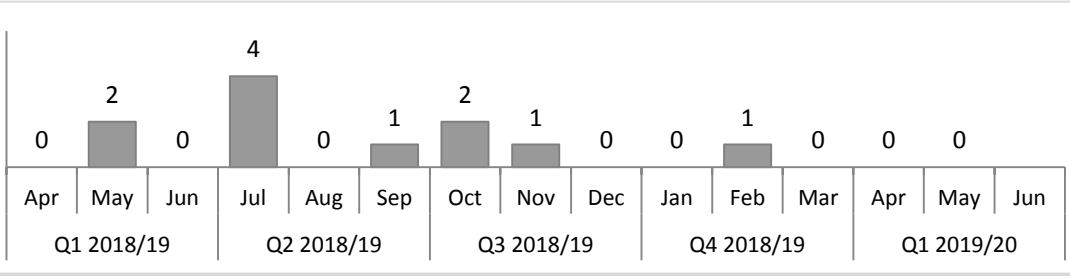
Indicator Detail

May-19	Pressure Ulcers: Device Related, Category 2
4	Total number of device-related category 2 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (May data) there has been a total of four x category 2 medical device related pressure ulcers that have occurred.
<= 5 *	



Actions
Currently we are over trajectory specifically both Integrated Care and Medicine Business Groups are above their target threshold. One of these MDRPU, has developed above a patients ear, under the strap that secures an Oxygen mask, one has occurred as a consequence of a NIVI ventilation mask to the bridge of a patients nose, one following the application of a splint to correct foot drop, and one from a urinary sheath: 129 staff have now received medical device tool box training across the Trust. Two clinical areas where the device related pressure damage has occurred has not yet received the training, these areas have now been prioritised to receive training later in the month. AMU have already changed practice in relation to one of these incidents and amended the units NIVI pathway to include a prompt reminding staff to utilise the medical device core care plan and check chart.

May-19	Pressure Ulcers: Device Related, Category 3
0	Total number of device-related category 3 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (May data) there has been no category 3 medical device related pressure ulcers that have occurred.
<= 1 *	

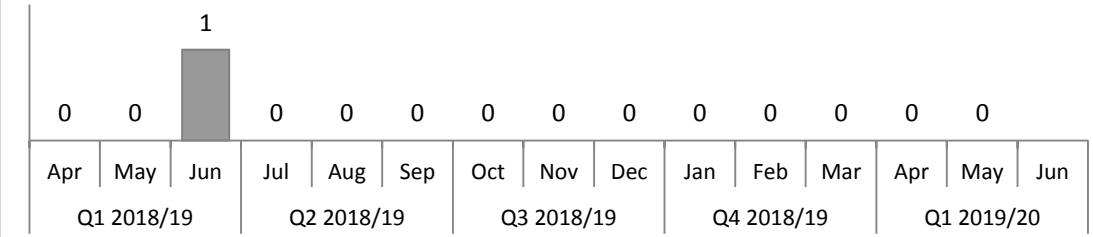


Actions
To date, 129 staff have now received medical device tool box training across the Trust, The first meeting of the reconvened task and finish group is to take place later this month

Indicator Detail

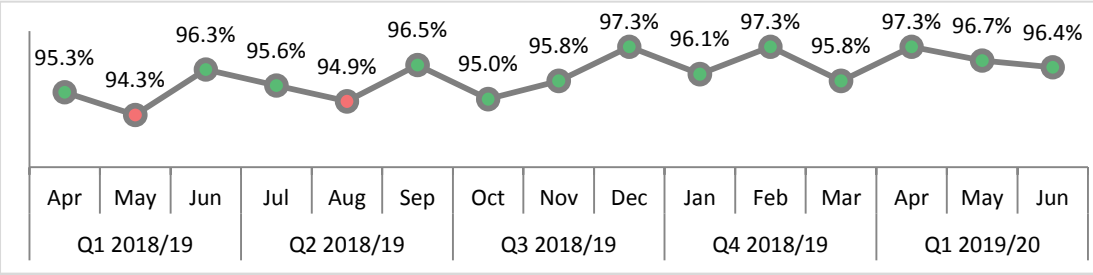
May-19	Pressure Ulcers: Device Related, Category 4
0	Total number of device-related category 4 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (May data) there has been no category 4 medical device related pressure ulcers that have occurred.
<= 0 *	

Actions
To date, 129 staff have now received medical device tool box training across the Trust, The first meeting of the reconvened task and finish group is to take place later this month



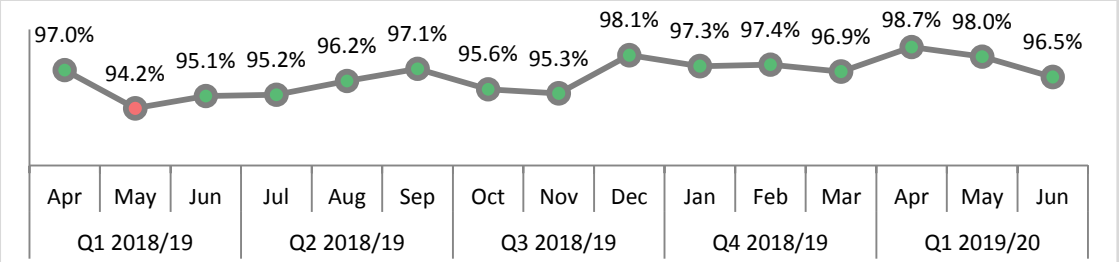
Jun-19	Safety Thermometer: Hospital
96.4%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The trust aim is greater than 95% of patients receive harm free care as monitored by safety thermometer. Result for June show we have achieved 96.4%
>= 95%	

Actions
Weekly validation meetings continue to be undertaken to improve the quality of the data Continuing to work with the informatics department to improve the reporting system



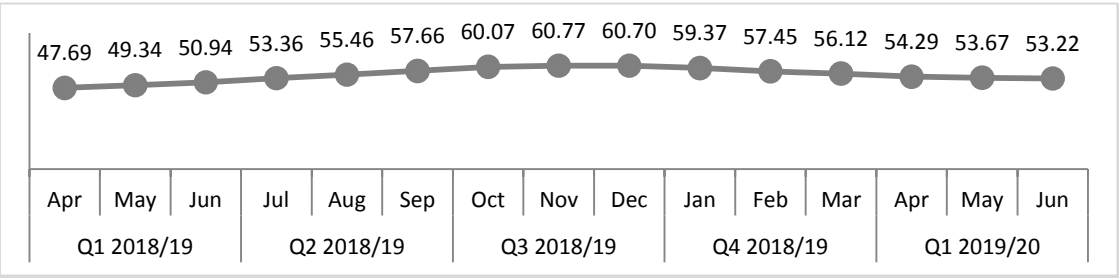
Indicator Detail

Jun-19	Safety Thermometer: Community
96.5%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that greater than 95% of patients receive harm free care as monitored by safety thermometer.
>= 95%	Results for June show we have achieved 96.5%



Actions
No actions required

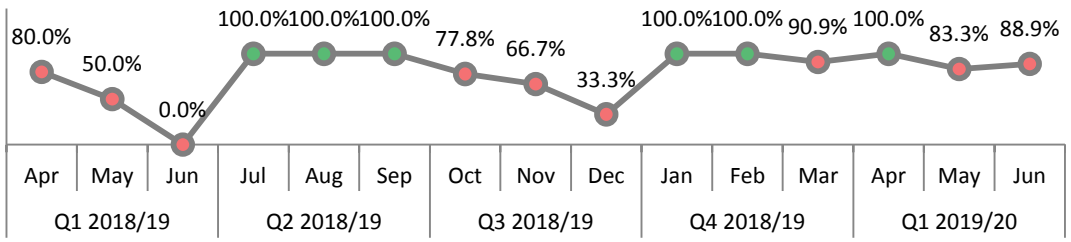
Jun-19	Patient Safety Incident Rate
53.22	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The number of patient safety incidents for every 1000 bed days has slightly reduced this month for the 7th month in a row. There were 1162 patient safety incidents reported for the month of June 2019, which was a slight increase from last month



Actions
The top five incidents in the month of June 2019: - Staffing issues - Pressure ulcers present on admission - Patient slips trips or falls - Uncooperative patient behaviour - Pressure ulcers developed during admission or whilst on case load. Each week, following the patient safety summit, an update is circulated to all staff. Key themes this month have been; - Use of correct giving sets when transfusing blood - Ensuring the correct patient details are on a referral form - Password security - Wrong Blood In Tubes (WBIT) - Checking the expiry date of medication - Appropriate removal of cannulas - Discharging patients for end of life care - Neurological observations following head injury - Recording transfers of patients at night

Indicator Detail

Jun-19	Patient Safety Alerts: Completion
88.9%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	8 out of the 9 alerts due to be closed in June, were completed.
>= 100%	



Actions

Alerts outstanding for June 2019

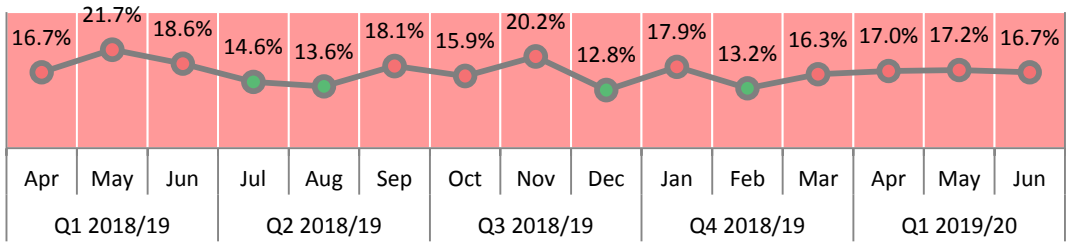
Drug Alert Class 2 M & A Pharmachem Limited Paracetamol 500mg Tablets, 1 x 1000.
Confirmation of closure is awaited from Pharmacy.

Alerts outstanding for May 2019

NHS/PSA/RE/2018/007 Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts.

Information is available on the microsite and topic has been discussed at huddles. Currently awaiting further information from the regional transplant unit to incorporate as they are updating their policy and guidance.

Jun-19	Emergency C-Section Rate
16.7%	The number of patients having an emergency c-section, as a percentage of all patients having registerable births.
Target	A decrease in the Emergency C-Section rate was noted in June to 16.7%
<= 15.4%	

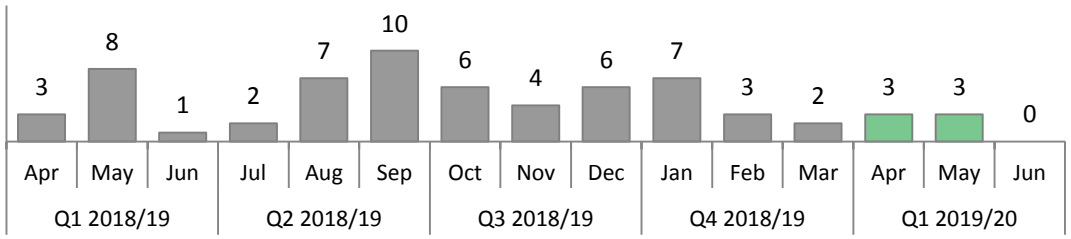


Actions

The emergency C-section rate needs to be taken into account alongside the number of ladies who had their labour induced. For the month of June the induction of labour rate was 34.8%. This is monitored through the maternity dashboard within the Business Group.

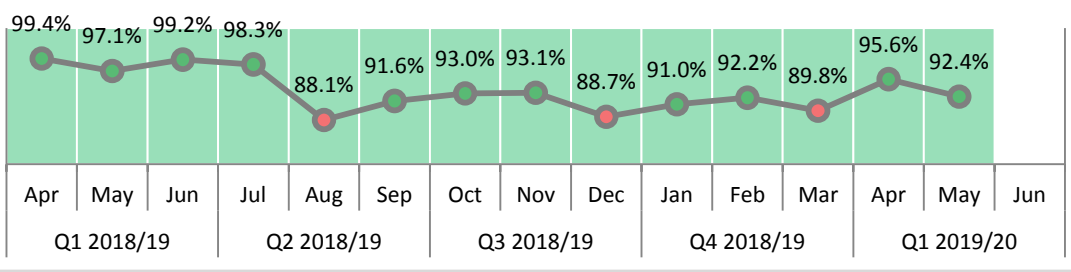
Indicator Detail

Jun-19	Term Babies Admitted to the Neonatal Unit
0	Number of term babies (greater than or equal to 37 weeks) admitted to SCBU/NICU, at birth, unexpectedly.
Target	In April, there were 0 babies admitted to the neonatal unit. The target was achieved in month.
<= 5	



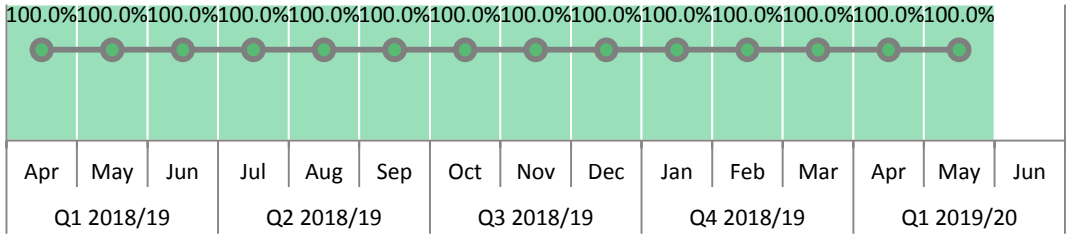
Actions
There are no actions required.

May-19	Dementia: Finding Question
92.4%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target has been achieved in month.
>= 90%	



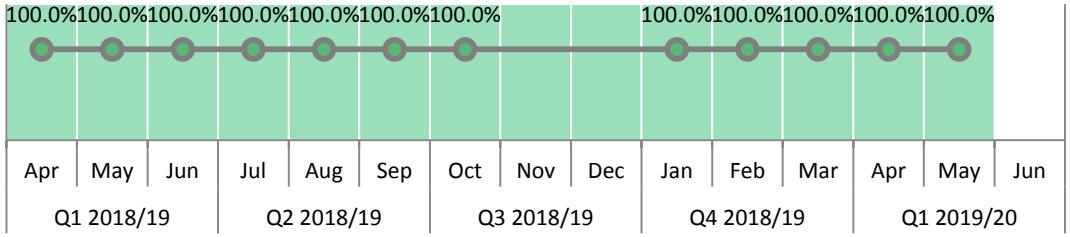
Actions
No actions required.

May-19	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target has been achieved in month.
>= 90%	



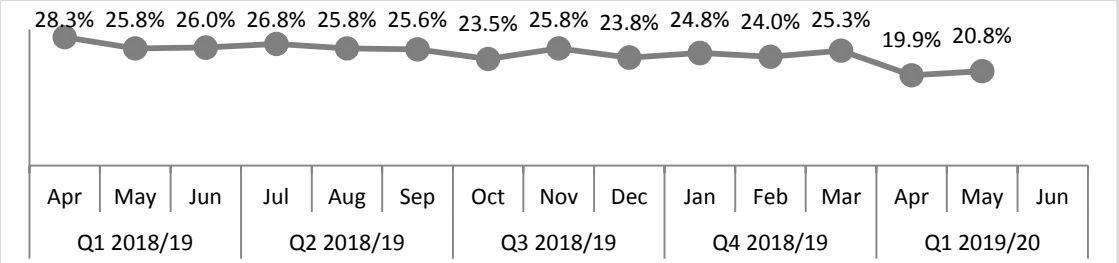
Actions
No actions required.

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



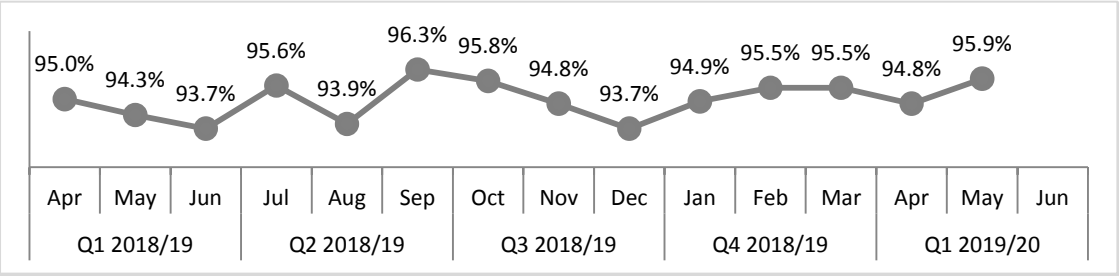
Actions
No actions required.

May-19	Friends & Family Test: Response Rate
20.8%	The percentage of eligible patients completing an FFT survey.
Target	Response rate achieved for May 2019 is 20.8%, this is a slight improvement on the previous month



Actions
Business Groups, wards and departments are encouraged to promote the importance of ensuring as many patients as possible provide feedback. This enables us to triangulate the information with other patient feedback mechanisms

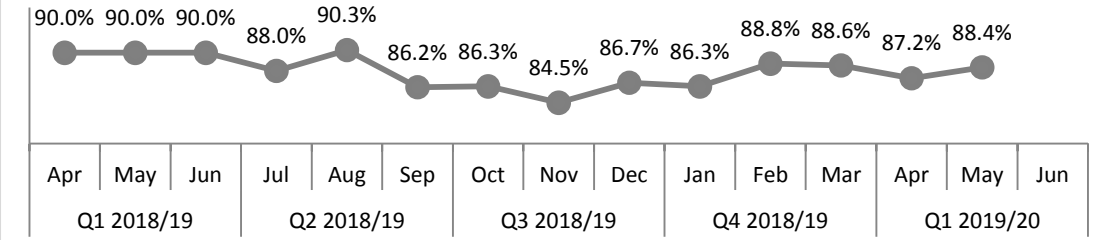
May-19	Friends & Family Test: Inpatient
95.9%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are likely or extremely likely to recommend the Trust for care



Actions
The top 3 themes collected by Healthcare Communications for May 2019 are: Positive 1. Staff attitude (618 responses) 2. Implementation of care (381 responses) 3. Environment (201 responses) Negative 1. Staff attitude (6 responses) 2. Waiting Times (5 responses) 3. Environment (4 responses)

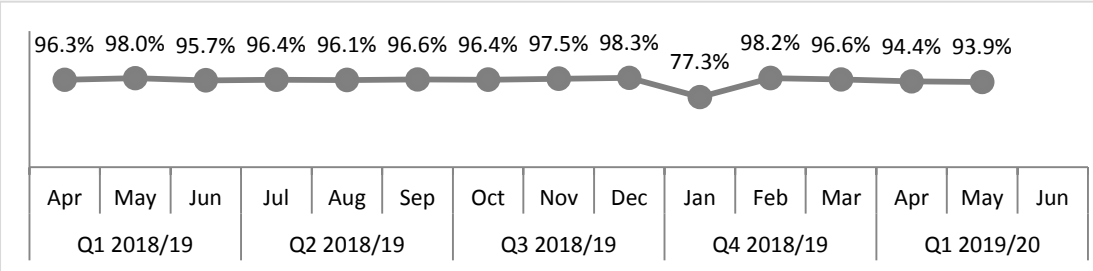
Indicator Detail

May-19	Friends & Family Test: A&E
88.4%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients who are extremely likely or likely to recommend the Trust for care.



Actions
The Top 3 themes collected by Healthcare Communication for A&E for May 2019 (Number of responses in bracket) are Positive 1. Staff Attitude (466) 2. Implementation of care (208) 3. Waiting time (155) Negative 1. Waiting time (43) 2. Staff attitude (35) 3. Clinical Treatment (27)

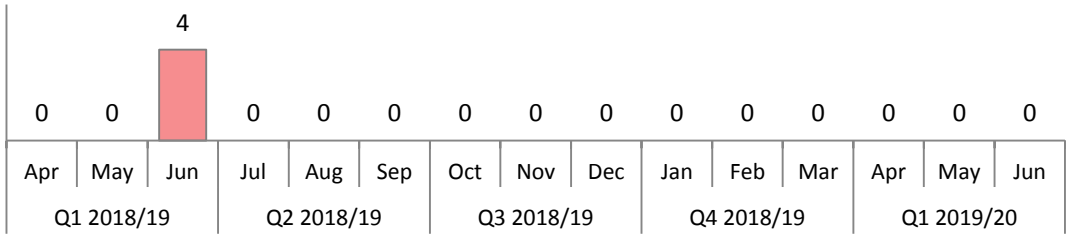
May-19	Friends & Family Test: Maternity
93.9%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed maternity inpatients (Birth Stage) who are extremely likely or likely to recommend the Trust for care



Actions
The Top 3 themes collected by Healthcare Communications in May 2019 (Number of responses) are: Positive 1. Staff attitude (81) 2. Implementation of care (48) 3. Patient Mood/Feeling (24) Negative None

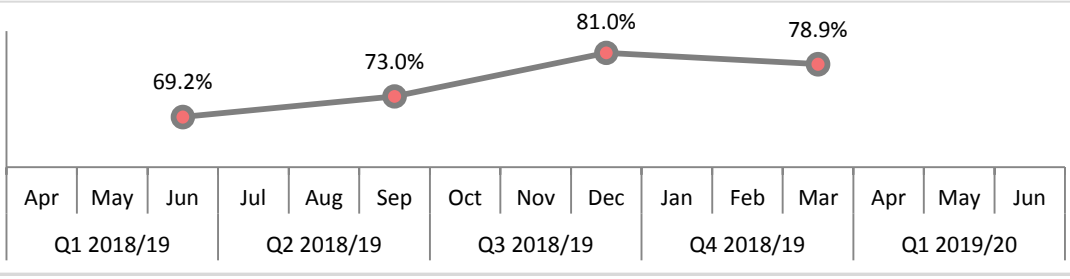
Indicator Detail

Jun-19	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	Total number of occasions that sexes were mixed as per trust standard operating procedure
<= 0	



Actions
No mixed sex breaches in the month of June

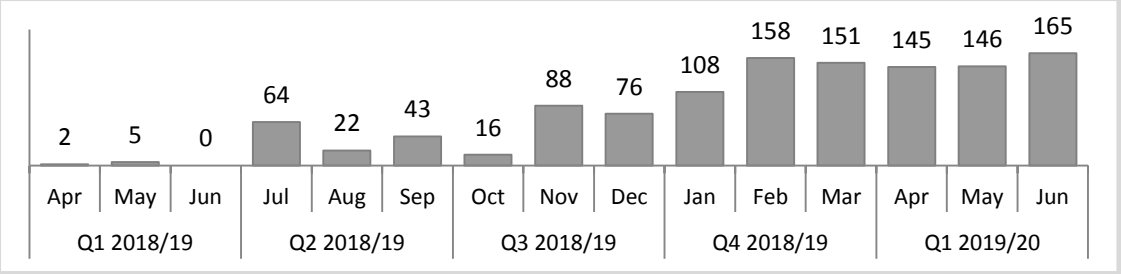
Mar-19	Learning Disability: Adjusted Care Plans
78.9%	The number of inpatients with a learning disability who have a reasonable adjustment care plan in place, as a percentage of all patients with a learning disability.
Target	The Trust has in place a flagging system to identify people who have learning disabilities. Adjusted care plans are formulated by referring to the Hospital Passport brought in with the patient and talking to the patient and / or their carers.
>= 100%	



Actions
To further underpin the leadership and management by the Business Groups in meeting the needs of patients with a learning disability in our care: - The Adult Safeguarding team established an audit process through the Audit Management and Tracking interface - Business Group Matrons will provide weekly evidence to the Adult Safeguarding Team in relation to the care and management of patients in our care with a learning disability. This data will be shared at Safety Quality and Leadership Group. - Weekly monitoring will be undertaken by the Adult Safeguarding team at ward level.

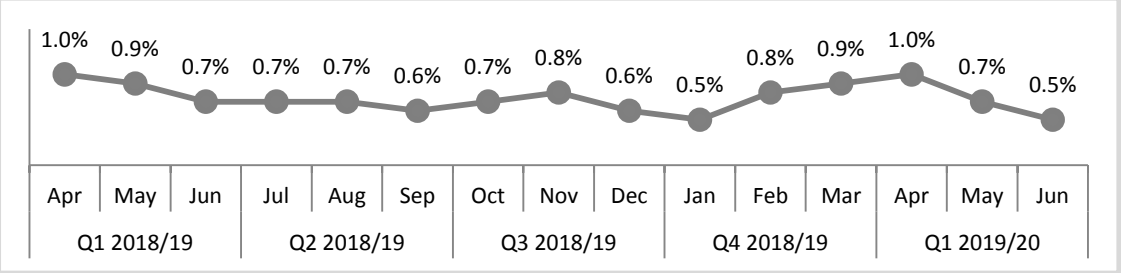
Indicator Detail

Jun-19	Compliments
165	Total number of compliments received.
Jun-19	For June 2019, 165 compliments have been received by the Trust.



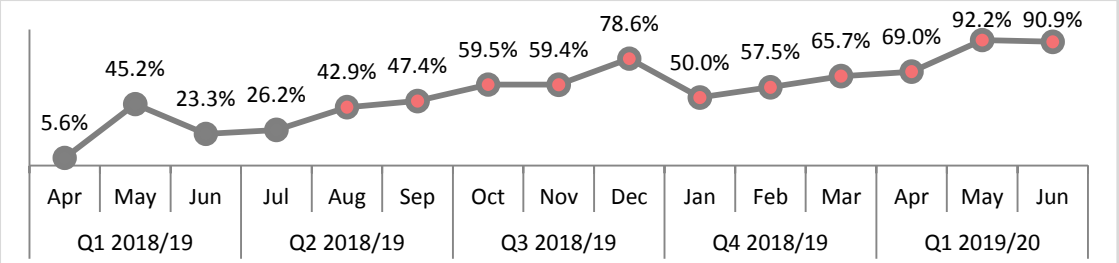
Actions
Any compliments received by the patient and customers services team are shared with the chief nurse & director of quality governance who acknowledges them in writing. If a member of staff is identified, the chief nurse & director of quality governance will present them with a Proud to Care Certificate in recognition of their hard work. Business groups and wards continue to capture compliments on the Datix system. This enables the Trust to capture a wealth of information from thank you cards, letters, gifts and verbal feedback . The information is populated on a dashboard for each clinical area and their respective business group.

Jun-19	Complaints Rate
0.5%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	26 complaints were received in June 2019: Integrated Care = 4, Medicine = 5, Surgery = 10, WCDS = 7 and Estates & Facilities 0



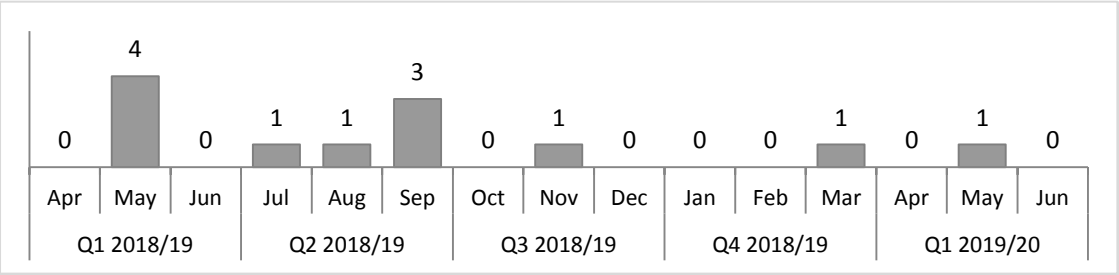
Actions
The Patient and Customer Services continue to focus on resolving concerns informally where appropriate with the hope to reduce the number of formal complaints.

Jun-19	Complaints: Response Rate 45
90.9%	The percentage of formal complaints responded to within 45 days.
Target	Of the 33 responses sent in June 2019, 30 were responded to on time resulting in a 90.9% response rate. The business group response rate is as follows: integrated care: 100%, Medicine: 90%, Surgery: 75%, WCDS: 100% and Estates & Facilities: 100%
>= 95%	



Actions
The patient and customer services team continue to liaise with the business groups and the executive team with the aim of improving the Trust complaints response rate. Complainants are kept informed of any delays that occur resulting in the Trust not being to respond in the agreed timeframe

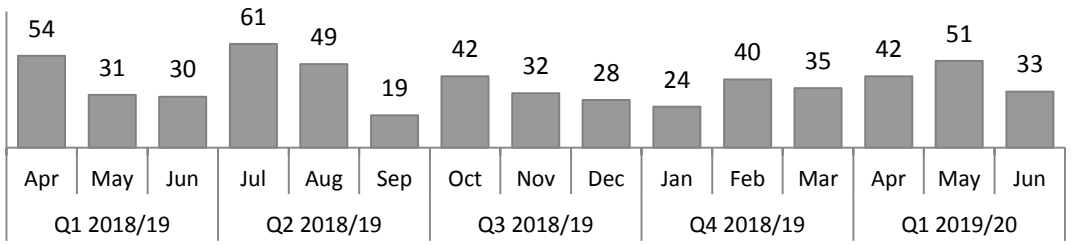
Jun-19	Complaints: Parliamentary & Health Service Ombudsman Cases
0	The total number of open Ombudsman cases.
Target	In June 2019, there were no new referrals received from the Parliamentary and Health Service Ombudsman and no final reports were received in month.



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

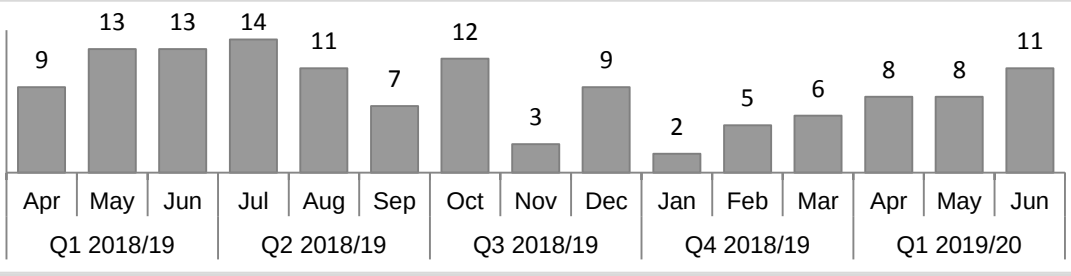
Jun-19	Complaints Closed: Overall
33	The total number of formal complaints that have been closed.
Target	In the month of June 2019, 33 responses were closed in month: integrated care closed 7, medicine closed 10, surgery closed 8, women, children & diagnostic services closed 7 and estates & facilities closed 1.

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

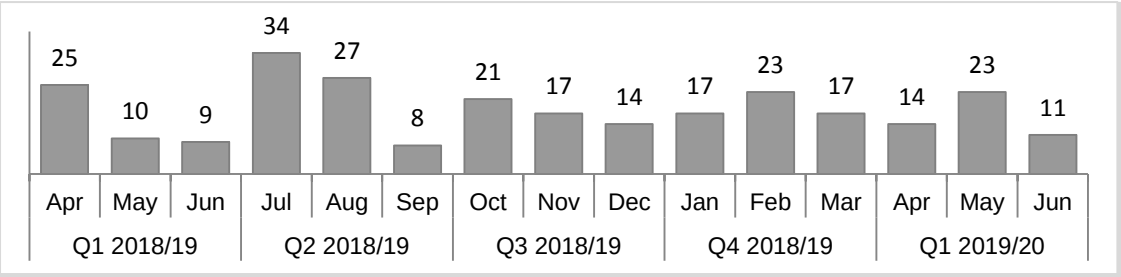


Jun-19	Complaints Closed: Upheld
11	The total number of upheld formal complaints that have been closed.
Target	In June 2019, 11 cases were upheld out of the 33 closed.

Actions
Learning from complaints shared via the Patient Experience Group and is always shared with the complainant.

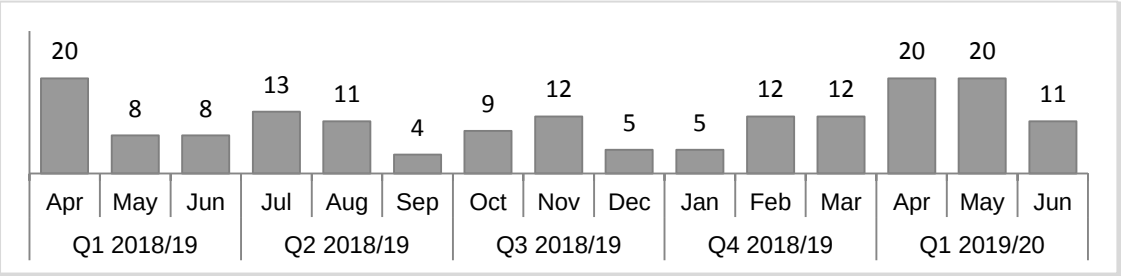


Jun-19	Complaints Closed: Partially Upheld
11	The total number of partially upheld formal complaints that have been closed.
Target	In June 2019, 11 of the cases were partially upheld of the 33 closed.



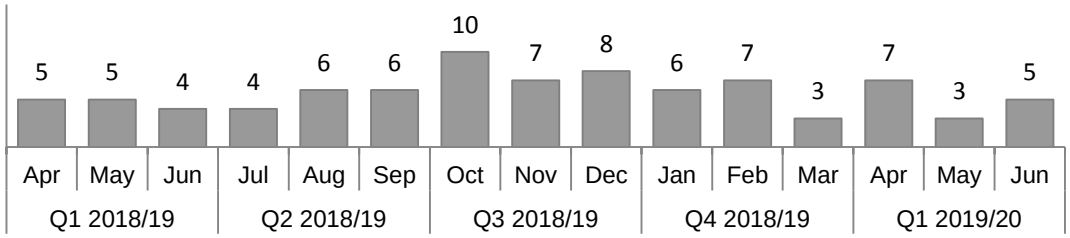
Actions
Where learning is identified on a partially upheld complaint, this is shared with the complainant in the Trust response and with appropriate staff for reflection.

Jun-19	Complaints Closed: Not Upheld
11	The total number of not upheld formal complaints that have been closed.
Target	In June 2019, 11 of the cases were not upheld of the 33 closed.



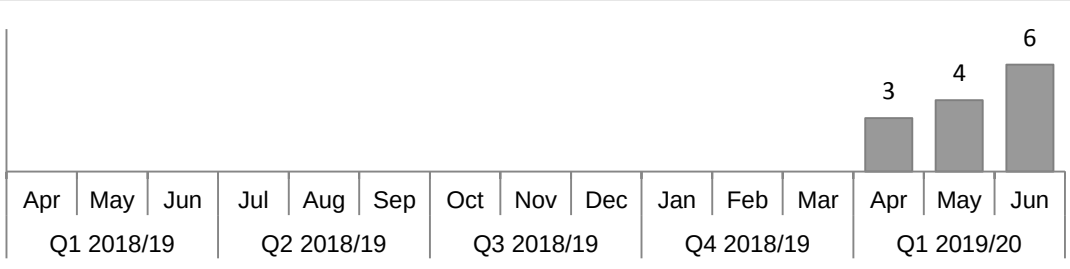
Actions
Complaints that have not been upheld may still have learning points for staff to reflect on. If this is the case, this will be shared with the complainant and fed back to appropriate staff.

Jun-19	Litigation: Claims Opened
5	Total number of claims opened in month.
Target	There were 5 claims opened in June 2019 - 3 Medical Negligence Claims - 2 Employment Liability Claims



Actions
The process for investigating the claims received has commenced in line with policies and procedures. A significant piece of work in being undertaken associated with Getting It Right First Time and NHS Resolution. 269 cases are being reviewed to ensure that the lessons learnt from them and any actions to be taken, have been appropriately completed.

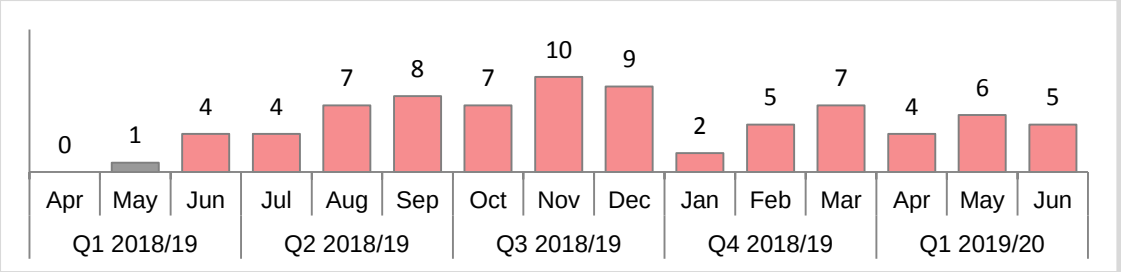
Jun-19	Litigation: Claims Closed
6	Total number of claims closed in month.
Target	There were 6 claims closed in June 2 Surgery, GI and Critical Care Business Group 2 Woman's, Children and Diagnostic Business Group 1 Medicine and Clinical Support Business Group 1 Integrated Care Business Group



Actions
Outcomes: 3 claims were settled with support from NHS Resolution. 3 claims were repudiated and as there has been no further correspondence from the claimants, NHS Resolution have advised to close the files.

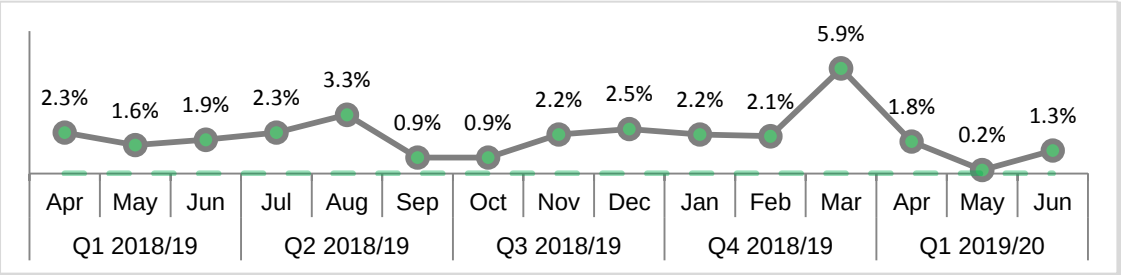
Indicator Detail

Jun-19	Referral to Treatment: 52 Week Breaches
5	The total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.
Target	In June 5 x 52 week breaches were reported. 1 x Gen Surgery; 1 x Gynae; 1 x Paeds; 1 x Oral Surgery & 1 x T&O.
<= 0	



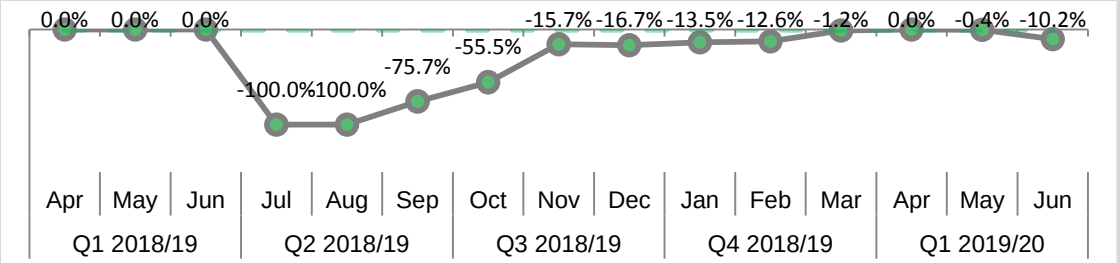
Actions
- Clinical reviews take place for patients wishing to defer treatment to ensure it is clinically safe to do so. - Long waiting patients are tracked at individual level each week via the PTL meetings. - Patients waiting > 52 weeks are subject to root cause analysis and patient harm review.

Jun-19	Financial Controls: I&E Position
1.3%	The percentage variance between planned financial position and the actual financial position.
Target	Target In the twelve months to 31st March 2020 the Trust has a planned underlying deficit of £24.5m after the planned achievement of a £14.2m CIP. This excludes non-recurring external support of £20.9m which will be received in full if the Trust achieves the agreed control total, reducing the overall planned deficit to £3.6m.
>= 0%	



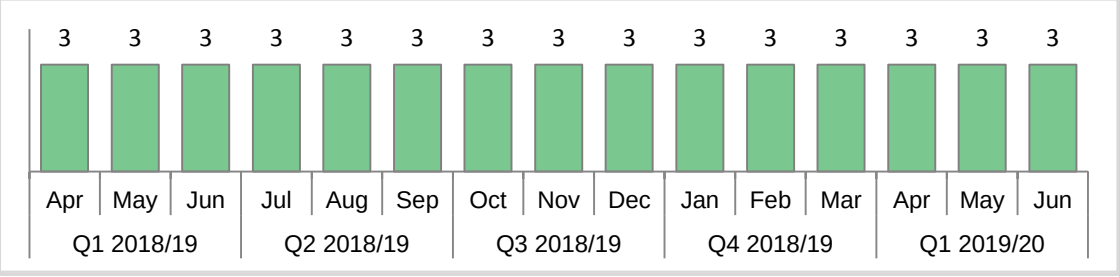
Actions
After the first quarter of the financial year the Trust has reported to NHS Improvement (NHSI) a loss of £5.5m, which is £0.1m favourable with the planned overall deficit and control total. However in achieving this the Trust has delivered less activity and income than plan by £1.1m, but also spent less than plan by £1.2m, so the expenditure underspend has been removed to CIP.

Jun-19	Cash
-10.2%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 30th June 2019 was £6.2m. This is linked to capital underspends against the profiled plan and the Trust's continued efforts to maintain a balance higher than the minimum cash balance allowed to protect working capital for the start of the financial year.
<= 0%	



Actions
The Trust did not borrow any funds in June 2019, maintaining the total borrowed to date at £27.6m since September 2018. Due to the external support agreed for 2019/20 and the planned profile of CIP required, borrowing is expected to peak and trough during the year as cash is received in advance and arrears for various elements. The requirement for a working capital support facility loan is continually being reviewed as part of the 13 week rolling cash flow forecast and the Trust continues to be in dialogue with NHSI's cash and capital team about requirements for cash. If the Trust fails to achieve the financial plan during 2019/20 and is moved into special measures with NHSI, then the cost of borrowing could be adversely impacted by an increase in the interest rate applied.

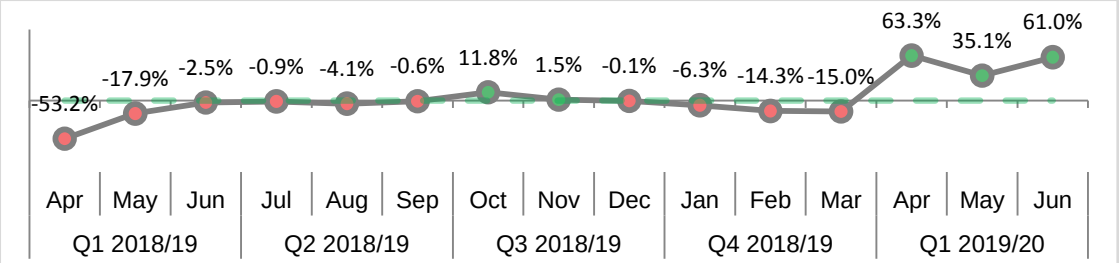
Jun-19	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's Use of Resources (UOR) draft score under the Single Oversight Framework is a 3, which is in line with plan.
<= 3	



Actions
Individual scores under the Finance & Use of Resources Metrics are shown below: Capital service cover = 4 (worst) Liquidity = 4 (worst) I&E margin = 4 (worst) Variance from control total = 1 (best) Agency spend = 1 (best) For the Trust's overall score to improve to a 2 then the Trust cash balance and liquidity would need to improve under the financial sustainability scores. As these two metrics score 4 in the operational plan for 2019/20, then this triggers an over-ride in the overall Use of Resources metric and limits the overall score to a 3.

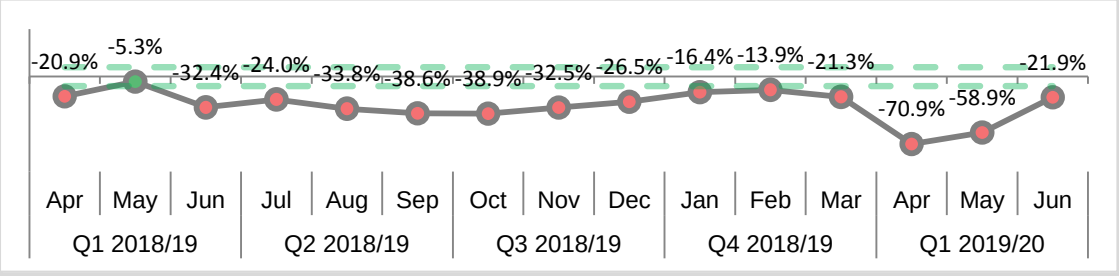
Indicator Detail

Jun-19	CIP Cumulative Achievement
61.0%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The cost improvement plan (CIP) is £0.9m favourable to date at the end of Q1 of the financial year, with £2.3m delivered against the £1.4m year to date target. Of the CIP delivered in the first quarter, £1.2m (54%) is non-recurrent vacancy factor. The profiled year to date target is 10% of the annual requirement.
>= 0%	



Actions
The Trust is £0.9m favourable to the profiled CIP plan to date, however this has been delivered through non-recurrent vacancy factor and there remains a significant risk to the delivery of the total CIP programme in 2019/20. At month 3 the Trust has identified £12.1m of schemes, and is working to identify schemes in order to bridge the £2.1m gap to the £14.2m requirement for 2019/20. £4.9m of CIP has been delivered against the £14.2m in year target, £2.6m of which is recurrent. The Trust has engaged external support to review the savings programme, This is in the early stages and their progress will be discussed with NHSI at the next Enhanced Oversight meeting.

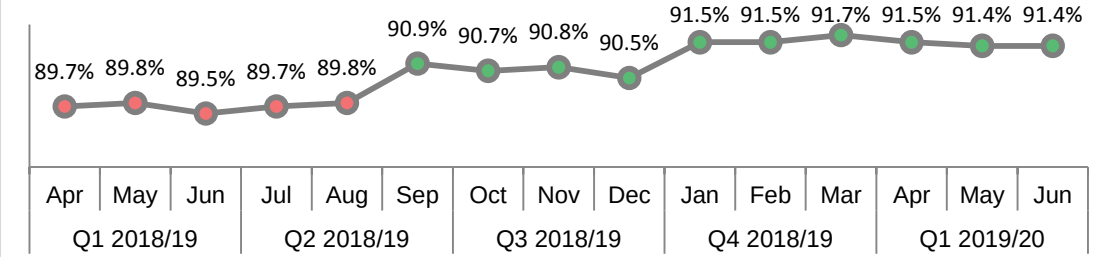
Jun-19	Capital Expenditure
-21.9%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £1.7m have been incurred in first quarter against a plan of £2.1m and so is £0.5m behind plan. This relates to the early termination of a finance lease (£0.4m); this expenditure will now fall later in the year for IT system stabilisation and the data warehouse.
+/- 10%	



Actions
The Trust has responded to requests from NHS Improvement and NHS England to review the capital forecast targetting a c.£5m reduction for Healthier Together in the context of supporting the national capital challenge. The Trust has therefore submitted a reduced capital forecast for 2019/20 from £17.3m to £12.2m. This protects internally funded capital investment at 2019/20 plan levels but defers Healthier Together spend into 2020/21. This will be reflected in the NHSI monthly returns from M04 (July).

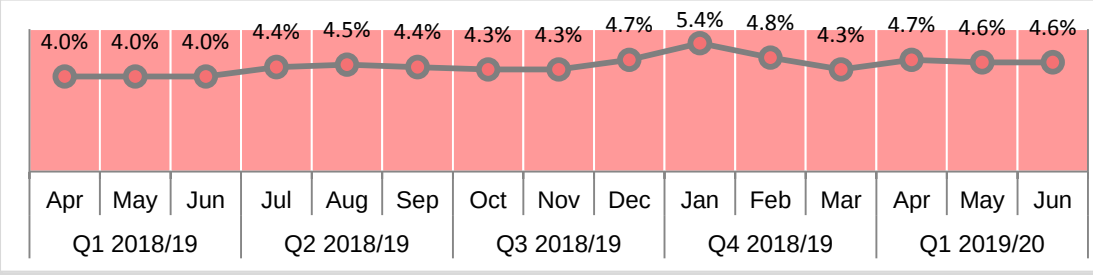
Indicator Detail

Jun-19	Staff in Post
91.4%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for June 2019 is 90.20% of the establishment (5,250.66 WTE). The percentage of staff in post has decreased in comparison to May, however, the actual FTE has increased by 0.21 to 4736.18 FTE. This is due to the overall establishment increasing by 66.73 FTE.
>= 90%	



Actions

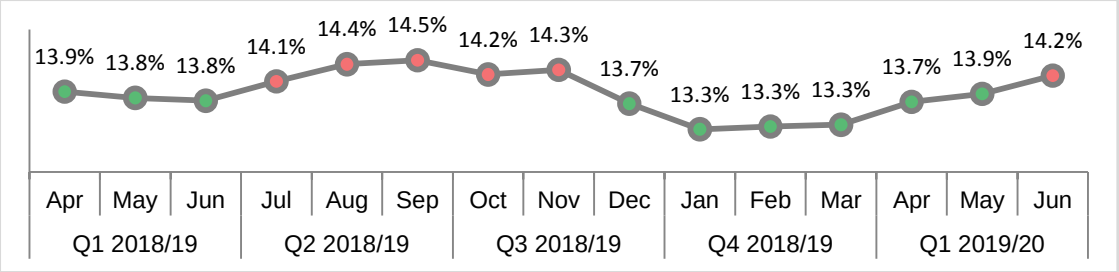
Jun-19	Sickness Absence Rate (UoR)
4.6%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for June 2019 is 4.56%; a decrease of 0.07% compared to the adjusted previous month's figure of 4.63%. □ The 12-month rolling sickness percentage for the period July 2018 to June 2019 is 4.58%.
<= 3.5%	



Actions
The review of the Sickness Absence policy has been completed; however further discussion with staff side is required before this can be approved & implemented. A trust-wide health and wellbeing day is planned for 29th July; providing staff with access to information and signposting for all health & wellbeing initiatives.

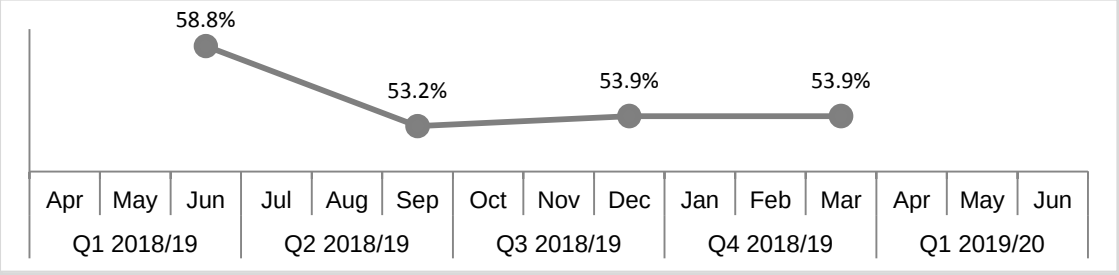
Indicator Detail

Jun-19	Workforce Turnover (UoR)
14.2%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of June 2019 is 14.19%, which is 0.19% above the Trust target. The adjusted rolling 12-month permanent headcount turnover figure for the same period is 13.08%. The top adjusted known leaving reasons are: Relocation 15.3%, Retirement 15.15%,
<= 13.94%	



Actions
Work to improve retention initiatives continues; the increase in turnover this month is related to Relocation 15.3%, Retirement 15.15%, and Promotion 14.85%.

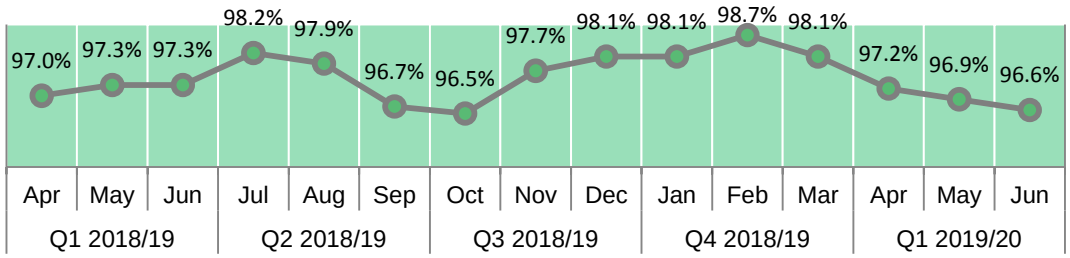
Mar-19	Staff Friends & Family Test: Recommend for Work
53.9%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust as a place of work.
Target	There has been a 1.23% increase since the previous quarter in staff recommending the Trust as a place to work and correlates with the response from the Staff Survey.



Actions
The increase is positive although it is still considerably lower than quarter one. There are a number of initiatives generated in response to these results including:- - Cultural Engagement Change Programme. - Promotion of Health and Wellbeing initiatives - Schwartz Rounds - Recruitment and Retention Strategy - Leadership and Development Programmes

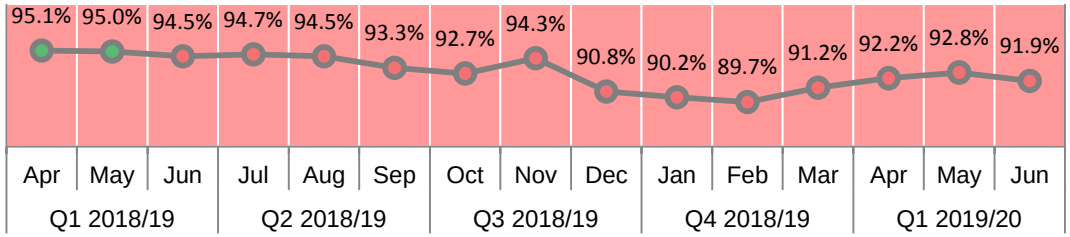
Indicator Detail

Jun-19	Appraisal Rate: Medical
96.6%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for May 2019 is 96.55%, a decrease on the last month's figure of 96.89% but this is still above the Trust target of 95%.
>= 95%	



Actions

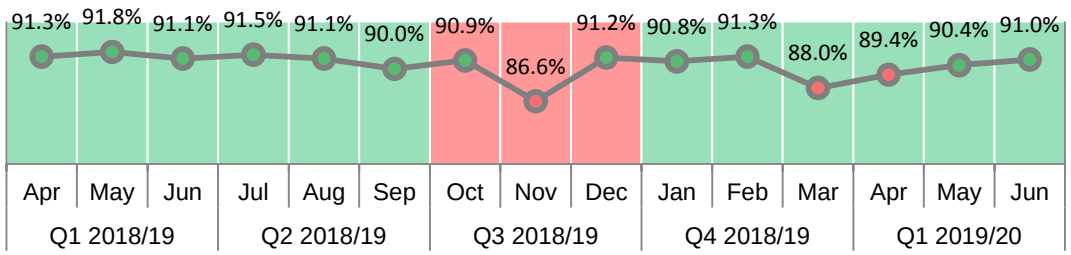
Jun-19	Appraisal Rate: Non-medical
91.9%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The appraisal rate has decreased slightly this month by 0.87% .Reminders mid month continue to be sent out to managers .
>= 95%	



Actions
Monthly compliance data is provided to business group leaders; including information of those due to expiry as well as non-compliant staff. A review of the appraisal process has been completed; with an improvement in the documentation and supporting guidance in order to ensure the emphasis is on the discussion rather than the completion of documentation; it is anticipated that this will have a positive impact on staff experience.

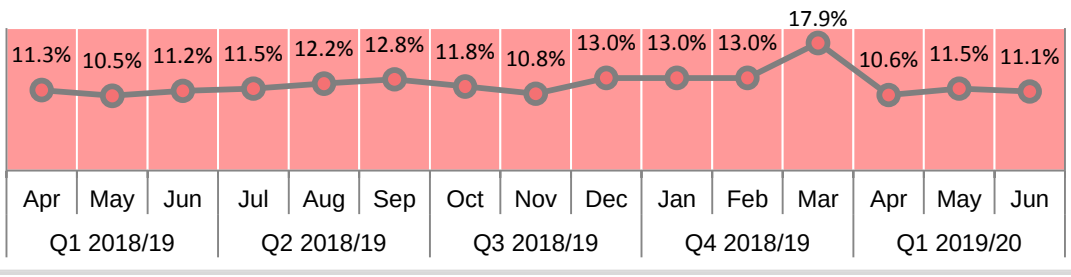
Indicator Detail

Jun-19	Statutory & Mandatory Training
91.0%	The percentage of statutory & mandatory training modules showing as compliant.
Target	Statutory and mandatory training is 91% this month; 1% above the target.
>= 90%	



Actions

	Bank & Agency Costs
11.1%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in June 2019 account for 11.11% (£2.12M) of the £19M total pay costs. This is a £110K decrease from the position reported in the previous month (£2.22M).
<= 5%	

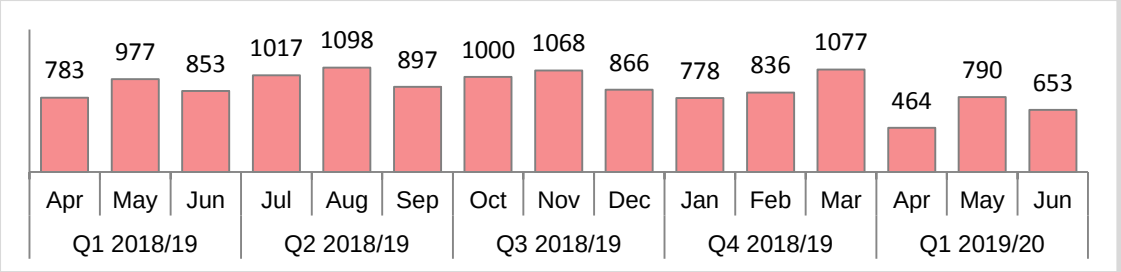


Actions

The Medicine & CS Business Group bank and agency spend has decreased by £110K to £679K in June 2019, but continues to have the highest spend on bank and agency equating to 32.22% of the Trust overall bank and agency spend.

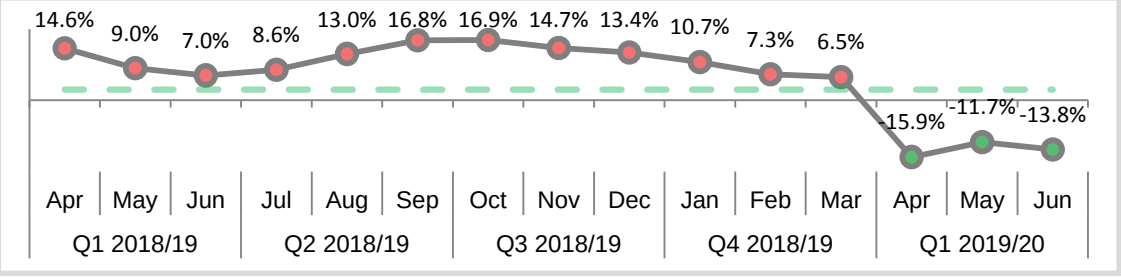
Indicator Detail

Jun-19	Agency Shifts Above Capped Rates
653	Number of agency shifts above above the provider spend cap.
Target	A total of 653 shifts were paid above the NHSI cap rate during the 4 week period from 3rd to 30th June 2019; equating to an average of 163 shifts per week, an increase of 5 shifts per week compared to May's figures. This is a decrease compared to the 214 shifts per week in June 2018.
<= 0	



Actions
The total number of agency shifts worked in this period, including shifts under cap, was 1,417 – an average of 354 per week; an average decrease of 8 shifts per week compared to May. There were a total of 123 shifts paid at or above £100 per hour, which required Chief Executive approval, an average of 31 shifts per week, compared to 22 shifts per week in May. Medicine have seen the highest number of agency cap breaches with an average of 59 shifts per week (an increase of 8 compared to May), due to an increase of medical locum shifts. This is followed by Surgery with 57shifts per week (an increase of 14 shifts per week).

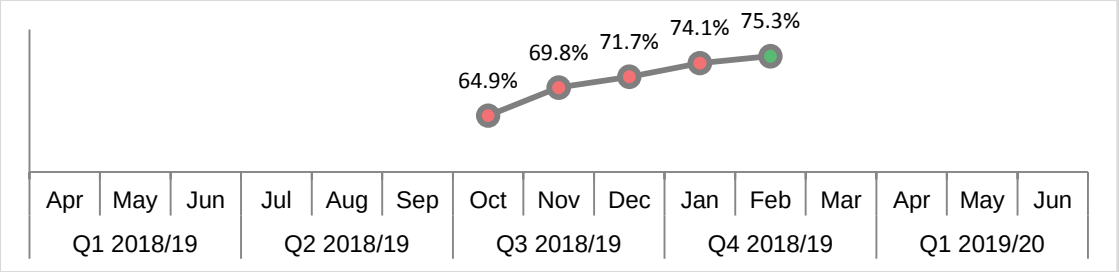
Jun-19	Agency Spend: Distance From Ceiling (UoR)
-13.8%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	Bank and agency costs in June 2019 account for 11.11% (£2.12M) of the £19M total pay costs. This is a £110K decrease from the position reported in the previous month (£2.22M).
<= 3%	



Actions

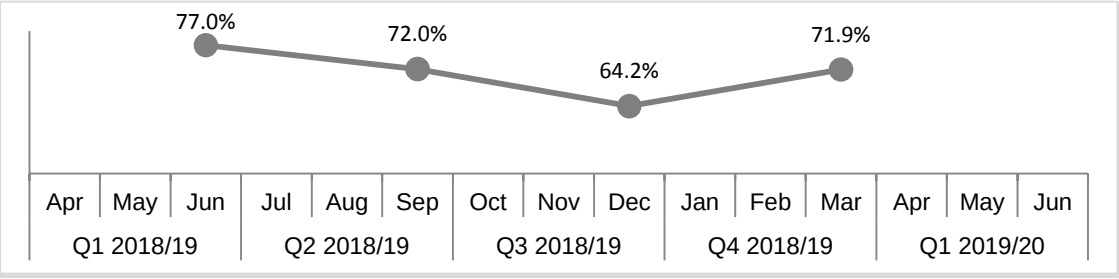
Indicator Detail

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



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

Mar-19	Staff Friends & Family Test: Recommend for Care
71.9%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The overall trust staff response rate for the Friends and Family test is 64%. This data was taken from the national staff survey for Qtr 3 where 598 staff responded.



Actions

Safer Staffing Report

Jun-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name (ACE rating applied to patterned cells)	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	3,960	3,306	3,240	3,192	3,600	3,236	2,970	2,926	83.5%	98.5%	89.9%	98.5%	1600	4.1	3.8	7.9	0	0	0	0
Clinical Decisions Unit	360	360	360	360	330	330	330	330	100.0%	100.0%	100.0%	100.0%	187	3.7	3.7	7.4	0	0	0	0
D4	1,125	878	765	727	660	649	660	649	78.0%	95.0%	98.3%	98.3%	473	3.2	2.9	6.1	0	0	0	0
A3	1,395	1,152	945	967	990	935	660	660	82.5%	102.3%	94.4%	100.0%	713	2.9	2.3	5.2	0	0	0	0
A10	2,790	2,086	1,980	2,123	1,980	1,760	1,320	1,496	74.8%	107.2%	88.9%	113.3%	776	5.0	4.7	9.6	0	0	0	0
A11	1,530	1,386	1,575	1,526	660	638	660	968	90.6%	96.9%	96.7%	146.7%	823	2.5	3.0	5.5	0	0	0	0
A12	1,170	751	585	897	660	660	660	660	64.2%	153.3%	100.0%	100.0%	477	3.0	3.3	6.2	0	0	0	0
B4	1,395	1,289	1,260	1,244	660	682	990	1,100	92.4%	98.7%	103.3%	111.1%	595	3.3	3.9	7.3	0	0	0	0
B6	1,170	1,104	2,010	1,746	660	636	660	529	94.4%	86.9%	96.4%	80.2%	600	2.9	3.8	6.7	0	0	0	0
Bluebell Ward	1,620	1,395	840	930	660	649	660	704	86.1%	110.7%	98.3%	106.7%	411	5.0	4.0	8.9	0	0	0	0
C4	1,170	825	585	1,033	660	660	660	792	70.5%	176.6%	100.0%	120.0%	472	3.1	3.9	7.0	1	0	0	1
Coronary Care Unit	810	708	450	350	660	610	330	330	87.4%	77.8%	92.4%	100.0%	155	8.5	4.4	12.9	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,035	1,017	1,935	1,941	660	660	660	1,133	98.3%	100.3%	100.0%	171.7%	505	3.3	6.1	9.4	0	0	0	0
E1	1,875	1,455	2,235	2,153	990	957	1,320	1,518	77.6%	96.3%	96.7%	115.0%	914	2.6	4.0	6.7	0	0	0	1
E2	2,205	2,199	1,530	1,895	990	979	990	1,320	99.7%	123.8%	98.9%	133.3%	1002	3.2	3.2	6.4	0	0	0	0
E3	2,205	2,174	1,530	1,644	990	957	990	1,485	98.6%	107.5%	96.7%	150.0%	1045	3.0	3.0	6.0	0	0	0	0

Safer Staffing Report

Jun-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
A1	1,350	1,160	1,170	1,170	990	990	660	660	85.9%	100.0%	100.0%	100.0%	770	2.8	2.4	5.2	0	0	0	0
C6	900	1,026	1,065	1,149	660	902	660	660	114.0%	107.9%	136.7%	100.0%	560	3.4	3.2	6.7	0	0	0	0
D1	1,620	1,349	1,305	1,321	660	660	990	990	83.3%	101.2%	100.0%	100.0%	730	2.8	3.2	5.9	0	0	0	0
D2	1,560	1,428	1,395	1,299	660	598	660	869	91.5%	93.1%	90.6%	131.7%	608	3.3	3.6	6.9	1	0	0	0
D6	1,260	1,235	1,005	969	660	638	660	825	98.0%	96.4%	96.7%	125.0%	599	3.1	3.0	6.1	0	0	0	0
M4	1,178	974	945	828	660	660	550	506	82.7%	87.6%	100.0%	92.0%	327	5.0	4.1	9.1	0	0	0	0
SAU	1,770	1,716	705	771	990	979	660	671	96.9%	109.4%	98.9%	101.7%	436	6.2	3.3	9.5	0	0	0	0
Short Stay Surgical Unit	1,782	1,702	770	730	836	825	660	654	95.5%	94.8%	98.7%	99.1%	643	3.9	2.2	6.1	0	0	0	0
ICU & HDU	4,530	4,110	360	360	3,960	3,486	330	330	90.7%	100.0%	88.0%	100.0%	302	25.2	2.3	27.4	0	0	0	0
Birth Centre	900	728	450	450	600	430	300	300	80.8%	100.0%	71.7%	100.0%	31	37.3	24.2	61.5				
Delivery Suite	2,700	2,535	450	435	1,800	1,750	300	300	93.9%	96.7%	97.2%	100.0%	189	22.7	3.9	26.6				
Maternity 2	1,575	1,568	900	900	660	650	330	330	99.5%	100.0%	98.5%	100.0%	441	5.0	2.8	7.8				
Jasmine Ward	900	900	450	470	600	600	0	17	100.0%	104.3%	100.0%	n/a	230	6.5	2.1	8.6	0	0	0	0
Neonatal Unit	2,250	1,718	0	0	1,575	1,190	0	0	76.3%	n/a	75.6%	n/a	181	16.1	0.0	16.1	0	0	0	0
Tree House	2,700	2,460	450	360	1,800	1,685	0	6	91.1%	80.0%	93.6%	n/a	514	8.1	0.7	8.8	0	0	0	0
	52,790	46,689	33,245	33,937	32,921	31,040	21,280	23,718	88.4%	102.1%	94.3%	111.5%	17309	4.5	3.3	7.8	2	0	0	2

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : June 2019			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	88.4% of expected RN hours were achieved for day shifts. This is the 10th month that staffing has been below the 90% benchmark. Any RN numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Deputy Chief Nurse. 13 areas indicate below 90% RN levels in month.	June 88.4% May 87.7% April 89.6%	The lowest RN staffing levels during the day were on Ward B4 at 64.2% are supported by 153.3% uplift in non -registered staff to support safe staffing. Harm free care metrics are optimal on the ward in month. Ward is closely monitored and supported by matron for safety assurance. Never less than 2 RNs on duty at any time.
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	94.3% of expected RN hours were achieved for night shifts. 2 areas report below 90% RN levels in month.	June 94.3% May 95.9% April 95.3%	The lowest RN night staffing levels are reported on the Birth Centre with 71.7% RN levels. Safe staffing is assured as activity and acuity levels in month were reduced. Harm free care metrics are optimal in month.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	102.1% of expected non-registered hours were achieved for day shifts. 4 areas report below 90% levels in month.	June 102.1% May 103.0% April 102.3%	The lowest non registered staffing levels for day duty are on the Coronary Care Unit at 77.8%. CCU never has less than 2 registered staff on this 6 bed unit at any one time. Harm free care metrics are optimal in month. CCU is co-located with ward A3 cardiology, which provides support. Close supervision & support by matron to assure safe care. A plan is in place and new staff are starting with it the unit over the next 2 months with a clear training plan for upskilling.

BOARD PAPERS – Quality, Safety & Experience Section : June 2019			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	111.5 % of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed by matrons. It is predominately due to wards requiring 1:1 support for patients following a risk assessment, or to support RN staffing numbers when there are unfilled shifts. 1 area reports below 90% levels in month.	June 111.5% May 112.5 % April 108.0%	Bluebell ward reports 80.2% non-registered fill rate supported by 96.4% RN fill rate. Never less than 2 RNs on duty. RN figures for nights 96.4% to support non registered staff. Recruitment successful, no vacancies at non- reg level & awaiting start dates. Harm free care metrics optimal in month. Support given from the main site as required. There have also been times of reduced bed occupancy which has reduced pressures within the unit
RN safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	June RN rates indicate 146.8 WTE Filled	Of the RN 146.8 WTE (demand 190.8 WTE) The fill rate overall is 77% of the shifts requested. 49% are NHSP and agency 28%.
Non-registered safe staffing levels are supported by temporary staff (NHSP Bank).	This is reported as demand versus NHSP and agency fills compared to substantive vacancies.	June Non registered rates indicate 136.2 WTE Filled	Of the non-registered 136.2 WTE (demand 163.4 WTE) the fill rate is 83%.

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 26/07/19		**Report of:** Quality Committee
Date of last meeting: 23/07/19		**Membership Numbers:** Quorate

1.	**Agenda**	The Quality Committee met on 23 July 2019 and considered an agenda which included the following items:
		
		• Developing and Implementing a Quality Improvement Faculty
		• Integrated Performance Report – Quality Metrics
		• Quality Improvement Plan
		• Quality Improvement Priorities Q1 Update
		• CQC Safe High Quality Care Improvement Plan
		• Clinical Governance Report
		• Safeguarding & Security Action Plan
		• Learning from Deaths Report
		• Key Issues Reports from subgroups
		  o Quality Governance Group
		  o Infection Prevention and Control Group
		  o Patient Experience Group
		  o Safeguarding Group
		  o Medicines Optimisation Group
		• Terms of Reference of subgroups:
		• Board Assurance Framework
		• Trust Risk Register
		• Consent Agenda – Policy Ratification
		  o Policy: Management of First Aid at Work
		  o Policy: Medical Equipment Policy

	Alert	• The Committee was alerted of the risk to the delivery of action plans by the Infection Prevention and Control Group. The Group had outlined that a number of actions were still outstanding and expressed concern regarding attendance at meetings. The Committee noted that the Chief Nurse had raised this at the Performance Meetings had ~~formally~~ contacted the relevant teams. • The Committee were alerted by the Quality Governance Group that the Trust is not able to fully comply with the NICE Quality Standard, *QS175 Eating Disorders*. The Committee heard that although elements of the standard relating to the Trust are compliant, full compliance is not achievable due to services availability in the community. The Committee heard that a meeting is due to be held to discuss the issues with commissioners and the providers of

		the service to address. The Committee will receive an update following this but wished to alert the Board of Directors to the current gap in service provision. • The Committee heard that the Safeguarding Group had noted that three areas of the Safe High Quality Care Improvement Plan were off track, and these also related to areas noted in the Clinical Services Review on 9 July 2019. Whilst excellent progress was noted in some areas, the Committee heard that the Safeguarding Group were convening a Part 2 of their usual meeting on 24 July 2019. The intention of this meeting is to ensure an extended review of activity reports.
	Assurance	• The Committee took assurance regarding progress against the 7 themes supporting the Quality Improvement Plan. The Deputy Chief Nurse also presented the Q.1 update on the Quality Improvement priorities which covered 9 areas in relation to Safety, Effectiveness and Experience. • The Committee received Key Issues Report from its subgroups which continue to provide a key source of assurance and demonstrate that a robust and effective quality process is embedded within the governance structures. • The Committee received and approved the Terms of Reference of three of its subgroups as part of the governance process. The Committee took significant assurance in relation to adherence and reflection of best practice. The Committee noted that the Infection Prevention & Control Group and the Safeguarding Group would be presenting their Terms of Reference along with their Effectiveness Reports in the August meeting, • The Committee took assurance from the Quality Governance report which provided a summary of activity regarding the safe provision of care identified by the Trust through its systems and processes. The report identified the outcomes of areas of clinical governance including key themes and the lessons learnt. • The Committee took assurance from the Clinical Services Review which took place on 9 July 2019, the Chief Nurse updated the Committee verbally on the findings, explaining that themes had been identified that are being monitored in various identified groups across the Trust.
	Advise	• The Director of Transformation & Deputy Chief Operating Officer delivered a presentation on Developing and Implementing a Quality Improvement Faculty. He outlined the Trust's approach to building its quality improvement capability across the organisation as well as the implications and challenges of developing the framework. The presentation also provided more detail in relation to the following: o Aims and objectives o Background including QI Faculty identification as one of the 7 themes of the refreshed Quality Improvement Plan and how Quality Faculty was central to the development and initiation of the Clinical Services Efficiency Programme. o Summary of the challenges faced so far and the next steps • The Deputy Chief Nurse presented a progress report on the new Safe High Quality Care Action Plan. The Committee noted that eight actions had no evidence of being on track and had breached the June 2019 milestone. Of

		these, four were must do actions associated with safeguarding and medical equipment. The Committee noted the work being undertaken by the Safety and Quality Leadership Group to ensure delivery against agreed actions. • The Committee received and approved the Terms of Reference the following subgroups: o Quality Governance Group o Medicines Optimisation Group o Patient Experience Group • Following a recommendation for approval from the Safety and Risk Group and Quality Governance Group, the following policies were ratified:. o Management of First Aid at Work o Medical Equipment Policy • The Deputy Director of Quality Governance presented the Board Assurance Framework and the Trust Risk Registers.		
2.	Risks Identified	Nil		
3.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Committee Secretary

This page has been left blank

Board of Directors' Key Issues Report

Report Date: 25/07/19		**Report of:** Finance & Performance Committee
Date of last meeting: 24/07/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Financial Performance Report • Operational Performance Report • Agency Utilisation Report • Performance Review Meetings – Key Issues Reports • Service Efficiency Programme Update • NHS Long Term Plan Implementation • Capital Programme Development Group Key Issues Report • Cancer 62 Day Performance Update • Winter Planning – Presentation • Breast Services – Financial Implications • 2019/20 National Capital Prioritisation • Corporate Services Delivery Vehicle • IT Systems – Stabilisation & Optimisation Plan • Finance and Performance Risks
	Alert	• The Committee received the Operational Performance Report which provided an overview of the key performance metrics of the Trust at the end of May. The Committee was alerted of the following items: o RTT- Due to Endoscopy nurse vacancies o Waiting List Size – Reduction in waiting list size remained positively below trajectory. o IP Elective activity plan Orthopaedics is at risk due to falling demand in key sub-specialty areas. • The pressure in Oral Surgery, Orthodontics and Gastroenterology has experienced significant growth in demand. The Committee noted the correlation between neighbouring providers closing these services and the rise in oral and orthodontic referrals. • The Committee was alerted of the changes to Agency Rules which were expected to come into effect on 16 September after an implementation period. • The Committee highlighted the need to escalate plans to review SFIs and associated training in light of the IT Systems Business Case.

	Assurance	• The Committee reviewed the Finance Performance Report for Month3 which set out progress and assurance against the financial objectives of the Trust after the first quarter of the financial year 2019/20 to 30th June 2019. The Committee noted the Q.1 performance and welcomed the achievement the committee was given regarding the delivery of Q.2 financial performance and took limited assurance on the year-end position. • The Committee took assurance from the Operational Performance Group, Key issues report which outlined progress against the performance objectives for the Trust as at the end of June 2019. • The Committee welcomed the improved performance against the ED 4hour standard and noted that for three days in a row, the Trust had the best performance against this indicator in GM. The Committee was assured that the short term recovery plan had made a positive impact. • The Committee received the Key Issues Reports from Executive Performance Review meetings held by all four Business Groups in July. These reports and the Operational Performance Group Key Issues Report continued to provide a key source of assurance for the Committee.
	Advise	• The Committee received a progress update on the delivery of the Clinical Service Efficiency Programme, 2019/20. The Committee recognised and welcomed the progress made and took low assurance regarding the delivery of the recurrent target. • The Associate Director of Finance delivered a presentation following the release of the NHS Long Term Plan Implementation Framework guidance in June 2019. The presentation presented an overview of the following: o 2019/20 Control Total o Economic Modelling Assumptions o Financial Modelling o Financial Scenarios and Key Considerations • The Committee received the report which detailed the Trust's agency usage and expenditure as of July 2019. The report highlighted that Month 3 performance was within the NHSI monthly ceiling value. The Committee noted the good progress in reducing the level of agency spend at the end of Q.1 and requested more information regarding the full year forecast. • The Committee received an update on performance and the improvement action plan to help recover the Cancer 62 day RTT standard of 85%. The committee noted progress made against the internal action plan and the anticipated timescales for completion. The Committee also acknowledged the continued demand and capacity pressures affecting performance against the 62-day Cancer standard and welcomed the GM supported initiatives and dependencies aimed at improving performance against the improvement trajectory set for 2019/20. • The Committee received and recommended the following for approval by the Board of Directors. o 2019/20 National Capital Prioritisation o Corporate Services Delivery Vehicle

		• The Committee received an update on activities undertaken to review the use of current IT systems and the recommendations for a stabilisation and optimisation delivery plan in the interim as the Trust considers long-term ambition of delivering an EPR solution. • The Committee welcomed the presentation by Delivery Director in relation to the Winter Planning preparations for 2019/20.		
2.	Risks Identified	Risk to the delivery of the CIP target.		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Committee Secretary

This page has been left blank

Board of Directors' Key Issues Report

NHS Stockport NHS Foundation Trust

Report Date: 31/07/19		**Report of:** People Performance Committee
Date of last meeting: 25/07/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Director of Workforce & OD Briefing • Annual Pensions Allowance Update • Learning Lessons to Support our People Practices • Workforce Plan • Agency Expenditure • Flowers Case – Judgement Update • Workforce Flash Results • Trust Risk Register • Key Issues Reports: - Joint Consultative Negotiating Committee - Culture & Engagement Group • Consent Agenda: - Freedom to Speak Up Guardian Report - Policy ratification: Pay Progression Policy; Employee Capability Policy; Term Time Only Policy; Volunteer Policy; Conflict of Interests Policy.
	Alert	• The Committee considered a report which detailed a number of potential mitigating actions the Trust could take to counteract the adverse effect the changes to the annual pension allowance could have on Trust staff. It was agreed that Mr Moores would continue to pursue the preferred options and report back to the Committee. • The Committee considered a report which provided an update on the potential implications of the Court Appeal decision in the 'Flowers v East of England Ambulance Trust' case. It was noted that the case, which related to the inclusion of overtime pay in holiday pay, was progressing to the Supreme Court. The Committee was advised that the potential, worst case scenario, financial impact to the Trust was circa £200,000 per annum, with a maximum impact of £1.2m if a 6-year rule was observed.
	Assurance	• The Committee considered a 'Learning Lessons to Improve our People Practices' report which provided an outcome of a review undertaken by an NHS Improvement (NHSI) task and finish advisory group, established following an independent enquiry into the tragic circumstances of the death of Amin Abdullah. The Chair of NHSI had consequently instructed all trusts to review their investigation and disciplinary cultures and practices. The Committee

		reviewed the Trust's resultant action plan and took positive assurance that a full review had been undertaken and the Trust was compliant in all relevant areas. • The Committee received an updated Workforce Plan and noted a number of associated engagement events being held with Trust staff. It was noted that the Workforce Plan was an iterative document and would continually be changing in response to service needs and changes. • The Committee was pleased to note a reduction in agency expenditure, which at Month 3 was within the monthly agency ceiling. The Committee heard about a number of initiatives in place to further reduce agency expenditure, including improved rota management, implementation of electronic rostering and substantive recruitment.		
	Advise	• Mr Moores advised the Committee of work around Values & Behaviours. He noted that a programme of engagement was ongoing across the Trust and with key stakeholders to help the Trust shape its Values and associated Behaviours. This work and its outputs would then feed into the Trust Strategy refresh and enable a new Vision to be shaped and defined, with critical involvement of staff and stakeholders. • The Committee was advised that BMA members had accepted the new Junior Doctor Contract, which was due to be implemented in August 2019. Mr Graham agreed to review the potential financial impact to the Trust following a decision to backdate the cost of living pay rise to 1 April 2019. • The Committee was advised that the Trust was launching an initiative for staff to be able to access savings and preferential loans through salaries. It was noted that the scheme, which the Trust was undertaking in association with Salary Finance, had been known to have a positive impact on health & wellbeing, including reducing stress levels. The Committee was also advised that following a review of the Car Lease Scheme, the choice of cars would be increased. It was anticipated that the changes would make the scheme more attractive to staff and consequently offer greater financial benefits to the Trust. • The Committee was advised of ongoing work to align Electronic Staff Record (ESR) and Disclosure and Barring Service (DBS) records. The Committee noted continuing focused work in this area which was having a positive impact on DBS compliance.		
2.	Risks Identified	• Potential impact of Annual Pension Allowance changes • Potential impact of the 'Flowers v East of England Ambulance Trust' case		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*			
4.	Report Compiled by	Catherine Barber-Brown, Chair	Minutes available from:	Soile Curtis, Membership Services Manager

Board of Directors' Key Issues Report

NHS Stockport NHS Foundation Trust

Report Date: 26/07/19		**Report of:** Audit and Risk Committee
Date of last meeting: 11/07/19		**Membership Numbers:** Quorate

1.	**Agenda**	The Committee considered an agenda which included the following:
		• Revised Internal Audit Plan 2019/20
		• Internal Audit Progress Report
		  o Review of progress against plan
		  o Reports issues since last meeting
		  o Major audit issues arising from audits
		  o Internal Audit Follow Up Tracker
		• Anti-Fraud Progress Report
		• External Audit Update
		• Declarations of Interest Progress Report
		• Reports from Board Committee members

	Alert	Nil
	Assurance	• The Committee took assurance that the Annual Report and Accounts 2018/19 had been submitted to the relevant bodies in accordance with the guidance set out in NHS Improvement's Annual Reporting Manual 2018/19. • The Committee was assured with the progress made with regards to implementing a new Conflict of Interest Process. The Committee noted that the new process was scheduled to be fully implemented by October 2019. • The Committee took assurance regarding the number of actions that have been put in place to mitigate non-adherence to SFIs and SOs. • The Committee received the Internal Audit Progress Report which provided an update on assurances, key issues and progress against the Internal Audit Plan for 2019/20. The Committee reviewed the Internal Audit Progress Report which detailed audit outcomes from the 2018/19 review of the ACE Accreditation for Continued Excellence (ACE) – (Substantial Assurance) • The Committee received the MIAA Anti-Fraud Progress Report which set out the work undertaken during the period of May and June 2019 and highlighted activities and outcomes undertaken.
	Advise	• The MIAA Engagement Lead presented the Revised Internal Audit Workplan for 2019/20 which included a 3 Year Strategic Audit Plan.

		• The Committee noted that no requests had been made to the Internal Audit Workplan 2019/20 were made during the reporting period.		
2.	Risks Identified	With the exception of risks noted in the Trust Risk Register, no further risks were identified.		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	David Hopewell, Chair	Minutes available from:	Committee Secretary

NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date of Meeting:**	31 July 2019
Subject:	Quality Improvement Plan – 7 Themes – Quarter 1 Update 2019/20		
Report of:	Chief Nurse and Director of Quality Governance	**Prepared by:**	Deputy Chief Nurse

REPORT FOR INFORMATION / ASSURANCE

Corporate objective ref: 2a 2b	2a and 2b
Board Assurance Framework ref:	2, 4, 5, 6 and 7
CQC Registration Standards ref:	Safe Effective Caring Well led Responsive
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

The Board is asked to note progress against the 7 themes from the Quality Improvement Plan for quarter 1, 2019/20

The high level progress is below:

Theme	Status
Safe, High Quality Care Improvement Plan	✓ [On-track]
Reducing Unwanted Variation	✓ [On-track]
Urgent Care Delivery	✓ [On-track]
Safety Collaboratives	✓ [On-track]
Quality Improvement Initiatives	✓ [On-track]
Safe Staffing	✓ [On-track]
Quality Faculty	✓ [On-track]

Attachments: None

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. Introduction

1.1. The Board is asked to note the progress and assurance against the 7 themes from the Quality Improvement Plan for quarter 1, 2019/20.

2. Background

2.1 In December 2018, the Trust was rated at 'Requires Improvement' by the CQC. The Trust Quality Improvement Plan describes the steps we plan to take to ensure that our patients to receive consistent, high-quality care and our ambition is that the pride taken in delivering care to our patients helps us become the employer of choice in the region.

2.2 We want our Quality Improvement Plan to take us from 'Requires Improvement' by being bold in taking us further on a trajectory to 'Good" and "Outstanding'. Of course we must address areas of concerns relating to patient safety that have been noted externally by the Care Quality Commission (CQC) and NHS Improvement, and those that we have recognised ourselves. We all want our patients to receive consistent, high-quality care and our ambition is that the pride taken in delivering care to our patients helps us to become the employer of choice in the region.

2.4 The continued delivery of our refreshed Quality Improvement Plan, underpinned by good governance and staff development, will ensure that the changes made already are sustainable, and that those outstanding can be delivered in agreed timeframes.

2.5.1 This report provides an overview of the progress made in Quarter 1, 2019/20 against the Quality Improvement Plan.

3. Progress to Date

3.1. The Quality Improvement Plan describes seven themes that support our Quality Improvement Plan. The high level progress against the 7 themes is below:

Theme	Status
Safe, High Quality Care Improvement Plan	✓ [On-track]
Reducing Unwanted Variation	✓ [On-track]
Urgent Care Delivery	✓ [On-track]
Safety Collaboratives	✓ [On-track]
Quality Improvement Initiatives	✓ [On-track]
Safe Staffing	✓ [On-track]
Quality Faculty	✓ [On-track]

3.2. The table on the following page displays the progress for quarter 1 2019/20 against the seven themes. A summary has been provided against each theme as to where it is up to against the plan. The key for the status is as follows:

Summary	Description
✓	On-track
✓	Off-track, but progress made

✓	Off-track, not recoverable

4. Progress Against Seven Themes, Quarter 1 2019/20

8.1 High Quality Safe Care Plan ✓		The Safe High Quality Care Improvement Plan (new) has been created in response to the publication of the CQC report detailing their findings from the unannounced visit, well-led assessment and use of resources assessment in December 2018.
		
		There are eight actions that do not have evidence of being on track and breached the May 2019 milestone;
		• The trust must ensure that the best interests' decision making is documented within patient records
		• The trust must ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs
		• The trust must take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs
		  ○ Audits of the safeguarding processes have provided limited assurance that they are embedded across the organisation.
		  ○ Plans in place to improve compliance include the increased monitoring of safeguarding through SQLS, further education sessions and increased visibility of the safeguarding team.
		• The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidelines
		  ○ The delay in meeting the agreed milestone dates is relating to; the recruitment of the contract manager post, delivery of RFID tracking and equipment library, and the development of the medical devices policy.
		  ○ The recruitment to the contract manager post is ongoing and work has commenced to scope the options for the medical equipment library. The policy is currently going through the internal governance processes with a target publishing date of September 2019.
		• The trust should consider improving Governor's understanding of the trust's strategic direction
		  ○ A further review of the content of the Trust strategy is being undertaken, which includes engagement with all staff groups and partners.
		• The trust should take appropriate actions so that staff competency records are reviewed, maintained and kept up to date.
		  ○ The task and finish group continues to work through the competency frameworks. There are three areas of focus; agreement on what competencies are relevant for which job roles, how to record competencies and finally how to demonstrate ongoing competency
		• The trust should take appropriate actions so patients have access to psychiatric support (in the Devonshire Unit).
		  ○ This work is interlinked with the Memorandum of Understanding with Pennine Care. Work

		continues with our commissioners to reach the appropriate level of service. • The trust should consider redesign of the birthing room where the toilet is behind a curtain ○ The contract has been awarded and due for completion in December 2019, which is later than anticipated.
8.2 Reducing Unwarranted Clinical Variation ✓		We aim to improve patient care and increase efficiency by *reducing variation* in practice across the Trust. The areas of focus are: Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and performance in the top quartiles Ensuring clinical service needs where required are delivered equitably across 7 days Introduction of the Accreditation for Continued Excellence (ACE) programme • We aim to continue our ward accreditation scheme with 4 new assessments each quarter and roll out the accreditation to the community, maternity, paediatrics, theatres and community. • ACE assessments continue across all areas. All inpatient areas now have undergone an assessment. 11 assessments were completed in Q1. • Pilots for Community, Maternity, Paediatrics and Theatres accreditation has commenced. Scoping for roll out in progress. Implementing advances in Information Technology, centred on a single electronic patient record across health and social care, which will support our journey of continuous improvement Delivering the efficiencies identified through the model hospital and reduce unwarranted variation across a range of productivity and clinical effectiveness measures, including: GIRFT programme, NATSIPPs, LOCSIPP's
8.3 Urgent Care Delivery ✓		Our system is under pressure and we want to improve the urgent and emergency care system so patients get the right care in the right place, whenever they need it. We are working hard with our partners to embed good practice to enable appropriate patient flow, including admission avoidance, better and more timely hand-offs between the emergency department and clinicians and wards, streamlined continuing healthcare processes, better discharge processes and increased community capacity. **i) Urgent Care Access** • A short term improvement plan based on the breach analysis above has been put in place to focus on

		reducing non-admitted breaches through Transformation work around streaming, response to surge and rapid assessment / early senior review. • A medium to long term focus on improvement has been maintained through a refresh of the Urgent Care Programme Delivery Board (UCPDG) priorities. The UCPDG is made up of four quadrants, each with an System SRO to ensure ownership of actions and the associated improvement from all partners in the locality, the quadrants are: • **Stay Well** – this has a focus on ensuring patients receive the care they need as close to home as possible and is closely aligned to the Stockport Neighbourhood Care model. • **Home First** – this has a focus on ensuring patients who attend the hospital are returned to the most appropriate place as soon as possible and that admission to hospital is avoided wherever possible. • **Patient Flow** – this has a focus on ensuring that those patients that require admission move through the hospital system as safely and efficiently as possible. • **Discharge** – this has a focus on ensuring patients are discharged from the hospital in a safe and timely manner. **ii) Patient Flow** • A focus on increasing the numbers of morning (<10am) discharges through the Discharge Lounge has seen a step change improvement in the past month. • Regular Business Group patient-level reviews, led by Business Group Directors and Senior Clinical staff in place across key areas. • Daily LLOS reporting at ward level in place with weekly senior review by Execs and Directors at the "Performance Wall". **iii) Complex Patients** • A refreshed approach to the user of SAFER and Red2Green across the Medical wards, supported by the Utilisation Management team. • A focused effort to close all escalation capacity by System partners, including a daily senior review of all complex LLOS patients by the Integrated Transfer Team. • Regular Business Group patient-level reviews, led by Business Group Directors and Senior Clinical staff in place across key areas.

8.4 Safety Collaboratives ✓		Safety collaboratives will remain a focus during 2019/20 with a focus on delivering definitive and measurable improvements in specific patient safety issues that have been identified through incident reports, complaints, serious incidents or nursing care indicator reports. **<u>Pressure ulcers – AIM</u>** we aim to achieve a 25% reduction in device related pressure ulcers by and a 10% reduction overall in pressure ulcers in the acute and community setting March 2020. **<u>Falls-Aim</u>** we aim to achieve a 10% reduction in in-patient falls *[max inpatient falls for 2019/2020 is 1100]*, with 10% reduction in falls with moderate and above harm *[max inpatient falls for moderate or above harm for 2019/20 is 26]* by March 2020. • 249 total falls in Q1 • 6 falls with moderate or above harm in Q1 **<u>Deteriorating patient</u>** we aim to improve the outcomes for our patients and identify patients whose condition deteriorates at the earliest opportunity. • NEWS 2 introduced in December 2018 • AIMS training compliance for RNs working in adult inpatient & acute areas established during quarter 1 as 27%. • Target established as 75% by end of March 2020.
8.5 Quality Improvement Initiatives ✓		Our information tells us that we must make improvements in the quality of care and treatment in some areas. We have agreed our quality improvement methodology. Our ambition is that, across a range of identified areas, improvements are clinically led and managerially supported so that they are embedded in practice and focussed on getting the best outcomes for our patient, by the right staff and the right time. These will utilise the AQuA methodology and all form part of the recent cohort. The next steps will be to agree the baseline, targets and plans. **Medicine & Clinical Support QI initiatives:** • **<u>Enhanced therapeutic observations</u>** • Project refreshed and a new Task and Finish working group established with membership across the Trust, chaired by Project Lead Nurse • Project is to ensure the safety of patients and provide quality care; ensuring the use of therapeutic observations is appropriate • Initial data gathered across high spending areas

		• Driver diagram produced with the change ideas and key drivers • Next steps are to prioritise the change ideas, (agreement of quick wins to commence PDSA), drill down into the data and complete initial audit • **FRIDAY handover tool** • Project aims to provide more effective and efficient weekend support for all patients • This should have a positive impact to: o Reduce weekend bleeps o Increase weekend discharges o Reduction in length of stay o Provide a platform for the introduction of nurse-led discharge o Increased flow across AMU as weekend time can spend more time on there (likely will have a positive impact to staff morale too) • Project has been successfully implemented on A11, and the next steps will be to embed into business as usual and roll out across more medicine wards **Surgery, GI & Critical Care QI initiatives:** • **Surgical wound care pathway for bowel operations** • New pathway currently being developed with the assistance of ward staff. • Aim is to complete the draft by the end of July. • **Reduce OP OWL** • Original aim was to reduce overdue FU OWL in General Surgery to zero this year. • Scope may expand to include Gastro and ENT as similar work is going on in those specialties. Project Team established with Trust, CCG and Primary Care Membership • Clinical validation of Gastro and Gen Surgery OWLs underway. • Outcome to be reviewed by Project Team at end of month. • Will form part of Elective Care Reform and broader GP referral pathway redesign. **Women, Children & Diagnostics QI initiatives:** •**Reduce x-ray waiting times** • Aim to reduce average waiting time for plain film x-ray to 30 mins by Aug 2020. • Audit of activity over a 3 week period. • Analysis showed waiting time peaks 11-1pm. • Liaised with rota team to facilitate changes to the working day. • Resulted in a reduction in staffing gaps over the lunch period.

		• Has resulted in a step change reduction in waiting time for patients.
8.6 Safe Staffing ✓		We aim to ensure safe staffing and a reduction on reliance on temporary staffing through a series of schemes associated with recruitment and retention. The overall aim is to reduce vacancies in year to 100 WTE RN/RM and to continue to reduce turnover with assistance from the NHSI support network . **<u>Recruitment programme – reduce vacancy rate to 100WTE by end of quarter 4</u>** • The variance from establishment rate in quarter one is circa 165 WTE RN / RM . Review of actual vacancies that we can recruit into are less than the 165 WTE as some of the positions, for example seconded posts and training posts cannot be classed as true vacancies. HR are currently reviewing the vacancies to address this anomaly to advise a more accurate vacancy position within the business groups. It is anticipated that there may be circa a 10 WTE variance in vacancy levels and variance from budgeted establishment . • The Nurse Associate programme is now starting to demonstrate benefits realisation as cohort one are now are all now in post (13 staff). 40 WTE are in training per annum with cohorts qualifying every 6 months. This is a significant new pipeline of qualified staff to support safe nurse staffing. • A Business Case for International recruitment and a campaign for summer 2019 for 22 WTE RNs was accepted. All 22 will have arrived by September 2019. 16 are on site as at July 19 with 8 who have already passed OSCEs and awaiting NMC registration. Of the 22, 18 are for medicine and 4 for AMU. Surgery and critical care have prepped a paper for 15 WTE to present for consideration of funding . • Business group and centrally-coordinated recruitment is now embedded. In quarter one bespoke campaigns for medicine and integrated care have been developed with support from an external company to see if a new approach generates more applicants . Multiple recruitment events are attended over the Manchester and Stockport region, with the Trust now attending Sheffield and Lancaster as an addition to the local recruitment events attended . • An average of 145 WTE Registered Nurse temporary workers per month over this quarter have been utilised to support safe staffing along with an average of 130 WTE per month non registered staff . **<u>Retention Programme – Reduce Turnover Rate by 1.5%</u>** • The first year NHSI results indicated a reduction in turnover of 0.9% against a target of 1.5%. The 4 campaigns have been refreshed and will be re-launched for this year's focus. They will be: 1) A continued focus on an improved newly qualified first year experience, which will include not only graduate nurses but also nurse associates AHPs and ODps . 2) A focus on band 6 and above BME recruitment processes.

		3) A focus on data and actions to support the top 10 turnover areas . 4) A review and refresh of the flexible working policy . • The Itchy Feet programme, launched in March 2018, where staff can approach Corporate Nursing staff to look for career development opportunities, is evaluating well. So far, 40 registered and non-registered nurses have been helped by this scheme and have chosen to stay within the Trust • NHSI has accepted as a paper to highlight as good practice ,the band 6 uplift scheme launched 12 months ago , which has proved to be a viable retention initiative . This will be reviewed to look if this initiative would be an option to support specific areas that have high turnover rates to retain staff. **Improved efficiencies in e-rostering against a range of measures** • In September / October 2019 it is anticipated that a band 7 and two band 3 e- roster / safecare live staff will be commenced in post following support from the Trust to fund this initiative . This new team will start to embed improved practices across all nursing department to enable improved grip and benefits realisation of the e roster programme • '**Development of a suite of measures with NHS Professionals** • A detailed NHSP report is reviewed at the monthly temporary staffing meeting • A suite of measures in this report are reviewed by the Chief Nurse, with the Matrons and Business groups ensuring accountability and transparency of issues • Key issues are reported to the Workforce Efficiency Group (WEG) • The Trust participates in the North West Client User Group meetings where a review of agency and NHSP strategic financial and qualitative objectives and outcomes are scrutinised and acted upon • A key focus in this quarter has been to reduce the number of retrospective bookings being made with a review by matrons of all shifts retrospectively booked . • Second tier authorisation has been introduced to ensure senior review of requested shifts . • Weekly meetings have been introduced by some triumvirates to review temporary staff bookings • A reduction by one point of the scale of NHSP critical care rates has been implemented April 19 . • Quality metrics have been introduced with agencies being reviewed quarterly against a suite of quality indicators to ensure that safe practices are embedded with the recommendation that shifts will be cascaded in order of quality metric compliance to ensure safety is as high an agenda focus as the financial aspects of temporary staffing . • A focus on nurse team leader and manager shift bookings (higher rate bookings) has been introduced in quarter one . • A plan to review the top 10 agency / nhsp personalised pay rate NHSP workers monthly at the temporary workers meeting from August has been proposed .

8.7 Quality Faculty ✓		We recognise improvement is more likely to succeed and be sustained if it is designed and led by the staff doing the job. In order to enable staff to make change happen they will be supported by improvement experts with quality improvement methodologies employed. We want to develop a hub of quality improvement champions working across the Trust, supporting and enabling the delivery of high quality, compassionate and continually improving care for all of our patients, their families and carers. The Faculty will encourage the sharing of best practice, improvement methods and approaches as widely as possible through the systems we work in. **Programme Set-up & Leadership:** • Two Executive QI Sponsors agreed • QI Faculty Steering Group • 3 year plan developed • QI Overview sessions provided for CDs and Business Group Management Teams • Senior leaders invited to QI project feedback sessions • More visible senior leadership commitment to embedding QI across the Trust • QI regularly discussed at SMT & EMG including approval of a Trustwide QI roles and training infrastructure • QI incorporated into senior leaders' objectives **Skills:** • Bitesize QI programme rolling out fortnightly at QI Club • Business group QI programmes developed and being rolled out • QI module delivered quarterly as part of Trust Leadership programme • QI roles, expectations and training infrastructure defined and agreed • Positive relationships established with AQUA including a review of AQUA training and events available to optimise value of subscription • QI Skills Survey launched • QI microsite developed including QI resources, tools and guides **Systems:** • Progress ongoing to establish a central repository for QI projects • QI objectives included in refreshed appraisal process and form • QI objectives agreed for senior leadership • Business groups establishing feedback mechanisms for their QI projects

		Communication & Engagement: • Weekly QI Club moved to Wednesdays publicised via Trust weekly update email, screensaver, targeted emails • QI communications branding toolkit developed • Options paper drafted to align staff recognition / reward events • Regular QI project feedback events organised

This page has been left blank

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors - public	**Date:**	31 July 2019
Subject:	Learning from deaths		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR INFORMATION

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'.

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

Attachments:	Appendix 1: summary conclusions from the quarterly LFD newsletter

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

- THIS PAGE IS INTENTIONALLY BLANK -

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 meets 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.

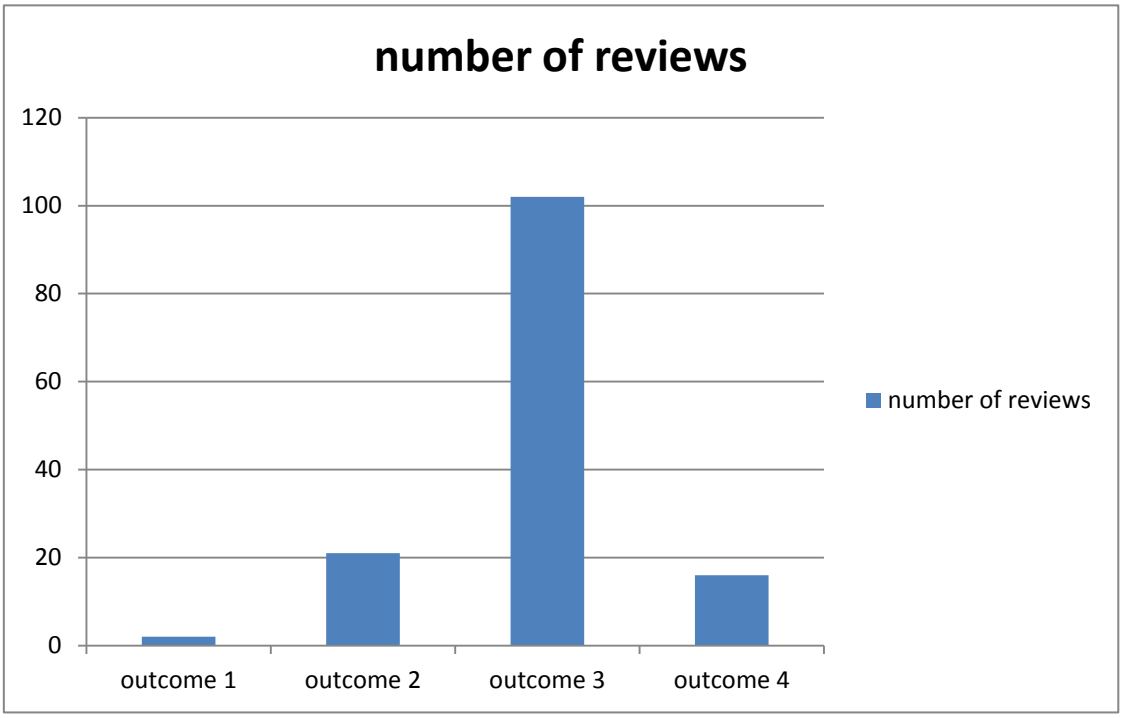
Outcome 2 Evidence of **suboptimal management**.

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.



The two outcome 1 deaths in the table involved (avoidably) delayed diagnosis and treatment of Guillain-Barre syndrome (a temporary failure of the nervous system) in one patient and of heart failure in another, leading to cardiac arrest in each case. These deaths were possibly avoidable (on the balance of probabilities) and were referred for Medical Director / Chief Nurse review. One is currently undergoing an SI review, the other is one of the focused learning points in this months newsletter, and is being discussed in clinical morbidity and mortality meetings.

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 July 2019
Standard: M&M documentation submitted to the shared drive in the past quarter.

Business groups continue to review compliance with this standard at their quality boards.

Business groups present a quarterly summary at the quality governance group.

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.

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

The three key messages for this quarterly LFD Newsletter were:

1. Acute onset polyneuropathy should be treated as possible Guillan Barre Syndrome (A temporary, severe failure of the nervous system), with the potential for acute severe further deterioration, unless proven otherwise. Urgent neurology review is therefore mandatory and early critical care referral in cases of suspected GBS is advised.

2. Acute onset severe shortness of breath, whether or not associated with wheeze, should never be assumed to indicate a chest infection/acute COPD. The diagnosis of acute heart failure must considered, particularly in the absence of a history of COPD and/or significant changes on the CXR suggestive of pneumonia.

3. Elderly patients presenting to the ED with isolated acute back pain may have a rupturing abdominal aortic aneurism, even in the complete absence of any other concerning clinical features (eg tachycardia, hypotension, abnormal ABGs etc).

The broader learning points from the LFD report are included in appendix 1.

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 reviewed by the Medical Director and Chief Nurse. If they support the conclusion, the case is 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.

All learning points outlined in the mortality newsletter are delegated to the most appropriate clinical or governance group to review: Deteriorating patients group (the majority of learning points are reviewed here), resuscitation committee, palliative care group, safeguarding group and the integrated care quality board.

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

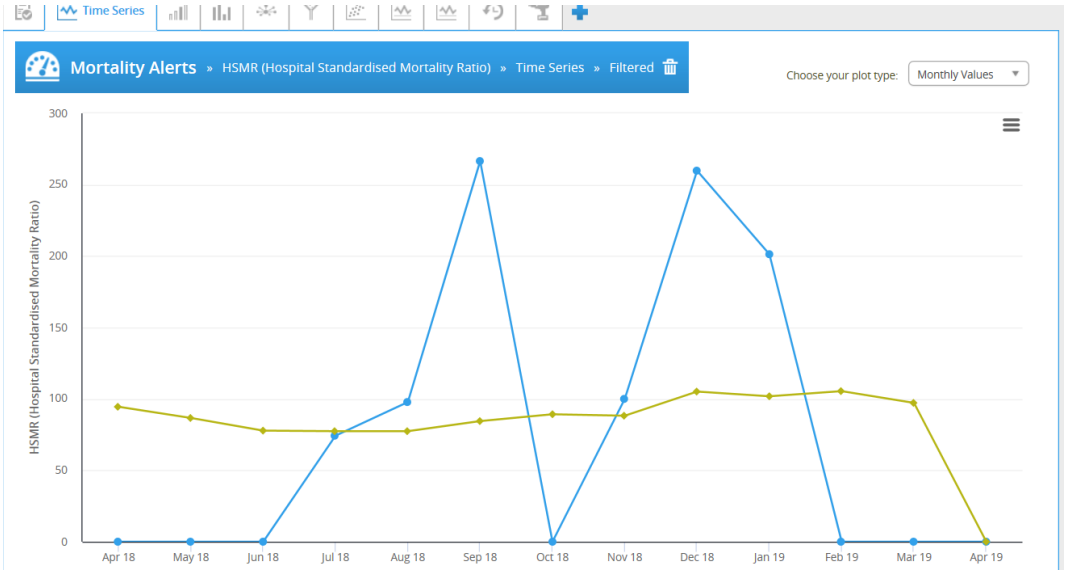
We have received two mortality alerts this year.

- Peripheral and visceral atherosclerosis.
  19 deaths (10 expected)

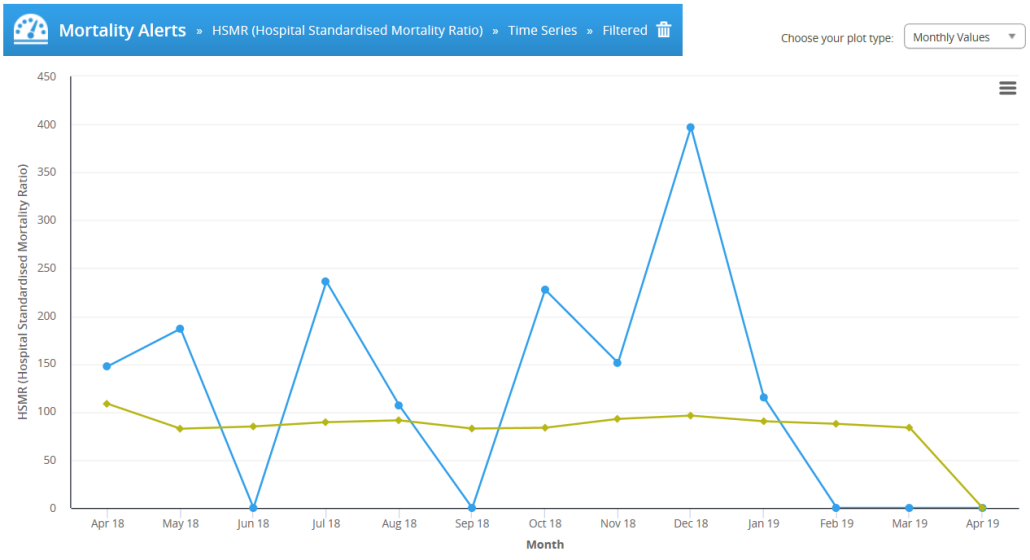
- Fluid & electrolyte disorders.
  35 deaths (25 expected)

Worthy of note is that the mortality index for fluid and electrolyte disorders and that of visceral and peripheral atheroma suggests a swinging mortality rate is driven by the small numbers each group. While the peaks that triggered a mortality alert are clearly evident, looked over twelve months, the mean rates are little different to the national average.

There have been no deaths in either group for the past two months, and our mortality indices have returned to within normal limits.



3.7



LFD reviews can serve as a further tier of assurance when such questions are asked.

LFD reviews have now been completed on a sample of these patients, and will now undergo and oversight review by the medical director, with presentation of a summary report to the quality governance group.

Family involvement

We have continued to struggle in establishing a robust process for informal feedback from our bereaved families. We continue to work with Beechwood Cancer Care to seek a solution, but failure to reach resolution represents a significant missed opportunity. It remains the subject of considerable focus at the mortality review group.

In the medium term, national strategy is for the development of the Medical Examiner role. The NHS patient safety strategy published this month outlines how this is likely to develop.

The **medical examiner system** will be a transformative part of the NHS safety system, giving the bereaved a voice, while ensuring that the period after death is as problem free as possible. Several important inquiries have recommended this system be established. Critically the system will knit together the good work already underway as part of Learning from Deaths.

We have several aims for the system:

- Provide a better service for the bereaved and an opportunity for them to raise concerns about care with a doctor not involved in that care
- Enhance patient safety by ensuring that all deaths are scrutinised by an independent medical examiner so that any issues with the quality of care can be identified and acted on
- ensure the appropriate direction of deaths to the coroner
- improve the quality of death certification.

While this will initially be a non-statutory system, it will be established in statute and the Department of Health and Social Care (DHSC), its sponsor department, will take the necessary legislation through parliament in due course.

England will have seven regional medical examiners to help implement the new system by providing direct support and supervision to medical examiners working in the system and ensuring they have links to regional teams.

In 2019/20, acute trusts in England are being asked to establish medical examiner offices to scrutinise the deaths occurring in their trust.

Over the course of 2020/21, the service will be expanded to encompass all deaths, including those occurring in the community and in independent providers.

Each medical examiner office team will:
• agree the proposed cause of death with the qualified attending practitioner to ensure the death certificate is accurate
• for non-coroner cases, discuss the cause of death with the next of kin and establish if they have any concerns with the care provided
• act as a source of medical advice to the local coroner and facilitate notification of deaths to them appropriately.

The development of a medical examiner role in Stockport will need to gain further momentum this year. We currently have two of our pathologists undergoing the required training. No funding has been provided nationally, and relatively little national advice has been issued relating to the pragmatic issues relating to developing such a service. Our current position is similar to that in other hospitals across Greater Manchester. Representation from the GM medical directors group are in consultation with the GM coroners to agree how best to develop this consistently across the city.

3.8 LFD lead role

Establishment of our LFD process has been driven to success by the efforts of a number of clinical enthusiasts. One clinician in particular must be singled out for praise. Dr McCluskey has undertaken the LFD lead role since the trust wide process established. He is now handing the role over to Dr Suzy Collins, consultant acute physician.

Dr McCluskey has been pivotal in the success of this program, a reflection of many hours of hard work, much of it in his own time

4. RISK & ASSURANCE

4.1 Development of our medical examiner system within the timescales outlined in the NHS patient safety strategy is unlikely to be met. This is true in most organisations, but must be the subject of further focus for us.

5. CONCLUSION

5.1 Progress establishing the LFD process is well 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.

Appendix 1: Actions from quarterly LFD report.

1. Acute onset polyneuropathy should be treated as possible Guillan Barre Syndrome (a failure of the nervous system), with the potential for acute severe further deterioration, unless proven otherwise. Urgent neurology review is therefore mandatory and early critical care referral in cases of suspected GBS is advised.

2. It is not enough to simply make a clinical referral. Steps to expedite review must be taken if the patient is deteriorating. This may require the direct intervention of the consultant.

3. All acutely ill patients, in particular those failing to respond to treatment, must be reviewed by a consultant on a daily basis.

4. The onset of acute dysphagia (inability to swallow) is a serious symptom. Inserting a nasogastric tube and requesting a speech and language assessment is not sufficient. A diagnosis must be sought urgently so that appropriate treatment can be instituted. This is particularly true in the context of other unexplained acute neurology.

5. It is essential to make careful note of what previous clinicians have said/documented about your patient. They may be right!

6. Acute onset severe shortness of breath, whether or not associated with wheeze, should never be assumed to indicate a chest infection/acute COPD. The diagnosis of acute heart failure must considered, particularly in the absence of a history of COPD and/or significant changes on the chest x ray suggestive of pneumonia.

7. A BNP assay (a blood test to check for heart failure) should be undertaken in all acutely breathless/wheezy patients where acute heart failure needs to be considered. A low result has a very high negative predictive value and allows the diagnosis to be excluded with some confidence. A high result suggests further urgent investigation (Echocardiograpy) and treatment is required.

8. High NEWS 2 scores must be actioned by appropriate timely senior 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.

9. All non-elective patients should have their resuscitation status (and any ceiling of care) considered on admission (or as soon as practicable) and the outcome documented in the patient's notes.

10. Resuscitation status should be routinely reviewed throughout a patient's inpatient stay on every consultant ward round and whenever there is a significant change in the condition of the patient.

11. All patients must have a mental capacity assessment documented if there is anything to suggest capacity may be impaired (eg dementia, acute confusion or other altered conscious level, abnormal or irrational behaviour etc).

12. When patients lack capacity, multidisciplinary Best Interests meetings must be convened to determine what treatment(s) is/isn't appropriate, to define ceiling of care etc going forward (ie not in an acute medical emergency). The views of family members are essential; it may often also be helpful to speak to the patient's GP, nursing home etc.

13. Reliable systems must be put in place to ensure that patient's admitted with a community DNACPR in place are reliably identified and that this DNACPR status is confirmed (assuming this is appropriate to do so in the context of the patient's hospital admission) as soon as possible.

14. Cardiac arrests in hospital are often unheralded by high EWS scores. Waiting for the EWS to score highly before considering DNACPR status and/or defining ceiling of care is poor practice. These should be routinely reviewed throughout a patient's inpatient stay on every consultant ward round and whenever there is a significant change in the condition of the patient and the outcome documented in the notes. These decisions must be guided, not just be the patient's current acute status, but also by a proper documented assessment of the patient's pre-morbid general health, comorbidities, functional ability and estimate of cardiorespiratory reserve.

15. In conjunction with consideration of resuscitation status, every non-elective inpatient should have any ceiling of care considered at regular intervals and the outcome documented. These decisions must be guided, not just be the patient's current acute status, but also by a proper documented assessment of the patient's pre-morbid general health, comorbidities, functional ability and estimate of cardiorespiratory reserve.

16. It is an absolute requirement that all blood tests and other investigations must be properly reviewed in a timely manner.

17. All significant abnormal results (as well as significant normal results) must be documented in the notes with an appropriate accompanying diagnosis/action plan.

18. Context in acute medicine is (often) everything. For example, although acute severe shortness of breath may have many causes, in the context of severe aortic stenosis (heart valve narrowing of the outflow of the heart), acute heart failure must be considered as a potential, if not the most likely, diagnosis.

19. It is also essential not to be unduly influenced by a previous clinician's diagnosis/mode of treatment. If <u>you</u> are now asked to assess the patient you must conduct your own (independent) investigation of the potential diagnosis and not blindly go along with the accepted wisdom.

20. An urgent head CT scan should always be considered in any patient presenting with acute confusion or with a fluctuating level of consciousness.

21. 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, that 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.

22. On many occasions the best thing a doctor can do for his patient is accept the inevitability of death and endeavour to make death a good as possible.

23. “For palliation if deteriorates” may often not be good medical practice, especially if made at consultant level. My experience of mortality review suggests to me that palliation often only occurs late, at or close to the point of death.

24. Elderly patients presenting to the ED with isolated acute back pain may have a rupturing abdominal aortic aneurism (dilated major artery in the abdomen), even in the complete absence of any other concerning clinical features (eg tachycardia, hypotension, abnormal ABGs etc).

25. An urgent CT scan should always be considered and the opinion of a senior (consultant) sought before diagnosing simple musculoskeletal acute back pain.

26. Elderly patients presenting to the ED with acute abdominal pain often have significant pathology.

27. Constipation should not be diagnosed solely on the appearances of an abdominal x ray.

28. Referral to a senior clinician and/or urgent CT scan should be undertaken before diagnosing constipation and sending home any elderly patient presenting to the ED with abdominal pain/distension/vomiting.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 July 2019
Subject:	Proposed changes to the Constitution		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	Mrs C Parnell

REPORT FOR APPROVAL

Corporate objective ref: N/A	**Summary of Report** The purpose of this report is to seek the Board's approval for a number of proposed changes to the Trust's Constitution. Any changes to the Constitution require the approval of the majority of the Council of Governors and the Board of Directors. This paper was discussed by the Council of Governors on 17 July 2019 and all the proposed changes were agreed.
Board Assurance Framework ref: N/A	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed X Not required	

Attachments:

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK -

PROPOSED CHANGES TO THE CONSTITUTION

1. Introduction

It is good practice for NHS Foundation Trusts to regularly review their Constitutions in line with the Model Constitution recommended by NHS Improvement. The Trust's Constitution was last reviewed in October 2018.

This paper sets out a number of proposed changes for consideration by the Council of Governors and then the Board of Directors. The Constitution states that:

> *44.1 The Trust may make amendments of its constitution only if:*
>
> *44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and*
>
> *44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.*

In line with the Health and Social Care Act, the Constitution is clear that only matters "*in relation to the powers and duties of the Council of Governors*" require presentation at the annual members meeting where members would be given the opportunity to vote on whether they approve the amendment.

None of the proposed amendments in this report relate to the "*power and duties of the Council of Governors"* and therefore do not require members' approval if agreed by the Council of Governors and Board of Directors.

2. Proposed changes

2.1 Governor tenure

In 2012 the Trust removed the maximum nine year tenure for all Governors. This was agreed by both the Board of Directors and Council of Governors, even though the Board raised a number of governance concerns about the move.

The Trust currently has five governors who have served more than nine years, which is the maximum tenure in the majority of NHS Foundation Trusts. In 2018 it was proposed to re-introduce a maximum tenure of nine years. This proposal was supported unanimously by the Board of Directors, but was fiercely debated by the Council of Governors.

After two debates at Council of Governor meetings in 2018 and 2019, the Chair taking private soundings from all Governors, and a working group meeting to look at the issues raised, the proposal to re-introduce a maximum tenure of nine years was put to a ballot that closed on 8 July 2019.

A total of 14 governors voted and the ballot result was:

- 8 for the re-introduction of a maximum nine year tenure for Governors,
- 6 against the re-introduction of a maximum tenure.

As the majority of Governors who voted are in favour of the re-introduction, the Trust's Constitution will be amended accordingly and a process introduced to implement the change with immediate effect.

In practice this will mean that all Governors who have served nine years or more will serve out the remainder of their current tenure. At the end of that tenure they will not be able to stand for re-election.

This change will require the following additions to section 14 of the Constitution:

> *14.3 An elected governor shall be eligible for re-election at the end of his/her term, and shall serve no more than three terms of office, resulting in a maximum 9 years tenure.*
>
> *14.6 An appointed governor shall be eligible for re-appointment at the end of his/her term and shall serve no more than three terms of office, resulting in a maximum 9 years tenure.*

2.2 Governor elections

The outcome of the Trust's annual Governor elections are concluded in October and currently the Constitution ties them into the annual members' meeting.

The aim of the annual members' meeting is to present the annual report and accounts for the previous year, and current arrangements mean that the Trust is reporting on a year that ended seven months prior to the meeting. The Trust should be holding its annual meeting within six months of the end of the final year, but the tie in with the annual elections prevents this.

It is proposed to separate the elections from the annual meeting, maintaining an annual schedule of elections with results announced on 1 October, but allowing the meeting to be held earlier in the year. Ideally this would be in July shortly after the annual report and accounts are laid before Parliament and therefore become public documents, but it should be no later than September each year.

This proposal would require changes to section 14 of the Constitution:

> *14.1 An elected governor may hold office for a period not exceeding three years commencing from when their election is announced on 1 October.*

14.7 For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after their election is announced.

2.3 Board of Directors – composition

The Trust is obliged to have a Board of Directors comprised of more Non-Executive than Executive Directors. Currently the Trust's Board is made up of six Executive and seven Non-Executive Directors, including the Chair.

As trusts develop and their leadership needs change many FTs have introduced a level of flexibility into their Constitution. This maintains the Non-Executive Director majority, but allows the Board flexibility in the number of members it has without having to change the Constitution each time it wants to amend the Board make-up.

It is proposed to change the Constitution to allow a more flexible approach to the make-up of the Board of Directors and this would require an addition to section 23 of the Constitution:

23.2 The Board of Directors is to comprise:
23.2.1 a non-executive chairman;
23.2.2 six to eight non-executive directors; and
23.2.3 six to eight executive directors.
23.3The number of Directors may be increased within the range of 23.2.2 and 23.2.3 above, with the approval of the Board, provided always at least half the Board comprises non-executive directors determined by the Board to be independent.

This addition would affect the numbering of this section of the Constitution.

2.4 Public Constituency

a) When the Trust took over responsibility for community services in Tameside and Glossop the Constitution was amended to designate one Governor seat for that area. As the Trust no longer provides those services it is proposed that the Tameside and Glossop seat is disbanded and the constituency amended to High Peak and Dales, with three Governor seats instead of the current two for that geographic area. This change would not alter the current the make-up of the Council of Governors.

b) Rest of England – a number of NHS Foundation Trusts have introduced a Rest of England constituency to ensure that anyone with any interest in the organisation can sign up as a member. For many organisations this extra constituency means that in practical terms they can attract a wider field of candidates for non-executive director roles.

The recent process to appoint a new non-executive director attracted significant interest from capable candidates who were subsequently disqualified because they lived outside the Trust's current public constituencies. The Trust already has an Outer Region constituency and it is proposed to broaden that constituency to cover the rest of England, and retaining the one governor seat.

c) Minimum numbers of members – all NHS Constitutions must specify the minimum number of members they must have in each of its constituencies. This is essentially the minimum number of members it needs to have to hold an election.

Currently the Trust specifies just four members for each of its public constituencies, and 16 members for the staff constituency. Both are low compared to other NHS Foundation Trusts. It is proposed to increase the minimum number of members to 50 for the public constituencies and 100 for the staff constituency to 100.

These proposals would require changes to Annex 1 - The Public Constituencies - to state:

The minimum number of members of each of the public constituencies is 50.

Annex 2 - The Staff Constituency of the Constitution – would also require a change to state:

The minimum numbers of members of the Staff Constituency is 100.

2.5 <u>Composition of the Council of Governors</u>

Council of Governors are generally made up of a mix of public and staff governors elected by their constituents, and Governors appointed by partner organisations as their representatives.

The Trust currently has just two appointed governors – one representing Stockport Metropolitan Borough Council and the other representing Stockport College of Education. There has always been good involvement in the Council of Governors from the local authority, but a less active role from the college representative.

As the Trust is keen to develop and maintain strong partnership arrangements with a wide variety of local stakeholders it is proposed to increase the number of organisations invited to put forward an appointed Governor. This would include:

- One for Stockport Metropolitan Borough Council,
- One for a medical/nursing school associated with the Trust,
- One for Stockport Clinical Commissioning Group,
- One for Stockport Healthwatch,
- One representative of a relevant local charity or third sector group, eg Age Concern.

This proposal would increase the current number of appointed Governors by three and the overall make-up of the Council of Governors to 29 from the current 26. These proposals would require the following change and addition to Annex 3 – Composition of the Council of Governors of the Constitution:

4. *One Governor to be appointed by a medical or nursing school associated with the Trust – a Partnership Governor.*
5. *One Governor to be appointed by Stockport Clinical Commissioning Group – a Partnership Governor.*
6. *One Governor to be appointed by Stockport Healthwatch – a Partnership Governor.*
7. *One representative of a local charity or third sector organisation – a Partnership Governor.*

8. Recommendation

The Council of Governors is asked to approve the following proposals and their associated amendments to the Constitution:

a) Separating the annual members' meeting from the annual elections. This would allow the annual meeting to be held earlier in the year but maintain the annual elections outcome in October.
b) Amending the make-up of the Board of Directors to allow greater flexibility, but maintaining the appropriate balance of Executive and Non-Executive Directors.
c) Remove the Governor seat for Tameside and Glossop.
d) Increase the number of Governor seats for High Peak and the Dales from two to three.
e) Broaden the Outer Region constituency to cover the rest of England.
f) Increase the minimum number of members required in each public and staff constituency, as set out in section 2.5c.
g) Increase the number of appointed Governors by three, in line with the proposal outlined in section 2.6.

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31st July 2019
Subject:	Annual report on Emergency Preparedness, Resilience and Response		
Report of:	Accountable Emergency Officer	**Prepared by:**	Emergency Preparedness Resilience & Response (EPRR) Manager

REPORT FOR NOTING

Corporate objective ref:	N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* To provide the Trust Board with an overview of the management of Emergency Preparedness, Resilience & Response (EPRR) within the Trust during 2018/2019 (specifically the period 1st July 2018 - 30th June 2019). EPRR is a statutory responsibility under the Civil Contingencies Act (2004) and is integral to the Care Quality Commissions Safety Domain.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 This report provides the necessary assurance to the Board that Stockport NHS FT fulfils its statutory duties outlined both within the Civil Contingencies Act (CCA) 2004 and within the Emergency Preparedness Resilience & Response (EPRR) "Core Standards" set by NHS England.

2. BACKGROUND

2.1 Stockport NHS FT is a 'Category One Responder' as defined in the Civil Contingencies Act (CCA, 2004) and therefore the Trust must fulfil four principle legal duties, simply stated these are as follows:

- To risk assess the emergencies we may have to deal with and use this to inform contingency planning
- To have effective business continuity management in place
- To have emergency plans in place; and
- To have suitable arrangements in place to warn and inform the public as appropriate

Under the CCA the Trust also has an obligation to share information and to co-operate with other local responders to enhance co-ordination and efficiency.

2.2 In support of the CCA NHS England have developed "EPRR Core Standards". These are the Standards which NHS England expects each NHS organisation to maintain in relation to their EPRR preparedness and an annual self-assessment is required to be undertaken.

3. CURRENT SITUATION

3.1 NHS organisations are required to participate in an annual Emergency Preparedness, Resilience & Response (EPRR) assurance process. In October 2018 the Trust undertook a self assessment against the 2018/19 EPRR Core Standards and measured 'Substantially Compliant' against these. A statement of compliance was submitted to the October 2018 Board meeting.

3.2 Future threats to the Trust include Capacity issues, staffing issues (e.g. industrial action), Extreme Weather, Infectious Diseases (e.g. Pandemic Flu & Viral Haemorrhagic Fever), terrorist acts, EU Preparedness and restructuring of the NHS.

3.3 The Trust has numerous EPRR policies; procedures and guidance in place to mitigate the impact of these potential risks, many of these documents are due for review/update to ensure they remain current and where applicable continue to reflect national standards/guidance.

3.4 The Trust EPRR Group meets quarterly and is chaired by the Accountable Emergency Officer (AEO). The group has good representation across all business groups and benefits from Non-Executive input & attendance.

3.5 It should be noted that the frequency of EPRR meetings increased in the lead up to the original date for EU Exit (29th March 2019) from quarterly to monthly and even weekly when required to ensure the Trust was engaging in the necessary preparedness and meeting national and regional reporting requests.

3.6 All NHS organisations are required to ensure training for all staff with a role in incident response. Annual EPRR Training for 1090 bleep holders, Senior Managers on call and Execs On-Call, was offered at various points throughout 2018/19. The training objectives were as follows;

- Understand the term EPRR.
- Understand types of Incidents & NHS Incident Classifications
- Understand 'Command & Control' and its application to the Trust response.
- Understand your role within an EPRR response.
- To be aware of locations of designated Incident Control Centres (ICCs) within the Trust
- To familiarise yourself with ICC resources (including the Loggist Function)
- To have an awareness of the Civil Contingencies Act (2004), the non-statutory NHS Emergency Planning Guidance and the Trust's obligations within each.

3.7 In addition, Trust representatives participated in Exercise Socrates 3. The scenario for all three Socrates exercises held to date has been a mass casualty scenario; Socrates 3 focused on the recovery phase of a major incident, whereas exercises 1&2 had dealt with the immediate response.

3.8 During 2018/19 a number of ED staff received specific Chemical, Biological, Radiological, Nuclear (CBRN)/Hazardous Materials (HazMat) training, which included donning and doffing of Powered Respirator Protection (PRPS) Suits. Plans are in place for this training to be cascaded to further ED staff to ensure the Trust could respond to a "Salisbury Incident" (CBRN Incident) or the accidental release of a hazardous material (HazMat Incident).

3.9 Specific training was provided for incident "Loggists" and Switchboard Operators (relating to the MAJAX Cascade procedure).

3.10 The Trust continues to work with the Greater Manchester Local Health Resilience Partnership (LHRP) and actively participates in Stockport's Health Economy Resilience Group (HERG); a multi-agency group with representation from Stockport MBC (Public Health, Social Care & Civil Resilience), Stockport CCG, Mastercall & Pennine Care.

4. RISK & ASSURANCE

4.1 The Board should be assured that the existing Trust resilience arrangements are in place.

5. CONCLUSION

5.1 Resilience is "everyone's business" and appropriate reaction to incidents/events is essential; it is therefore vital that the Trust continues to participate in the resilience "agenda" to embed a positive, pro-active culture across the Trust, this can be achieved via continued commitment and support of EPRR workstreams such as Training & Exercising / Business Continuity.

6. RECOMMENDATIONS

6.1 That the content of this report be noted.