Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

28 JUNE 2018

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 28 June 2018

This page has been left blank

Board of Directors Meeting
Thursday, 28 June 2018

Held at 9.00am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

AGENDA

Time			Enc	Presenting
0900	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		
0905	**4.**	Patient Story		**A Lynch**
	5.	**OPENING MATTERS**		
0920	5.1	Minutes of Previous Meeting: 24 May 2018	✓	**A Belton**
0925	5.2	Chair's Report	✓	**A Belton**
0930	5.3	Chief Executive's Report	*Verbal*	**H Thomson**
0935	5.4	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
0950	6.1	Performance Report	✓	**H Mullen**
1015	6.2	Urgent Care - Presentation		**S Toal / J Wood**
	7.	**FINANCE & QUALITY**		
1040	7.1	CNST Incentive Scheme	✓	**A Lynch**
1050	7.2	Update on 2017 Staff Survey Outcomes	✓	**H Brearley**
	8.	**GOVERNANCE**		
1100	8.1	Governance Declarations	✓	**P Buckingham**
1110	8.2	Trust Risk Register	✓	**A Lynch**
	9.	**CONSENT AGENDA**		
	9.1	Nil Consent Agenda Items		
	10.	**DATE, TIME & VENUE OF NEXT MEETING**		
	10.1	Thursday, 26 July 2018, 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 on Thursday, 24 May 2018 2018 10.00am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

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

In attendance:

Mrs S Curtis	Membership Services Manager

115/18 Apologies for Absence

An apology for absence had been received from Ms C Drysdale and it was noted that Ms A Smith would be arriving late. The Chair welcomed Ms J Wood, Improvement Director – Urgent and Emergency Care, to her first Board meeting.

116/18 Declaration and Annual Review of Interests

There were no interests declared.

117/18 Patient Story

The Medical Director and Chief Nurse presented a slide set on the New Early Warning Score (NEWS2). The presentation, entitled 'Care of the deteriorating patient', covered the following subject areas:

- Learning from patient experience
- What's an early warning score (EWS)?
- Implementing NEWS2: Driver Diagram
- People, Processes…
- …and Systems

- Implementing NEWS2.

In response to a question from the Director of Corporate Affairs, the Medical Director advised that the early warning score would be utilised by all clinical staff, from Health Care Assistants to Consultants. In response to a question from the Interim Chief Executive, the Medical Director and Chief Nurse provided an overview of measuring cardiac arrest figures. In response to a question from Mrs C Anderson, the Chief Nurse advised that a policy regarding the implementation of the New Early Warning Score (NEWS2) would be presented to the Quality Committee for approval. In response to a question from the Chair, the Director of Corporate Affairs advised that reports relating to learning from deaths were presented to the Board six-monthly and quarterly to the Quality Committee. He noted that the next report was scheduled to be presented to the Board in September 2018.

In response to a question from the Chair, the Chief Nurse advised that the Trust was part of a regional safety collaborative which enabled the Trust to take learning from other trusts regarding NEWS2. In response to a question from Mrs C Barber-Brown, regarding measuring the early warning score, the Chief Nurse briefed the Board on measures taken in this area. In response to a question from the Chair, the Chief Nurse provided an overview of patient stories scheduled for future Board meetings.

The Board of Directors:

- Received and noted the Patient Story.

118/18 Minutes of the previous meeting

The minutes of the previous meeting held on 26 April 2018 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

119/18 Report of the Chair

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. In response to a comment from the Chair, the Head of Communications briefed the Board on activities planned to celebrate 70 years of the NHS.

The Board of Directors:

- Received and noted the Report of the Chair.

120/18 Report of the Chief Executive

The Interim Chief Executive provided a verbal update with regard to national and local strategic and operational developments. She briefed the Board on a Leaders' Summit scheduled for mid-June 2018. The Interim Chief Executive also advised that a draft report following the Care Quality Commission (CQC) system review was expected imminently, with the final report due to be published at the end of June 2018. She

advised that a system summit, led by the CQC, would be held following the publication of the report.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

121/18 Key Issues Reports

Quality Committee

Dr M Cheshire presented a Key Issues Report which detailed matters considered at a meeting of the Quality Committee held on 8 May 2018 and provided a brief overview of content. He noted that the Committee had been informed of twenty instances since May 2017 where the Trust's Maternity Unit had been either closed or subject to a divert status. Dr M Cheshire advised that this level was higher than the norm and that a recovery plan had been requested by the Chief Nurse. He noted that a status report would be presented to the Committee on 10 July 2018. In response to a question from Mr J Sandford, the Chief Nurse advised that the issues relating to the closure of the Maternity Unit or diversion from the Unit were separate from the issues raised by the Care Quality Commission (CQC) and briefed the Board in this area. The Chair queried whether the Trust's compliance of 91% with regard to safeguarding adults training was satisfactory. The Chief Nurse advised that the target was 90% and noted that the Trust compared favourably with other trusts in this area.

Dr M Cheshire reported that the Medical Director had alerted the Committee to continuing resource issues for the microbiology service and noted a consequent impact on Antibiotic Stewardship ward rounds. He advised that the Committee had been given assurance that the matter was recorded in the Trust's Risk Register. Dr M Cheshire concluded his report by advising the Board that, in relation to the CQC Action Plan, the Committee had noted that an action related to improved timeliness for Discharge Summaries remained red-rated. The Committee had been briefed of the current situation and the Chief Operating Officer had agreed to prepare an improvement plan, including milestones and key dates, for consideration by the Committee on 19 June 2018.

Finance & Performance Committee

Mr M Sugden presented a Key Issues Report which detailed matters considered at a meeting of the Finance & Performance Committee held on 16 May 2018 and provided a brief overview of content. He made reference to the Committee's consideration of the A&E 4-hour standard but noted that the Chief Operating Officer would brief the Board on this subject matter later on the agenda, during consideration of the Integrated Performance Report. Mr M Sugden advised that the Committee had received verbal assurance on progress with the Trust's Winter Plan but had noted the need for similar assurance on development of the system winter plan for Stockport where there was a lack of clarity on progress to date. He also advised the Board that the Committee had considered the Month 1 Finance Report and noted an adverse position of £0.3m for elective income. Mr M Sugden reported that the Committee had requested an assurance report at its next meeting on 20 June 2018 to detail the

activity plan for the year, including day-case activity, together with a risk assessment on plan delivery.

With regard to the Cost Improvement Programme, Mr M Sugden advised that the Committee had noted a shortfall of £0.3m against the Month 1 plan position of £0.5m. He commented that the position had not improved in Month 2 and therefore noted low assurance on the Cost Improvement Programme. In response to a concern raised by the Chair, who noted the Board's collective concern with regard to the delivery of the Cost Improvement Programme, the Director of Finance provided an overview of mitigating actions in this area. In response to a question from Mr J Sandford, there followed a lengthy discussion regarding the delivery of the Cost Improvement Programme and it was consequently agreed that the Interim Chief Executive and the Director of Support Services would consider means of practical support from Board members. Reference was also made to the importance of communicating the seriousness of the situation to the whole organisation.

In response to a comment from the Chair, who queried whether monthly review of the Cost Improvement Programme was adequate, Mr M Sugden noted that the Finance & Performance Committee had requested a robust forecast for the Cost Improvement Programme at its meeting in June 2018. He suggested that following that meeting, a view could be taken whether more frequent reporting was necessary. The Director of Finance commented that he would give consideration to providing the Finance & Performance Committee with Key Issues Reports from the Financial Improvement Group.

<u>People Performance Committee</u>

Mrs C Anderson presented a Key Issues Report which detailed matters considered at a meeting of the People Performance Committee held on 17 May 2018 and provided a brief overview of content. She reported that the Committee had been advised of the continued national issue relating to visa restrictions which was adversely impacting the Trust's overseas medical recruitment. Mrs C Anderson commented that national discussions continued in this area and the Board received an update from the Interim Director of Workforce and the Medical Director regarding the issue. Mrs C Anderson advised the Board that in considering a report relating to the monitoring of Trainee Doctors working hours for doctors who remained on the 2002 contract, the Committee had been alerted to recent cases of historic claims for banding, dating back six years. The Committee had noted a potential financial risk if the cases led to "piggy-back" claims against the Trust. The Interim Director of Workforce advised that the Trust was monitoring this issue closely and that the Board would be kept updated on progress.

Mrs A Smith joined the meeting.

Mrs C Anderson advised the Board of rota issues in Gastroenterology and noted that the issue would be further reviewed by the Deputy Medical Director and the Deputy Director of Workforce. She advised that the Committee had taken positive assurance from a report on Medical Appraisal and Revalidation and wished to congratulate the Deputy Medical Director for the improved position in this area. Mrs C Anderson also advised that the Committee had commended the improved format of the Annual Workforce Performance Report and noted that the report had been included for information of the Board in Annex A of the Key Issues Report. Mr J Sandford

commented that the report did not include the necessary consequential information. In light of these comments, Mrs A Smith and the Interim Director of Workforce agreed to review the presentation of the report further.

Mrs C Anderson advised the Board that colleagues were invited to review and comment on an outline plan for the Workforce Strategy which was available in the office of the Interim Director of Workforce. It was noted that the Workforce Strategy was subject to consideration at the Board workshop session later that afternoon. Mrs C Anderson advised the Board that the Committee had received a presentation on the HR Systems Optimisation Programme. She reported that the Committee had been disappointed at the level the Allocate HealthRoster System was being used across the Trust and that the timescale for full implementation appeared overly long. Mrs C Anderson advised that the Committee would receive an update at the meeting on 25 October 2018 once further clarity was available with regard to expectations and resource requirements. In response to a question from Mr J Sandford, the Interim Director of Workforce provided further clarity regarding the implementation of the Allocate HealthRoster System and the associated resource issues.

The Board of Directors:

- Received and noted the Key Issues Reports.

122/18 Trust Performance Report – Month 1

The Chair advised that the new style Integrated Performance Report had been shared with the Council of Governors on 23 May 2018 and noted the need for further review of the report's presentation following feedback received from a number of Governors. The Director of Support Services presented the Integrated Performance Report (IPR) for the month of April 2018. He commented that, compared to the previous IPR, the new style report included a greater focus on Quality metrics and assurance regarding forward actions. The Director of Support Services briefed the Board on the content and layout of the report and provided an overview of the following three sections: Executive Summary; Domain Summary; and Indicator Detail. In response to questions from Board members, the Director of Support Services provided further clarity regarding the content of the report.

In response to a number of comments from Board members regarding the presentation and content of the report, it was agreed to arrange a workshop to enhance Board member understanding and use of the revised IPR. On behalf of the Board, the Chair acknowledged the significant improvement made to the IPR. In response to a question from Mr J Sandford, the Medical Director briefed the Board on the various mortality indicators.

The Chief Operating Officer provided an overview of red-rated performance indicators. She referred the Board to page 28 of the report and briefed the Board on the A&E 4-hour standard. The Chief Operating Officer reported that performance in May had continued to improve, with the month to date position standing at 90% against the 82% trajectory. She noted, however, that whilst the acuity of patients had reduced, the numbers of attendances had increased. The Chief Operating Officer briefed the Board on work in this area and noted the following areas of focus: single point of access; workforce at night; surge at night; stranded patients; winter planning; out of hospital

care; crisis response team and neighbourhoods; and keeping patients at home. In response to a question from Mr J Sandford, the Chief Operating Officer advised that the Trust's current A&E 4-hour performance compared favourably with other Greater Manchester trusts. In response to a question from Mr M Sugden, regarding initiatives to reduce the number of people presenting at the hospital, the Chief Operating Officer briefed the Board of actions in this area, including work around neighbourhoods, GP 7-day services and the Urgent Treatment Centre.

The Chief Nurse then briefed the Board on Quality metrics and made specific reference to the following areas:

- Falls
- Patient safety alerts
- Complaints response rates
- Serious Incidents.

The Chief Nurse also advised the Board that information with regard to safe staffing was now included in the IPR. She reported that, while there remained some areas that were not fully staffed, the Trust had seen a significant improvement with regard to staffing since the closure of A15.

The Interim Director of Workforce briefed the Board on Workforce metrics and made specific reference to the following areas:

- Agency spend
- Staff in post
- Statutory and mandatory training.

The Director of Finance then briefed the Board on Finance metrics and made specific reference to the following areas:

- Cost Improvement Programme performance
- Elective activity
- Cash performance. The Director of Finance advised the Board that, as anticipated, the Trust was likely to require revenue support in July 2018.

The Board of Directors:

- Received and noted the revised Integrated Performance Report.

123/18 Presentation – Role of Urgent & Emergency Care Improvement Director

The Urgent & Emergency Care Improvement Director delivered a presentation to the Board with regard to her role. The presentation covered the following subject areas:

- Background
- Role
- Organisational fit
- Next steps.

The Urgent & Emergency Care Director advised the Board that her appointment with the Trust was until the end of October 2018 and that she would next present an update report to the Board on 26 July 2018. In response to a question from the Chair, the Urgent & Emergency Care Director noted her intention to be part of the Urgent Care Delivery Board and reported good engagement to date with system partners.

The Board of Directors:

- Received and noted the presentation.

124/18 Quality Improvement Plan

The Chief Nurse presented the final draft Quality Improvement Plan 2018-2020 to the Board of Directors. She briefed the Board on the content of the report and noted that the Quality Committee had endorsed the Quality Improvement Plan for Board approval. In response to a question of the Chair, the Chief Nurse advised that the Plan had been developed in consultation with Governors, patients, staff, stakeholders, Quality Committee, Board of Directors and the Executive Management Group. In response to a question from Mr J Sanford, the Chief Nurse noted that the seven themes identified in the Plan were already in place, some of which had costs identified. She noted that the Trust had also requested additional support from the NHS Improvement to enable delivery of the Plan. In response to a question from Mr J Sandford, regarding capability and capacity to deliver the Plan, the Chief Nurse advised that resource requirements were taken into account in the Culture & Engagement work led by the Interim Director of Workforce.

In response to a question from Mr J Sandford, the Chief Nurse acknowledged the ambitious nature of the Trust's target to become a 'good' or 'outstanding' organisation in two years' time but noted the expectation from regulators for the Trust to make bold changes with regard to the key areas of focus. In response to a follow up question from Mr J Sandford, these comments were also endorsed by the Director of Finance. In response to a question from the Chair, the Interim Chief Executive advised that the Quality Improvement Plan would be reviewed monthly by the Improvement Board and the Director of Corporate Affairs agreed to liaise with the Chief Nurse with regard to scheduling updates to the Board.

The Board of Directors:

- Received and noted the report and approved the Quality Improvement Plan.

125/18 Risk Management Strategy & Framework

The Chief Nurse presented the Risk Management Strategy & Framework 2018-20 to the Board of Directors. She briefed the Board on the content of the report and advised that the Risk Management Strategy & Framework replaced the current Risk Management Strategy following extensive review of external sources and strategies. The Chief Nurse noted that, following a recommendation for approval by the Audit & Risk Committee on 17 May 2018, the Board was asked to approve the Risk Management Strategy & Framework and endorse the framework as the overarching plan to achieve the Trust's ambition to be a Risk Enabled organisation by 2020.

In response to a comment from the Chair, Mr J Sandford advised that following discussion at the Audit & Risk Committee regarding the Risk Management Strategy & Framework, it had been agreed that he, the Chief Nurse and Dr M Cheshire would meet to consider the remit of the Audit & Risk Committee and Quality Committee to ensure clarity and avoid duplication in this area. In response to a question from the Chair, it was noted that a six monthly report of the plan would be presented to the Audit & Risk Committee and Quality Committee and that the Board would be updated on progress via the Committee Key Issues Reports.

The Board of Directors:

- Received and noted the report and approved the Risk Management Strategy & Framework 2018-20.

126/18 Review of Undertakings - Progress Report

The Interim Chief Executive presented a report which provided the Board with assurance on progress to address weaknesses identified during the Review of Undertakings completed by NHS Improvement. She thanked the Director of Corporate Services for preparing the report and provided a brief overview of content. In response to a comment from the Chair, regarding the brevity of s3.4 of the report, the Director of Corporate Affairs noted that the regulatory expectation was for the Trust to have a Strategy. He advised that the report had been discussed at the Quarterly Review Meeting on 12 April 2018 and NHS Improvement had requested sight of the report following today's Board meeting. The Chair wished to thank the Director of Corporate Affairs for preparing the report and the Director of Corporate Affairs thanked his Executive colleagues for provision of the relevant information.

The Board of Directors:

- Received and noted the report and noted the assurance provided on progress.

127/18 Annual Governance Statement 2017/18

The Director of Corporate Affairs presented a report, the purpose of which was to present the draft Annual Governance Statement 2017/18 to the Board of Directors for approval. He briefed the Board on the content of the report and advised that feedback from External Audit had been incorporated in the draft statement included at Annex A. The Director of Corporate Affairs also reported that the draft Annual Governance Statement had been reviewed by the Quality Committee on 8 May 2018 and by the Audit & Risk Committee on 17 May 2018 and that both Committees had recommended the draft statement to the Board of Directors for approval.

Mr J Sandford endorsed the reference to 12-hour breaches as a significant control issue. The Director of Corporate Affairs acknowledged this comment and noted the heavy emphasis in the Annual Reporting Manual (ARM) guidance for trusts to identify significant control issues in their Annual Governance Statements.

The Board of Directors:

- Received and noted the report and approved the Annual Governance Statement 2017/18.

128/18 Governance Declarations

The Director of Corporate Affairs presented a report, the purpose of which was to allow the Board to determine a positive declaration against General Condition 6 and the Continuity of Services Condition 7 of the NHS Provider Licence or identify why such a declaration could not be made. He briefed the Board on the content of the report and advised that the requirements of both Conditions were reproduced for reference at Appendix 1 of the report and a copy of the required declarations was included at Appendix 2. The Director of Corporate Affairs noted that, in considering the Continuity of Services Condition 7 last year, the Board had held a lengthy debate which had led to the certification of a 'Confirmed' response to question 3a. He briefed the Board on the main factors of the statement and proposed a certification of a 'Confirmed' response to question 3a with similar factors than in last year's declaration.

In response to a question from Mr J Sandford, the Director of Corporate Affairs provided an overview of current regulatory requirements regarding Governance Declarations. Mr J Sandford proposed that the declaration should include specific reference to the draw down facility which the Trust would be required to use early on in the Financial Year 2018/19. The Director of Corporate Affairs endorsed this proposal and suggested that the declaration be adapted accordingly following the Board's consideration of the Going Concern declaration at the private Board meeting later that afternoon.

The Board of Directors:

- Received and noted the report and agreed a 'Confirmed' response to questions 1 and 3a, subject to the inclusion of relevant commentary with regard to the draw down facility.

129/18 Trust Risk Register

The Chief Nurse presented the Corporate Risk Register and provided an overview of content. She advised that the Risk Register had been recently considered by all of the Board Assurance Committees. The Chief Nurse referred the Board to s1.6 of the report which, she noted, provided information regarding risk movement for all risks scoring 15 and above as at April 2018. Whilst noting the continued improvement with regard to the presentation of the Risk Register, the Chief Nurse acknowledged that the register was still work in progress. Mrs C Barber-Brown commended the improved presentation of the Risk Register and noted the benefit of reviewing risks specific to the Board Assurance Committees. In response to a question from Mrs C Barber-Brown, the Board received an update on risks that had the 'due date' column highlighted in amber.

In response to a question from Mr J Sandford, the Chief Nurse acknowledged the issue of potential over-scoring of risks and noted the importance of educating risk owners to ensure appropriate risk scoring. The Medical Director endorsed these comments and advised that risk scores were reviewed and challenged at the Quality Governance Group.

The Board of Directors:

- Received and noted the Trust Risk Register.

130/18 Consent Agenda

a) Code of Governance Compliance Report

The Board of Directors received and noted the report approved the Code of Governance disclosures as presented at Appendix 1.

131/18 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next scheduled meeting of the Board of Directors would be held on Thursday, 28 June 2018, 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
20/17	28 Sep 17	225/17	Draft Alliance Provider Agreement	In response to a question from the Chair, the Interim Provider Director advised that he would provide an update with regard to the risk and gain share agreement at the next Board meeting. **Update 27 Oct 17** – The Interim Provider Director advised that he had written to all Directors of Finance with regard to the risk and gain share agreement and noted that the issue would be discussed at the Locality Finance Meeting on 6 November 2017. **Update 30 Nov 17** – The Director of Finance reported that this issue was yet to be resolved as a legal agreement. The Interim Provider Director noted that he would ensure that a risk and gain share agreement was in place by 28 February 2018 at the latest. **Update 28 Feb 18** – The Director of Finance advised that while a number of principles had been agreed regarding the risk and gain share agreement, this issue was yet to be resolved as a legal agreement. It was agreed that the Director of Support Services and the Director of Finance would take this action forward and report back at the Board meeting on 29 March 2018. **Update 29 Mar 18** – The Director of Finance briefed the Board on developments in this area but noted that the risk and gain share agreement was still being enacted without a legal agreement. He commented that there were two aspects to the risk and gain share agreement; one with the Council and the CCG and one between the four providers of Stockport Together. Mr M Sugden noted the importance of ensuring that the basis of both agreements was equitable. The Director of Finance noted that the intention was to have resolved this issue by the next Board meeting on 26 April 2018. **Update 26 Apr 18** – The Director of Finance briefed the Board on progress with preparing a formal risk and gain share agreement and noted ongoing discussions with SMBC. **Update 24 May 18** – The Director of Corporate Affairs advised that the risk and gain share agreement would be considered at the Private Board	K Spencer (Interim Provider Director) H Mullen (Director of Support Services) & F Patel (Director of Finance)

				meeting on 24 May 2018 due to the report being commercial in confidence. **Update for 28 June 2018 –** Risk and gain share agreement approved by the Board of Directors on 24 May 2018. Action complete.	
03/18	28 Feb 18	52/18	Stockport Together Progress Report	In response to a number of question and comments from Board members, the Managing Director of Stockport Neighbourhood Care agreed to revise the Deployment Status table (Fig 1) to provide greater clarity in future reports, with effect from March/April 2018 reports. The Director of Finance requested that more granular information be provided to the Board as an appendix to the report. **Update 29 Mar 18** – The Managing Director of Stockport Neighbourhood Care advised that the table would be included in the April update report. **Update 26 Apr 18** – The Managing Director of Stockport Neighbourhood Care briefed the Board on ongoing work and advised that the information would be included in the May Board report. **Update 24 May 18** – In response to a comment from Mr J Sandford, who raised a concern regarding the delay in the provision of key performance indicators relating to Stockport Together, the Director of Support Services briefed the Board on progress in this area. He acknowledged the concern regarding the delay and advised that the issue had also been raised with partner organisations. The Board of Directors noted their collective concern regarding the delay and requested that an Integrated Service Solution, along with an update regarding discussion with partners be presented to the June Board meeting.	C Drysdale (Managing Director, SNC)
04/18	28 Feb 18	52/18	Stockport Together Progress Report	In response to a comment from the Director of Corporate Affairs, it was agreed that the final Stockport Together business cases would be submitted to the Board for approval. **Update for 29 Mar 18 –** Scheduled for presentation to Board on 26 April 2018. **Update 26 Apr 18** – It was noted that the final Stockport Together business cases would now be submitted to the Board for approval on 24 May 2018. **Update 24 May 18** – It was noted that this issue would be picked up once the Managing Director of Stockport Neighbourhood Care was back from leave.	C Drysdale (Managing Director, SNC)

05/18	29 Mar 18	79/18	Audit Committee Key Issues Report	Mr J Sandford advised that the Committee had recommended that the People Performance Committee undertook a 'deep dive' on e-rostering to assess whether optimum benefits were being derived from the system. It was proposed that the 'deep dive' be undertaken at the People Performance Committee meeting on 17 May 2018, with an audit on the system to be held in Quarter 4 2018/19. **Update 24 May 18** – It was noted that the People Performance Committee had received a presentation on e-rostering at its meeting on 17 May 2018. Action complete.	E Stimpson (Deputy Director of Workforce & OD)
07/18	26 Apr 18	95/18	Report of the Chair	It was proposed that to link in with the Board's consideration of the Estates Strategy in June 2018, the Director of Support Services would organise a tour of the hospital site and tunnels for the Board of Directors. **Update 24 May 18** – The Director of Support Services advised that he was looking to arrange two or three dates for the site tour. It was noted that the Estates Strategy was now due to be considered by the Board in July 2018 and the Director of Finance agreed to check with NHSI that the delay would not cause any issues.	H Mullen (Director of Support Services)
08/18	26 Apr 18	97/18	Key Issues Report – Quality Committee	It was agreed that progress on preparation of 'standard questions' for Risk Register reviews would be reported to the Board of Directors on 24 May 2018. **Update 24 May 18** – The Board noted that the preparation of the standard questions was still in progress.	A Lynch (Chief Nurse) & C Wasson (Medical Director)
09/18	26 Apr 18	98/18	Performance Report	It was agreed that progress against Urgent & Emergency Care Recovery Plan would be reported to the Board on 26 July 2018.	H Thomson (Interim Chief Executive)
10/18	26 Apr 18	100/18	Operational Plan 2018/19	In response to a question from the Chair, regarding the availability of an Urgent & Emergency Care Plan, the Interim Chief Executive advised that the Trust was currently receiving support from the North East Commissioning Unit in this area and noted that a report would be produced at the end of the process which would be presented to the Board of Directors on 26 July 2018.	H Thomson (Interim Chief Executive)

11/18	26 Apr 18	102/18	Staff Survey 2017	It was agreed that a progress report on the 3-5 year plan would be presented to the Board of Directors on 28 June 2018.	H Brearley (Interim Director of Workforce & OD)
12/18	24 May 18	121/18	Finance & Performance Key Issues Report	In response to a question from Mr J Sandford, there followed a lengthy discussion regarding the delivery of the Cost Improvement Programme and it was consequently agreed that the Interim Chief Executive and the Director of Support Services would consider means of practical support from Board members.	H Thomson (Interim Chief Executive) & H Mullen (Director of Support Services)
13/18	24 May 18	122/18	Integrated Performance Report	In response to a number of comments from Board members regarding the presentation and content of the report, it was agreed to arrange a workshop to enhance Board member understanding and use of the revised IPR.	P Buckingham (Director of Corporate Affairs)

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 June 2018
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

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

Attachments:	Nil

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 The Trust received correspondence from NHS Improvement on 8 June 2018 which provided feedback on content of the Operational Plan 2018/19 and included a request for clarification of elements of the Plan relating to Activity, Capacity Planning, Workforce and Finance. The correspondence detailed an opportunity to revise relevant sections and re-submit the Operational Plan.

2.2 Following thorough review and evaluation by management, an extraordinary meeting of the Board was convened on 18 June 2018 to consider and approve proposed amendments to the Plan. A revised Operational Plan 2018/19 was subsequently submitted to NHS Improvement in advance of the deadline on 20 June 2018.

3. BOARD DEVELOPMENT

3.1 The meeting on 28 June 2018 will be the final meeting for Mr J Sandford whose term of office will be completed on 30 June 2018. I would like to thank John on behalf of the Board for his dedicated service and contribution to the Trust since his initial appointment in July 2011. John's successor as Non-Executive Director and Chair of Audit, Mr D Hopewell, commences work with the Trust from 1 July 2018 following the approval of his appointment by the Council of Governors on 23 May 2018.

3.2 David is a Fellow of the Institute of Chartered Accounts and held senior finance positions with Shell in both the UK and West Africa. He moved into the public sector in 1994 and operated as a Board Director at the Government Office for the North West from 1998-2006 where his portfolio included finance, audit and communications. David has pursued a portfolio career since 2007 and is currently in the final stages of his term of office as a Non-Executive Director with Mid-Cheshire NHS Foundation Trust.

3.3 The Board held a development session on 20 June 2018 which included an informative discussion with colleagues from Stockport CCG on the subject of commissioning and contracting. Both parties found the session helpful in developing a mutual understanding of the situation relating to future commissioning and we plan to hold a further joint session in the Autumn.

4. CHAIR ENGAGEMENTS

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

31 May 2018	Visits to Ward D5 and the Short Stay Surgical Unit
5 June 2018	Attended a WRES meeting for Greater Manchester organisations.
7 June 2018	Attended the Long Service Awards ceremony for volunteers.
11 June 2018	Met with the Chair from Tameside & Glossop Integrated Care NHS Foundation Trust together with a number of Non-Executive colleagues.
12 June 2018	Met with the Leader of Stockport Metropolitan Borough Council.
14 June 2018	Met with Mr D Dunn, Chair of Mid-Cheshire NHS Foundation Trust
18 June 2018	Chaired an extraordinary meeting o fthe Board of Directors.
18 June 2018	Attended a Leaders Summit for Stockport Providers.
19 June 2018	Attended the Junior Doctors' Forum
20 June 2018	Attended the Board Development session.
26 June 2018	Scheduled to undertake a Patient Safety Walk-around.

5. REGULATORY DEVELOPMENTS

5.1 A Enhanced Oversight meeting with NHS Improvement was held on 20 June 2018. Mr M Sugden, Deputy Chair, attended the meeting along with the Interim Chief Executive and Director of Finance. The Board will be briefed on outcomes on 28 June 2018.

6. FORWARD LOOK

6.1 A summit meeting to consider the report on outcomes from the CQC Local System Review is scheduled to be held on 28 June 2018 and we anticipate that the report will be published by the CQC following the summit meeting. The Interim Chief Executive will be representing the Trust at the summit meeting.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/06/18		**Report of:** Quality Committee
Date of last meeting: 19/06/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • CQC Plan Update • Quality Metrics • Discharge Summaries - Progress Report • Management Group Key Issues Reports • Clinical Governance Report • Corporate Risk Register
	Alert	• In considering the Key Issues Report from the Quality Governance Group (QGG), the Committee was alerted to the QGG's concerns relating to the level of assurance associated with compliance against NICE standards for Sepsis and Obesity. The Committee received assurance from the Medical Director that both subjects had been referred to the relevant management groups for further review prior to re-presentation to the QGG in September 2018. • The Committee reviewed a Key Issues Report from the Infection Prevention Group and noted concerns relating to the material condition of a number of ward kitchen areas. The Chief Nurse & Director of Quality Governance advised the Committee that the Director of Estates & Facilities had been commissioned to undertake a comprehensive survey and risk assessment of all ward kitchens. The Committee will be seeking assurance on actions to address outcomes from this survey.
	Assurance	• The Committee reviewed the CQC Action Plan and took positive assurance from the range of developments implemented for organisational development in relation to quality. These included implementation of a standard quality improvement methodology and enhanced medical leadership arrangements. With regard to progress against 'must do' and 'should do' recommendations, the Committee noted just 2 red-rated actions which related to A&E performance and timeliness of discharge summaries (see below). • The Committee received a verbal report from the Chief Operating Officer on progress with actions to improve Discharge Summary performance. The Committee noted a significant improvement against the 95% target, with a performance level of 89% in May 2018 compared to 85.3% in the previous month. Two Business Groups had achieved performance levels in excess of

		90% The Committee was advised that a further improvement is expected in June 2018 as a result of IT developments. The Committee will receive a formal report on this subject at its next meeting on 10 July 2018.		
	Advise	• The Committee considered its practice in reviewing Quality Metrics in the context of data availability. It was agreed that the Committee would undertake detailed consideration of metrics a month in arrears together with review of current information if available. • The Committee reviewed the Trust Risk Register and was satisfied that matters considered during the meeting were reflected in Register entries. The Committee plans to invite Business Group representatives to future meetings in order to seek assurance on the effectiveness of controls in place to mitigate Business Group-related risks. In addition, the Committee noted that, while much improved, further work is now required to refine risk register content.		
2.	Risks Identified	Nil		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Company Secretary

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 28/06/18		**Report of:** Finance & Performance Committee
Date of last meeting: 20/06/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Month 2 Finance Report • Month 2 Agency Utilisation Report • Operational Management Group (OMG) - Key Issues Report • Outpatient Waiting List (OWL) Report • CIP Progress Report • Medium Term Financial Strategy • Theatres & Endoscopy - CIP Presentation • Post-Implementation Benefits - Fluoroscopy Scanner • Capital Projects Development Group - Key Issues Report • Update on Emergency Department Capital Schemes • Greater Manchester Theme 3&4 - Update Report • Financial Risks • Policies for Approval
	Alert	• The Committee reviewed the Key Issues Report from the Operational Management Group and noted downturn in performance against the Cancer, RTT and Diagnostics standards. This deterioration in performance will be reflected in the Integrated Performance Report on 28 June 2018. In contrast, the improved performance against the A&E 4-hour standard in April 2018 continued in May 2018, and performance levels in both months were above the agreed improvement trajectory. • The Chief Operating Officer presented a report on Outpatient Waiting List (OWL) performance which detailed Improvement Schemes designed to improve performance in relevant specialties. The Committee endorsed the improvement trajectories, with the exception of those relating to Gastroenterology, Cardiology and Respiratory Medicine, and requested a follow-up report on actions relating to these specialties at the next meeting on 18 July 2018. • In reviewing a Key Issues Report from the Capital Projects Development Group, the Committee noted receipt of a draft Six-Facet Survey report which indicated a significantly increased backlog maintenance value. The Committee was alerted to the potential that outcomes may necessitate an amendment to the Estates & Facilities capital profile, and was advised that the outcomes from the Survey,

		and any associated implications, will be formally reported to the Board of Directors.		
	Assurance	• On the basis of the Month 2 Finance Report, the Committee can report a moderate level of assurance on overall delivery of the 2018/19 financial plan with a deficit position of £7.3m against a plan position of £7.4m as at 31 May 2018. The Committee noted risks relating to CIP delivery and potential winter plan expenditure which could impact the full year outturn position. • With regard to the above, the Committee reviewed the CIP Progress Report and noted a shortfall position of £0.2m against plan at Month 2. The Committee considered the current position and agreed to undertake a comprehensive review of CIP delivery, on the basis of the Quarter 1 position, at its next meeting on 18 July 2018. At present, the Committee has only limited assurance on delivery of the CIP programme. On a more positive note, the Committee took a degree of assurance from a presentation delivered by Mrs K Hatchell, Business Group Director, on the constituent elements of the Theatres & Endoscopy CIP work stream.		
	Advise	• The Committee considered an initial report which outlined the basis for development of a Medium Term Financial Strategy and Board members are advised that it is planned to develop the strategy document for consideration and approval by the Board on 26 July 2018. This subject is scheduled for discussion during the Board strategy session on 28 June 2018. • The Committee considered the outcomes of a Post-Implementation review relating to the procurement and installation of a Fluoroscopy Scanner and noted a positive approach to the identification of 'learning points' to inform the approach to future projects. • The Committee reviewed the high-level finance and performance-related risks in the Trust Risk Register and cross-referred matters discussed during the meeting with Register content. The Committee recommended that a risk assessment on outcomes of the Six-Facet Survey be completed.		
2.	Risks Identified	• Delivery of the cost improvement programme • Six-Facet Survey outcomes • Patient experience in relation to OWL performance		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Company Secretary

Board of Directors' Key Issues Report

Stockport NHS Foundation Trust

Report Date: 28/06/18		**Report of:** People Performance Committee
Date of last meeting: 21/06/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Update on Staff Survey 2017Outcomes • Agenda for Change Pay Deal • Culture Plan • Leadership & Development Plan – measuring the impact • Friends & Family Test • Trade Union (Facility Time Publication Requirements) Regulations 2017 • Workforce Flash Report • Month 2 Agency Utilisation Report • HEE NW Update Report • Critical Incident Report • Trust Risk Register • Key Issues Reports : - JLNC - Culture & Engagement Group - WEG • Policies for Validation: - Partnership Agreement.
	Alert	• The Head of Learning & OD presented reports to the Committee on the outcomes of the Staff Survey and the Friends & Family Test and delivered a presentation on the Culture Plan. In considering the reports and the presentation, the Committee was alerted to concerning issues regarding Culture and Engagement. Given the impact this was having on the organisation, the Interim Director of Workforce agreed to consider the format and frequency of reporting to the Committee on Culture and Engagement. • In reviewing the Workforce Efficiency Group Key Issues Report, the Committee was advised that as at Month 2, Workforce had delivered £57.2k against a £3million Cost Improvement Programme target. It was also noted that non-recurrent vacancy factor no longer formed part of the Workforce savings and that further opportunities were being scoped to mitigate the risk, which was circa £1.2million. The Deputy Director of Workforce briefed the Committee on mitigating actions in this area and advised that update reports would be presented to the Workforce Efficiency Group and the Financial Improvement Group.

	Assurance	• The Committee noted a reduction in agency expenditure in month and was advised that the main area of reduction had been achieved at middle grade level in the Medicine and Clinical Support business group. The Committee also received assurance that the national visa issue had been resolved, although it was noted that that the impact of the issue would still remain evident for some time. • The Committee took positive assurance from a Workforce Flash Results report and noted good progress made with regard to Workforce key performance indicators. • The Committee considered a Critical Incidents Feedback Data Report and noted that one of the recommendations following the HEE NW / GMC Enhanced Monitoring Visits in 2016 and 2017 had been for the Trust to ensure that all medical staff received feedback following Datix submission, for incidents they were either involved or named in. The Committee noted positive assurance for developments in this area.
	Advise	• The Committee considered a report regarding a proposed pay deal for Agenda for Change staff. It was noted that the staff side of the NHS Staff Council had decided to accept the proposed deal and the formal ratification of the deal by the full NHS Staff Council would take place on 27 June 2018. The Committee was advised that in the new deal, starting salaries would increase across all pay bands and there were fewer pay points in the structure and a new system for pay progression. It was noted that staff would be paid the new rates of pay in July 2018, with backdated pay (to 1 April 2018) to be paid in either July or August 2018, subject to local payroll processes. • In reviewing the Agency report, the Committee was advised that a change in reporting across all NHS providers meant that all bank and agency shifts paid above £100 per hour required approval by the Chief Executive and reporting to NHS Improvement. In addition, any agency shifts that were 50% over the agency cap would require ECP approval. The Committee consequently approved a proposal to change the standard consultant rate from £100 to £99.50 per hour for any additional bank hours worked. • The Committee considered a report regarding Trade Union (Facility Time Publication Requirements) Regulations 2017 and approved the publication of the relevant information with regard to Trade Union facility time. • In reviewing the HEE NW Update Report, the Committee was advised that there would be either an Enhanced Monitoring Visit or a further Round Table discussion with the Trust on 4 October 2018. The Committee noted that the format of the day would depend on the results of a GMC trainee survey due to be published at the end of June 2018. The Committee was advised that the Trust was expected to produce a plan by September 2018, and noted the challenge with regard to the short timescale. • In reviewing the Workforce Efficiency Group (WEG) Key Issues Report, the Committee was advised that a key issues report from the temporary nursing staffing meeting had alerted WEG to an issue that the Primary Care Referral Unit was still open, which was classed as escalation beds. It was noted that the Chief Operating Officer would review this issue further.

2.	Risks Identified	• Culture & Engagement • Workforce Cost Improvement Programme		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

This page has been left blank

Report To:	Board of Directors	**Date:**	28 Jun 2018
Subject:	Integrated Performance Report		
Report of:	Deputy Chief Executive	**Prepared by:**	B.I. & Performance Teams

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:	Regulation, 10, 12, 17 & 18
Equality Impact Assessment:	☐ Completed ☑ Not Required

Summary of Report

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

Attachments:

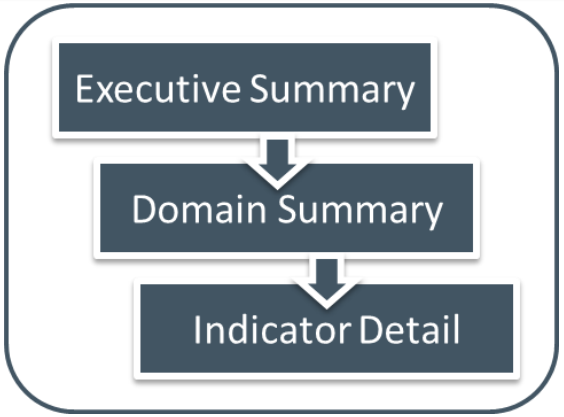
This subject has previously been reported to:	☐ Board of Directors	☐ SD Committee
	☐ Council of Governor	☐ Charitable Funds Committee
	☐ Audit Committee	☐ Nominations Committee
	☐ Executive Team	☐ Remuneration Committee
	☐ Quality Assurance Committee	☐ Joint Negotiating Council
	☐ F&P Committee	☐ Other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

Introduction

The Board report layout consists of three sections:

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

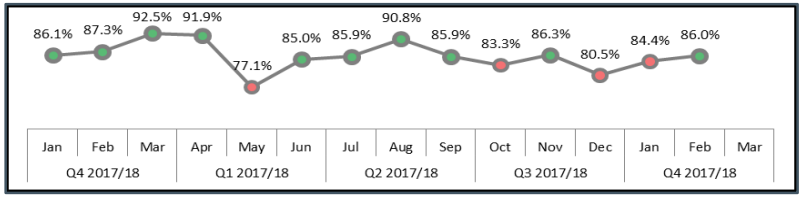
Domain Summary: Provides a summary of indicator level performance, arranged by Care Quality theme. For each indicator, performance against target is shown at both Trust and Business Group level, where applicable. Page numbers on this level of the report will advise on which page of the report the detailed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



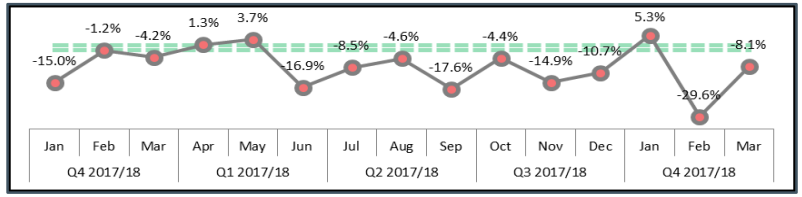
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

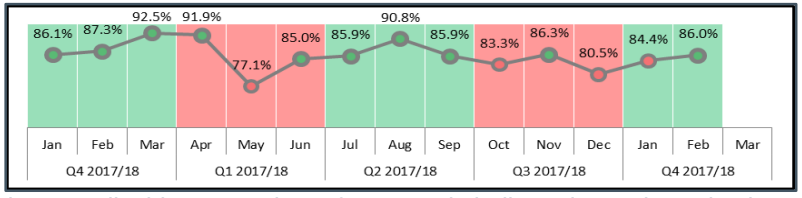
The following chart types are in use throughout the report:



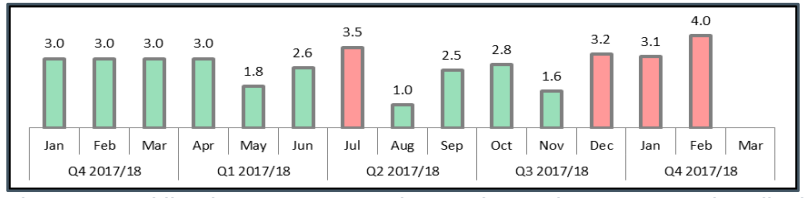
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



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



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

Executive Summary

Stockport NHS Foundation Trust

Key Changes to the indicators in this period are:

Safe:
Pressure ulcer reporting has increased in line with expectations as awareness is raised amongst teams

Effective:
The emergency c-section rate has increased in month triggering a review.

Caring:
There has been a slight improvement in 45 day reponse rate to complaints

Responsive:
A&E performance has improved.

Diagnostic and Cancer 62 day performance has deteriorated in month.

Efficient:
Safer staffing 91.2% at day time for RNs and 94.2% on night duty - both are very slight decreases from previous month.

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Apr-18		7.57							7.57		34
C.Diff Infection Count (lapses in care)	CN&DQG	Apr-18	<=1 *	0							0		34
MRSA Infection Rate	CN&DQG	Apr-18		0.89							0.89		35
MSSA Infection Rate	CN&DQG	Apr-18		8.90							8.90		35
E.Coli Infection Rate	CN&DQG	Apr-18		20.03							20.03		36
E.Coli Infection Count	CN&DQG	Apr-18	<=3 *	1							1		36
Falls: Total Incidence of Inpatient Falls	CN&DQG	May-18	<=229 *	117							242		37
Falls: Causing Moderate Harm and Above	CN&DQG	May-18	<=30 *	0							1		37
Pressure Ulcers: Hospital, Stage 2	CN&DQG	Apr-18	<=3 *	9							9		38
Pressure Ulcers: Hospital, Stage 3	CN&DQG	Apr-18	<=1 *	2							2		38
Pressure Ulcers: Hospital, Stage 4	CN&DQG	Apr-18	<=0 *	1							1		39
Pressure Ulcers: Community, Stage 2	CN&DQG	Apr-18	<=8 *	21							21		39
Pressure Ulcers: Community, Stage 3	CN&DQG	Apr-18	<=3 *	3							3		40

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Stage 4	CN&DQG	Apr-18	*<=0 **	1							1		40
Safety Thermometer: Hospital	CN&DQG	May-18	*>= 95%*	94.3%							94.8%		41
Medication Errors: Overall	CN&DQG	May-18		98							162		41
Medication Errors: Moderate Harm and Above	CN&DQG	May-18		5.1%							4.3%		42
VTE Risk Assessment	CN&DQG	May-18	*>= 95%*	96.1%							96.5%		42
Clinical Correspondence	COO	May-18	*>= 95%*	67.6%							69.6%		43
Flu Vacination Uptake	DoW&OD	Mar-18	*>= 70%*	78.6%							71.1%		43
Discharge Summaries	MD	May-18	*>= 95%*	89.0%							87.2%		44

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	May-18		48.34									20
Emergency C-Section Rate	CN&DQG	May-18	<= 15.4%	22.8%							19.8%		21
Never Event: Incidence	CN&DQG	May-18	<= 0	0							0		21
Duty of Candour Breaches	CN&DQG	May-18		0							0		22
Stranded Patients	COO	May-18	<= 35%	42.2%							44.6%		22
Delayed Transfers of Care (DTOC)	COO	May-18	<= 3.3%	1.9%							2.0%		23
Medical Optimised Awaiting Transfer (MOAT)	COO	May-18	<= 40	93							203		23
Bank & Agency Costs	DoW&OD	May-18	<= 5%	10.5%							10.9%		24
Mortality: HSMR	MD	Mar-18	<= 100	98.78									24
Mortality: SHMI	MD	Nov-17	<= 1	0.95									25
Mortality: Deaths in ED or as Inpatient	MD	May-18		112							219		25
Mortality: Case Note Reviews	MD	May-18		30							63		26
Emergency Readmission Rate	MD	Feb-18	<= 7.9%	8.4%							8.6%		26

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Patient Safety Alerts: Completion	CN&DQG	May-18	>= 100%	50.0%							71.4%		12
DSSA (mixed sex)	CN&DQG	May-18	<= 0	0							0		12
Complaints Rate	CN&DQG	May-18		0.9%							0.9%		13
Complaints: Response Rate 25	CN&DQG	May-18		0.0%							1.2%		13
Complaints: Response Rate 45	CN&DQG	May-18		45.2%							20.0%		14
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	May-18		4							4		14
Complaints Closed: Overall	CN&DQG	May-18		31							85		15
Complaints Closed: Upheld	CN&DQG	May-18		13							22		15
Complaints Closed: Partially Upheld	CN&DQG	May-18		10							35		16
Complaints Closed: Not Upheld	CN&DQG	May-18		8							28		16
Compliments	CN&DQG	May-18		5							7		17
Friends & Family Test: Response Rate	CN&DQG	May-18		25.8%							27.0%		17
Friends & Family Test: Inpatient	CN&DQG	May-18		94.3%							94.7%		18

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: A&E	CN&DQG	May-18		90.0%		→					90.0%	Δ	18
Friends & Family Test: Maternity	CN&DQG	May-18		98.0%		↑					97.3%	Δ	19
Staff Friends & Family Test	CN&DQG	Mar-18		73.7%		↓					76.4%		19
Diabetes Reviews	MD	May-18	>= 90%	73.0%		↑					71.4%	Δ	20

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Apr-18	>= 90%	99.4%							99.4%		27
Dementia: Assessment	CN&DQG	Apr-18	>= 90%	100.0%							100.0%		27
Dementia: Referral	CN&DQG	Apr-18	>= 90%	100.0%							100.0%		28
Serious Incidents: STEIS Reportable	CN&DQG	May-18		12							18		28
Litigation: Claims	CN&DQG	May-18		5							10		29
Litigation: Key Risk Claims Rate	CN&DQG	May-18		100.0%							100.0%		29
A&E: 4hr Standard	COO	May-18	>= 95%	88.5%							84.5%		30
A&E: 12hr Trolley Wait	COO	May-18	<= 0	0							7		30
Cancer: 62 Day Standard	COO	May-18	>= 85%	76.4%							82.6%		31
Referral to Treatment: Incomplete Pathways	COO	May-18	>= 92%	87.9%							87.8%		31
Diagnostics: 6 Week Standard	COO	May-18	>= 99%	98.7%							99.0%		32
Outpatient Activity vs. Plan	COO	May-18	<= 1%	-0.5%							-0.5%		32
Elective Activity vs. Plan	COO	May-18	+/- 1%	-4.7%							-4.7%		33

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Financial Efficiency: I&E Margin	DoF	May-18	<= 2	4							8		44
Financial Controls: I&E Position	DoF	May-18	<= 1%	-1.6%							-1.6%		45
Cash	DoF	May-18	+/- 1%	0.0%									45
Financial Use of Resources	DoF	May-18	<= 3	3							6		46
CIP Cumulative Achievement	DoF	May-18	+/- 1%	-17.9%							-17.9%		46
Capital Expenditure	DoF	May-18	+/- 10%	-5.3%							-5.3%		47
Financial Sustainability	DoF	May-18	<= 2	4							8		47
Sickness Absence Rate	DoW&OD	May-18	<= 3.5%	3.9%							4.0%		48
Appraisal Rate: Non-medical	DoW&OD	May-18	>= 95%	95.0%							95.1%		48
Appraisal Rate: Medical	DoW&OD	May-18	>= 95%	97.3%							97.2%		49
Statutory & Mandatory Training	DoW&OD	May-18	>= 90%	91.8%							91.6%		49
Workforce Turnover	DoW&OD	May-18	<= 13.94%	13.8%									50
Staff in Post	DoW&OD	May-18	>= 90%	89.8%							89.8%		50

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

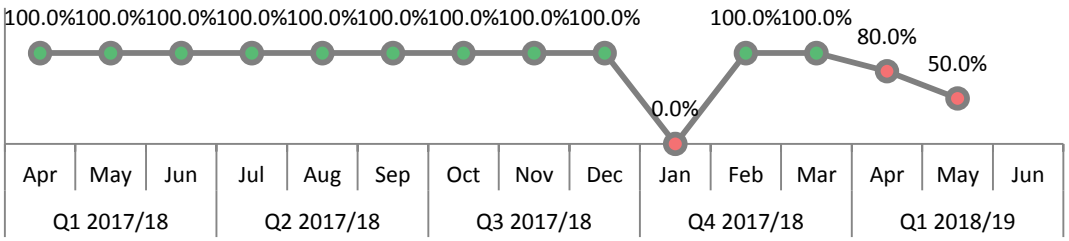
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	May-18	<= 0	977							1760		51
Agency Spend: Distance From Ceiling	DoW&OD	May-18	<= 3%	9.0%							9.0%		51

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Indicator Detail

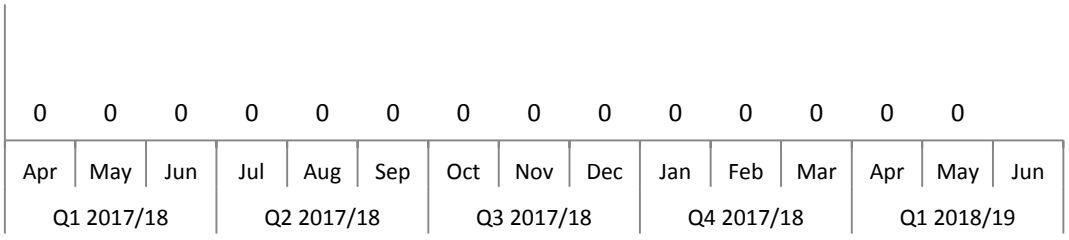
May-18	Patient Safety Alerts: Completion
50.0%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	In May 2018, there were 2 safety alerts that were due to be closed with all actions taken. One alert was not closed within agreed timescales/
>= 100%	



Actions

The delay in closing one alert has been investigated and has resulted in a review of the process within the team.

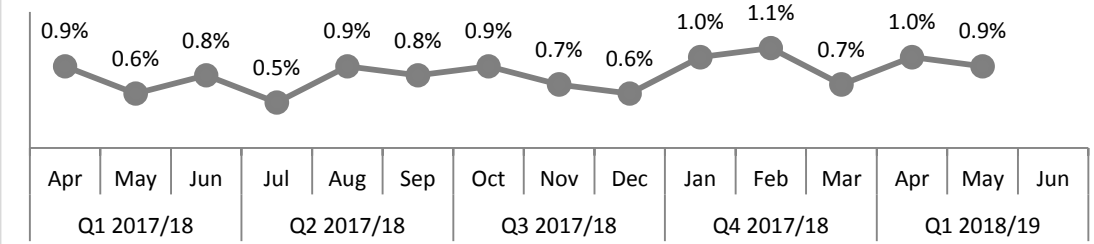
May-18	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	There were no mixed sex accommodation breaches in the month of May.
<= 0	



Actions

Indicator Detail

May-18	Complaints Rate
0.9%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	Whilst there is no National target, it is the Trusts' ambition to remain under 1.5%. 42 complaints were received in May (Integrated Care 12; Medicine & CS = 10; Surgery, I & CC = 12; Women, Children & Diagnostics = 8).



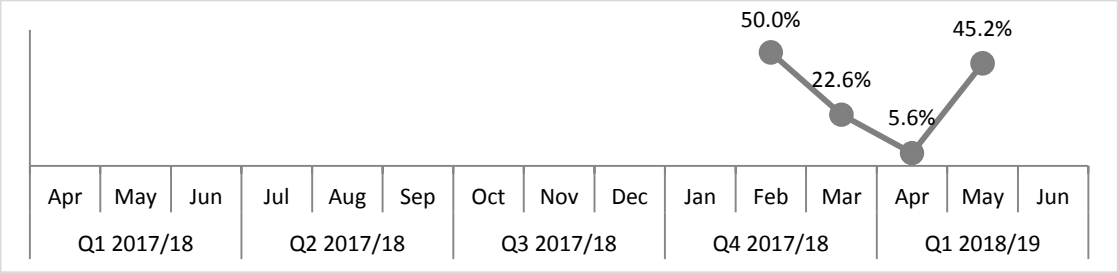
Actions
The new complaints process includes identification of themes and trends that will result in resolution to concerns raised, with the overall outcome of maintaining the complaint rate under 1.5%.

May-18	Complaints: Response Rate 25
0.0%	The percentage of formal complaints responded to within 25 days.
Target	Following discussions with our commissioners, there has been an agreement to change the timescales of formal complaints being handled within 25 days to 45 days. Data relates to the month the complaint was closed.

Actions
All Business Groups are being supported by the Governance and Corporate teams to ensure the in-depth investigations that they carry out are undertaken within agreed timescales. In the month of My 2018 0 complaints were closed within 25 days of receipt.

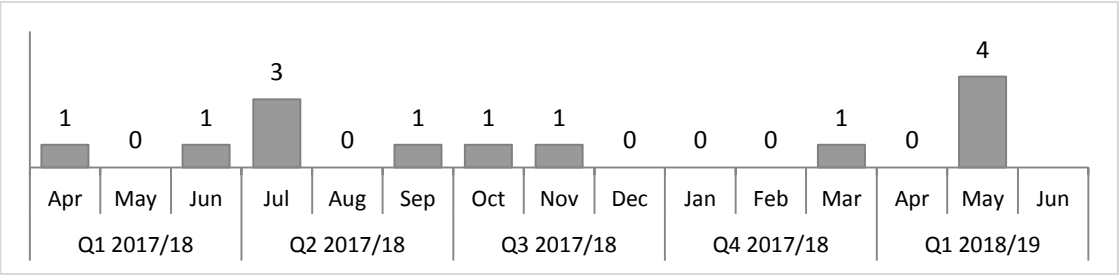
Indicator Detail

May-18	Complaints: Response Rate 45
45.2%	The percentage of formal complaints responded to within 45 days.
Target	Following discussions with our commissioners, there has been an agreement to change the timescales of formal complaints being handled within 25 days to 45 days. The data relates to the month the complaint was closed.



Actions
A trajectory for achieving compliance with the 45 day response target is in place. Business Groups are being supported to achieve this. In May 2018 14 complaints were closed Integrated Care = 3; Surgery, GI & CC = 4 Women, Children and Diagnostics = 7 Medicine & Clinical Support = 0

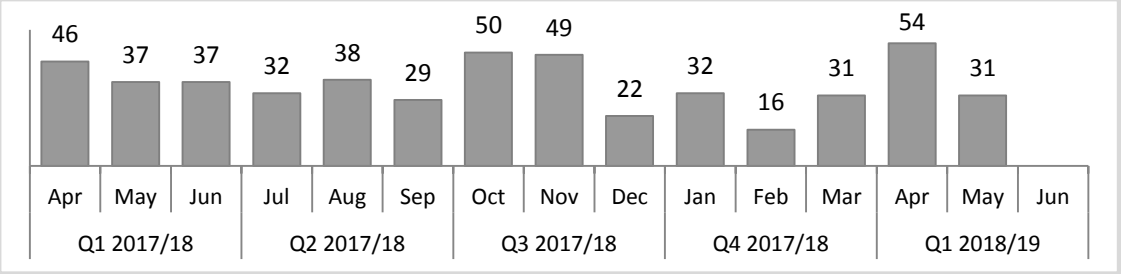
May-18	Complaints: Parliamentary & Health Service Ombudsman Cases
4	The total number of open Ombudsman cases.
Target	If a complainant remains dissatisfied with the handling of the complaint by the Trust, they can ask the Parliamentary and Health Service Ombudsman (PHSO) to review the case. The PHSO may investigate a complaint where, for example, a complaint is not satisfied with the result of the Trust investigation or that they believe their concerns have not been resolved.



Actions
The four cases received are being reviewed by the appropriate Business Group.

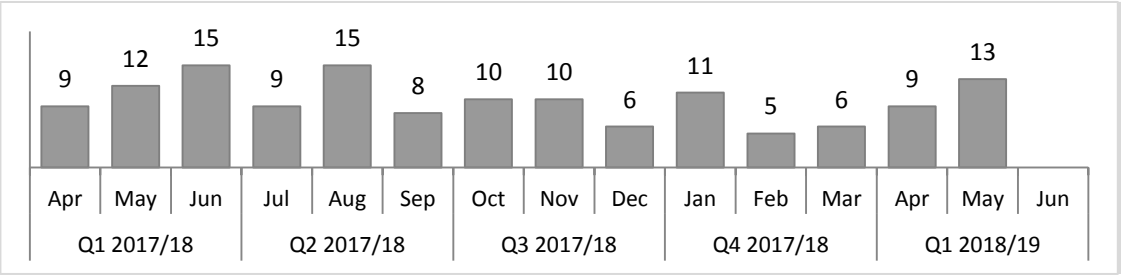
Indicator Detail

May-18	Complaints Closed: Overall
31	The total number of formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed. In May 2018 31 complaints in total were closed.



Actions
The complaints closed by Business Group were as follows: Integrated Care = 9 Medicine & Clinical Support = 2 Surgery, GI & CC = 9 Women, Children & Diagnostics = 11

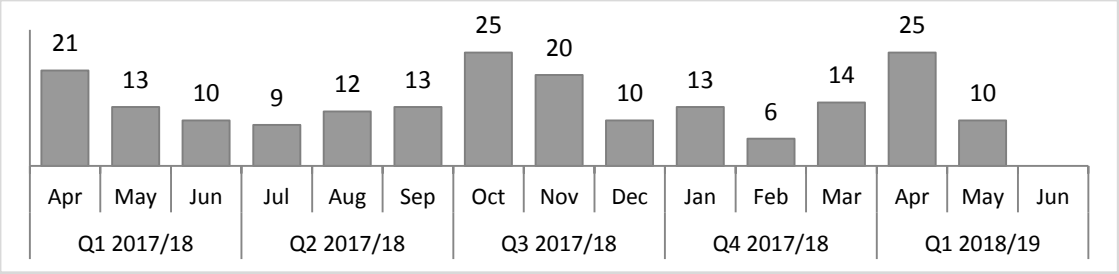
May-18	Complaints Closed: Upheld
13	The total number of upheld formal complaints that have been closed.
Target	If a complaint is received which relates to specific issues, and substantive evidence is found to support all the concerns made, the complaint is recorded as 'upheld'.



Actions
In May the Trust reported 13 complaints upheld. The number of upheld complaints closed by Business Group were as follows: Integrated Care = 4 Medicine & Clinical Support = 1 Surgery, GI & CC = 2 Women, Children & Diagnostics = 6

Indicator Detail

May-18	Complaints Closed: Partially Upheld
10	The total number of partially upheld formal complaints that have been closed.
Target	If a complaint is made regarding more than one issue, and one or more of these issues are upheld, the complaint is recorded as 'partially upheld'.

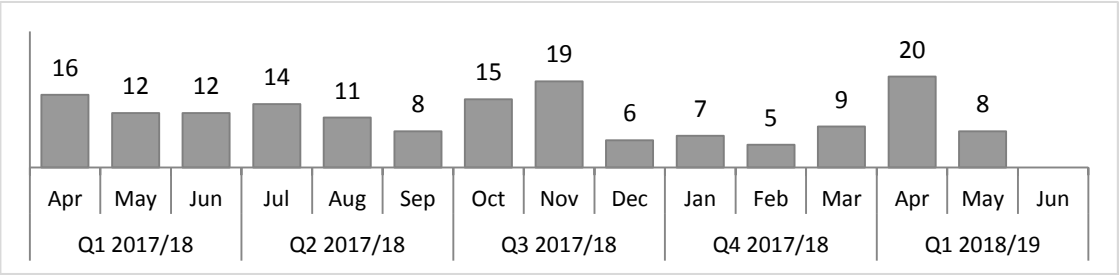


Actions

In May the Trust reported 10 complaints partially upheld.

The number of upheld complaints closed by Business Group were as follows:
Integrated Care = 3
Medicine & Clinical Support = 0
Surgery, GI & CC = 4
Women, Children & Diagnostics = 3

May-18	Complaints Closed: Not Upheld
8	The total number of not upheld formal complaints that have been closed.
Target	Where there is no evidence to support any of the concerns raised, the complaint is recorded as 'not upheld'.



Actions

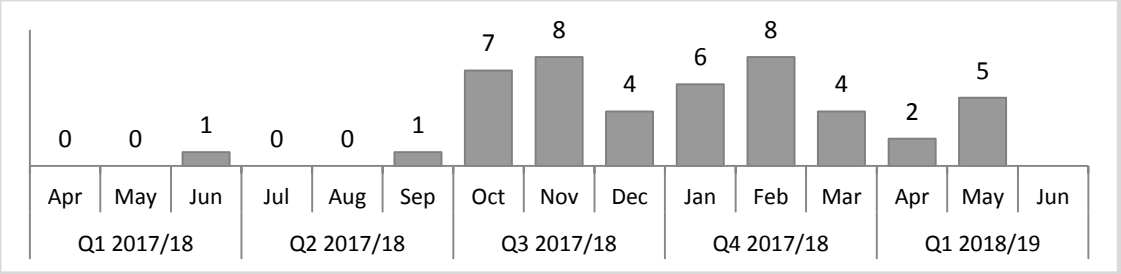
In May the Trust reported 8 complaints not upheld.

The number of upheld complaints closed by Business Group were as follows:
Integrated Care = 2
Medicine & Clinical Support = 1
Surgery, GI & CC = 3
Women, Children & Diagnostics = 2

Indicator Detail

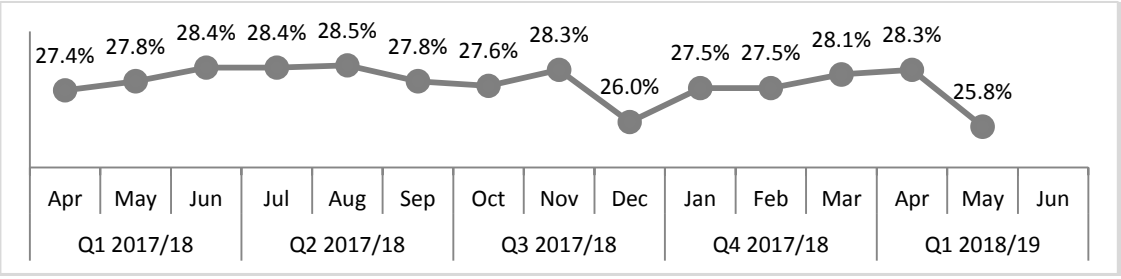
May-18	Compliments
5	Total number of compliments received.
Target	It is important that the Trust has a process to formally record compliments. Not only does this provide feedback to individual staff about the positive impact their care and treatment had, it also allows best practice to be shared widely. In May 1 compliment was received for Integrated Care and 4 for Surgery, GI & CC.

Actions
A process for managing the receipt of compliments is being devised to ensure consistent capture and reporting of compliments across all Business Groups. Ward managers are being asked to collate the compliments received on a monthly basis and this will be reported to the patient experience team.



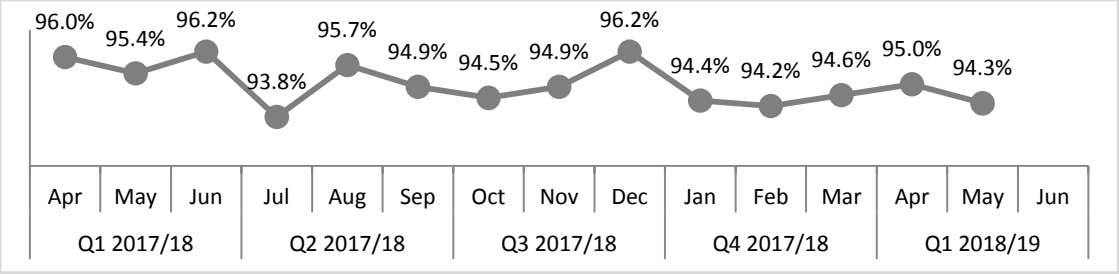
May-18	Friends & Family Test: Response Rate
25.8%	The percentage of eligible patients completing an FFT survey.
Target	The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to provide views after receiving care or treatment across the NHS.

Actions
The importance of feedback from patients and relatives is crucial to supporting the quality improvement plan for the organisation. The Patient Experience Strategy is in development and will outline the key areas of focus in line with the objectives of the quality improvement plan.



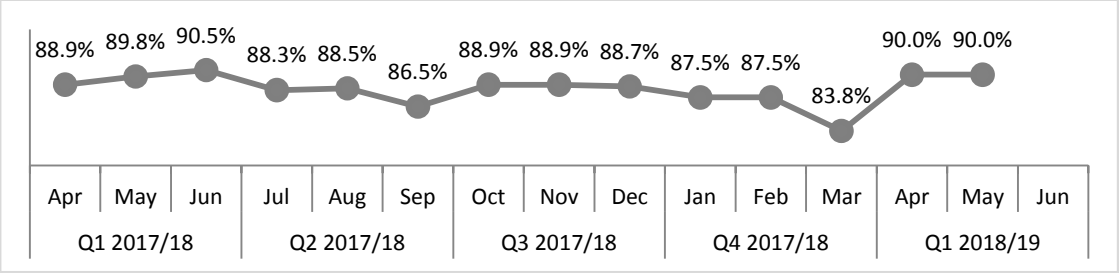
Indicator Detail

May-18	Friends & Family Test: Inpatient
94.3%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments received for inpatient areas were related to kind, friendly, professional staff. Negative comments continue to relate to the lack of nursing staff, cleanliness in some areas and communication.



Actions
We ensure feedback is provided to the teams involved in providing care. In June 2018 we are launching our new Patient Safety and Quality Boards across clinical areas where FFT information will be displayed. Further work is underway to ensure the Trust can triangulate FFT with other key experience indicators.

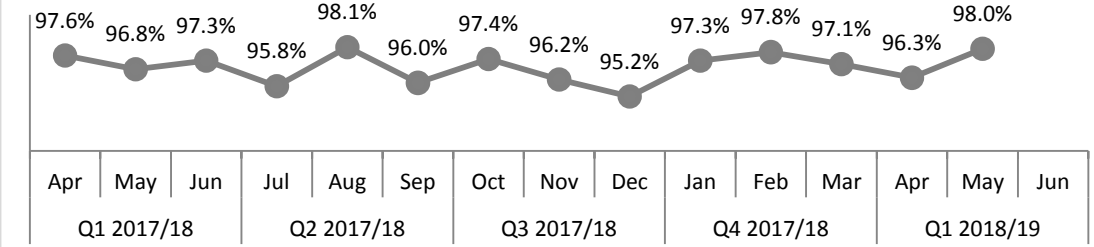
May-18	Friends & Family Test: A&E
90.0%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments related to caring staff working extremely hard under challenging circumstances. Many positive comments related to friendly, cheerful staff. Negative comments continue to relate to long waiting times.



Actions
Ensure the positive feedback is received to the teams involved in providing care. The Trust has developed a work-stream as part of the Urgent & Emergency Care improvement programme, we expect to see an improvement in patient experience as a result.

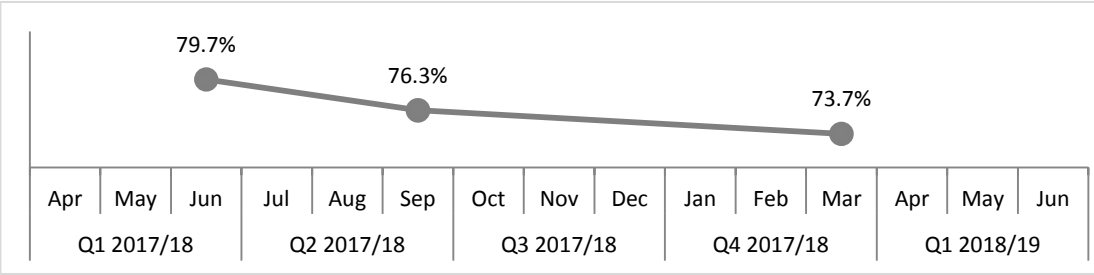
Indicator Detail

May-18	Friends & Family Test: Maternity
98.0%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	All comments continue to be positive and continue to be related to caring and compassionate staff. Many positive comments were made about the excellent advice and support given in relation to breastfeeding.



Actions
We ensure feedback is provided to the teams involved in providing care. In June 2018 we are launching our new Patient Safety and Quality Boards across clinical areas where FFT information will be displayed. Further work is underway to ensure the Trust can triangulate FFT with other key experience indicators.

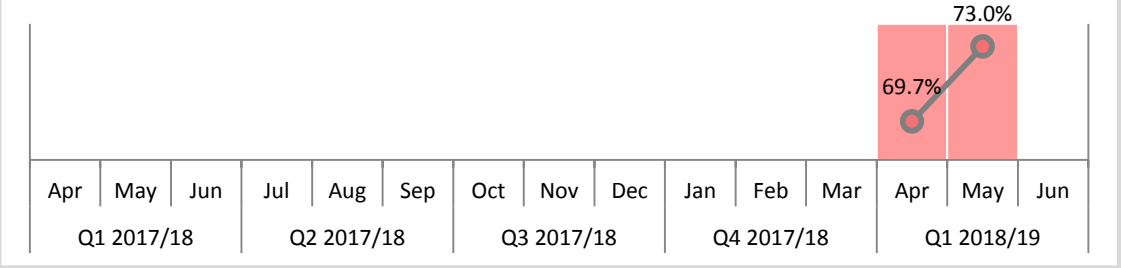
Mar-18	Staff Friends & Family Test
73.7%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The survey is undertaken on a quarterly basis.



Actions

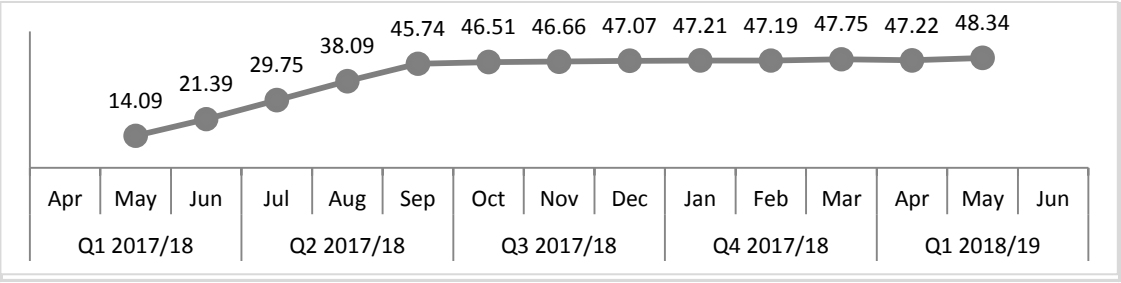
Indicator Detail

May-18	Diabetes Reviews
73.0%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	This is a new metric since last month. The trajectory is in the right direction, but we are not meeting the stretch target set for our diabetes team. Review of clinically significant hypoglycemia events by the diabetes team is an important metric, and we will continue to track progress and ensure robust data collection.
>= 90%	



Actions
While we will continue to strive for efficient review of all such clinical events, we will also focus on effective recording of these reviews to ensure a fair appraisal of the service delivered can be given using this metric.

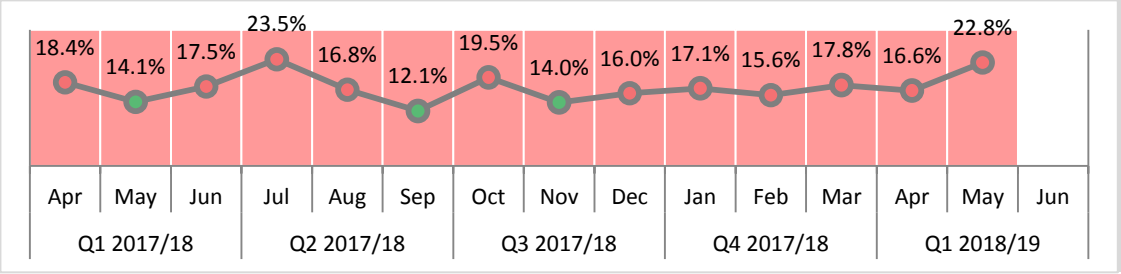
May-18	Patient Safety Incident Rate
48.34	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	There have been 994 patient safety incidents reported in May. The Top 3 incidents are: Pressure ulcers In-patients falls Medication incidents



Actions
There are Safety Collaboratives in place for: Pressure Ulcer Reduction Patient Falls Reduction In relation to medication incidents, these are reviewed at the Medicines Optimisation Group and work is underway to consider the development of a Medicines Safety Nurse and to introduce more electronic pumps to deliver intravenous medications.

Indicator Detail

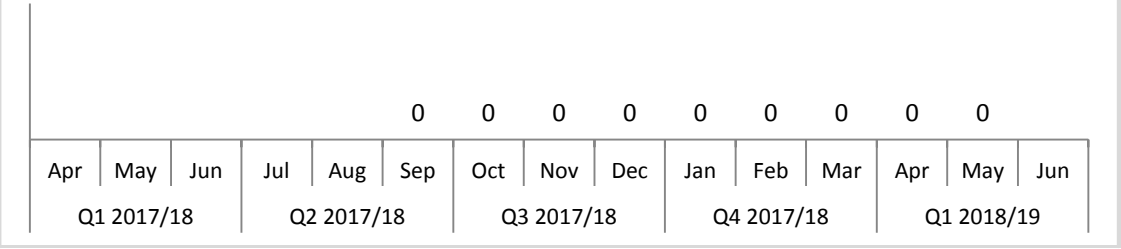
May-18	Emergency C-Section Rate
22.8%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	The Emergency C-section rate has increased again this month.
<= 15.4%	



Actions

Following the recent months increase in the Emergency C-Section rate,the team have identified a Professional lead to undertake a review. The outcomes will be reported back in 2 months time.

May-18	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There were no never events reported in May 2018.
<= 0	



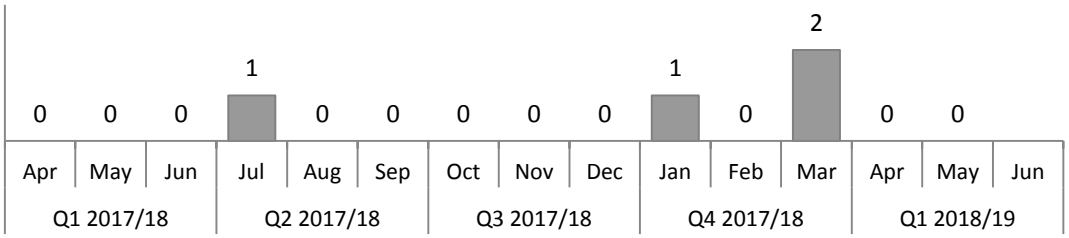
Actions

Incidents are reviewed in the business groups, with scrutiny and oversight provided by the weekly Patient Safety Summit.

The Never Event list has been circulated and can be accessed via the intranet.

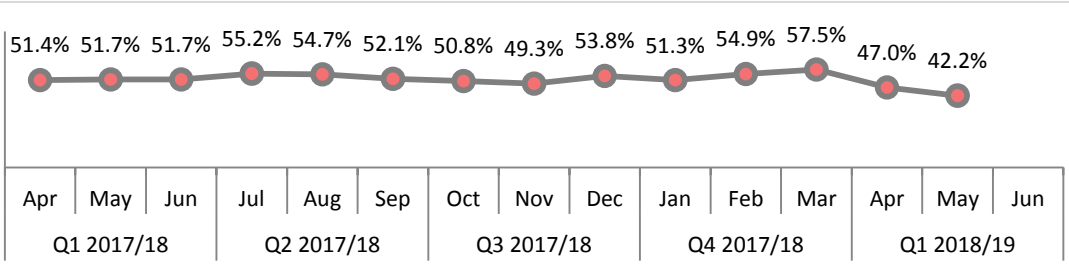
Indicator Detail

May-18	Duty of Candour Breaches
0	Total number of Duty of Candour breaches in month.
Target	In May 2018, 11 incidents required Duty of Candour to be open. This has been completed by the Business Groups.



Actions
Business Groups have been reminded about the timeliness of opening Duty of Candour following the identification of an incident where severe harm has been caused. Business Groups have been requested to record Duty of Candour in the Datix system accurately to support reporting.

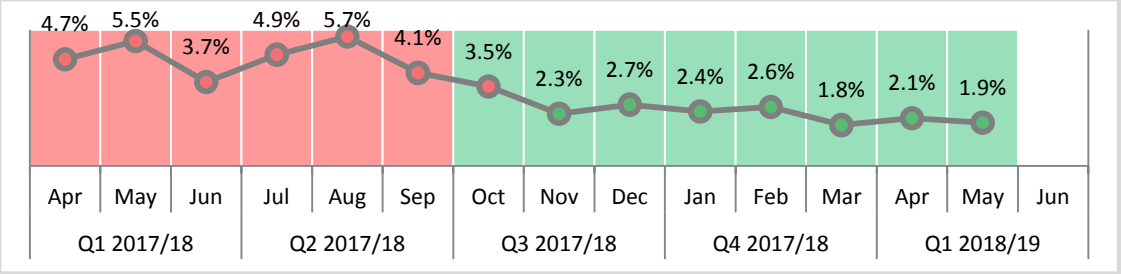
May-18	Stranded Patients
42.2%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	Performance against this standard continues to improve month on month.
<= 35%	



Actions
- Weekly Business Group level reviews led by the Triumvirate teams have been introduced to ensure all patients with a Length of Stay greater than 7 days are scrutinised and to ensure a plan is in place. - Key themes and patients requiring escalation are captured during the Business Group reviews and escalated to a System Senior Leaders group on a weekly basis for further attention and discussion. - A suite of metrics is in development, including the use of benchmark data to compare our progress with peers across Greater Manchester.

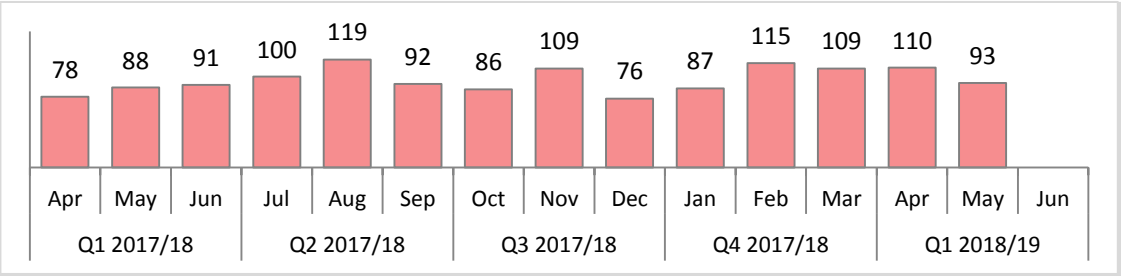
Indicator Detail

May-18	Delayed Transfers of Care (DTOC)
1.9%	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	Performance against this standard continues to achieve, and shows further improvement in month.
<= 3.3%	



Actions
- The Integrated Transfer Team (ITT) continue to focus on minimising the number of Delayed Transfers by adopting the "Activation" approach, bringing together senior leaders from across the Stockport System to expedite any actions or overcome any potential blockages to discharge. - The ITT are working to make stronger links with neighbouring boroughs and providers to ensure delays with transfer of patients out of the area are minimised.

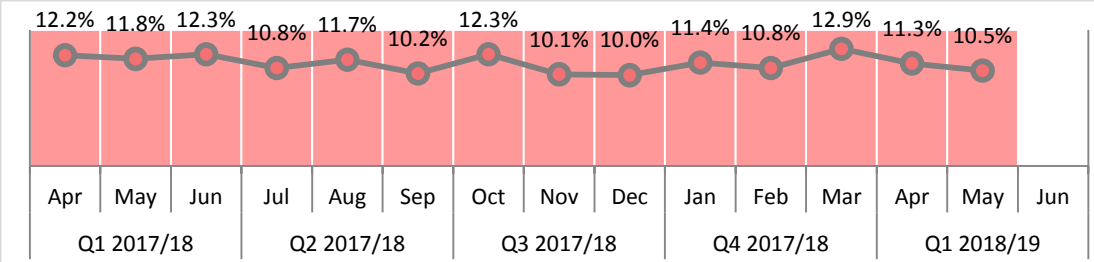
May-18	Medical Optimised Awaiting Transfer (MOAT)
93	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	Performance against standard continues to improve, but remains distant from the target level.
<= 40	



Actions
- Patients classified as Medically Optimised Awaiting Transfer (MOAT) are included in the Stranded Patient reviews, so as a result are subject to the same level of scrutiny. - In addition, MOAT patients are managed on a case by case basis by the Integrated Transfer Team to ensure timeliness of discharge. - Plans to develop an off site Transfer to Assess Unit and the implementation of the integrated community Stroke service will reduce the number of medically optimised patients in acute beds on the Stepping Hill Hospital site - circa 32 beds by the end of Q3

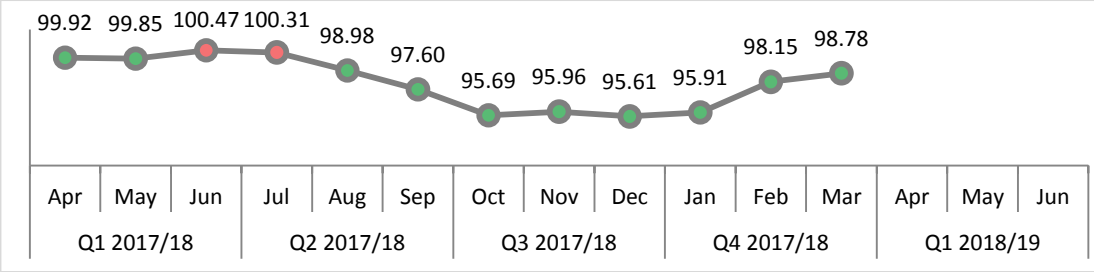
Indicator Detail

May-18	Bank & Agency Costs
10.5%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in May 2018 account for 10.52% (£2.024M) of the £19.239M total pay costs. This is a £0.64M decrease from the position reported in April 2018 (£2.088M).
<= 5%	



Actions
Continue to progress the following actions: Substantive recruitment from within the UK targeted at newly qualified professional groups and International recruitment to source professionals with appropriate qualifications to attract registration with an enhanced induction. This route has been restricted due to the national visa issues. Development and growth of the nursing and medical bank to better use a more affordable, flexible workforce rather than rely on the agency workforce at much more premium rates. Medical bank expansion continues with over 40% of the flexible workforce now engaged on the bank. Increased booking and approval controls to ensure that agency staff are only brought in when truly needed. Further revisions will be necessary in light of approval changes communicated by NHSI.

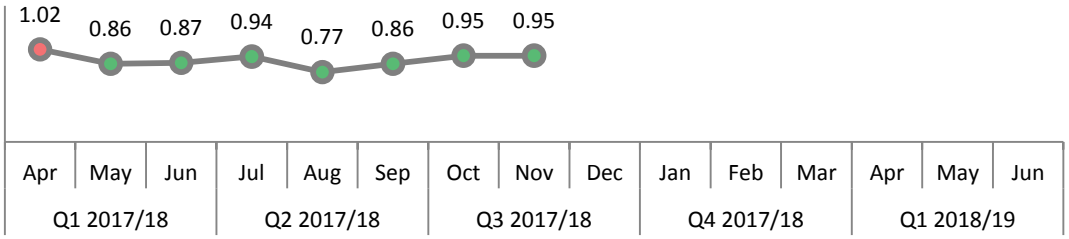
Mar-18	Mortality: HSMR
98.78	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	HSMR is adversely affected by our low palliative care coding rate. We have made a commitment to invest in our palliative care service, which should see the rate of coded palliative care interventions increase, with an improvement in HSMR.
<= 100	



Actions
Progress the palliative care recruitment.

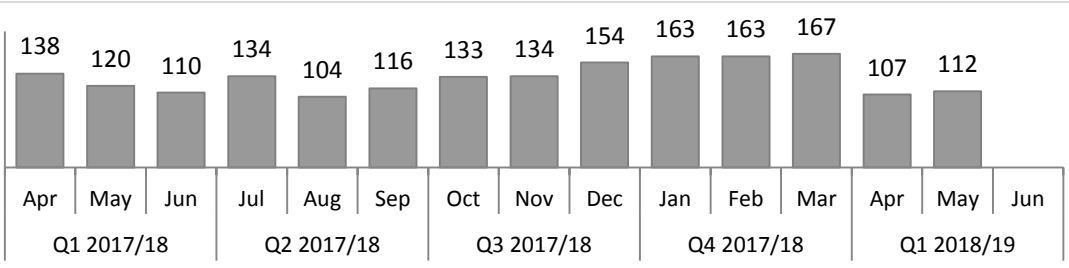
Indicator Detail

Nov-17	Mortality: SHMI
0.95	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	SHMI remains better than average, and the second best in the region.
<= 1	



Actions
Monitor specific areas of high mortality using CHKS case specific data.

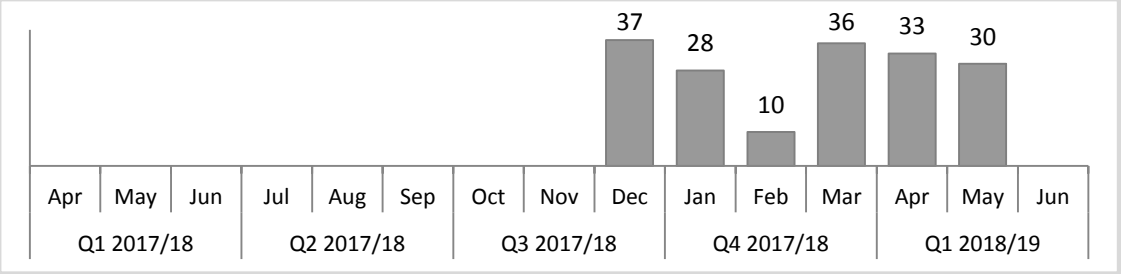
May-18	Mortality: Deaths in ED or as Inpatient
112	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	A similar trend in the number of deaths in May is reflected in last year's figures.



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

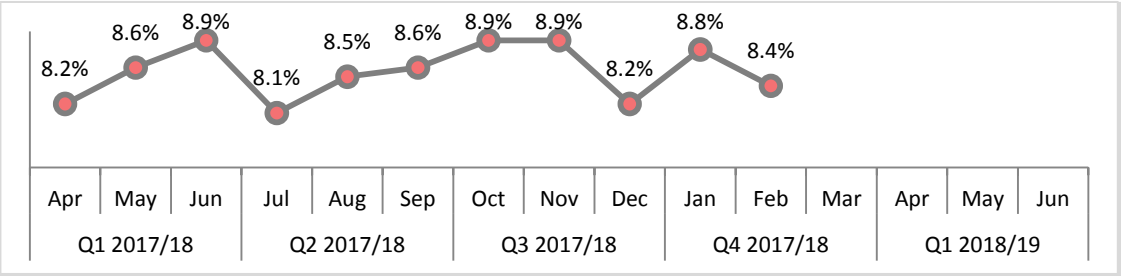
Indicator Detail

May-18	Mortality: Case Note Reviews
30	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	In May 30 case note reviews were undertaken. This is slightly below the 30% target that we aspired to achieve by the end of this year. Since December there have been two serious incident investigations triggered for potentially avoidable deaths identified at LFD review.



Actions
Not all surgical reviews are included in this figure. This will be rectified in next month's figures. Process improvements to assist our reviewers in accessing patient records will also improve the time actually spent reviewing records.

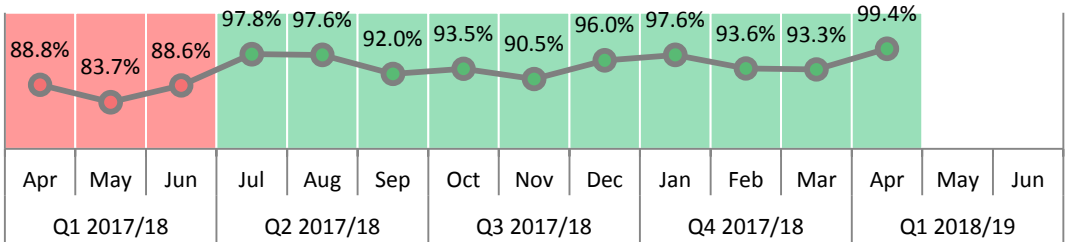
Feb-18	Emergency Readmission Rate
8.4%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	Static picture, which should be improved by the investment in crisis response and Stockport Neighbourhood integration.
<= 7.9%	



Actions

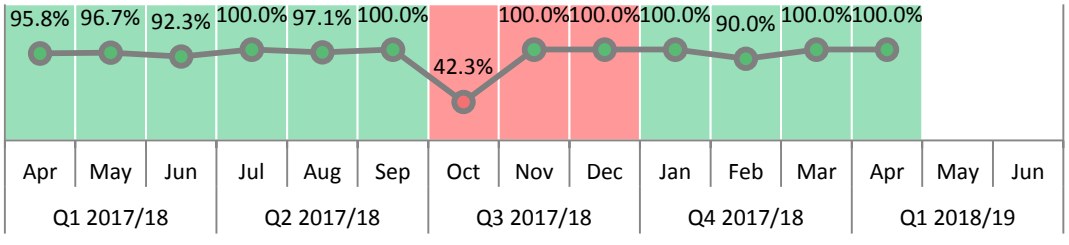
Indicator Detail

Apr-18	Dementia: Finding Question
99.4%	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 action required.

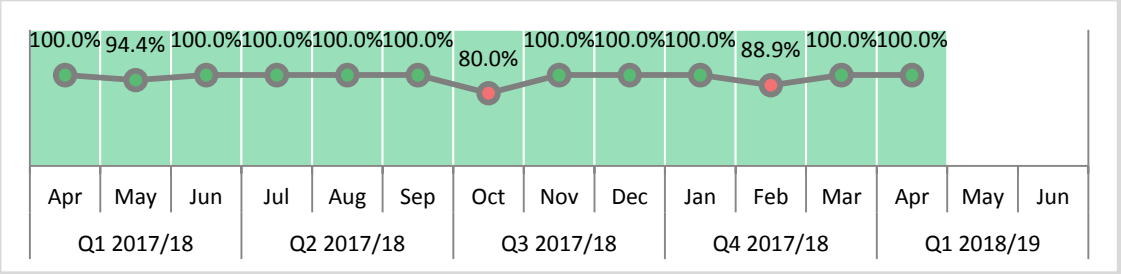
Apr-18	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target has been achieved in month
>= 90%	



Actions
No action required.

Indicator Detail

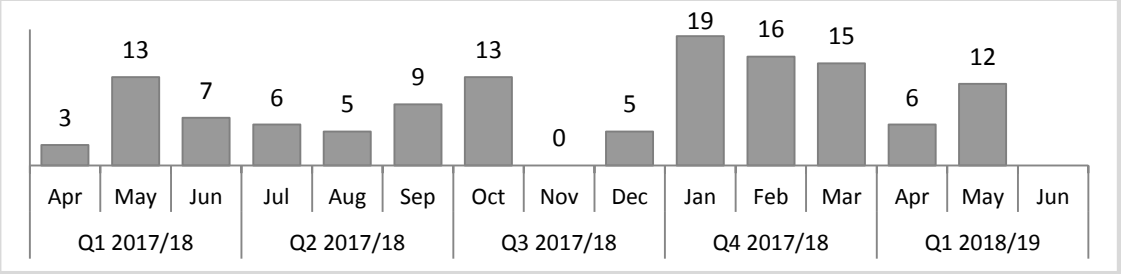
Apr-18	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target has been achieved in month
>= 90%	



Actions

No actions required.

May-18	Serious Incidents: STEIS Reportable
12	The total number of STEIS reportable incidents.
Target	There have been 12 incidents reported via StEIS in May. All Serious Incidents have been reviewed by the Chief Nurse & Director of Quality Governance and the Medical Director.

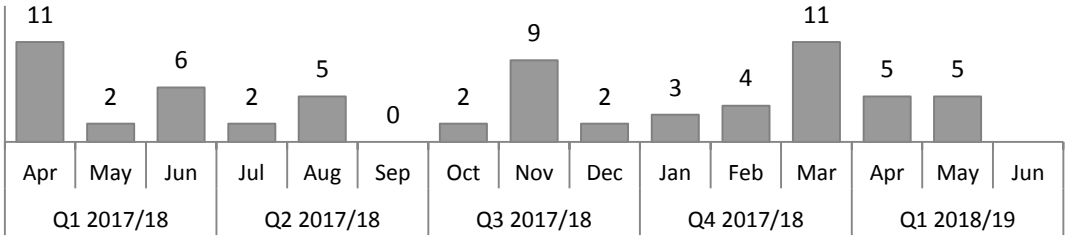


Actions

Investigations are underway in accordance with the Trust policy to identify the root causes of the incidents and present their findings to a hearing panel chaired by an executive director to ensure a thorough investigation has been undertaken with appropriate actions agreed.
7 relate to concerns about the delivery of care
A contaminant was found in a kitchen
A patient had a cardiac arrest
A child had an incorrect test used for eye screening
A patient died following discharge from a Pulmonary embolism
A patient had to have an open procedure, rather than laproscopic, due to an equipment malfunction
A patient died following a potential failure to escalate a deteriorating patient
2 patients developed stage 3 pressure ulcers
A power outage which affected business
A patient had a fall resulting in subdural bleed
A maternity unit closure

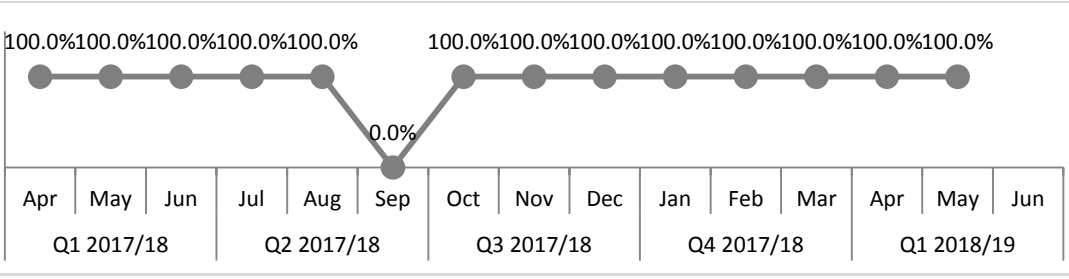
Indicator Detail

May-18	Litigation: Claims
5	Total number of claims opened in month.
Target	In May, the Trust received 5 litigation claims. 4 claims were potential medical negligence claims. 1 claim was a potential employment claim.



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

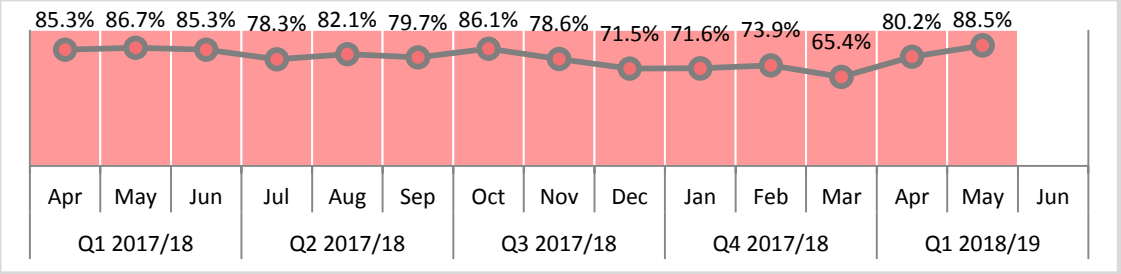
May-18	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	In May 2018, six claims were closed of which one was unsuccessful with no costs to the Trust. Three of the remaining five relate to key risks.



Actions
Key risk claims include those relating to; Obstetrics Slips, trips or falls Failure or delay in treatment Failure or delay in diagnosis All the claims this month relate to care given prior to 2016. Two claims related to saline poisoning incidents from July 2011

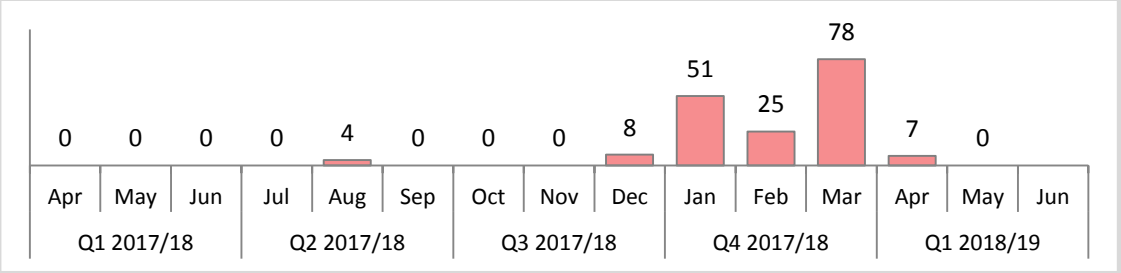
Indicator Detail

May-18	A&E: 4hr Standard
88.5%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance against the 4hr standard continued to improve in May, achieving 88.5% against the 82% improvement trajectory. While performance is strong in May against the trajectory, at the time of writing, in June, attendances have been 16% higher than the previous year.
>= 95%	



Actions
- The Urgent Care Programme Delivery Group continues to focus on four key work streams to ensure short term improvement in performance against the 4 hour standard across the Stockport System, they are: - Pre-admission - Attendance & Management - Admission - Discharge - The key areas of focus within the Acute Trust are performance overnight and minimising breaches, enhancing ambulatory care capacity and flow across the hospital. The forecast risk rating (amber) is based on the achievement of the 85% improvement trajectory

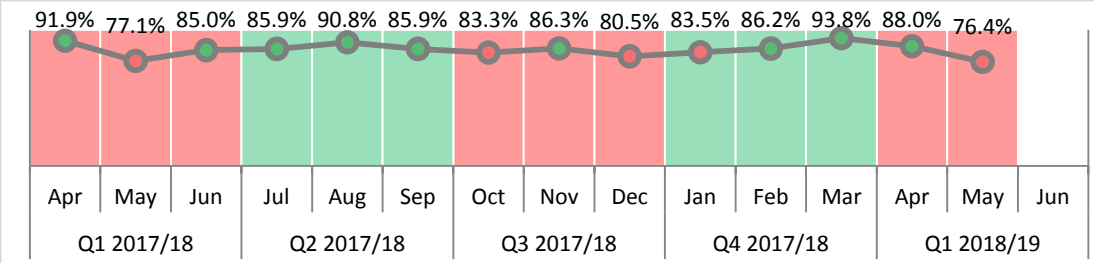
May-18	A&E: 12hr Trolley Wait
0	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	No 12hr trolley waits occurred in May.
<= 0	



Actions
The revised SoP is being ratified and will be implemented by Q2

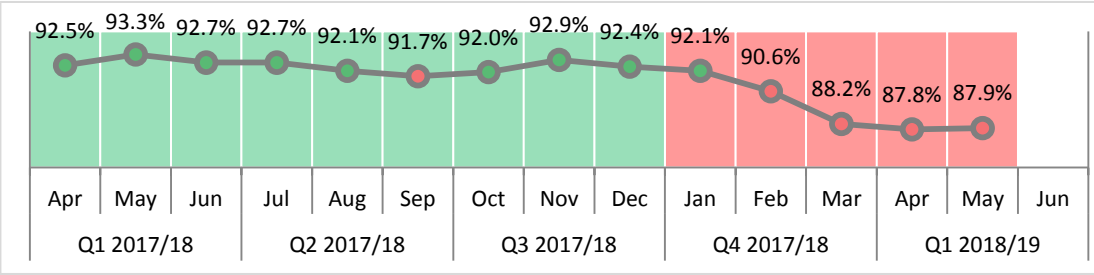
Indicator Detail

May-18	Cancer: 62 Day Standard
76.4%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	The Trust is predicting to fail the 62 day cancer standard for May with a significant number of breaches. The indicative performance at the time of writing is 76.4% Delays in internal and external diagnostics feature in several pathways, particularly Histopathology reporting.
>= 85%	



Actions
Histopathology are recruiting to vacant Consultant posts, and may take the opportunity to over-establish. A tracker post is also being considered. A bespoke cancer PTL is being instituted between cancer services and histopathology. The enhanced pre-assessment model facilitating quicker access to Endoscopy has commenced for colorectal patients. An improvement against the standard is expected in Q2

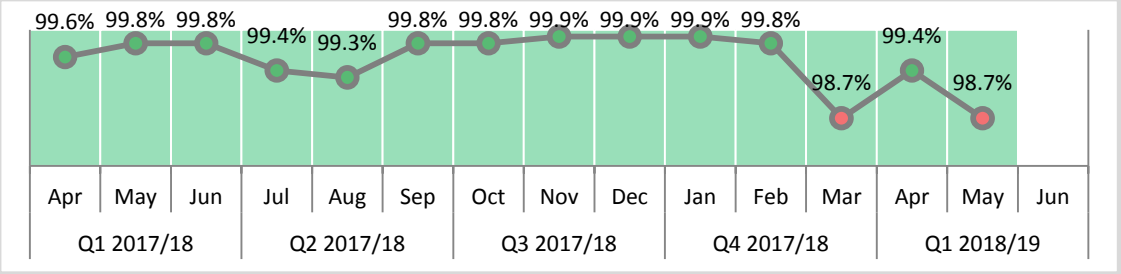
May-18	Referral to Treatment: Incomplete Pathways
87.9%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	Performance for May remains significantly below the improvement trajectory of 91.0%. The main area of concern is the non-admitted backlog.
>= 92%	



Actions
- Specialty teams have been tasked with recovery trajectories. - Business Groups have been asked to review the deployment of resources to ensure maximum effect and focus across each area. - NHSI have been alerted to the issues around booking and the impact on the non-admitted backlog. External support is currently reviewing the position with a view to making recommendations Improvement to the RTT Standard is expected to be seen in Q2

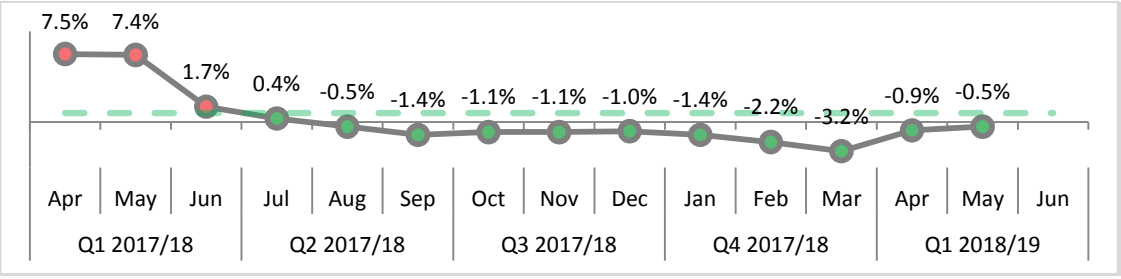
Indicator Detail

May-18	Diagnostics: 6 Week Standard
98.7%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust failed to achieve the diagnostic standard in May. This related to capacity issues within Echocardiography, an area that is nationally recognised as difficult to recruit to.
>= 99%	



Actions
- Capacity & demand modelling is underway to inform the nature of resource required and the options to recurrently meet demand. - Continue with additional lists out of hours - Flexibly use existing capacity The Business Group is working on the longer term plan for sustainability

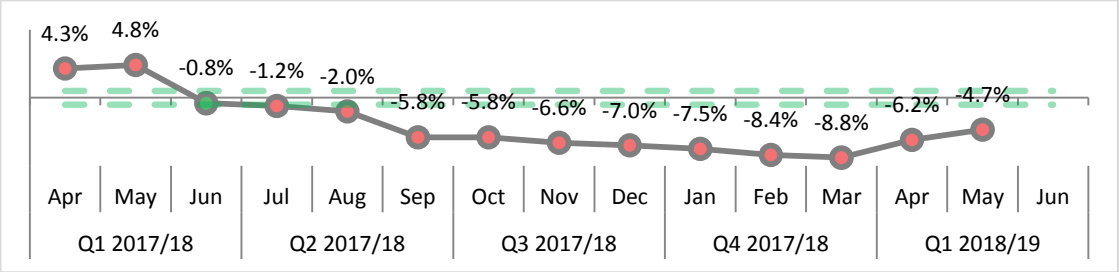
May-18	Outpatient Activity vs. Plan
-0.5%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Outpatient activity is within the expected tolerance for May.
<= 1%	



Actions
This will continue to be monitored by the Operational Performance Group.

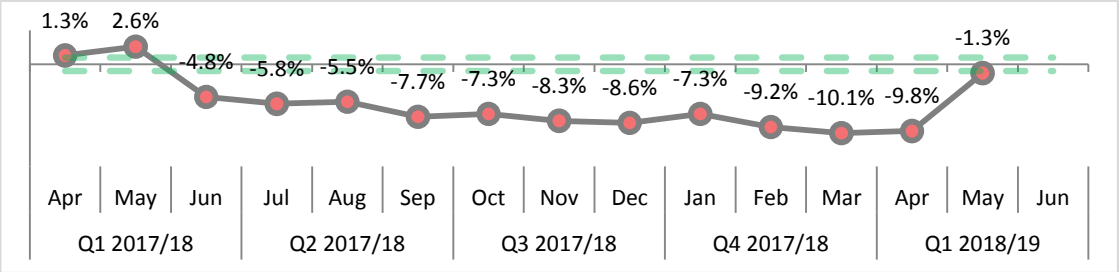
Indicator Detail

May-18	Elective Activity vs. Plan
-4.7%	The percentage variance between planned elective activity and actual elective activity.
Target	The Trust is behind plan in month 2 and year to date for elective activity. This is mainly being driven by under-performance in day-case activity, particularly Endoscopy.
+/- 1%	



Actions
Continue to monitor via the Operational Performance Group Review list utilisation to ensure maximum effectiveness There is a level of assurance that this will be back on plan in Q2 The profile of activity has been set to accommodate winter urgent care demand but there remains the risk of non delivery if the Trusts experiences extended winter pressures beyond February

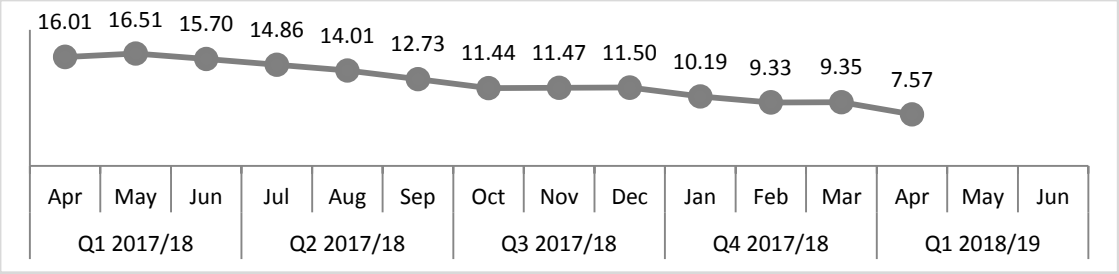
May-18	Elective Income vs. Plan
-1.3%	The percentage variance between planned elective income and the actual elective income.
Target	Elective income is behind plan in month and year to date, correlating to the deficit in activity numbers. However, the income deficit is proportionately smaller which reflects the switch to an increased throughput of inpatient work as opposed to day-case.
+/- 1%	



Actions
- continue with the Orthopaedic plan of increased joint throughput over the next 6 months - continue to monitor theatre utilisation to ensure maximum effectiveness of resources - Risk to delivery as per the activity vs plan and extended winter pressures

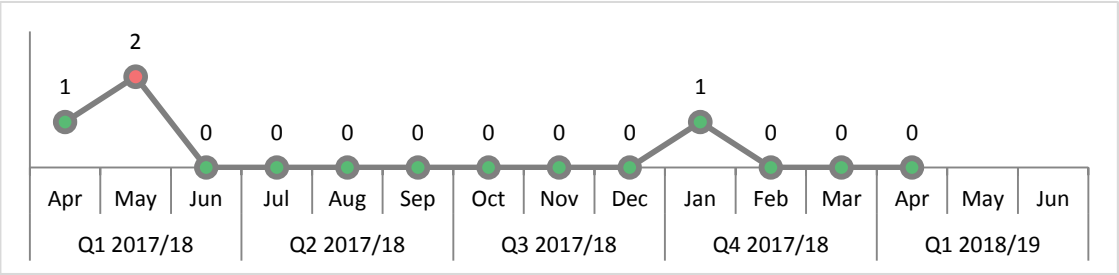
Indicator Detail

Apr-18	C.Diff Infection Rate
7.57	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 Clostridium difficile rate objective for 2018/19 is set at 7.0



Actions
There are processes in place by which any HCAI is identified and investigated. There are underlying frameworks in place to ensure best practice is in place to avoid unnecessary infections occurring. More work is required in relation to Antimicrobial Stewardship, which has been refreshed and will meet again following a considerable period of time without meeting.

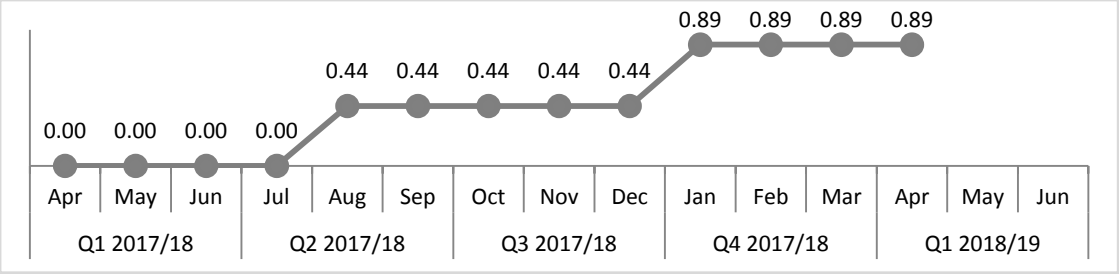
Apr-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care, in April we have had no cases of Clostridium difficile and therefore no lapses in care
<=1 *	



Actions
A review of the new NICE draft guidance to combat drug resistant UTI's with the antibiotic pharmacists and Consultant microbiologist has been undertaken. Awaiting final guidance to be published. Further work will be undertaken with the new site coordinator team around isolation of patients following review and update of the isolation SOP. There are processes in place by which any HCAI is identified and investigated. There are underlying frameworks in place to ensure best practice is in place to avoid unnecessary infections occurring. More work is required in relation to Antimicrobial Stewardship, which has been refreshed and will meet again following a considerable period of time without meeting. Following a Clostridium difficile investigation the case will be presented to the harm free care panel.

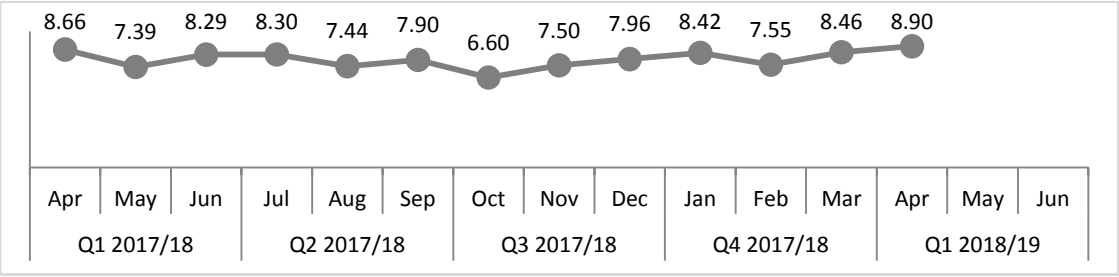
Indicator Detail

Apr-18	MRSA Infection Rate
0.89	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	The MRSA target remains zero for 2018/19



Actions
The target is monitored through the Infection Prevention and Control Group. There are processes in place by which any HCAI is identified and investigated. There are underlying frameworks in place to ensure best practice is in place to avoid unnecessary infections occurring. More work is required in relation to Antimicrobial Stewardship, which has been refreshed and will meet again following a considerable period of time without meeting.

Apr-18	MSSA Infection Rate
8.90	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	The MSSA infection rate is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases 2 cases were reported by the Medicine & Clinical Support Business Group in month.

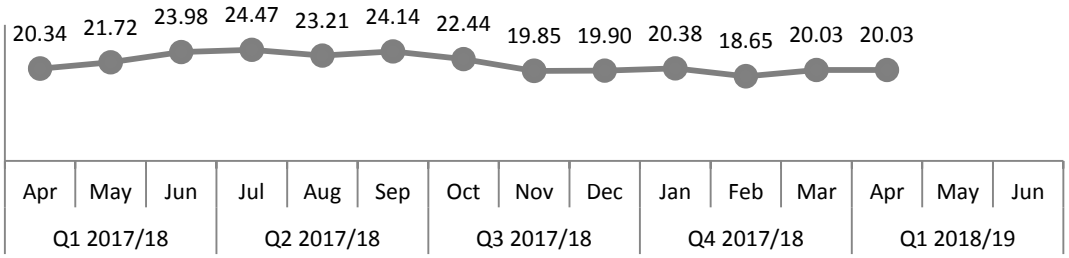


Actions
This is monitored through the Infection Prevention and Control Group.

Indicator Detail

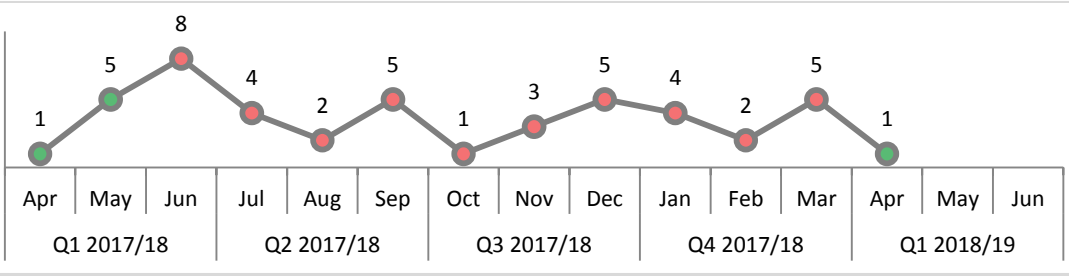
Apr-18	E.Coli Infection Rate
20.03	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Nationally there is an aim to reduce healthcare 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.

Actions
A reduction plan has been developed collaboratively between the Trust, Health protection nurses and CCG. This plan will be monitored through the Infection Prevention and Control Group.



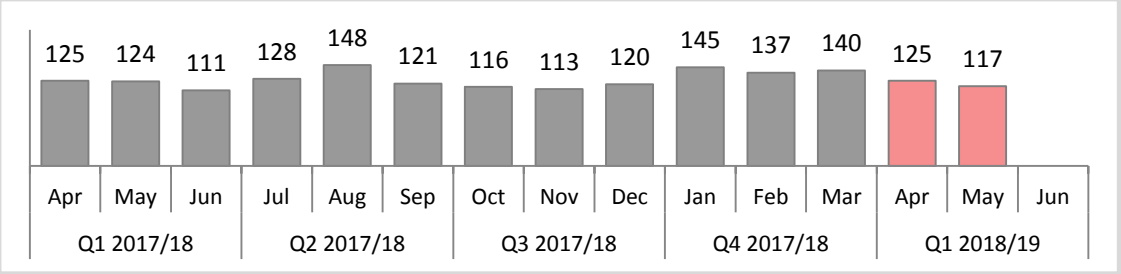
Apr-18	E.Coli Infection Count
1	Total number of E.Coli infections.
Target	The E.Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases.
<=3 *	The 1 case reported was from within the Medicine & Clinical Support Business Group.

Actions
This is monitored through the Infection prevention Committee



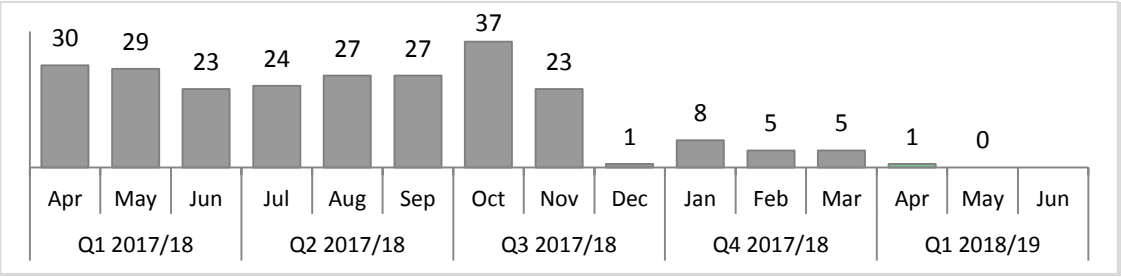
Indicator Detail

May-18	Falls: Total Incidence of Inpatient Falls
117	Total number of Inpatient falls
Target	Our Quality Improvement aim is to reduce in-patient falls with harm by 25% compared to the total falls recorded in 2017/18 (total number of falls with harm was 239). The total number of falls with harm for April was 1. This resulted in a fractured pubic rami. This has been reported through the Strategic Executive Incident System.
<=229 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 2018/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls. The incidents that occurred in May 2018 are currently under investigation by the business group. The incident causing severe harm, a fractured neck of femur, is under investigation by the Trust and the moderate harm incident is awaiting review by the business group.

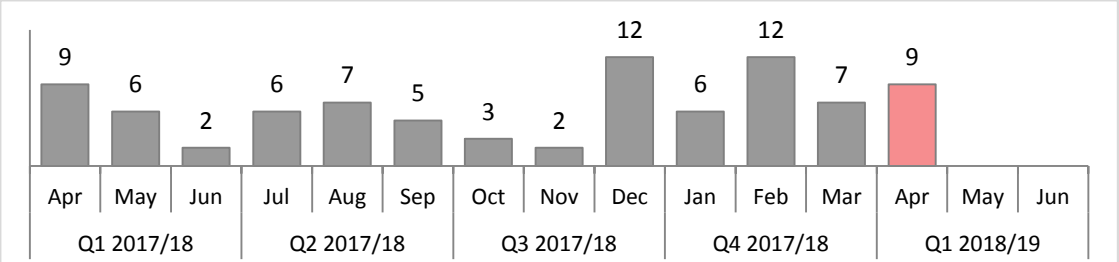
May-18	Falls: Causing Moderate Harm and Above
0	Total number of falls causing moderate harm and above.
Target	The total number of falls with harm for April was 1. This resulted in a fractured pubic rami. This has been reported through the Strategic Executive Incident System.
<=30 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 2018/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls.

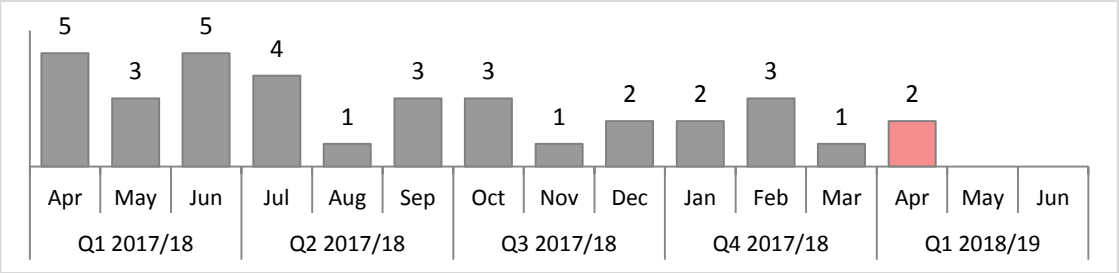
Indicator Detail

Apr-18	Pressure Ulcers: Hospital, Stage 2
9	Total number of stage 2 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 2 pressure ulcers by 50% by end March 2019. In April 2018 there were 9 PU's (May 2018 data not yet validated). Integrated Care = 1 Medicine & Clinical Support = 4
<=3 *	



Actions
In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include: The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18 A training and education work stream which is focusing on the roll out of the React to Red training package An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers The Fracture clinic has introduced a red strip within all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant

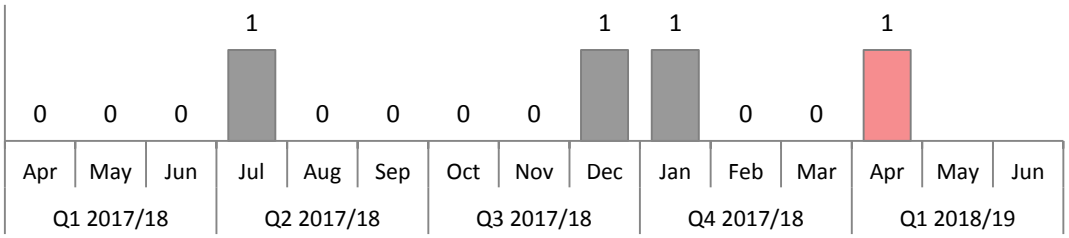
Apr-18	Pressure Ulcers: Hospital, Stage 3
2	Total number of stage 3 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 3 pressure ulcers by 50% by end March 2019. In April 2018 (May data still to be validated) the Trust has reported 2 stage 3 pressure ulcers, both within Medicine & Clinical Support Business Group.
<=1 *	



Actions
In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include: The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18 A training and education work stream which is focusing on the roll out of the React to Red training package An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers The Fracture clinic has introduced a red strip to all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant

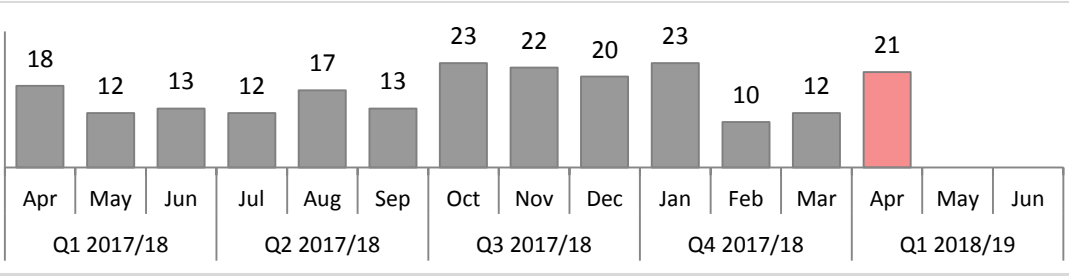
Indicator Detail

Apr-18	Pressure Ulcers: Hospital, Stage 4
1	Total number of stage 4 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 4 pressure ulcers by 50% by end March 2019. In April 2018 (May data yet to be validated) 1 stage 4 pressure ulcer was reported within the Medicine & Clinical Support Business Group.
<=0 *	



Actions
In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include: The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18 A training and education work stream which is focusing on the roll out of the React to Red training package An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers The Fracture clinic has introduced a red strip to all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant

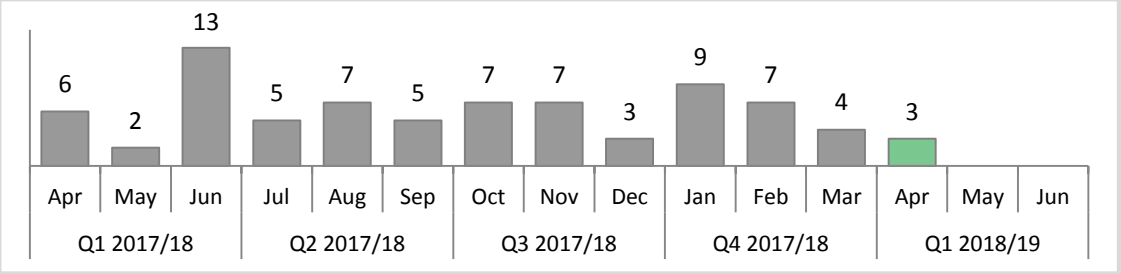
Apr-18	Pressure Ulcers: Community, Stage 2
21	Total number of stage 2 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 2 pressure ulcers by 50% by end March 2019. The figure represented here relates to April 2018 as stage 2 pressure ulcers that relate to May 2018 are not yet validated.
<=8 *	



Actions
In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include: The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18 A training and education work stream which is focusing on the roll out of the React to Red training package An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers The Fracture clinic has introduced a red strip to all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant.

Indicator Detail

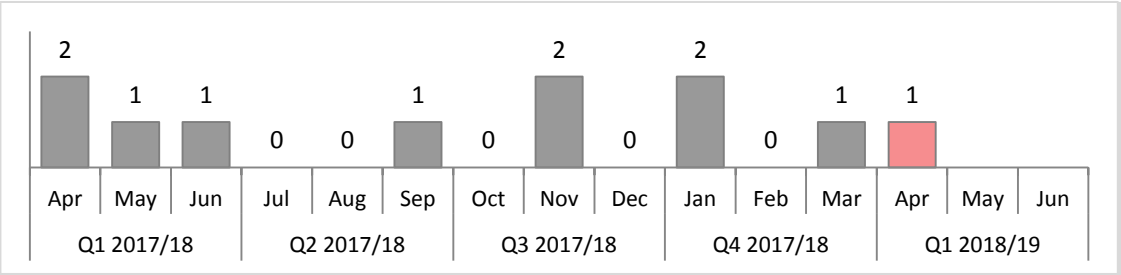
Apr-18	Pressure Ulcers: Community, Stage 3
3	Total number of stage 3 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 3 pressure ulcers by 50% by end March 2019. The figure represented here relates to April 2018 as stage 3 pressure ulcers that relate to May 2018 are not yet validated
<=3 *	



Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include:
The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18
A training and education work stream which is focusing on the roll out of the React to Red training package
An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers
The Fracture clinic has introduced a red strip to all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant

Apr-18	Pressure Ulcers: Community, Stage 4
1	Total number of stage 4 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 4 pressure ulcers by 50% by end March 2019. The figure represented here relates to April 2018 as stage 4 pressure ulcers that relate to May 2018 are not yet validated
<=0 *	

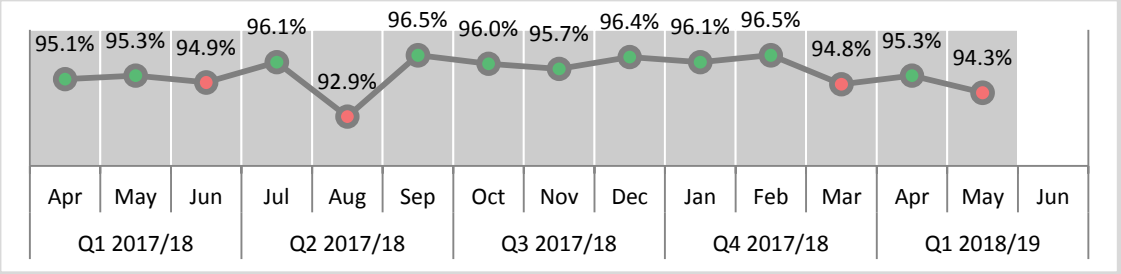


Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include:
The introduction of Purpose T an alternative Pressure ulcer risk assessment tool to the currently used Waterlow pressure ulcer risk assessment tool is commencing on the 18/6/18
A training and education work stream which is focusing on the roll out of the React to Red training package
An equipment work stream which is focusing on heel offloading devices in order to reduce the occurrence of heel pressure ulcers
The Fracture clinic has introduced a red strip to all POPs where patients are identified as being at increased risk of pressure ulcer development to alert staff to be more vigilant

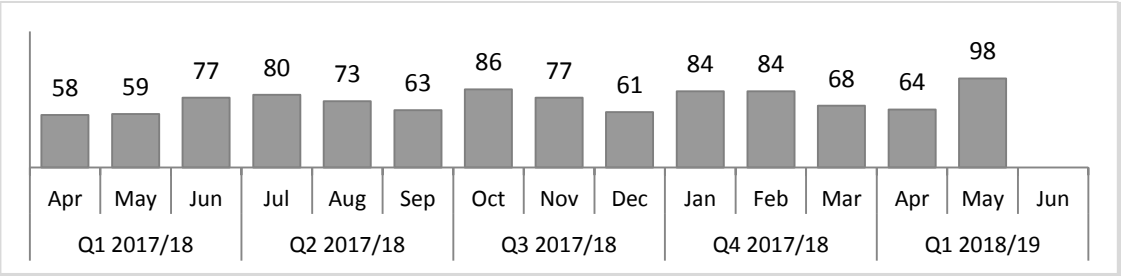
Indicator Detail

May-18	Safety Thermometer: Hospital
94.3%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by the Safety Thermometer. In May 2018, 94.3% of our patients received harm free care as measured by the Safety Thermometer.
>= 95%	



Actions
The Trust has introduced a more robust validation process in relation to harms associated with the safety thermometer. Actions taken in relation to falls and pressure ulcers will have a positive impact on future results.

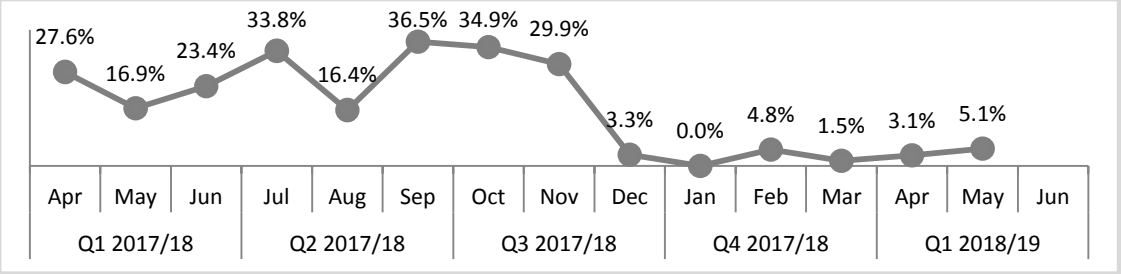
May-18	Medication Errors: Overall
98	Total number of Medication Errors.
Target	In May 2018, there have been 74 medication incidents reported. This is higher than last month and slightly higher than the average for 2017 / 18 which was 72 a month.



Actions
All medication incidents are reviewed weekly by a trust executive at the Patient Safety Summit. This month a theme has been identified through the weekly Patient Safety Summit relating to the use of anticoagulants. Staff have been reminded about the importance to ensure anticoagulation therapy is monitored closely through the Patient Safety Summit update.

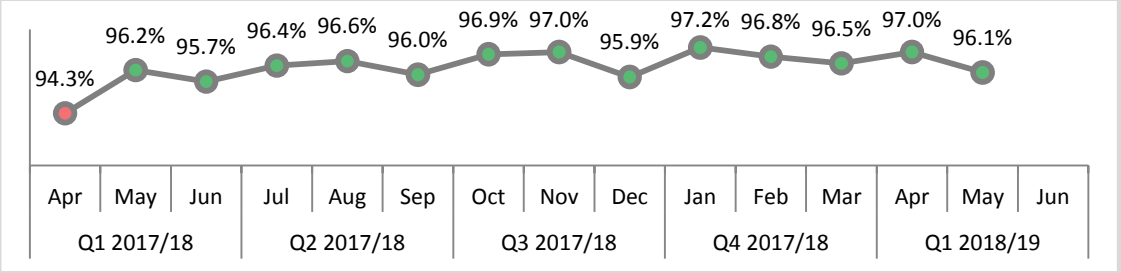
Indicator Detail

May-18	Medication Errors: Moderate Harm and Above
5.1%	The percentage of medication errors causing moderate harm and above.
Target	In April 2018, five medication errors were reported as incidents where moderate harm had occurred. Three of these incidents were the same incident.



Actions
The incidents reported are currently under investigation by the Business Groups. A trajectory of medication incidents causing moderate harm or above is to be agreed by the end of Quarter 1 2018/19.

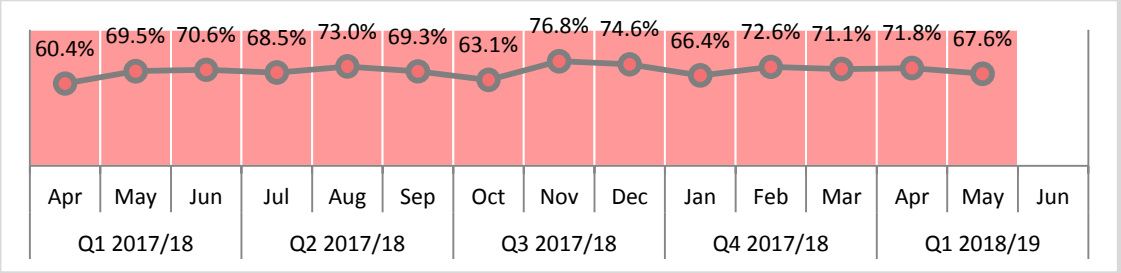
May-18	VTE Risk Assessment
96.1%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).
>= 95%	



Actions
The Trust has achieved the target in month.

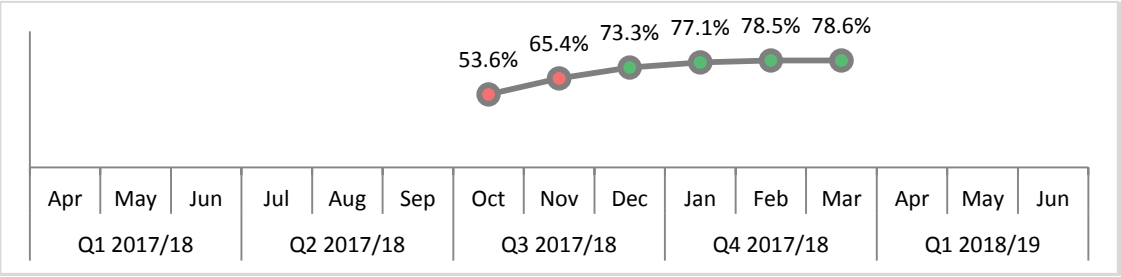
Indicator Detail

May-18	Clinical Correspondence
67.6%	The percentage of clinical correspondence typed within 7 days.
Target	The backlog of letters within Paediatrics has been outsourced and successfully reduced, negatively impacting on the performance the clinical correspondence standard for the month. The benefits will be seen in month 3. Gynae and T&O are showing a deteriorating position.
>= 95%	



Actions
The Paediatric service commenced outsourcing of letters which had a significantly positive effect on the number of letters waiting. Outsourcing is planned to continue for Paediatrics until they become fully staffed at the end of June. Both T&O and Gynaecology will be part of phase 2 transfer to the hub making them less vulnerable to workforce variations. To mitigate Gynaecology and T&O are looking to outsource in the short term. Within the correspondence hub, recruitment to the significant vacancies continues.

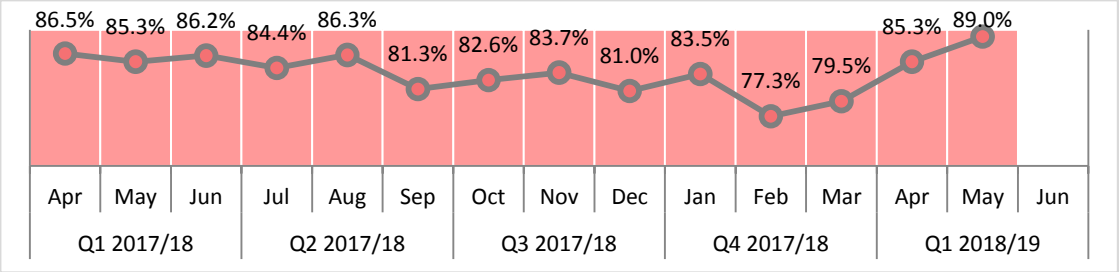
Mar-18	Flu Vaccination Uptake
78.6%	The percentage of staff receiving the flu vaccination.
Target	This was the final position as of March 2018.
>= 70%	



Actions
The flu campaign will restart in September 2018.

Indicator Detail

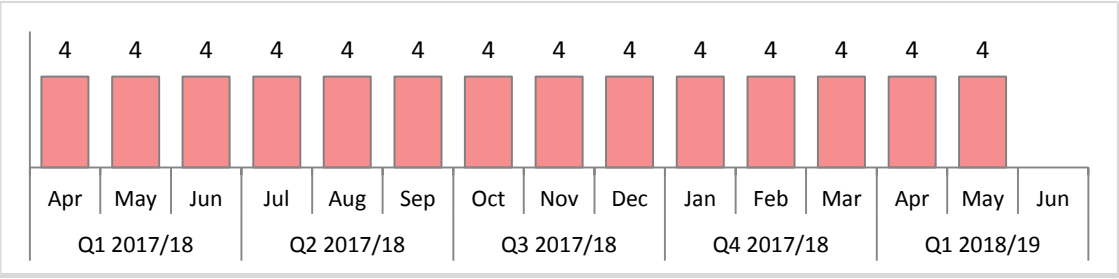
May-18	Discharge Summaries
89.0%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Three months of consistent improvements in HCR completion reflect a daily email to clinical areas with outstanding HCR's, and embedding of the actions in response to these alerts.
>= 95%	



Actions

Further software changes are being implemented, which should lead to further improvements in HCR publication rates.

May-18	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	To improve to a 3 the planned deficit would need to improve by £31.5m to a deficit of £2.5m (within 1% of planned operating income)
<= 2	

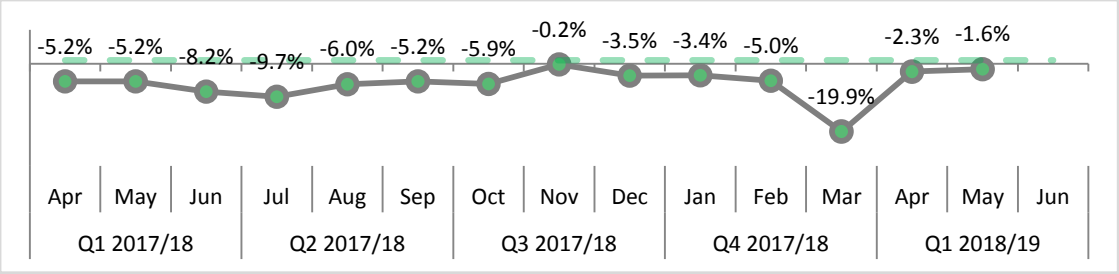


Actions

The Trust is coming under increasing scrutiny from NHSI through the Enhanced Financial Oversight Process. The Trust will begin to review the underlying run-rate with a view to improve over the coming months.

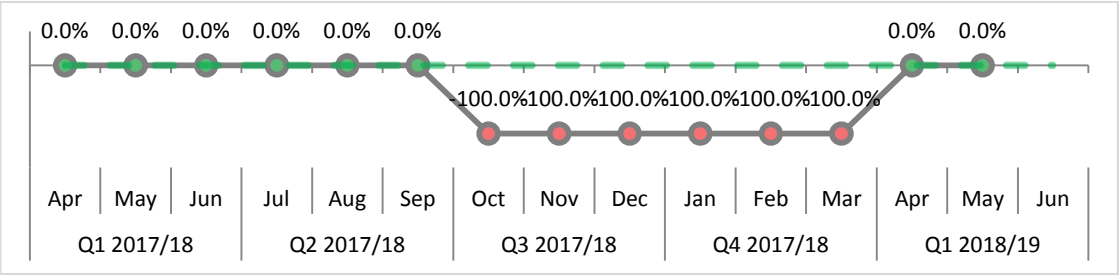
Indicator Detail

May-18	Financial Controls: I&E Position
-1.6%	The percentage variance between planned financial position and the actual financial position.
Target	In the first two months of the financial year the Trust has lost £7.3m. The planned deficit was £7.4m so this is £0.1m favourable to plan. The loss is £0.9m worse than the same period last year, and the average loss is £119,000 per day.
<= 1%	



Actions
As the Trust is favourable to plan this scores a 1 (best) under the NHSI use of resources (UoR) metric within the Single Oversight Framework. The Trust Finance & Performance Committee has been given significant assurance at this stage in the financial year that the forecast plan will be delivered. However there are a number of risks which will need to be actively managed to maintain that level of assurance.

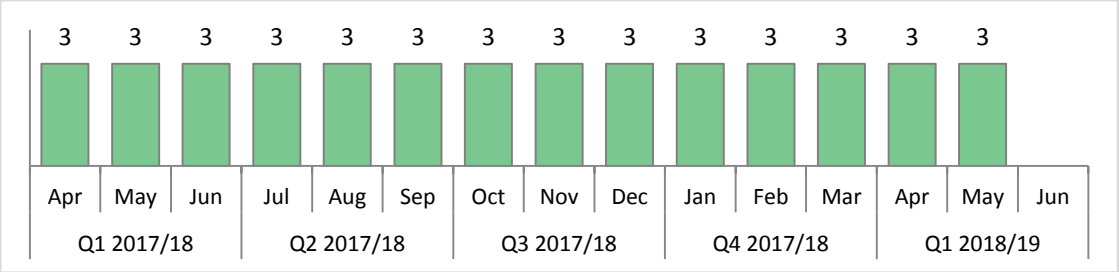
May-18	Cash
0.0%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st May 2018 was £10.9m, which is £2.5m less than last month and £3.9m better than planned. The graph shows that the Trust has not accessed borrowing which is better than plan. When the Trust does access borrowing the graph will compare the plan to actual.
+/- 1%	



Actions
Cash is carefully managed and the requirement for a working capital support facility loan is now likely to be in July/August 2018. The Trust's risk assessment on cash has been updated to reflect the impact of anticipated payment of the national Agenda for Change (AfC) pay award and back pay in July 2018, and associated HM Treasury funding for this. The Trust has plans in place to enact the governance process in relation to the loan which includes a 13-week cash flow forecast.

Indicator Detail

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



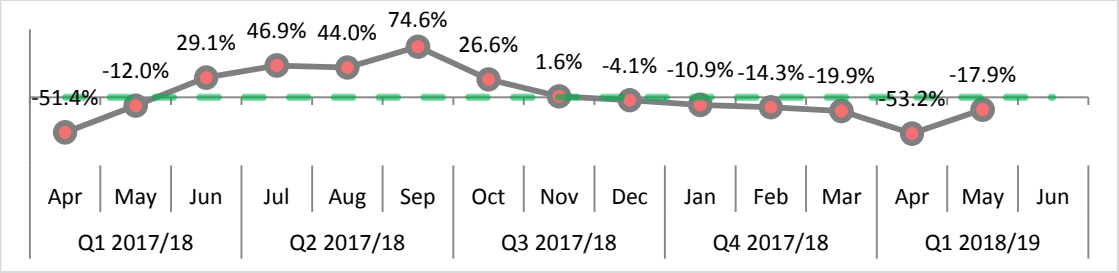
Actions

For the three metrics on financial sustainability and financial efficiency the Trust scores a 4 (worst). This is not expected to change.

The Trust remains in breach of the agency ceiling in month so this score is a 2 (second best).

NHSI have updated the calculation method for the finance and use of resources metrics score for 2018/19 and decimal places are now allowed. Previously if the average of the five individual scores was a decimal point above, it would be rounded up to the higher score, so for example a calculated score of 3.2 would round up to 4. However now it would round down to 3. This is good news as the Trust's score should only deteriorate to a 4 and fall into the special measures segment if the deficit is missed by 2% (£0.68m) rather than 1% (£0.34m).

May-18	CIP Cumulative Achievement
-17.9%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is £0.2m adverse to the profiled plan in the two months to May 2018; £1.0m (7%) was expected by this stage in the year when £0.8m (6%) has been transacted
+/- 1%	



Actions

Recurrent CIP delivery is the most significant risk to the Trust's financial position for 2018/19 and beyond, as it is a key driver for the deterioration in the Trust's underlying financial position and planned £34m deficit in 2018/19. Even with potential mitigation the Trust can only provide limited assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

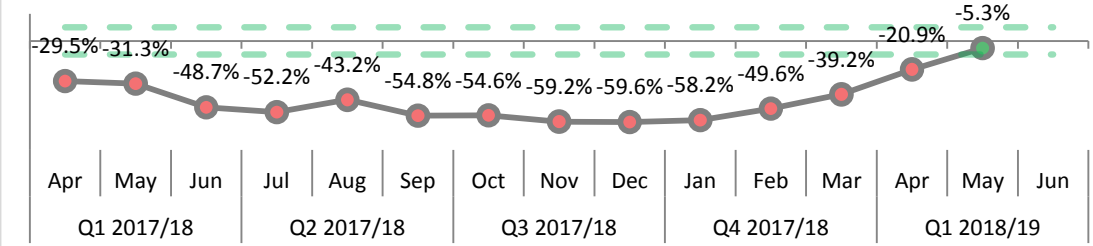
Work continues within the themes to progress supporting documentation and risk assessments have been undertaken by each of the SROs in relation to the current forecast position.

Additional external resource has been secured to accelerate delivery.

The Trust is now on fortnightly reporting of CIP to NHSi.

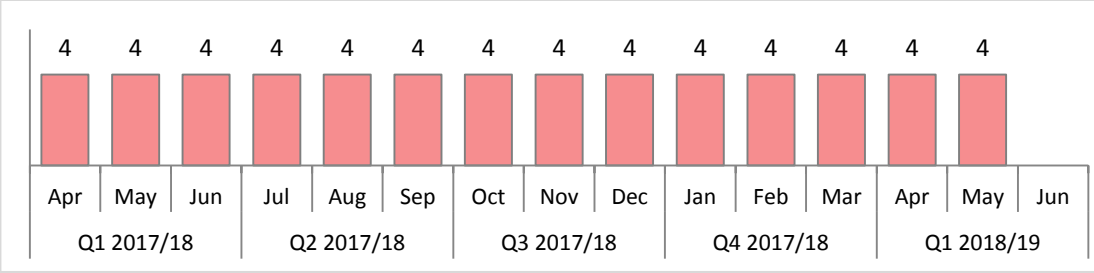
Indicator Detail

May-18	Capital Expenditure
-5.3%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £0.827m have been incurred to the end of May 2018 against a plan of £0.873m, and so is £0.045m behind plan.
+/- 10%	



Actions
The externally funded Healthier Together schemes are fundamental to the delivery of the capital programme but is reliant on external parties and their approval processes. In May 2018 the Greater Manchester Combined Authority (NHS in Greater Manchester) and NHS Transformation Unit have requested the long term financial model to be updated, which will then have to go through a review process with local and national NHSI, then department of health (DHSC) and treasury (HMT) approval. The latest information suggests that the earliest authorisation will now be February 2019, so as a result the Trust's capital plan is likely to show a variance for the Healthier Together schemes in year. All other schemes are progressing in line with the agreed plan.

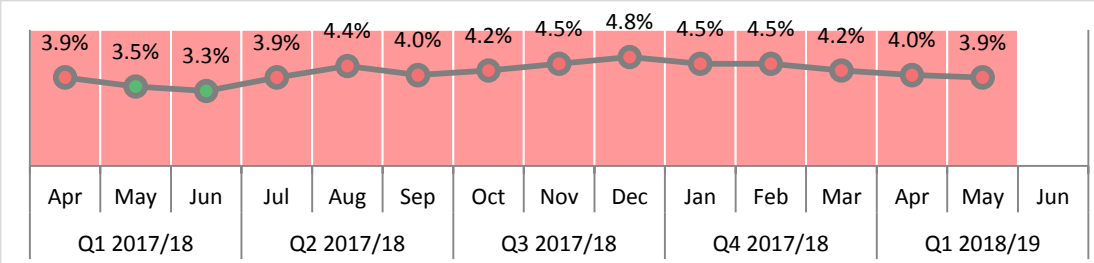
May-18	Financial Sustainability
4	A calculated score based on the Capital Service Capacity (the degree to which the Trust's generated income covers its financial obligations) and Liquidity in days (the number of days of operating costs held in cash or cash-equivalent).
Target	For the two metrics on financial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



Actions

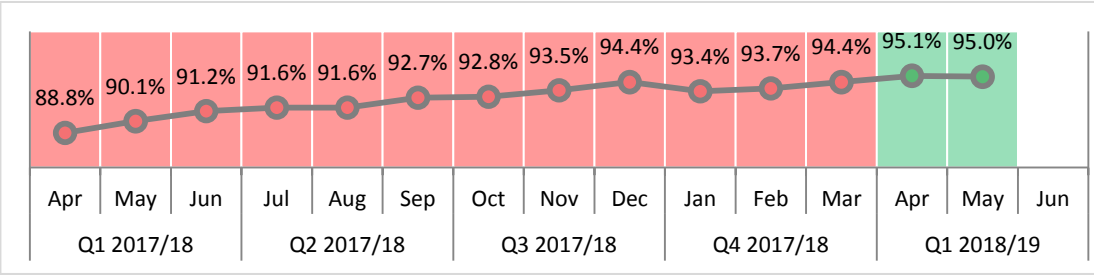
Indicator Detail

May-18	Sickness Absence Rate
3.9%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for May 2018 is 3.94%; a decrease of 0.07% from the adjusted April 2018 figure (4.01%). The sickness rate for comparison in May 2017 was 3.51%. The 12-month rolling sickness percentage for the period June 2017 to May 2018 is 4.16%.
<= 3.5%	



Actions
Absence trackers are reviewed monthly, with action plans agreed for hot spot areas. Top 3 reasons for absence are Back/musculoskeletal (including injury/fracture), Anxiety/stress/depression and gastrointestinal problems. Return to work interviews are audited for compliance against our policy. Proactive support for early returns include phased return and early occupational health support.

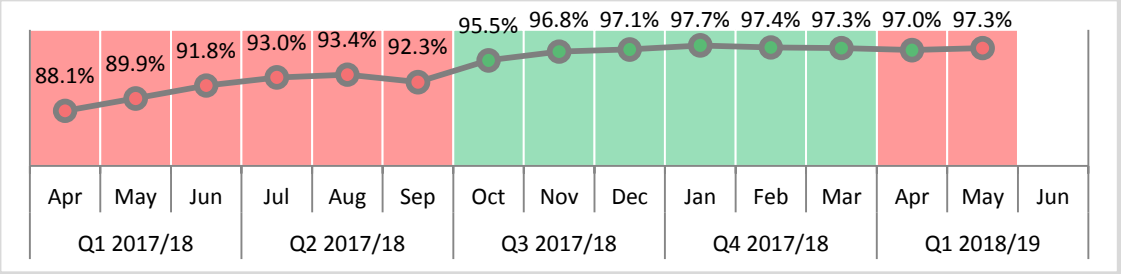
May-18	Appraisal Rate: Non-medical
95.0%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for May 2018 is 95.02%, a slight decrease from April's data which was 95.12%.
>= 95%	



Actions
Appraisal compliance targets are monitored at bi-monthly performance meetings. Support to the Business groups provided by the Learning & Development team continues. Appraisal training is offered to all managers & supervisors who conduct appraisals. Areas of low compliance are identified and focussed support provided to managers in these areas.

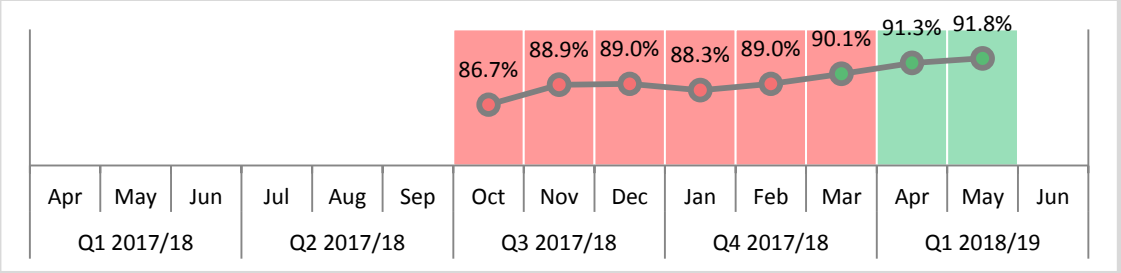
Indicator Detail

May-18	Appraisal Rate: Medical
97.3%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for May 2018 is 97.01%.
>= 95%	



Actions
Performance of the medical appraisal compliance continues to be monitored via the performance meetings. Regular progress updates circulated by Medical Director with targets set for local compliance areas.

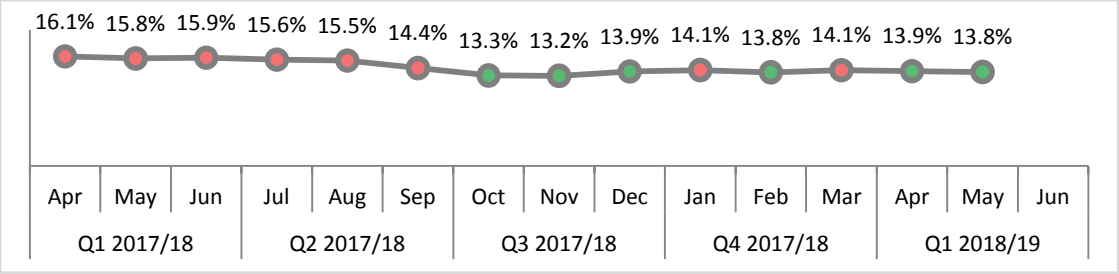
May-18	Statutory & Mandatory Training
91.8%	The percentage of statutory & mandatory training modules showing as compliant.
Target	This month's statutory and mandatory training rate is 91.76%; an improvement on last month's performance.
>= 90%	



Actions
Bespoke sessions to increase compliance for topics below target, commencing from 23rd July. Drop-in eLearning sessions continue to be available to support individuals in completion of outstanding modules. Train the trainer sessions are in place to assist business groups to increase availability of training in topic areas below compliance and with limited capacity causing delays in completion. An issues log has been created to capture issues relating to access to e-Learning. emerging themes will be used to form an action plan for resolving outstanding issues.

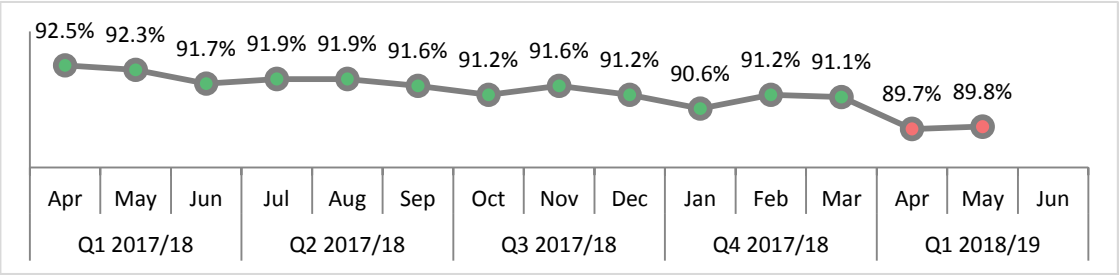
Indicator Detail

May-18	Workforce Turnover
13.8%	The percentage of employees leaving the Trust and being replaced by new employees.
May-18	The rolling 12-month permanent headcount unadjusted turnover figure at the end of May 2018 is 13.80%. The adjusted rolling 12 month permanent headcount turnover figure in the period June 2017 to May 2018 is 12.86%; both of which fall below the target.
<= 13.94%	



Actions
Pro-active recruitment strategies, including recruitment open days, flexible working and job design, participation in national conferences to raise the Trust profile continue. The Trust is participating in the NHSI Nursing Recruitment & Retention programme. In support of this 4 work-streams are being progressed with focus on graduates, the itchy feet programme, retire and return and hot spots for turnover.

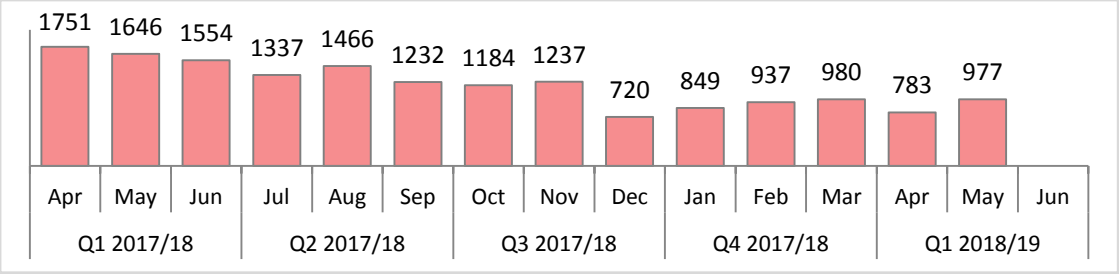
May-18	Staff in Post
89.8%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for May 2018 is 89.85% of the establishment, which is an increase of 0.15% from 89.70% in April 2018. Staff in post reduced by 5.27 FTE & establishment decreased by 14.24 FTE, however, the vacancy rate has remained marginally above target at 10.15%. (This is due to the realigning of budgets).
>= 90%	



Actions
The Registered Nursing vacancy rate has reduced to 10.91% (172.53 FTE), a decrease of 22.09 FTE from April 2018. The Medical vacancy rate is 11.84% (64.35 FTE), an increase on the previous month. Add Prof Scientific and Technical vacancy rate at 14.89% (29.24 FTE) has increased since the previous month attributed to an increase in establishment (4.78 FTE). Work to progress the actions and interventions as detailed in the recruitment & retention strategy implementation plan are on-going.

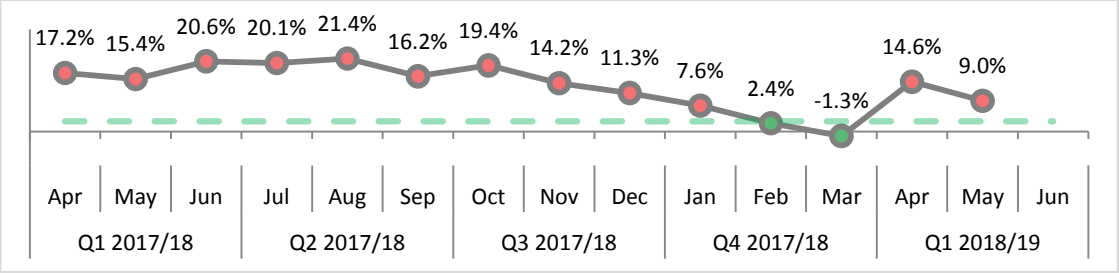
Indicator Detail

May-18	Agency Shifts Above Capped Rates
977	Number of agency shifts above above the provider spend cap.
Target	During the 5 week period from 30th April to 3rd June 2018 there were 977 agency shifts above capped rates This is an average of 195 shifts per week, consistent with the previous 2 months; no significant change per BG from the previous month's figures. 97 shifts paid at or above £120 per hour, requiring Chief Executive approval.
<= 0	



Actions
Changes to NHSI approvals and reporting have recently been communicated to the Trust, work to ensure compliance with the revised arrangements are underway.

May-18	Agency Spend: Distance From Ceiling
9.0%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	Total Trust spend has reduced from last month and is a significant reduction from May 2017. This month's spend has been significantly impacted by unsuccessful recruitment to hard to fill medical vacancies, on-call Health restrictions for small number of doctors & VISA restrictions.
<= 3%	



Actions
Pro-active UK and international recruitment continue. Growth of nursing and medical bank to reduce our reliance on the use of agency staff. Increased booking and approval controls are embedded. Pro-active session planned with agencies to ensure commission and costs are competitive and appropriate.

Safer Staffing Report

May-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers	Falls with Harm	Catheters & UTIs	VTEs
AMU	4,092	3,660	3,348	3,450	3,720	3,192	3,069	3,388	89.4%	103.0%	85.8%	110.4%	1420	4.8	4.8	9.6				
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	137	5.2	5.2	10.4				
Short Stay Olders People's Unit	1,163	1,065	791	768	682	671	682	682	91.6%	97.2%	98.4%	100.0%	394	4.4	3.7	8.1				
A3	1,423	1,355	977	984	1,023	902	682	682	95.2%	100.8%	88.2%	100.0%	696	3.2	2.4	5.6				
A10	2,790	2,388	2,046	2,034	2,046	1,860	1,364	1,364	85.6%	99.4%	90.9%	100.0%	643	6.6	5.3	11.9				
A11	1,581	1,446	1,628	1,613	682	682	682	682	91.5%	99.1%	100.0%	100.0%	802	2.7	2.9	5.5				
A12	1,907	1,850	1,442	1,539	682	682	682	898	97.0%	106.8%	100.0%	131.7%	766	3.3	3.2	6.5				
A15																				
B4	1,209	744	605	977	682	682	682	682	61.5%	161.5%	100.0%	100.0%	492	2.9	3.4	6.3				
B6	1,209	1,202	1,070	1,250	682	682	682	1,045	99.4%	116.8%	100.0%	153.2%	631	3.0	3.6	6.6				
Bluebell Ward	1,209	1,209	2,077	2,077	682	682	682	682	100.0%	100.0%	100.0%	100.0%	552	3.4	5.0	8.4				
C4	1,209	962	605	911	682	682	682	682	79.6%	150.6%	100.0%	100.0%	433	3.8	3.7	7.5				
Coronary Care Unit	837	841	465	435	682	682	341	365	100.5%	93.5%	100.0%	107.0%	163	9.3	4.9	14.3				
Devonshire Centre for Neuro-Rehabilitation	1,070	1,070	2,000	1,988	682	682	682	682	100.0%	99.4%	100.0%	100.0%	509	3.4	5.2	8.7				
E1	1,952	1,479	2,310	2,205	1,023	924	1,364	1,364	75.8%	95.5%	90.3%	100.0%	924	2.6	3.9	6.5				
E2	2,279	2,266	1,581	2,005	1,023	1,023	1,023	1,364	99.4%	126.8%	100.0%	133.3%	1008	3.3	3.3	6.6				
E3	2,279	2,256	1,581	1,737	1,023	1,012	1,023	1,353	99.0%	109.9%	98.9%	132.3%	1059	3.1	2.9	6.0				

Safer Staffing Report

May-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers	Falls with Harm	Catheters & UTIs	VTEs
A1	1,442	1,314	1,209	1,187	1,023	968	1,023	1,023	91.2%	98.1%	94.6%	100.0%	783	2.9	2.8	5.7				
B3	837	838	977	912	682	660	495	550	100.1%	93.4%	96.8%	111.1%	383	3.9	3.8	7.7				
C6	837	777	977	989	682	682	682	803	92.8%	101.2%	100.0%	117.7%	475	3.1	3.8	6.8				
D1	1,581	1,281	1,349	1,356	682	682	1,023	1,023	81.0%	100.6%	100.0%	100.0%	603	3.3	3.9	7.2				
D2	1,143	991	977	947	682	671	594	594	86.7%	96.9%	98.4%	100.0%	465	3.6	3.3	6.9				
D6	1,209	1,134	1,209	1,082	682	682	682	682	93.8%	89.5%	100.0%	100.0%	659	2.8	2.7	5.4				
M4	1,568	1,287	1,674	1,703	682	637	1,023	1,236	82.1%	101.7%	93.4%	120.8%	748	2.6	3.9	6.5				
SAU	1,814	1,784	977	965	1,023	1,012	682	682	98.3%	98.8%	98.9%	100.0%	408	6.9	4.0	10.9				
Short Stay Surgical Unit	1,907	1,805	771	709	891	891	594	594	94.7%	91.9%	100.0%	100.0%	672	4.0	1.9	6.0				
ICU & HDU	4,464	4,248	775	775	4,123	4,015	0	0	95.2%	100.0%	97.4%	na	300	27.5	2.6	30.1				
Birth Centre	930	750	465	450	620	530	310	300	80.6%	96.8%	85.5%	96.8%	57	22.5	13.2	35.6				
Delivery Suite	2,790	2,685	465	465	1,860	1,820	310	310	96.2%	100.0%	97.8%	100.0%	202	22.3	3.8	26.1				
Maternity 2	1,628	1,620	930	885	620	610	310	290	99.5%	95.2%	98.4%	93.5%	498	4.5	2.4	6.8				
Jasmine Ward	930	915	465	465	620	620	0	0	98.4%	100.0%	100.0%	na	243	6.3	1.9	8.2				
Neonatal Unit	2,325	1,899	0	0	1,628	1,292	0	0	81.7%	na	79.4%	na	197	16.2	0.0	16.2				
Tree House	2,790	2,460	465	465	1,860	1,541	0	0	88.2%	100.0%	82.8%	na	533	7.5	0.9	8.4				
	54,771	49,950	36,576	37,694	34,697	32,694	22,391	24,343	91.2%	103.1%	94.2%	108.7%	17855	4.6	3.5	8.1				

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : May 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	91.2% of expected Registered Nurse hours were achieved for day shifts. Any Registered Nurse numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Director of Quality & Deputy Chief Nurse.	May 2018 91.2% April 2018 91.5% March 2018 91.1%	The lowest RN staffing levels during the day were on Ward B4 at 61.5%. B4 RN days results indicate sub optimal staffing. There are never less than 2 RN on duty. Non registered nurses at 161% day duty support the registered team. Close supervision and support by the matrons assures safe staffing.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	94.2% of expected Registered Nurse hours were achieved for night shifts.	May 2018 94.2 % April 2018 94.4% March 2018 94.2%	The lowest staffing levels during the night were on the neonatal ward at 79.4%. Activity and acuity in month was low and staffing levels were adjusted accordingly. Matron confirms that RN staffing levels were appropriate and safe.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	103.1% of expected Non-registered hours were achieved for day shifts.	May 2018 103.1% April 2018 102.5% March 2018 99.4%	The lowest staffing levels during the day are on ward D6 at 89.5%. Vacancies are being recruited to and short term sickness has also impacted. Matron assures safety.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	108.7% of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed & is predominately due to wards requiring 1:2:1 specials for patients following a risk assessment or to support Registered Nurses staffing numbers when there are unfilled Registered Nurse shifts.	May 2018 108.7% April 2018 108.7% Mar 2018 106.9%	All wards report above 90% average on night duty. The lowest staffing levels during the night were on maternity 2 at 93.5%

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 June 2018
Subject:	Clinical Negligence Scheme for Trusts Incentive Scheme		
Report of:	Chief Nurse and Director of Quality Governance	**Prepared by:**	Head of Midwifery and Women's Health

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** NHS Resolution is trialling a CNST incentive scheme during 2018/2019 to improve safety within maternity services. The scheme asks Trusts to demonstrate their progress to date against ten defined maternity safety actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of the maternity premia). This potential rebate has a value of £290k to Stockport NHS Foundation Trust. The report that follows clarifies the progress of Stockport NHS Foundation Trust in relation to the attainment of the ten defined actions. The evidential requirements have been approved by the Chief Nurse prior to submission to the Trust Board and confirm that evidence can be provided to demonstrate compliance with 60% of the defined actions. Approval and sign off is required by the Trust Board prior to submission of a verification paper to NHS Resolution.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:	Annex A – Draft Incentive Scheme Submission Document

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this paper is to seek sign off from the Trust Board that the evidential requirements have been approved for the Clinical Negligence Scheme for Trusts Incentive Scheme prior to submission of a verification paper to NHS Resolution.

2. BACKGROUND

2.1 The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety.

2.2 NHS Resolution is supporting this work during 2018/2019 trialling the CNST incentive scheme. The scheme asks Trusts to demonstrate their required progress against ten defined actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of the maternity premia). This rebate has a potential value of £290k to Stockport NHS Foundation Trust.

3. CURRENT SITUATION

3.1 Defined evidential requirements are identified for each of the ten defined actions in order to provide assurance that the action has been attained.

3.2 Stockport NHS Foundation Trust can meet the evidential requirements to demonstrate full compliance with 6 (60%) of the required actions and partial compliance with the remaining 4 (40%) actions.

3.3 Proposed actions to address the areas of identified improvement are detailed in the draft Submission Document included at Annex A. The evidential requirements are to be considered by the Trust Board prior to sign off and submission to NHS Resolution.

4. RISK & ASSURANCE

4.1 As the Trust is only unable to demonstrate the required progress against some of the actions The National Maternity Safety Champions and Steering group will review the submission details and at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust.

4.2 Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement will be non-recurrent and must be used by the Trust for making progress against one or more of the 10 actions.

5. CONCLUSION

5.1 The Submission Document at Annex A clarifies the progress of Stockport NHS Foundation Trust in relation to the attainment of the ten defined actions and details the proposed actions to be taken to improve safety within the service if the rebate is approved.

5.2 The evidential requirements have been approved by the Chief Nurse and Director of Quality Governance and are now to be considered by the Trust Board prior to sign off and submission to NHS Resolution.

Stockport NHS Foundation Trust Board Report on progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme relating to maternity safety actions

Date: June 2018

Summary

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety.

NHS Resolution is supporting this work during 2018/2019 trialling the CNST incentive scheme. The scheme asks Trusts to demonstrate their required progress against ten defined actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of the maternity premia). This rebate has a potential value of £290k to Stockport NHS Foundation Trust.

The report that follows details the evidence that has been collated to date in relation to the ten required actions. The evidential requirements have been approved by the Chief Nurse and Director of Quality Governance prior to submission to the Trust Board.

Proposed actions to address the areas of identified improvement are detailed within the embedded report.

The evidential requirements are to be considered by the Trust Board prior to sign off and submission of the paper to NHS Resolution.

SECTION A: Evidence of Trust's progress against 10 safety actions:

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	We are partially compliant with this action and the required evidential requirements. Authorisation for staff members to register with MBRRACE-UK and use the national Perinatal Mortality Review Tool on behalf of Stockport NHS Foundation Trust was submitted on the 14 February 2018 and subsequently approved. Since we have had approval confirmed we have one eligible case relating to an intrapartum stillbirth that will be reported using the tool. The coroner is involved in this case and a level 2 investigation is currently in progress and is due to complete on the 6 June 2018. We have not however currently reviewed any deaths prior to the implementation of the tool as recommended in the evidential requirements. Appendix 1 – Perinatal tool registration forms Appendix 2 – Perinatal mortality report	**No** **(Action plan 1)**

	Appendix 3 – Evidence to implementation of tool in practice	
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	We are fully compliant with this indicator and can confirm that we have submitted data on all 10 defined criteria and have thus met the required standard. Appendix 4 – Confirmation of submission of all MSDS criteria October 2017-March 2018	**Yes**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	We are currently partially compliant with this action. At Stockport we deliver transitional care to babies who require intravenous antibiotics on the postnatal ward. This enhances the patient experiences and negates the need to separate mother and baby. All staff who administer the intravenous antibiotics have completed local Trust training and a competence tool. We also have a defined area for the provision of transitional care within the Neonatal Unit that is used for mothers discharged from the maternity unit and is supported by staffing from the Neonatal Unit. Community Midwifery staff currently attend to mothers who have babies requiring ongoing care on the NNU. We have an on-going action plan in progress to support the delivery of the ATAIN programme and have recently introduced the 'Red Hat for Babies' project to reduce the number of babies admitted with	**No** **(Action plan 2)**

	hypothermia/hypoglycaemia to the NNU. Appendix 5 – ATAIN presentation Appendix 6 – Copy of neonatal antibiotic workbook	
4). Can you demonstrate an effective system of medical workforce planning?	We are fully compliant with this action and submitted our completed RCOG workforce staffing tool using the required template on the 15 May 2018 Appendix 7 - Copy of RCOG submitted workforce staffing tool Appendix 8 – Completed medical staffing rosters for March 2018	**Yes**
5). Can you demonstrate an effective system of midwifery workforce planning?	We are fully compliant with this required action. The safe staffing policy is currently being revised and updated to reflect changes to current service provision and Business Group changes The coordinator is super numary within practice and the revised policy. A formal review of our staffing levels was last undertaken in June 2017 by Birth Rate Plus and this highlighted a staffing deficit within our service. An outline Business Case was then formulated in response to the findings and additional staffing was approved. We informally monitor staffing levels on a monthly basis at performance	**Yes**

	management meeting with the Ward Leads using the staff in post reports. Datix incidents relating to red flags, maternity diverts and staffing incidents are also monitored on a monthly basis and escalated via the key issues report and at the strategic staffing meeting held within the Trust. A six monthly review of the safe staffing levels is also undertaken by the HOM/Chief Nurse and is presented to Trust Board in the strategic staffing paper. Appendix 9 – Copy of Birth Rate Plus service review report – June 2018 Appendix 10 – Trust Strategic Safe Staffing report	
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	We are compliant with this action. We monitor our compliance in relation to the implementation of the Saving Babies Lives Care Bundle within the GMEC network and report our progress on a quarterly basis. We have now implemented all four elements of the care bundle and our progress is detailed in the document attached. We currently deliver 75% of element 2 of the care bundle that relates to the identification and surveillance of pregnancies with growth restriction. We have undertaken audits of 34 sets of clinical notes over the past twelve months. An additional resource is required to undertake and embed the audit element of the bundle requirement within practice.	**Yes**

	Element 4 relates to effective fetal monitoring and we have implemented the fresh eyes recommendations into practice. Although 25% compliance was reported in the last survey this indicator is improving as the recommendation is embedded into practice. An audit of compliance has not yet been undertaken to demonstrate the improvement in practice. In April 2018 we reported a 98% compliance rate with the K2 CTG competency tool and we have funding to support the use of this package for a further two years. Appendix 11 – Confirmation of compliance with bundle submitted to the Strategic Clinical Network – Survey 9	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	We are fully compliant with this action. In addition to ipad surveys and Friends and Family Feedback we also hold bi monthly Stockport Maternity Service Liaison Group Meetings led by maternity service representatives on a unpaid basis to involve the service users in the development and co design of our service. We are currently in the process of transitioning to a local Maternity Voices Partnership from an established Maternity Service Liaison Group. We take minutes of meetings and are currently engaging with service users to develop our workplan for 2018/2019. The MVP work plan for 2015-2016 and the minutes of the last meeting are attached as evidence.	**Yes**

	We also contribute as a local provider to the GMEC MVP and development of services for patients within the GM network Appendix 12 – Minutes of MSLC meeting July 2017 Appendix 13 – MSLC action plan 2015-2016 Appendix 14 – MVP launch presentation Appendix 15 – Dates of upcoming MVP Meetings for 2018	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	We are partially compliant with this action. On the 22 May 2018 79.30% of our staff had attended obstetric emergencies multidisciplinary training within the last calendar year. This figure includes members of the obstetric and midwifery multidisciplinary team and evidence of attendance is recorded on a local training database that fulfils the CNST requirements and can be used to filter attendees by staff group. Currently this reported figure does not include anaesthetic staff, as the anaesthetic team jointly deliver the AIMS training course with Maternity staff and participate in live skills drills on Delivery Suite to promote and support multidisciplinary team working. Appendix 16: Skills Drills training programme 2018-2019 (content specific)	**No** **Action plan 3**

	Appendix 17: Skills Drills programme of dates 2018-2019	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	We are partially compliant with this action. Bi monthly meetings have been arranged with the Clinical Director, HOM and Chief Nurse throughout 2018 to discuss issues relating to the safety of maternity services. The Maternity Safety Champions have previously escalated any issues of concern via the Business Group Quality Board and then escalated to the Trust Quality Governance Committee and the CCG Quality Assurance Board. We can provide evidence of the effective escalation of key national reports such as EMBRRACE at the Quality Governance Committee that reflect issues impacting upon the safety of mother and baby and service provision. Appendix 18: MBRRACE reports submitted to Trust Quality Governance Committee	**No** **Action plan 4**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	We are fully compliant with this indicator all relevant incidents have been reported to date. Appendix 19: Early notification submission form	**Yes**

SECTION B: Further action required:

Please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

Action Plan 1 Summary

An ongoing serious incident investigation and ongoing coroners investigation has delayed the inputting and review of the remaining case. We will use the NMPRT tool to assist in the review of the outstanding case and all future perinatal deaths in a robust, objective, systematic and standardised way.

Action Plan 2 Summary

Funding would be used to develop and trial an alternative transitional care service model to implement the provision of a transitional care service within our postnatal and intrapartum areas. We would like to consider an in reach model initially basing the TC team in the NNU, progressing to babies being discharged from the postnatal ward and returning to the NNU TC team for their intravenous antibiotics from home if required. We anticipate that this model would require an implementation period of six months to allow for recruitment of staff and then it would be trialled for twelve months thereafter and then reviewed. We anticipate that this scheme will cost in the region of £200k to staff and implement within practice.

Action Plan 3 Summary

If funding is received we propose that key members of the team led by a (0.6 wte) Band 7 Practice Educator will undertake the PROMPT trainer course and then deliver PROMPT multidisciplinary cascade training to all remaining members of the multidisciplinary team.

Action Plan 4 Summary

Due to a change in senior leadership appointments we did not schedule bi monthly meetings as Maternity Safety Champions during 2017-2018. The Maternity Safety Champions previously escalated any issues of concern via the Business Group Quality Board and then escalated to the Trust Quality Governance Committee and the CCG Quality Assurance Board. We have since scheduled meetings as Maternity Safety Champions during 2018 – 2019 in order to ensure that safety within the maternity service remains a key priority of focus. Meeting bi monthly will enable the maternity safety action plan to be robustly monitored and ensure key safety issues are highlighted and actioned.

Appendix 20: Action plan submission document

SECTION C: Sign-off

……..

For and on behalf of the Board of Stockport NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: …….

Date: …….

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Appendix 1 – Perinatal tool registration forms

Appendix 2 – Perinatal mortality report

Appendix 3 – PMRT report to evidence implementation of tool in practice

Appendix 4 – Confirmation of submission of all MSDS criteria October 2017- March 2018

Appendix 5 – ATAIN presentation – implementation of actions

Appendix 6 – Copy of neonatal antibiotic workbook

Appendix 7 - Copy of RCOG submitted workforce staffing tool

Appendix 8 – Completed medical staffing rosters for March 2018

Appendix 9 – Copy of Birth Rate Plus service review report – June 2018

Appendix 10 – Trust Strategic Safe Staffing report

Appendix 11 – Confirmation of compliance with Saving Babies Lives care bundle submitted to the Strategic Clinical Network

Appendix 12 – Minutes of MSLC meeting July 2017

Appendix 13 – MSLC action plan 2015-2016

Appendix 14 – MVP launch presentation

Appendix 15 – Dates of upcoming MVP Meetings for 2018

Appendix 16: Skills Drills training programme 2018-2019 (content specific)

Appendix 17: Skills Drills programme of dates 2018-2019

Appendix 18: MBRRACE reports submitted to Trust Quality Governance Committee

Appendix 19: Early notification submission form

Appendix 20: Action plan submission document

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 June 2018
Subject:	Update on staff survey 2017 outcomes		
Report of:	Interim Director of Workforce & Organisational Development	**Prepared by:**	Head of Organisational Development & Learning

REPORT FOR APPROVAL

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

Summary of Report

- The staff survey results for 2017 identified 5 key areas for improvement which are detailed in section 2 of the report.
- The overall level of staff engagement had also reduced marginally from 52%-50%.
- A Trust Culture and Engagement Plan has been developed which includes actions to address the issues identified in the staff survey, as well as Leadership and Development, Equality, Diversity and Inclusion, Workforce Health & Wellbeing and Professional Education.
- Delivery against this plan will be led by the Culture and Engagement Group, reporting in to the People & Performance Committee.

Attachments: Annex 1 - Health & Wellbeing Leaflet

This subject has previously been reported to:

☐ Board of Directors	x☐ People Performance Committee
☐ Council of Governors	☐ Charitable Funds Committee
☐ Audit Committee	☐ Nominations Committee
☐ Executive Team	☐ Remuneration Committee
☐ Quality Assurance Committee	☐ Joint Negotiating Council
☐ Finance & Performance Committee	☐ Other

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The Purpose of this report is to provide the Trust Board with an update on the development of a 3 – 5 year Culture and Engagement Plan following discussion at the April Board meeting on the outcomes of the 2017 staff survey.

2. BACKGROUND

2.1 In April 2018, the Board considered the outcomes of the 2017 staff survey.

2.2 The survey results identified that the Trust's survey outcomes had improved in the following areas:

- More staff had an appraisal
- Less harassment and bullying or abuse from patients/service users, their relatives or members of the public
- Immediate managers gave clear feedback
- Adequate adjustments are made to enable disabled employees to carry out their work
- Less discrimination from managers team leaders or other colleagues.

There were five areas requiring improvement:

- Giving feedback about changes made in response to reported errors
- Staff always recommending the organisation as a place to work
- Identifying training learning or development needs in appraisals
- Reporting experiences of physical violence
- Taking positive action on health and well-being.

2.3 In addition, the Trust overall staff engagement score had reduced from 3.75 to 3.73, which the Trust considered to be an early warning that further action was required.

3. CURRENT SITUATION

3.1 Following discussion at the April Board meeting, it was agreed that these actions would be included in a broader 3 to 5 year Culture and Engagement Plan for the Trust in recognition that applying short term solutions in response to staff survey results only, would not achieve sustainable and embedded improvement in workforce culture and engagement.

3.2 The developing Stockport People Strategy includes Learning and Development and Culture and Engagement as two of its four key themes and will describe how the Trust will engage and develop our workforce to meet the future needs of the Trust within the wider healthcare system. The Culture and Engagement Plan is aligned to these themes.

3.3 Progress against the staff survey key actions continues as part of the Culture and Engagement Plan and includes:

3.3.1 The Datix system has been reviewed and upgraded. This commenced December 2017 and new processes allow for feedback methodology that informs staff of revisions and necessary changes.

3.3.2 Listening events have occurred through the cultural Ambassador network and the feedback is aligned to the Friends and Family Test (FFT) and new starter events which are held quarterly.

The Head of Organisation Development/Learning and the Learning and Development Manager are holding culture feedback sessions on 22nd and 29th June 2018 to discuss staff experience and engagement six months post survey and current FFT.

'Celebrating Stockport; continues to grow with two good practice/celebration events taking place (December and March) with a third event due on 13th July to incorporate 70 years of the NHS and Windrush. The 'Thank You' cards have launched with the Chief Executive support. Team member of the month launched in May with Chris Brazil, a Porter from Endoscopy, the chosen winner with 14 votes from various areas across the Trust. The Cultural Ambassadors have developed change pledges and positivity Boards with diverse teams and continue to promote the Trust as a positive place to work.

3.3.3 The Appraisal Policy and process has been reviewed and re-launched to ensure equity in the development and agreement of Personal Development Plans (PDP'S). The Training Needs Analysis was successful in 2016/17 and the process has been repeated in 2018 with alignment to individual PDP's.

3.3.4 Individual Business Groups are encouraging Staff to report and share their experiences in relation to physical violence and how this is reported.

3.3.5 Health and Well-being is a core element of the Culture plan and there is a variety of interventions in place to support staff health and well-being at work.

3.4 Trust Business Groups have been provided with their Group specific survey results and will be supported by the Learning & Organisation Development team to develop action plans specific to their group needs and plans.

4. CONCLUSION

4.1 The Trust has developed a Culture and Engagement Plan to support the delivery of the staff survey and additional key actions that support a positive staff experience and enable motivated and engaged staff to deliver safe, quality and effective care. The plan commenced in 2017 and will continue to 2022.

5. RECOMMENDATIONS

5.1 The Board is asked to note the establishment of the Culture & Engagement Group which will lead on the delivery of the Trust, and Business Group specific Culture and Engagement Plans aligned to the developing Stockport People Strategy.

5.2 The Board is asked to note the progress against the key areas of improvement based on the 2017 staff survey results.

5.3 The Board continues to receive regular update reports on progress against the Staff Survey, having noted the reduction in overall engagement score, and as a key element of the developing Stockport People plan.

Smoking Cessation / Alcohol Support / Weight Management

Healthy Stockport is a free, confidential local support service to help people make positive lifestyle changes. You can contact them by telephone on: START 0161 474 3141 or by visiting their websites: www.healthystockport.co.uk or visit the Pharmacy Shop for a free consultation for smoking cessation.

Pharmacy Shop

The Pharmacy Shop offers the following services for staff members:

- 20% discount for all staff members on most over-the-counter purchases
- Healthy Living Advice
- Blood Pressure Checks
- Seasonal Flu Vaccination Service
- Smoking Cessation Service
- Emergency Hormonal Contraceptive Services

The Pharmacy Shop can be contacted on: 0161 419 4466.

Complementary Therapy

If you feel stressed or run down, perhaps you need a lift. Why not try a complementary therapy such as **Massage, Indian Head Massage, Reiki, Aromatherapy, Spiritual Healing, Metamorphic Technique, Reflexology or Bach Flower Remedies**. Treatments have been subsidised by the Trust and, therefore, cost to the client is **£15 per session for up to 6 sessions per year** per client. For further details, or to arrange an appointment, please contact Sue Atkinson on 0161 285 1903 or Janet Kaye on 0161 485 2667.

Staff Travel

We encourage staff to minimise car use as much as possible. The following benefits are available to all those wishing to walk, cycle or take public transport:

- Separate male and female shower and changing facilities
- Secure cycle parks across the hospital site
- Walking to work will improve your fitness (pedometers are available on loan from the Occupational Health Department)

For more information, please contact the Travel Administration office on 0161 419 5032.

Reduced Cost Membership at Life Leisure Stockport

Life Leisure is a not for profit social enterprise company and registered charity. They provide high quality, excellent value fitness clubs with the aim of improving the quality of life for people in Stockport. As a member you will have access to state-of-the-art gyms, swimming pools and extensive aerobic timetables and much more.

Staff at the Trust can sign up for reduced cost memberships from as little as £26.50/month. For further information, contact a member of the Life Leisure Team on 07798 698 630.

NHS Stockport NHS Foundation Trust

Health and Wellbeing

Staff Benefits for Healthy Living

- Occupational Health • Complementary Therapies
- Staff Podiatry • Staff Physiotherapy
- Staff Lifestyle Assessments
- Staff Travel Incentives • Staff Counselling/Mental Health
- Pharmacy Shop
- Reduced Cost Membership at Life Leisure

Visit the Health and Wellbeing microsite on the Intranet
or call Occupational Health on
0161 419 5491 for more details

Your Health. Our Priority.

Staff Health and Wellbeing

The Trust runs a host of services designed to help you in all aspects of your working life — from physical and mental wellbeing, right the way through to looking after your pocket. This leaflet gives you more information about the services we offer.

Tai Chi / Zumba only £3 per session

Classes are available at Stepping Hill Hospital as follows:

Tai Chi on **Mondays 5:15 – 6:00 pm** in the Physio Gym
Zumba on **Tuesdays 5:15 - 6:00 pm** in Pinewood House.
Yoga (no need to book) (£3 a session, collected by Instructor):

Beginners	Mondays	5:15 - 6:30 pm	Pinewood House
Intermediate	Thursdays	5:15 - 6:30 pm	Pinewood House
Anyone	Tuesday	12:00 - 1:00 pm	Devonshire Royal Unit

Walk to Run Wednesdays 4:30 - 5:15 pm (free) - meet outside Main Reception.

Wednesday Walks 12:30 – 1:00 pm (free) – meet outside Oasis building.

Discounted Personal Training Sessions

PT Hut in Cheadle are offering a 10% discount on 1:1 Personal Training sessions for NHS Staff. No matter what it is you're interested in, whether it's body building, strength training, callisthenics, losing weight, toning up etc; they have a personal trainer that can help or classes you can join. Contact them on Tel: 07446 696463; e-mail: info@thepthut.co.uk; Website: Facebook: thepthutstockport.

Occupational Health

The Occupational Health Department offers a range of services including telephone based advice and guidance on a self-referral basis. An appointment with an Occupational Health Practitioner can be arranged where appropriate. If you would like to self–refer, please contact the Occupational Health Service for confidential advice on 0161 419 5491. Case Conferences can also be facilitated with a staff member, their manager and HR representative to better understand the impact of any health issues at work or the ability to return to work, resolve miscommunication, or provide explanations in relation to health issues, and discuss options to optimise adjustments to assist or aid a return to work.

iWill: Your Own Health & Wellbeing Online Resource Centre

Occupational Health offers you the opportunity to access your own personal, confidential, online Health & Wellbeing Resource Centre (called **iWill):**

http://iwill.warwickicsystems.com

User name: **Stockport** Password: **S7tockport!**

There are a range of topics that will provide you with the tailored lifestyle guidance on the subject or subjects of your choice, this could be balancing your life or drinking less caffeine. In each category you will find a mix of information sheets, measurement tools as well as podcasts and videos to get you started and keep motivated.

Health and Wellbeing Lifestyle Assessments

Occupational Health offer Health and Wellbeing lifestyle assessments. This initiative supports the Trust in continuing to work towards improving the health and working lives of staff. Please contact the Occupational Health Service on 0161 419 5491 to arrange an appointment, then complete the Life Style assessment form on the Occupational Health microsite (also take a look at iWill for additional support, log in details above).

Staff Podiatry

Staff can self-refer to the Podiatry Service. If you have painful feet then find out why; telephone 0161 419 5787 to make an appointment at the Staff Podiatry Clinic at Stepping Hill Hospital, or to find out about the drop-in clinics located throughout Stockport.

Staff Counselling/Mental Health

Staff Counselling Service: To self-refer please telephone 0161 419 5432 leaving your name and contact details and you will receive a call back to arrange an appointment. In addition to self-referring via telephone, please email your name and contact details to: referrals.staffcounselling@stockport.nhs.uk

Telephone Helplines:

- Health Minds, Stockport 0161 419 5725 / Stockport MIND 0161 285 1827
- CBT/Computerised CBT - Stockport Psychological Wellbeing Service 0161 480 2020/232 7834
- The Sanctuary (24hr mental health crisis line) 0300 003 7029.

Online Resources:

Etherapy - www.selfhelpservices.org.uk
Free of charge - https://ecouch.anu.edu.au/new_users/welcome01
Free of charge - http://www.cci.health.wa.gov.au/resources/consumers.cfm
Free of charge - https://www.nhs.uk/Conditions/stress-anxiety-depression
Free of charge - https://www.mind.org.uk

Staff Physiotherapy

Staff with a newly developed Musculoskeletal problem can have it assessed and treated by the Trust`s Outpatient Physiotherapy staff. The service is designed as a relatively fast turnaround service to assist in keeping staff at work, or aide their return to work.

It is also to prevent problems becoming chronic, and for that reason it is **only new acute and sub-acute problems that have only existed for 4 weeks** in duration or less that can be accepted. There are, however, no restrictions on the area of the body that is involved. Physiotherapy is available at Outpatient Therapies at Stepping Hill Hospital or Kingsgate House. Please complete the Physio Referral Form on the Occupational Health Microsite.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 June 2018
Subject:	Governance Declarations		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

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

The purpose of this report is to present draft Governance Declarations for consideration and approval by the Board of Directors.

Attachments: Appendix 1 – Draft Governance Declarations

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this report is to present draft Governance Declarations for consideration and approval by the Board of Directors.

2. BACKGROUND

2.1 Declarations relating to Provider Licence Condition FT4, 'the Corporate Governance Statement', and Governor Training are required to be self-certified by the Board of Directors by the deadline of 30 June 2018.

2.2 Guidance issued by NHS Improvement in April 2017 advised that, while Boards are still required to complete relevant self-certifications, there is no longer a requirement to automatically submit the declarations to NHS Improvement. Instead, an audit process has been introduced whereby NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified.

3. CURRENT SITUATION

3.1 A draft self-certification template is included for consideration by the Board at Appendix 1 to this report. In considering responses to the various elements, the Board should take into account assurances recently provided in relation to the Annual Report & Accounts 2017/18 such as:

- External Audit reports on audit of the 2017/18 Financial Statements and Annual Quality Report
- Director of Internal Audit Opinion 2017/18
- Internal Audit Opinion on the Board Assurance Framework
- Compliance declarations in relation to the NHS Foundation Trust Code of Governance
- Annual Governance Statement 2017/18

3.2 Other relevant factors to consider include enhancements to governance arrangements resulting from the Review of Undertakings and implementation of a Quality Framework and Quality Improvement Plan. A number of risks to continued compliance are included in the draft template at Appendix 1. The Board should consider whether there are any additional risks to forward compliance that are relevant for inclusion.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Consider and approve the draft declarations included at Appendix 1 to the report.

This page has been left blank

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Stockport NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board continues to apply principles and standards of good corporate governance and developments during 2017/18 were informed by outcomes of both a CQC inspection and a Review of Undertakings carried out by NHS Improvement.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board has robust systems in place to assess and respond to guidance issued by NHS Improvement.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board adopts a continuous improvement approach to both Board and Committee arrangements with developments informed by best practice and outcomes of relevant reviews. The governance architecture for reporting to the Quality Committee was fundamentally reviewed and revised during 2017/18. In addition, Committee reporting to Board has been enhanced through a revised Key Issues Report format based on an Alert, Assure and Advise approach.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board confirms that the Trust meets this requirement in the context of both continued application of an additional licence condition relating to achievement of the 4-hour A&E standard, further modified in December 2017 as a result of the Review of Undertakings, and a Requires Improvement outcome of the CQC Inspection. The Trust's progress in mitigating associated risks is subject to regular review by NHS Improvement with formal monitoring through a monthly Quality Improvement Board involving regulatory and local system stakeholders. With regard to requirement 4d, the Board is fully aware of the Material Uncertainty relating to Going Concern applied in the ISA260 report following audit of the 2017/18 Financial Statements and is assured that plans are in place for a working capital facility, if required, to mitigate associated risk. In addition, the Trust's financial performance is subject to monthly Enhanced Oversight from NHS Improvement. Any risks relating to general effectiveness of systems and processes will be tested during a CQC Well Led Review which we anticipate will be undertaken in Quarter 3 2018/19.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	With regard to requirement 5c, the Board notes that the limited assurance report on the Annual Quality Report 2017/18 resulted in a qualified opinion on the Referral to Treatment incomplete mandated indicator. While improvements had been achieved during 2017/18, the qualified opinion was made on the basis of weaknesses in data management process and practice. Continued progress and improvement will be monitored by the Audit Committee. With regard to requirement 5f, practice and accountability for quality of care has been significantly enhanced through the implementation of a Board approved Quality Governance Framework and Quality Improvement Plan.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Robust recruitment and selection processes are in place for both Non-Executive Director and Executive Director positions. Risks associated with current interim Chief Executive and Director of Workforce will be mitigated through recruitment activity to secure substantive appointees.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Adrian Belton **Name** Helen Thomson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A1

Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Adrian Belton	**Name**	Helen Thomson
Capacity	Chair	**Capacity**	Interim Chief Executive
Date	28 June 2018	**Date**	28 June 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 June 2018
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR ASSURANCE

Corporate objective ref:	-----	**Summary of Report** **The data for this report was collated on 6 June 2018. At the Safety and Risk Group on the 13 June 2018 a further 2 risks were approved and are now included on the risk register.** This paper provides an overview of the current Trust Risk Register. This report includes all current risks of 15 and above for the members to review. There are currently 276 live risks recorded on the Risk Register systems. There are 29 risks rated 15 or above on the Trust Risk Register with corporate approval. Across the 29 risks rated 15 or higher that have been corporately approved; • 7 risks are associated with staffing issues • 6 risks are associated with financial issues • 5 risks are associated with capacity issues or increase in demand • 4 risks are associated with equipment issues Members are asked to note the risks and the identified actions to mitigate those risks
	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☑ Not required	

Attachments: Nil

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

- THIS PAGE IS INTENTIONALLY BLANK -

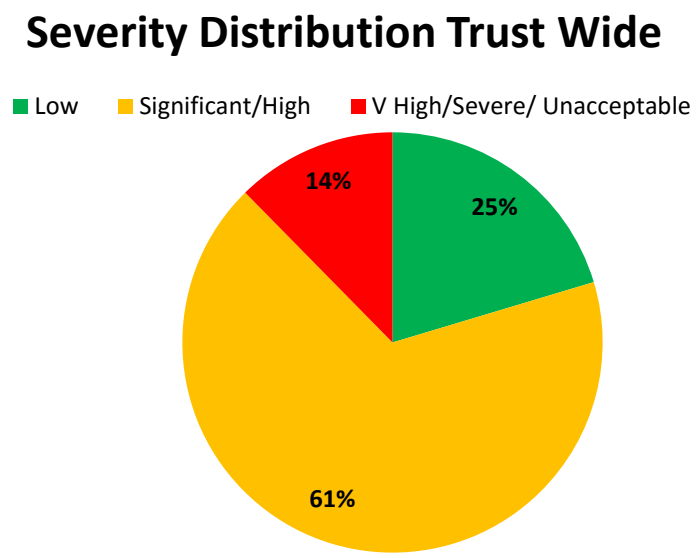
1.0 Trust Wide Risk & Severity Distribution

1.1 There are currently 274 live risks recorded on the new Risk Register system. This is an increase of 11 from last month

1.2 There are no live risks on the old risk register.

1.3 Trust wide distribution of risk is shown below:-

		Low				Significant			High			Very High		Severe	Unacceptable
	0	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Old System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
New System	3	1	3	11	38	2	32	30	44	7	71	8	16	8	0



1.5 Trust Risk (approved) distribution across Business Groups.

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

1.6 Risk movement of risks of 15 and above in month

Corporate Approved Risks														
Risk number	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
46	16	20	20	20										↓
67				16										N
75	16	16	16	16										↔
76	16	16	16	16										↔
78	20	20	20	20										↔
96	16	16	16	16										↔
101	20	20	20	20										↔
108	16	16	16	16										↔
125	16	16	16	16										↔
126	16	16	16	16										↔
127	16	16	16	16										↔
130	20	20	20	20										↔
134	20	20	20	20										↔
135	20	20	20	20										↔
159	20	20	16	12										↓
162	15	15	15	15										↔
167	16	16	16	16										↔
183	16	16	16	16										↔
231	20	20	20	20										↔
261	16	16	16	16										↔
286		15	15	15										↔
305				15										N
354	16	16	16	16										↔
362	15	15	15	9										↓
399		15	15	15										↔
408			15	15										N
429			20	20										↔
458				16										N
461			16	16										N
469				20										N
499				15										N

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

Business Group Approved Risks														
Risk number	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
64	16	16	16	12										↓
233	20	20	20	12										↓
274			16	12										↓
360			16	16										↔
400		15	15	15										↔
431				15										N
443			20	12										↓
466				16										N
476				15										N

1.7 Risk movement in previous months

Risks removed from the Trust Risk register in previous months														
Risk number	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
53	16	12												↔
74	25	10												↔
87	16													C
91	15													C
109	16	16	1											↔
137	16	16												↔
145	16													C
160	15	15	8											↔
177	15	12												↔
282	15	15	12											↓
288	15	15	9											↓
296	15	15												C
318	15	6												↔
319	15													C
355	15	15	12											↓

Business Group Approved Risks – movement to below 15 in previous months														
Risk number	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
86	16	9	9											↔
193	20													C
207	16	12	12											↔
263	15	12	12											↔
285	20													C
346	15	15												C
358		15	9											↓

2.0 New Risks Identified

2.1 7 new risks have been added to the Trust risk register in month. 2 were sitting on the Business Group Risk registers and have been escalated to the Trust risk register. 5 were approved at the Safety and Risk Group in May and 2 were approved in June.

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Corporate Risk	469	Wiss, Kay	Patel, Feroz	Finance	There is a risk that the Trust will not deliver its 2018/19 financial performance	The performance management framework implemented in April 2017 will be refreshed for 2018/19 and used to ensure under-performance is escalated and managed. This will be through bi-monthly business group performance review meetings chaired by the Deputy CEO. A monthly financial improvement group (FIG) chaired by the CEO will hold SROs to account for their respective delivery programmes. The Trust has implemented an Executive Management Group attended by triumvirate leadership to review and manage the overall performance of the organisation. This group will be supported by an operational management group and SMT both chaired by the COO. Corporate resource support to the SROs has been refocused on the delivery of CIP in 2018/19. Stockport Together benefits will be managed by the Alliance Provider Board as part of the strengthened governance arrangements.	20	5	4	20	10	Implement an operational management group	29/06/2018
												Ensure that the Business Groups are held to account on the delivery of their respective operational plans	29/03/2019
												Develop a demand and capacity model	28/09/2018
												Preparation of a workforce plan	28/09/2018
												Principles for the Stockport Together risk share	29/06/2018
												Develop a medium term financial strategy	29/06/2018
												To regularly report the key issues facing the Trust as part of the Stockport Together Programme	29/03/2019

Business Group Risk	67	Drury, Margaret	Brearly, Hilary	Women Children & Diagnostics	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	Approval granted for 2 locums posts Part time locum being recruited 3 days per week for 6 months. Temporary staffing processes being followed including use of standard placement as alternative to direct engagement Antibiotic pharmacists working from laboratory office to be in proximity to consultant.	20	4	4	16	8	Appoint to substantive posts	29/06/2018
Business Group Risk	461	Hatchell, Karen		Surgery GI and Critical Care	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment e.g., physician associates, ANP's etc. Validation of all activity with a view to alternative modes of delivery e.g., virtual clinics Robust financial controls in place across the Business Group	16	4	4	16	12	Monitoring weekly of activity v plan	04/07/2018
Business Group Risk	458	Hatchell, Karen		Surgery GI and Critical Care	There is a risk of not achieving the Theatre & Endoscopy CIP Programme 2018-19	Implementation of a theatre and endoscopy improvement programme. Steering Group and benefits realisation working group in place. Weekly activity monitoring against plan across elective specialties.	16	4	4	16	8	Monitoring of weekly activity v plan	31/08/2018

Business Group Risk	305	Rigby, Susan	Patel, Feroz	Finance	There is a risk that the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements	Regular team briefings are held to mitigate the uncertainty around potential shared services. Succession plan in place – training group for department, individuals identified and on a development plan Part of finance staff development network Clear line of sight of what projects are coming up and who is working on what – operational planning group that has a timetable. Year end processes timetable. Mean clear on deadlines Weekly senior team meeting every Tuesday morning Individual team meetings to cascade information Monthly team briefs Replacing ledger? Impact on staff of managing that project	10	5	3	15	5	Business Case for Replacement of ledger	29/06/2018
												Review of Shared Services	29/06/2018
												Understand the implications of revised contracting model under the Provider Alliance Agreement	31/07/2018
												Business Accountant Maternity Cover	31/07/2018
												Replacement of Associate Director of Finance	29/06/2018
Business Group Risk	408	Damant, Mrs Gillian		Medicine and Clinical Support	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	To maintain a pharmacy service the following controls are in place. Suspended input to palliative care patients Reduced pharmacist prescribing input to support chemotherapy prescribing on EMPE Capacity planning review prior to initiation of new treatments. Reduced support to oncology Staff working outside hours to complete financial reports Delayed provision of information to NHSE Delaying patients treatment if numbers at an unsafe level	15	3	5	15	3	Discuss pharmacy capacity issues with Richard Bell	31/05/2018
												Bank pharmacist	25/06/2018
												Agree with haematologists a business case requirement for more pharmacy staff	31/05/2018
Corporate Risk	499	Buckley, Lisa	Lynch, Aliosn	Corporate Nursing	There is a risk that complaints responses are not being completed within Trust timescales	Action plan set up for business groups to have cleared their backlog and be working in real time by 31 July 2018. Monitored by the reporting process	15	3	5	15	4	weekly monitoring of complaints that are overdue	31/07/2018

3.0 Existing Risks

3.1 There are 27 risks rated 15 or above on the Trust Risk Register with corporate approval. This is an increase of 3, compared to last month.

3.2 Movement this month;

- 5 new risks have been added as identified above
- 2 risks have been reduced to below a risk of 14

4.0 Trends

4.1 The risk register is presented in order of consequence, with the highest consequence first

4.2 Across the 27 risks rated 15 or higher that have been corporately approved:-

- 7 risks are associated with staffing issues
- 6 risks are associated with financial issues
- 5 risks are associated with capacity issues or increase in demand
- 4 risks are associated with equipment issues

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Assessed consequence rating 5													
Strategic Risk	101	Rigby, Susan	Patel, Feroz	Finance	There is a risk that the Trust will not have sufficient cash reserves to operate	Daily cash reconciliation Cash flow forecast on a 13 week basis with a 15 month look ahead Cash Action Group meets on a monthly basis Cash reporting to Finance and Performance Committee Cash reporting to Board of Directors as part of IPR Liquidity days reported to NHSI as part of the Trust's Use of Resources finance score Updated Finance and Performance Committee on the process to draw down a revolving working capital facility.	20	5	4	20	5	Stress testing of the 13 week cash flow by the Cash Action Group on a monthly basis	31/03/2019
												As part of Finance & Performance meetings highlight the Trust cash position and the inter-dependencies on a monthly basis	31/03/2019
												Implementation of No PO No Pay policy	01/06/2018
Strategic Risk	162	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, quality experience and Trust reputation	NHSI improvement Board Patient Quality Summit weekly Safe, High Quality care action plan Quality Governance Framework Regular contact with the CQC	20	5	3	15	5	Deliver Safe, High Quality Care Action Plan	31/07/2018
Corporate Risk	399	Lehnert, Mrs Jean	Mullen, Hugh	Information and IT	There is a risk to patient care due to the potential Failure of PACs Infrastructure	•GE currently supports PACs but will no longer guarantee SLAs due to inability to source essential components. •Our current business continuity can support short term downtime, and is normally associated with planned down time for software upgrades or unplanned outages for power and network, but would struggle to support any major long term issues.	15	5	3	15	6	Data Migration	29/06/2018

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Assessed consequence rating 4													
Corporate Risk	78	Carpenter, Jane	Lynch, Alison	Medicine & Clinical Support	There is a risk that the quality of care to patients and of poor documentation, due to high numbers of registered nurse vacancies compounded by long term sick and maternity leave. There is a risk that wards cannot reach their safe staffing standard of RNs on a ward shift by shift, causing higher use of agency resulting in overspend of nursing budgets.	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons Daily staffing safety Huddle with Surgery Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment Quarterly organisational one stop recruitment events Management of sickness in line with Trust policy Effective and efficient duty rostering, completed 6 weeks in advance and as per rostering policy Effective and efficient duty rostering in line with agreed levels for annual leave Matrons scrutinise ward rosters to ensure they are fit for purpose and approved appropriately Planned week day Matron rounds each morning Monthly monitoring of turnover and sickness	20	4	5	20	8	Continue with existing Controls	13/07/2018
												Reference to the Minimum Safe Staffing Escalation Policy	13/07/2018
												Local recruitment	13/07/18

Corporate Risk	231	Glynn, Marie	Lynch, Alison	Corporate Nursing	There is a risk that the IP service is unable to meet all its obligations due to a lack of medical and nursing staff resulting in only mandatory work being undertaken.	• 2 Consultant Microbiology posts have been advertised with one including the IP doctor role • Pathology have provided the IP service team a member of staff for an hour per week to input the information on to the MESS data collection system • Monthly meetings have taken place between the DIPC and the IP strategic lead nurse • Business case was produced in May 2017 and taken to SMG twice	20	4	5	20	8	Review BG for wider IP team	28/11/2018
												Review links with sepsis agenda	28/06/2018
												review long term option for IV service	28/09/2018
												Current work load undertaken by the IP service team	31/08/2018
												To produce a gap analysis against the Health & Social Care Act	29/06/2018
												Present compliance data against the H&SC Act	29/06/2018
Strategic Risk	134	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk that Subject Access requests are not responded too in a timely manner, breaching the data protection act, due to vacancies and long term sickness within the team.	Workload is discussed weekly between band 3 and Risk and Customer Services Manager. All mail is checked on arrival and priority is given to court orders, emails are checked and the same principle applies.	20	4	5	20	8	Weekly updates from Team	30/06/2018
												Continue weekly monitoring of situation for 3 months	30/06/2018
												Use volunteers and bank staff to increase throughput	30/06/2018
Corporate Risk	130	Plummer, Sue	Toal, Sue	Integrated Care Business Group	There is a risk of poor patient experience, patient safety breaches, reputational issues with commissioners and financial penalties, due to the failure to deliver high quality care to patients in a timely manner and breaching the 4 hour target	Existing internal escalation processes	20	4	5	20	10	High Impact Priority Action Plans	01/11/2018
Strategic Risk	135	Lehnert, Jean	Lynch, Alison	Information & IT	There is a risk that the Subject Access Provision is not meeting data protection requirements	1. Medico Legal Team adhere closely to guidance (see earlier risk re pressures) 2. There is a clear process (doesn't include all areas) 3. Health Records follow process	20	4	5	20	8	Determination of requirements to meet legislation post review	30/06/2018

Corporate Risk	46	Smethurst, Richard	Mullen, Hugh	Women Children & Diagnostics	Telepath Server Failure Due to Obsolete 'live' and 'shadow' Telepath servers, causing potential loss of IT links between Lab Medicine and GPs / Wards and electronic access to results, leading to delayed treatment/diagnosis/discharge.	Telepath has 24/7 365 day support (hardware 7 years old). This system also has a failover server (also 7 years old). Mirrored Hard Disks Daily data tape backup, with monthly operating system backups Manual processes to book requests directly into analysers for emergency requests. Send routine work to other laboratories This emergency service would mean manual transcription of lab results, and greatly increases risks of serious errors. This service could only be maintained for a relatively short period of time (up to 48 hrs) and has a significant impact on departmental staffing requiring additional hours, and all managerial staff aiding in keeping the emergency service functioning.	16	4	5	20	4	Replacement Telepath Server.	30/06/2018
Corporate Risk	429	Curtis, Mrs Kelly		Women Children & Diagnostics	There is a risk that there is inadequate capacity to meet demand in Paediatric ADHD services	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	20	4	5	20	8	Define new ADHD pathway with CCG and HYMs	17/08/2018
												Paper to SMT to agree resource requirement for increase demand on service	20/07/2018
												Paper to contracting meeting to request additional resource from CCG	20/07/2018
												Advertise additional consultant PA's to provide ADHD Service	31/07/2018
												Additional Consultant PA's in post to provide ADHD service	19/10/2018

Risk Assessment	261	Nuttall, Lynn	Toal, Sue	Surgery GI & Critical Care	There is a risk to patients of delays and cancelations to the endoscopy list due to an aging JetAer automated scope reprocesser. This could lead to the failure to meet Cancer waiting targets.	Silver service maintenance contract with 'Cantel' medical for quarterly service, Quarterly HTM and annual validation. Scopes are processed in Endoscopy in event of breakdowns.	12	4	4	16	4	Purchase new AER	31/07/2018
Corporate Risk	75	Waterman, David	Toal, Sue	Integrated Care Business Group	There is a risk that; patients may not receive timely and appropriate palliative care, reputational issues with commissioners and financial penalties may be incurred due to a single Consultant in Palliative Medicine for the Organisation. This may result in a failure to provide consultant cover over weekends and during the doctors absences to specialist palliative care patients.	During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. Clinical Nurse Specialists attend some cancer MDT's if they have capacity.	20	4	5	16	8	Funding costs of Year ONe Business case for Specialist Palliative Care	29/06/2018
Business Group Risk	126	Harrop, Jen	Toal, Sue	Integrated Care Business Group	There is a risk that when there is a surge in demand in the Emergency Department, Patients are cared for on trollies in the corridor , leading to poor patient experience, patient safety breaches, reputational issues, failure to meet national standards and CQC requirements.	Use of Trust escalation policy - this focuses on assessing demand in ED, assessing capacity in the Acute Medical units (AMU 1 and 2)) and hospital wards. There are RAG rated trigger thresholds that correspond with actions for senior manager, directors and executives.	20	4	4	16	8	Review SURGE planning	22/06/2018
												Ambulance turnaround	29/06/2018

Business Group Risk	125	MR1	Toal, Sue	Integrated Care Business Group	Inability to recruit the number of medical staff needed to fulfil the rota for ED cover due to a tight labour market, resulting in an increased reliance on locum medical staff and internal staff covering extra shifts Consequence of uncertain delivery of key objectives / service due to lack of substantive staff and loss of key staff due to low staff morale.	Dependent on internal cover and locum bookings.	20	4	4	16	8	New Consultant rota to be negotiated.	29/06/2018
Strategic Risk	183	Hodgson, Karen	Toal, Sue	Executive Teams	Failure to meet the 62 day Cancer target standards	Monthly Cancer Board chaired by Trust Lead Cancer Clinician There is an established team of experienced Cancer Trackers and Cancer MDT Coordinators who are tracking all cancer patients to ensure they are treated within 31 and 62 days. Cancer Services Manager monitors performance on a daily basis using the 'Predictor tool' Cancer Access Manager undertakes weekly Tumour specific PTL meetings with Business Manager and Cancer Pathway Tracker. Weekly Trust-wide PTL chaired by the Director of Operations An escalation policy is in place to alert business groups of any issues causing delay to patient pathways	12	4	4	16	8	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	29/06/2018
												Action plan being created with input from Business Groups to ensure sustained performance	29/06/2018
												Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	29/06/2018

Corporate Risk	108	Jones, David	Toal, Sue	Women Children & Diagnostics	Failure to provide a robust imaging service due to reduced Radiographer staffing	Service currently supported by extra sessions which is provided on a voluntary basis Part time staff working additional hours 2 x Locum Radiographers contracted until 26/08/16 Review of processes to optimise efficiency Rolling advert on NHS Jobs for Band 5 Radiographer posts	16	4	4	16	8	Staff vacancies recruited too. Awaiting Staff to commence	30/06/2018
Business Group Risk	127	Armitage, Nadine	Shaw, Jayne	Medicine & Clinical Support	There is a risk that the BG overspends due to agency costs	Monthly reporting of finance and performance; including review of Clinical Income (including activity), Expenditure budgets and CIP. Documentation highlighting financial position shared to Business Group senior management team and cascaded as appropriate. Weekly local meeting with Business Accountant to review requirement for medical locums and position against national agency cap. Twice weekly local meeting with Medical Staffing and Business Accountant to review locum rates and contractual arrangements.	16	4	4	16	12	Introduction of medical e-rostering	11/05/2018
												Increasing pool of medical bank staff	14/09/2018
												International recruitment	14/09/2018
												Domestic recruitment	14/09/2018
												Management of Nurse e roster	15/06/2018
Corporate Risk	76	Bryson, George	Mullen, Hugh	Integrated Care Business Group	Potential financial and operational risk of failure in retaining / finding new clinical accommodation to operate the Stockport Wheelchair Service	Business as usual whilst the Service prepares for 'worst case' scenario and develops a contingency plan, quality impact assessment and an action log which identifies potential issues and the mitigating actions	16	4	4	16	12	Clarify timescales for remedial building work	29/06/2018
Business Group Risk	96	Rogers, Stuart	Toal, Sue	Medicine & Clinical Support	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	Waiting list sessions are undertaken by Consultants, middle grade doctors to backfill current lists and clinics where possible. Constant validation is also taking place and urgent	16	4	4	16	8	Virtual clinics	13/07/2018
												Review spend on WLI and convert to substantive	13/07/2018

						cases and short term follow ups are being prioritised Glaucoma and DRS patients are given top priority for capacity						Create an OP SOP in line with RC Ophth guidance	29/06/2018
												Clinical review of overdue Glaucoma patients by consultants	13/07/2018
Business Group Risk	167	Connaughton, Michelle	Mullen, Hugh	Surgery GI & Critical Care	Due to Lack of secure storage facilities on wards / units causing insecure patient records leading to failure of CQC / ICO standards in relation to confidentiality of patient information	Patient records are stored notes trollies, most of which are placed in non-patient areas. The notes are accessed by multiple members of the clinical teams - medical, nursing, midwifery and therapy.	16	4	4	16	8	Install new kit on arrival	28/09/2018
Risk Assessment	354	Ainsworth, Simon	Lynch, Alison	Women Children & Diagnostics	The risk of abduction or paediatric patient absconding.	Staff are more vigilant on checking who people are but at busy times they are not able to visualise who is entering and leaving. Minimal ward clerk cover till the approx. 17:00	16	4	4	16	8	implementation of new access/exit control	29/06/2018
												Approval of work at CPDG	29/06/2018
Assessed consequence rating 3														
Business Group Risk	286	Wheelton, Mrs Fiona	Toal, Sue	Surgery GI and Critical Care	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	Current controls in place are waiting list initiative (WLI) sessions which are run on an adhoc basis and a premium cost which are covered by Consultants and Nurses. Mediscan is an insourcing company who we have a contract with to provide the extra capacity on a Saturday morning to ensure that patients receive timely and appropriate care.	15	3	5	15	3	Meet with CCG	04/072018

5.0 Business Group Approved Risks

5.1 The new risks identified by the Business Groups are emerging issues, with controls and action plans yet to be determined.

5.2 There are 5 risks that score 15 or over that have been approved by the Business Groups

- 3 are new risks

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Corporate Risk	466	Armitage, Mrs Nadine		Medicine and Clinical Support	There is a risk that the BG will fail to deliver the CIP Target	Financial monitoring within BG occurs monthly Financial reports to monitor CIP schemes Tactical CIP schemes developed for the BG Improving patient flow work stream with metrics and governance arrangements Reporting of CIP savings, progress and escalation via Finance Improvement Group	16	4	4	16	8	Programme Management for CIP	19/09/2018
Business Group Risk	431	Hatchell, Karen		Surgery GI and Critical Care	There is a risk to service provision, from failure of kit, by not having a planned Medical Equipment capital replacement programme	EBME maintenance and service contracts cover some kit but not all equipment has cover, due to high cost or unavailability of parts due to the age of the equipment.	12	3	5	15	3	Manage equipment failures	01/10/2018
Corporate Risk	476	damant, Mrs gillian		Medicine and Clinical Support	There is a risk of not achieving the empiric review of antibiotic prescriptions &reduction in antibiotic consumption CQUIN 18/19	Assessing the current situation via an options appraisal paper seeking formal communication Director, Business Manager and CD to meet with the Gastroenterology Consultants who perform ERCPs.	15	3	5	15	6	Consider additional antibiotic pharmacist post	29/06/2018
												Recruit to microbiology vacancies	31/08/2018

5.3 The existing risks for the Business Groups are for information

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Business Group Risk	360	Wheelton, Mrs Fiona		Surgery GI and Critical Care	There is a risk to patient safety for lack of a full GI Bleed Rota	To address this risk we are implementing a phase one; launching the 'Unstable GI Bleed' rota from 2nd February which will provide weekend cover from Friday at 5pm to Monday morning at 9am. Endoscopy Nurse Consultation is now complete with staff signed up to deliver the rota. 24/7 bleed rota will go live following successful recruitment of two more Gastro Consultants. One advert is currently out to advert closing on 28.02.2017. The advert has been out 3 times, since October without any interest. The advert has been re-written and due to other service improvements developing this should make the job more inviting. Currently the Surgical 'HOT' team support the care of these patients which depending on who is on call can leave staff and patients in a precarious situation as not all of the General Surgeons are trained to deal with life threatening patients such as a Varicial bleed as it is not where their expertise lays.	16	4	4	16	4	Consultant Interviews	03/08/2018
												Completion of Job Planning	29/06/2018
Business Group Risk	400	Sperring, Mrs Carol		Women Children and Diagnostics Business Group	Capacity V Demand Issues in Children's Therapies	The service has published its 'local offer' as required by the Special Educational Needs and Disabilities (SEND) code of practice. This defines what the NHS in Stockport provides to children with a Stockport GP. The therapists will recommend what a child needs and if this is above what the NHS provides then this duty falls to a school if this is an educational need (that which trains or educates a child. However in practice it is very hard to define the educational versus the health aspect.	15	3	5	15	6	Capacity needed to meet demand	30/06/2018
												Local Offer defined for 2018	31/08/2018

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

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

The risk factor = severity x likelihood

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

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

QUALITATIVE MEASURE OF CONSEQUENCE

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

This page has been left blank