NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

27 SEPTEMBER 2018

Your Health. Our Priority.

Board of Directors - 27 September 2018

Board of Directors Meeting
Thursday, 27 September 2018

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

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		
0930	**4.**	Patient Story		**A Lynch**
	5.	**OPENING MATTERS**		
0945	5.1	Minutes of Previous Meeting: 30 August 2018	✓	**A Belton**
0950	5.2	Chair's Report	✓	**A Belton**
0955	5.3	Chief Executive's Report	*Verbal*	**H Thomson**
1000	5.4	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
1015	6.1	Performance Report	✓	**H Mullen**
1035	6.2	Winter Plan 2018/19 – Update Report	✓	**J Wood**
	7.	**FINANCE & QUALITY**		
1045	7.1	Quality Improvement Plan	✓	**A Lynch**
1055	7.2	Liverpool Community Health – Independent Review	✓	**A Lynch**
1105	7.3	Trainee Experience	✓	**C Wasson**
1115	7.4	Staff Survey 2017 Outcomes – Update Report	✓	**H Brearley**
1125	7.5	Medical Appraisal & Revalidation	✓	**C Wasson**
1130	7.6	Safeguarding Annual Report 2017/18	✓	**A Lynch**
	8.	**STRATEGY & GOVERNANCE**		
1135	8.1	Trust Strategy	✓	**H Mullen**
1145	8.2	Estates Strategy	✓	**H Mullen**
1155	8.3	People Strategy	✓	**H Brearley**

1205	8.4	Medium Term Financial Strategy	✓	**F Patel**
1215	8.5	Proposed Amendments to Constitution	✓	**P Buckingham**
1220	8.6	Trust Risk Register	✓	**A Lynch**
1230	8.7	Board Assurance Framework	✓	**A Lynch**

9. CONSENT AGENDA

9.1
- Nil Consent Agenda items

10. DATE, TIME & VENUE OF NEXT MEETING

10.1 Wednesday, 31 October 2018, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
on Thursday, 30 August 2018
11.00am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr M Sugden	Non-Executive Director (in the Chair)
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr D Hopewell	Non-Executive Director
Ms 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
Dr C Wasson	Medical Director
Ms J Wood	Urgent and Emergency Care Improvement Director

In attendance:

Mrs S Curtis	Membership Services Manager
Mr S Goff	Deputy Chief Operating Officer

203/18 Apologies for Absence

Apologies for absence had been received from Mr A Belton, Mr P Buckingham, Ms A Smith and Ms S Toal.

Mr M Sugden welcomed Board members and observers to the meeting, making particular reference to Mr S Goff who was deputising for the Chief Operating Officer. He advised that the meeting had been arranged at a relatively short notice and that instead of following the usual agenda, the meeting would focus on progress against performance issues.

204/18 Declaration of Interests

There were no interests declared.

205/18 Minutes of the previous meeting

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

(5 minutes)

206/18 Report of the Chief Executive

The Interim Chief Executive presented a report which provided an update with regard to national and local strategic and operational developments. She briefed the Board on the content of the report and provided an overview of Government preparations for a 'No Deal' Brexit scenario. The Interim Chief Executive reported that the Secretary of State for Health & Social Care had written to NHS organisations on 23 August 2018 to advise of the Government's preparations for a such a scenario. The Board noted that a copy of the letter was included for reference at Annex A of the report. She commented that the situation was unclear at present but that the letter provided clarity on the continuity of supply of medicines with a clear instruction that local stockpiling was not necessary.

In response to a question from Mrs C Barber-Brown, who referred to a letter sent out by NHS Providers on the same subject matter, the Interim Chief Executive commented that her understanding was that the letter from the Secretary of State for Health & Social Care included the government's response to the issues raised by NHS Providers. In response to a question from Mr M Sugden, the Director of Support Services advised that the subject matter would be discussed at the Emergency Preparedness, Resilience & Response (EPRR) meeting in September 2018, a meeting which would be attended by Mrs C Anderson. He agreed to circulate any outcomes from the discussion to Board members.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

(3 minutes)

207/18 Key Issues Reports

<u>Quality Committee</u>

Dr M Cheshire presented a Key Issues Report which detailed matters considered at a meeting of the Quality Committee held on 14 August 2018. He briefed the Board on the content of the report and made particular reference to the 'Alert' section of the report. Dr M Cheshire reported that, in considering a Key Issues Report from the Safeguarding Group, the Committee had noted the Group's review of the Stockport Safeguarding Assurance Action Plan which had identified a number of areas of concern. He advised that the Group had also identified a risk that performance against Safeguarding Level 3 Child Training could decline as a result of a review of profession-specific competencies. The Committee had noted that actions were in place to mitigate the risk.

With regard to the 'Assurance' section of the report, Dr M Cheshire advised that the Committee had noted good progress against the Safe, High Quality Care Action Plan with just two actions identified as red-rated. He advised that these related to performance against the 4-hour A&E standard and security of records, the latter relating to a delay in the supply of new equipment. The Chief Nurse briefed the Board on mitigating actions taken to ensure security of records pending receipt of the new equipment. Dr M Cheshire advised that, in considering a Key issues Report from the

Quality Governance Group, the Committee had taken assurance that the expected increase in the number of subject access requests post-GDPR implementation had not materialised. He also advised the Board that the Committee had been briefed by the Chief Nurse of plans to engage a Safeguarding expert on a temporary basis to support the Safeguarding Team and further develop safeguarding principles. The Chief Nurse briefed the Board on improved safeguarding processes and advised that a representative from the Clinical Commissioning Group had been invited to be part of the Safeguarding Group. She advised the Board of an issue relating to Prevent training and briefed the Board on mitigating actions, including a request for the Safeguarding Team to produce an associated trajectory.

With regard to the 'Advise' section of the report, Dr M Cheshire advised that the Committee had considered its practice in reviewing the Quality Metrics included in the Integrated Performance Report. He commented that this was in the context of identifying a practical approach which would enable the Committee to review the most recent metrics prior to presentation to the Board. Dr M Cheshire reported that, as a result, the Committee had agreed to reschedule further meetings so that dates fell in the week before Board meetings, which was consistent with the practice of the other Assurance Committees. The Interim Chief Executive welcomed the change in meeting dates which, she noted, would enable enhanced triangulation between the Assurance Committees. Dr M Cheshire concluded the report by advising the Board that the Committee had noted that work was in progress to revise the format and presentation of the Clinical Governance Report, to ensure a greater focus on assurance relating to trends and themes.

(8 minutes)

The Board of Directors:

- Received and noted the Quality Committee Key Issues Report.

208/18 Trust Performance Report – Month 4

The Director of Support Services presented the Trust Performance Report for month 4. The Interim Director of Workforce briefed the Board on the Workforce indicators in the report, noting bank and agency expenditure as an area of concern. She briefed the Board on mitigating actions and noted increased engagement from Clinical Directors in this area. The Medical Director commented on the need to capture the improved engagement and agreed to progress this further at the Clinical Directors Forum. The Interim Director of Workforce then reported that, while there had been a slight improvement in sickness absence rates, the Trust remained non-compliant with the target. She noted a concern regarding stress related sickness, which was an issue nationally and locally, and briefed the Board on work undertaken by the Occupational Health department in this area. In response to a question from Mr D Hopewell, who queried the financial impact of sickness absence to the Trust, the Interim Director of Workforce commented that work was still ongoing to understand these figures but that the information would be available for the Board meeting in September 2018.

In response to a question from Mrs C Barber-Brown, regarding the trajectory for agency shifts above capped rates, the Interim Director of Workforce briefed the Board on work in this area and noted the need for improved profiling of the target going

forward to take into account the summer holiday period. The Interim Chief Executive advised the Board that Jasmine Ward had today been awarded the first gold ward accreditation and noted the link between improvements in wards and improved workforce metrics. The Interim Director of Workforce welcomed Board members to view a workforce metrics "heat map" which was located in her office.

The Director of Finance briefed the Board on the Finance indicators in the report. He provided an overview on the Trust's Income & Expenditure position and reported that elective activity was significantly behind plan. With regard to the Cost Improvement Programme (CIP), the Director of Finance advised that, to date, the Trust had identified £10m against the £15m CIP target. With regard to the Trust's Cash position, the Director of Finance reported that the requirement for revenue support was expected to materialise in September 2018. In response to questions from Mr D Hopewell and Mrs C Anderson, the Director of Finance provided further clarity regarding the 'RAG' rating of the indicators. He acknowledged the comments that the RAG ratings were sometimes misleading as they related to the Trust's position against plan rather than against regulatory compliance.

In response to a question from Dr M Cheshire, the Interim Chief Executive provided further clarity regarding the link between service change and recurrent CIP savings. In response to a question from Mr M Sugden, who queried progress against actions ahead of the next NHS Improvement (NHSI) Oversight meeting, the Director of Finance advised that there were currently two outstanding actions, relating to accountability framework and leading indicators, which were being progressed by the Director of Support Services and Chief Operating Officer respectively. Mr M Sugden noted the importance of ensuring that all actions were completed by the next NHSI Oversight Meeting and the Director of Finance agreed to meet with Mr M Sugden separately to consider the detail behind the actions.

The Director of Finance briefed the Board on the significant CIP challenge and associated mitigating actions, noting work being progressed by Mr M Brearley in this area. He also advised that the Trust had applied to NHSI to extend the duration of Mr M Brearley's support until the end of the year. In response to a question from Mr D Hopewell, the Director of Finance and the Interim Chief Executive advised that the expectation from NHSI was for the Trust to identify £12m worth of recurrent schemes as part of the delivery of the overall £15m CIP target. The Director of Finance noted that, in response to a question raised by the Chair, a review was being undertaken to establish a way in which overall Quality Improvement (QI) methodology was being captured regarding the transformation programme.

In response to a question from Mrs C Barber-Brown, who queried the culture regarding CIP, the Interim Chief Executive commented that this varied between business groups. She briefed the Board on the weekly CIP meetings during which business groups were robustly held to account for delivery of their CIP targets. In response to a question from Dr M Cheshire, the Deputy Chief Operating Officer advised that the Transformation Team would cascade the QI methodology across the organisation and that an associated report would be presented to the Finance & Performance Committee. The Chief Nurse noted that the Trust was ahead of schedule with regard to the delivery of the Quality Improvement Plan.

The Deputy Chief Operating Officer briefed the Board on the Performance indicators in the report and reported non-compliance against the A&E 4-hour standard; Cancer 62-day standard; and Referral to Treatment (RTT) Incomplete Pathways standard. He noted that levels of assurance against the delivery of these targets had changed from the assurance reported at the Board meeting on 26 July 2018. The Deputy Chief Operating Officer reported limited assurance that performance against the Cancer standard would be compliant for August 2018. He briefed the Board on mitigating actions in this area, noting that an analysis had been undertaken to understand the reasons for the declined position. The Deputy Chief Operating Officer highlighted a significant increase in suspected cancer referrals as a key contributing factor and reported that initial discussions had taken place regarding future demand management and that the escalation procedure had been revised and re-launched. He also noted the adverse impact the declined Clinical Correspondence position had on a number of performance areas, such as Cancer and RTT.

In response to a question from Mrs C Anderson, the Deputy Chief Operating Officer reported moderate assurance that performance against the Cancer standard would be compliant for September 2018. He advised, however, that this was subject to resolving an issue in Breast Services and noted that discussions were ongoing with the Clinical Commissioning Group (CCG) with regard to the issue. Mr M Sugden referred to staffing issues and queried whether planned annual leave was a contributory factor for adverse performance. The Interim Director of Workforce advised that this was unclear at the moment and that e-roster would provide the necessary information in this area. She then briefed the Board on ongoing work with regard to annual leave planning.

Mr M Sugden referred to Clinical Correspondence being a contributory factor for the failure to achieve the Cancer and RTT standards and queried why it was expected to take seven months to resolve. The Deputy Chief Operating Officer briefed the Board on recruitment plans to fill the current vacancies, noting an issue of a significant turnover of staff. In response to a question from Mr D Hopewell, the Deputy Chief Operating Officer commented that the Trust did not compare favourably with its peers regarding job banding in this area and explained ways in which the Trust was attempting to make the post more attractive. There followed a discussion regarding Clinical Correspondence performance and, in conclusion, the Board requested that a resolution be presented to the Board meeting on 27 September 2018 detailing how the Trust was planning to regain compliance by the end of the Financial Year.

With regard to RTT performance, the Deputy Chief Operating Officer advised that, following an analysis undertaken in this area, he was only able to report limited assurance that performance against the standard would be compliant for September 2018. He briefed the Board on a number of process issues which had adversely affected performance. The Deputy Chief Operating Officer advised that one of the issues related to the Booking Team and noted that NHSI had produced a turnaround plan and were working with the team. In response to a question from Mr M Sugden, the Deputy Chief Operating Officer reported moderate assurance that performance against the RTT standard would be compliant by the end of Quarter 3.

In response to a question from Mr D Hopewell, who queried the reasons for the decline in RTT performance, the Deputy Chief Operating Officer noted the adverse impact the national mandate to cease all non-urgent elective surgery over the previous winter period had on performance. He also noted that the significant increase in GP

referrals had adversely affected performance. In response to a question from Mrs C Barber-Brown, who queried whether the delay in the implementation of the Stockport Together Programme had been a contributory factor to the increased GP referrals, the Interim Chief Executive noted that the issue was a national one and was not peculiar to Stockport. The Director of Support Services acknowledged the reference made to the delays in the implementation of the Stockport Together Programme and advised that this was an area of focus for the CCG's new Chief Operating Officer.

Dr M Cheshire commented that it would be useful to include further figures in the report as the denominator appeared to be continually shifting. In response to questions from Dr M Cheshire and Mr M Sugden, who noted that further clarity was required regarding productivity, the Deputy Chief Operating Officer commented that the Use of Resources data had identified that the Trust compared favourably with its peers in this area. Mrs C Barber-Brown made reference to the Board's risk appetite for the performance targets and queried whether the factors for the adverse RTT performance were outside of the Trust's control. The Interim Chief Executive noted that there was still a national emphasis on targets but reported that the RTT position was understood by NHSI. She noted that NHSI were supportive in this area, acknowledging that the Trust was putting every available resource to recover position, and were working with the Trust on an action plan. In response to a comment from Mrs C Barber-Brown, who noted that, collectively, the Board was not content with Quarter 3 recovery, the Interim Chief Executive commented that assurance would be gained by reviewing performance on a specialty by specialty basis.

With regard to the 4-hour A&E standard, the Deputy Chief Operating Officer was only able to report limited assurance that compliance would be achieved for Quarter 2. He referred the Board to pages 26 and 27 of the report and provided an overview of the contributing factors for the adverse position, including increased numbers of Stranded Patients, Delayed Transfers of Care (DTOC) and Medical Optimised Awaiting Transfer (MOAT). The Deputy Chief Operating Officer reported that, on a more positive note, the number of patients staying in hospital for 21+ days had plateaued. He briefed the Board on actions that had enabled the improvement, which included increased clinical ownership. The Deputy Chief Operating Officer noted that patients staying in hospital between 7-21 days were an area of focus and provided an overview of mitigating actions in this area. In response to a question from Mr D Hopewell, the Deputy Chief Operating Officer reported a recent 'spike' in attendances and briefed the Board on actions in this area, including ongoing work with the North West Ambulance Service (NWAS) to manage ambulance drop-offs.

Mr M Sugden commented that at the Board meeting in July 2018, the Chief Operating Officer had reported moderate assurance that the improvement trajectory of 85% would be achieved for Quarter 2. The position had now changed to limited assurance. He queried to what extent the Board was able to rely on assurances given at Board meetings, given the amount of external factors affecting performance and noting that a number of performance related assurance levels had changed since the last meeting. The Interim Chief Executive reported that the Trust had held conversations with Regulators advising them that the Trust was not going to meet the Quarter 2 trajectory and noted that the key issue was to improve the position with regard to stranded patients. The Interim Chief Executive then briefed the Board on a productive conversation held with the Stockport Metropolitan Borough Council and the Clinical Commissioning Group with regard to improving out of hospital provision. She noted

that the partners had articulated firm commitment during the conversation. Mr M Sugden requested that the Board be kept updated on progress in this area.

The Chief Nurse briefed the Board on the Quality indicators in the Performance Report. She referred the Board to the Safe Staffing Report and noted that nurse staffing had been a significant challenge in month with a high number of vacancies. The Chief Nurse briefed the Board on actions in place to ensure safe staffing, noting Ward B4 as a particular area of concern. The Chief Nurse noted a significant increase in the reporting of medication errors and advised that a trajectory for this metric would be agreed in due course. She also reported a considerable improvement with regard to the closing of complaints and the Board wished to record its gratitude to all involved for this achievement. The Chief Nurse then briefed the Board regarding E-Coli and the Patient Safety Incident Rate.

The Chief Nurse advised the Board that a separate report on Pressure Ulcers was attached to the Performance Report this month. She provided an overview of performance in this area and noted an improved data position. The Board noted that similar granular level information would be included in next month's report with regard to Falls. The Medical Director referred the Board to page 28 of the report and briefed the Board on the HSMR and SHMI mortality ratings, explaining the difference between the two ratings. He noted a slight increase in the HSMR rating and briefed the Board on mitigating actions in this area, agreeing to keep the Board updated on progress.

In response to a question from Mrs C Anderson, regarding the lack of a target for the 'Mortality: Deaths in ED' indicator, the Medical Director advised that the Trust was required to include these figures in the report but noted that the information was felt to be of limited benefit. In response to a question from Mr D Hopewell, regarding the same indicator, the Medical Director advised that the significant decrease in the number of deaths in April 2018 was as a direct result of improved weather and the consequent reduction in winter related illnesses. The Chief Nurse concluded her report by advising the Board that there had been 21 Strategic Executive Information System (StEIS) reported incidents in July 2018, which was considered to be a high number. She advised that a review would be undertaken in this area, results of which would be reported to the Quality Committee.

The Board of Directors:

- Received and noted the Trust Performance Report for Month 4.

(1 hour 24 minutes)

209/18 Elective Care Expectations

The Deputy Chief Operating Officer presented an Elective Care Expectations Report. He provided an overview of content and noted that a number of issues included in the report had already been covered during the earlier consideration of the Performance Report. In response to a question from Mr M Sugden, regarding the sign off process for the Trust's response to Mr I Dalton's letter, the Deputy Chief Operating Officer advised that the Interim Chief Executive would respond to NHSI in writing by the

deadline date of 5 September 2018. The Interim Chief Executive agreed to circulate the Trust's response to Board members for information.

The Board of Directors:

- Received and noted the Elective Care Expectations Report.

(2 minutes)

210/18 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next meeting of the Board of Directors would be held on Thursday, 27 September 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
18/18	28 Jun 18	152/18	Finance & Performance Key Issues Report	In response to a comment from Mrs C Barber-Brown, the Director of Finance agreed to assess how learning from the Quality Improvement Programme could be applied to CIP governance arrangements. **Update 30 Aug 18 –** The Director of Finance briefed the Board on progress in this area and advised how learning had been applied to CIP governance arrangements. Mrs C Barber-Brown suggested that this subject area be considered in more detail at the Finance & Performance Committee. The Board of Directors agreed to close this action.	F Patel (Director of Finance)
19/18	28 Jun 18	152/18	People Performance Committee Key Issues report	In response to a question from the Chair, the Interim Director of Workforce advised that a draft Workforce Strategy would be available for initial review by the Board in September 2018.	H Brearley (Interim Director of Workforce)
20/18	28 Jun 18	156/18	Update on 2017 Staff Survey Outcomes	The Interim Director of Workforce agreed to present a progress report to the Board on 27 September 2018.	H Brearley (Interim Director of Workforce)
21/18	26 Jul 18	179/18	Performance Report	In response to a question from the Chair, it was agreed to schedule a follow-up development session on the use of the revised Performance Report in Autumn 2018.	Mr P Buckingham (Director of Corporate Affairs)
22/18	26 Jul 18	181/18	Winter Plan – Progress Report	The Urgent & Emergency Care Improvement Director advised that a fully-costed Winter Plan document would be presented to the Board of Directors on 27 September 2018.	Mrs J Wood (U&EC Improvement Director)
23/18	26 Jul 18	187/18	Draft Estates Strategy	It was agreed that a final draft of the Estates Strategy would be presented to the Board of Directors for approval on 27 September 2018.	Mr H Mullen (Director of Support Services)
24/18	30 Aug 18	206/18	Report of the Chief Executive	The Interim Chief Executive reported that the Secretary of State for Health & Social Care had written to NHS organisations on 23 August 2018 to advise of the Government's preparations for a 'No Deal' Brexit scenario. The Director of Support Services advised that the subject matter would be discussed at the Emergency Preparedness, Resilience & Response (EPRR)	Mr H Mullen (Director of Support Services)

				meeting in September 2018, a meeting which would be attended by Mrs C Anderson. He agreed to circulate any outcomes from the discussion to Board members.	
25/18	30 Aug 18	208/18	Trust Performance Report – Month 4	In response to a question from Mr D Hopewell, who queried the financial impact of sickness absence to the Trust, the Interim Director of Workforce commented that work was still ongoing to understand these figures but that the information would be available for the Board meeting in September 2018.	Ms H Brearley (Interim Director of Workforce)
26/18	30 Aug 18	208/18	Trust Performance Report – Month 4	There followed a discussion regarding Clinical Correspondence performance and, in conclusion, the Board requested that a resolution be presented to the Board meeting on 27 September 2018 detailing how the Trust was planning to regain compliance by the end of the Financial Year.	Mr S Goff (Deputy Chief Operating Officer)
27/18	30 Aug 18	209/18	Elective Care Expectations	In response to a question from Mr M Sugden, regarding the sign off process for the Trust's response to Mr I Dalton's letter, the Deputy Chief Operating Officer advised that the Interim Chief Executive would respond to NHSI in writing by the deadline date of 5 September 2018. The Interim Chief Executive agreed to circulate the Trust's response to Board members for information.	Mrs H Thomson (Interim Chief Executive)

NHS
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Report to:	Board of Directors	**Date:**	27 September 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:	Annex A – Board of Directors Role Description

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

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1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 The Care Quality Commission (CQC) visited the Trust and carried out an unannounced core service inspection during week commencing 10 September 2018. A CQC inspection, together with colleagues from NHS Improvement will visit the Trust again 2-4 October 2018 to complete a Well Led Review. To date, no formal feedback on findings during the unannounced inspection has been received and an update on the position will be provided at the Board of Directors meeting on 27 September 2018.

2.2 The CQC visit was preceded by a Use of Resources Assessment which was carried out by NHS Improvement representatives on 6 September 2018. NHS Improvement conduct this assessment on behalf of the CQC and the outcomes will be incorporated in the CQC report on the Well Led Review. The various assessments and inspections were conducted against the backdrop of sustained Urgent & Emergency Care pressures with activity at levels normally experienced during the winter period. Having visited our Emergency Department and Site Management office several times over last month, I fully appreciate just how much pressure all colleagues, Board members included, have been under in recent weeks. Therefore, a very big thank you on behalf of Board.

2.3 The Trust's Finance Department has recently been awarded the highest level of accreditation by the Finance Skills Development Network. The Level 3 rating recognises the Department's commitment to finance staff development, innovation in the service, good governance, sharing and adopting best practice and providing the best possible service to users across the Trust. The assessment involved submission of a wide range of evidence and a series of interviews with stakeholders. The peer review panel complimented the Trust on how the Department had developed over the past two years and how valued the service was to users. There are 21 acute trusts in the North West and the Trust is just the fifth trust to achieve the Level 3 standard.

3. BOARD DEVELOPMENT

3.1 The Remuneration Committee met on 6 September 2018 and approved plans for interview of candidates for the substantive Chief Executive position. The interviews will be held on 1 October 2018 and we look forward to a successful outcome. The Committee also agreed plans for recruitment of a substantive Director of Workforce & OD and a Company Secretary to replace the Director of Corporate Affairs who is scheduled to retire in February

2019.

3.2 The Board continues to make progress against its Development Programme and Board members have recently had the opportunity to participate in coaching sessions for CQC interviews in advance of the Well-Led Review. Upcoming development subjects include; Board responsibilities in relation to Health & Safety, Safeguarding and use of the Board Assurance Framework. A follow-up Relationships & Team Building session is scheduled to take place on 26 October 2018 which will again be facilitated by Mr C Lewis CBE.

4. CHAIR ENGAGEMENTS

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

21 August 2018	Visited the Chest Clinic
21 August 2018	Held an introductory meeting with Dr Jaweeda Idoo, new Chair of Viaduct Care
23 August 2018	Hosted a visit to the Trust by Mrs Ruth George MP
3 September 2018	Attended the Governance & Membership Committee meeting
5 September 2018	Chaired the Workforce Race Equality Standard (WRES) Steering Group meeting
6 September 2018	Participated in the Use of Resources Assessment
6 September 2018	Chaired a meeting of the Remuneration Committee
13 September 2018	Attended a NHS Employers Equality, Diversity & Inclusion event in Birmingham
17 September 2018	Attended a St Ann's Hospice annual celebratory event
17 September 2018	Visited the Marjory Warren Unit and the Clinical Correspondence Hub
19 September 2018	Attended an 'Our Stockport' meeting involving Board members from 21 organisations across the health, social care and home sectors to identify ways of improving collaborative working
26 September 2018	Scheduled to attend a NHS Improvement Learning from Improvement event in London.

5. REGULATORY DEVELOPMENTS

5.1 The Enhanced Oversight meeting with NHS Improvement which was scheduled to be held on 20 September 2018 will now take place in October 2018. I would like to thank Board colleagues who have participated in the development of a Medium Term Financial Strategy, a draft of which was considered by the Finance & Performance Committee on 19 September 2018 prior to formal review by the Board.

6. FORWARD LOOK

6.1 At its meeting held on 28 September 2017, the Board approved a Role Description for the Board of Directors, which is recognised good practice. This document is now scheduled for review and is included for reference at Annex A of the report. A desktop review completed by the Director of Corporate Affairs suggests that no amendments to the document are required. Consequently, the Board is recommended to re-adopt the Role Description as presented.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.
- Re-adopt the Board of Directors Role Description included at Annex A.

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NHS Stockport NHS Foundation Trust

BOARD OF DIRECTORS

BOARD OF DIRECTORS – ROLE DESCRIPTION

1. THIS DOCUMENT

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

2. ROLE AND PURPOSE

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

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

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

i. formulating strategy;

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

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

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

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

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

3. RESPONSIBILITIES

3.1 General Responsibilities

The general responsibilities of the Board are:

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

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

3.2 Leadership

The Board provides active leadership to the organisation by:

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

3.3 **Quality**

The Board:

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

3.4 **Strategy**

The Board:

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

3.5 **Culture, Ethics and Integrity**

The Board:

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

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

3.6 **Governance / Compliance**

The Board:

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

3.7 **Risk Management**

The Board:

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

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

3.8 **Committees**

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

3.9 **Communication**

The Board:

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

3.10 **Finance**

The Board:

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

4. ROLE OF THE CHAIR

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

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

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

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

5. ROLE OF THE CHIEF EXECUTIVE

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

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

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

6. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS

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

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

7. OTHER MATTERS

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

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

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

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NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 27/09/18		**Report of:** Quality Committee
Date of last meeting: 18/09/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Medicine Business Group Briefing • Quality Metrics • Duty of Candour Policy • Quality Governance Framework Update • Quality Improvement Plan • Quality Improvement Priorities • Report of the Liverpool Community Health Independent Review • Maternity Update Report • Key Issues Reports: - Quality Governance Group - Safeguarding Group - Infection Prevention Group • Clinical Governance Report • Board Assurance Framework • Trust Risk Register
	Alert	• In considering a Key Issues Report from the Quality Governance Group, the Committee was alerted to a deterioration in the Trust's HSMR identified through an NHS Improvement Mortality Report. The Committee was advised by the Medical Director that assurance provided through SHMI outcomes suggested that the mortality alerts were associated with coding practice, particularly in relation to palliative care. However, further investigation is taking place to determine that this is the case.
	Assurance	• The Committee considered a series of reports from the Chief Nurse & Director of Quality Governance which provided positive assurance on progress against the; Quality Governance Framework, Quality Improvement Plan and Quality Improvement Priorities. Board members should note that the latter will form an integral part of the Trust's Quality Account for 2018/19. The Committee acknowledged the improved quality of each of the respective reports. • The Committee also took positive assurance from a report which detailed the outcomes of a comprehensive gap analysis based on findings from the Liverpool Community Health Independent Review. The analysis detailed the Trust's

		position against each of the relevant areas together with arrangements for on-going monitoring and assurance reporting. No areas of concern were identified as a result of the gap analysis which will also be presented to the Board on 27 September 2018. • The Committee considered a report on the outcomes of analysis of Maternity dashboard indicators to determine whether there was a direct correlation between the rate of emergency caesarean sections and an increase in the number of diverts and formal complaints during the period April – July 2018. The Committee was assured that no correlation had been identified from the analysis.		
	Advise	• The Committee received a report from the Deputy Director Quality Governance regarding development of a revised Duty of Candour & Being Open Policy. The Committee approved the revised policy. • From review of the Key Issues Report from the Safeguarding Group, the Committee noted preparation of an overarching Safeguarding Review & Action Plan. The Committee also received a verbal update from the Chief Nurse on development of a draft Security Action Plan. • The Committee reviewed what will be the final Clinical Governance Report in its current form and noted incorporation of the relevant metrics in the Integrated Performance Report.		
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

Board of Directors' Key Issues Report

Stockport NHS Foundation Trust

Report Date: 27/09/18		**Report of:** People Performance Committee
Date of last meeting: 20/09/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Draft Nursing, Midwifery & AHP Strategy • Draft People Strategy • Staff Survey Update • Gender Pay Gap Report - GM Benchmarking • Equality, Diversity & Inclusion Update Report • Medical Education Update Report • Midwifery Staffing Deficit Report • Medical Appraisal & Revalidation Report • Guardian of Safe Working Report • Workforce Flash Report • Agency Utilisation Report • Trust Risk Register • Key Issues Reports from Management Groups • Policies for Validation
	Alert	• Mrs J Cotton, Head of Midwifery presented a report which detailed a number of clinical risks associated with a deficit of 13.85wte between the funded midwifery staffing establishment, and the establishment recommended by a Birthrate Plus workforce planning assessment. The Committee was advised of action taken to partially reduce the deficit, and noted that a business case seeking to adjust the Midwifery staffing establishment is currently being progressed through the Trust's approval process. Board members should note that the Midwifery Service will continue to be exposed to staffing-related clinical risks pending resolution of the business case. • The Committee considered a report on Agency Utilisation as at 30 August 2018 and noted that expenditure in month had increased in comparison with July 2018 and had exceeded the agency ceiling. The Committee noted progress with the recruitment of substantive consultants and was briefed on the development of proposals to address the prevalence of use of middle grade locums.
	Assurance	• The Committee took positive assurance from a report on Medical Appraisal and Revalidation which was presented by Dr G Burrows, Deputy Medical Director. The Committee noted in particular a Medical Staff Appraisal rate of 98.73% in

		2017/18. The Annual Report will be presented for consideration by the Board of Directors to facilitate submission of a Statement of Compliance by the Interim Chief Executive. • The Committee was similarly assured by the content of a draft People Strategy presented by the Interim Director of Workforce. The Committee noted that preparation of the Strategy had been informed by extensive engagement and recommended the People Strategy to the Board of Directors for approval. The Committee will into account the content of the People Strategy in reviewing its Terms of Reference in October 2018.		
	Advise	• The Chief Nurse presented an initial draft of a Nursing, Midwifery & Allied Health Professional Strategy for consideration and comment by the Committee. The Committee endorsed both the inclusion of Allied Health Professionals and the presentation of the Strategy which makes the document easily acceptable. It was noted that a number of further updates are required prior to submission for final review by the Committee in October 2018 and subsequent approval by the Board. • The Committee considered a report which provided an update on 2017 Staff Survey Outcomes and noted that this would be the subject of an agenda item for consideration by the Board on 27 September 2018. The Committee acknowledged progress made against Staff Survey key actions but endorsed the need to ensure that on-going work is incorporated in a broader Culture and Engagement Plan. • The Committee approved the following policies: - Redeployment Policy - Alcohol & Substance Misuse Policy - Agile & Homeworking Policy - Disciplinary Policy - Raising Concerns at Work Policy - Fixed Term Contract Policy - Monitoring Policy for Junior Doctors Hours - Remediation Policy for Medical & Dental Staff		
2.	Risks Identified	• Clinical risks associated with Midwifery service staffing levels		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

Report To:	Trust Board	**Date:**	27 Sep 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 concern and change from the previous month.

Members are reminded that the report is structured into three sections that show varying levels of detail:

Level 1: Executive Summary
Level 2: Domain Summary
Level 3: Indicator Detail Level 3 information provides narrative and the associated actions for each indicator.

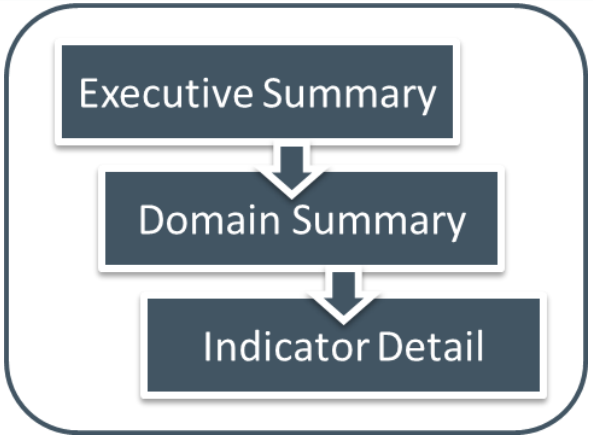
Attachments:

This subject has previously been reported to:

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

Introduction

The Board report layout consists of three sections:



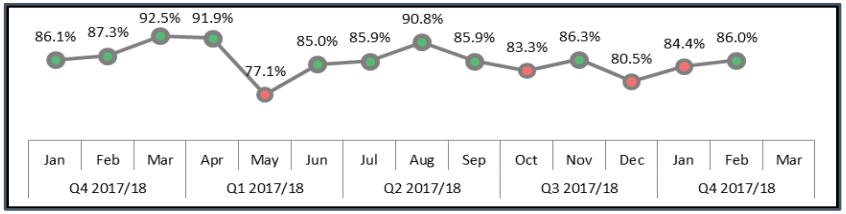
Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

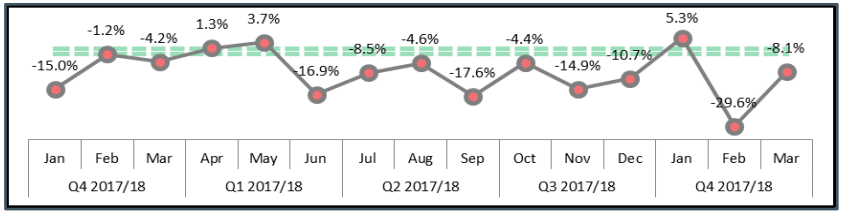
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

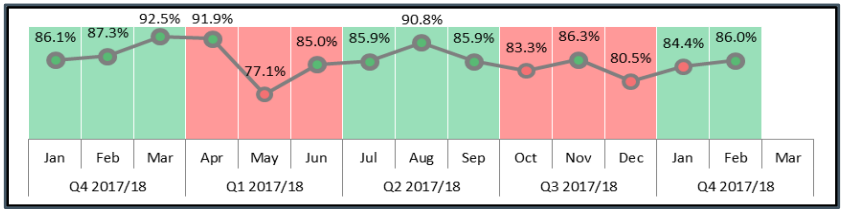
The following chart types are in use throughout the report:



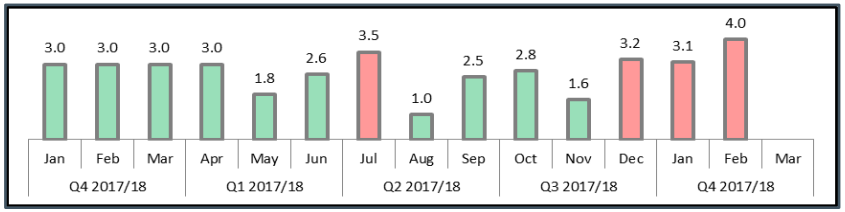
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



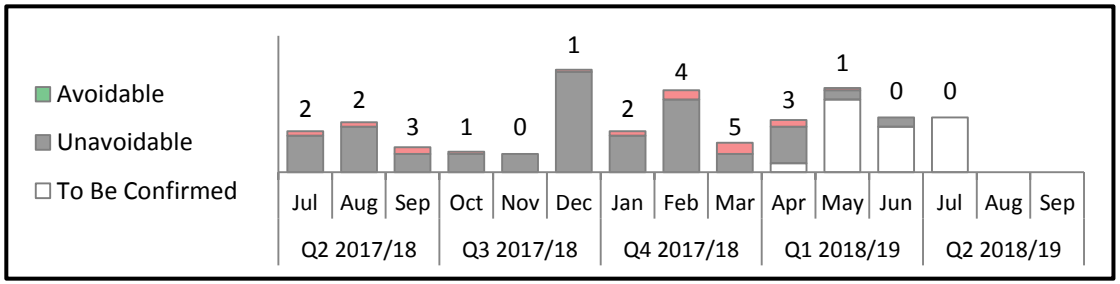
For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



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

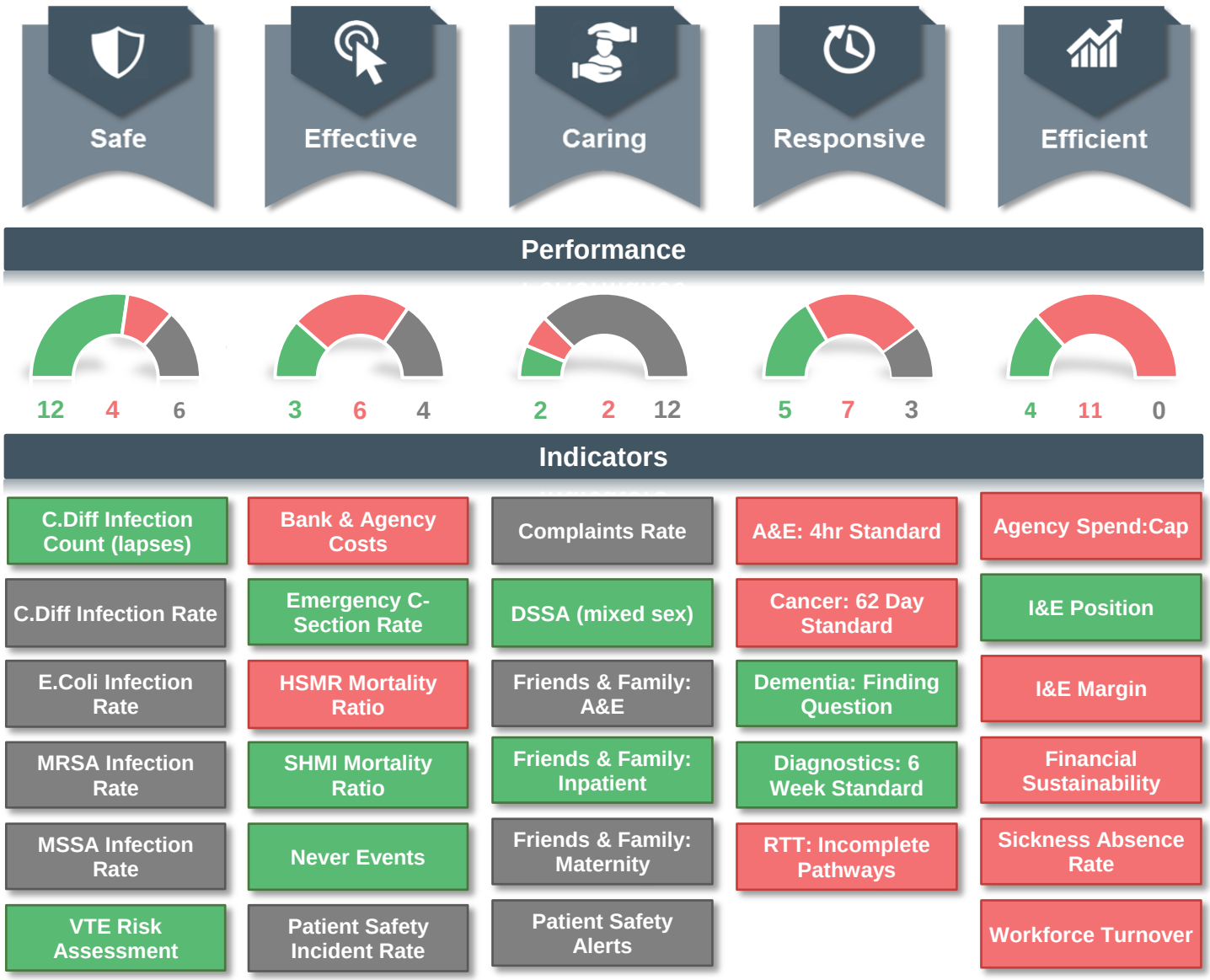


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.



Executive Summary

Stockport NHS Foundation Trust



Key Changes to the indicators in this period are:

Key Areas of Concern are:

- Cancer 62 day
- A&E 4hr
- Referral to Treatment & Waiting list size
- Clinical Correspondence
- HCRs
- DTOC and stranded patients
- Bank & Agency costs
- Agency shifts above cap
- Elective activity & Income v plan.
- CIP
- In-patient falls

Compliance regained:

- Emergency C-Section rate

Notable Improvement:

- Complaints response within 45 days.

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	Jul-18		7.66							7.19		14
C.Diff Infection Count (lapses in care)	CN&DQG	Jul-18	<=3 *	0							0		14
MRSA Infection Rate	CN&DQG	Jul-18		0.90							0.90		15
MSSA Infection Rate	CN&DQG	Jul-18		7.21							8.43		15
E.Coli Infection Rate	CN&DQG	Jul-18		15.77							17.87		16
E.Coli Infection Count	CN&DQG	Jul-18	<=12 *	3							8		16
Falls: Total Incidence of Inpatient Falls	CN&DQG	Aug-18	<=574 *	98							547		17
Falls: Causing Moderate Harm and Above	CN&DQG	Aug-18	<=13 *	6							12		17
Pressure Ulcers: Hospital, Avoidable Category 2	CN&DQG	Jul-18	<= 4 *	0							4		18
Pressure Ulcers: Hospital, Avoidable Category 3	CN&DQG	Jul-18	<= 2 *	0							1		18
Pressure Ulcers: Hospital, Avoidable Category 4	CN&DQG	Jul-18	<= 0 *	0							1		19
Pressure Ulcers: Community, Avoidable Category 2	CN&DQG	Jul-18	<= 13 *	0							4		19
Pressure Ulcers: Community, Avoidable Category 3	CN&DQG	Jul-18	<= 3 *	0							0		20

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Avoidable Category 4	CN&DQG	Jul-18	*<= 1 **	0							0		20
Safety Thermometer: Hospital	CN&DQG	Aug-18	*>= 95%*	94.9%							95.3%		21
Safety Thermometer: Community	CN&DQG	Aug-18	*>= 95%*	96.2%							91.7%		21
Medication Errors: Overall	CN&DQG	Aug-18		93							477		22
Medication Errors: Moderate Harm and Above	CN&DQG	Aug-18		3.2%							4.8%		22
VTE Risk Assessment	CN&DQG	Aug-18	*>= 95%*	96.6%							96.6%		23
Clinical Correspondence	COO	Aug-18	*>= 95%*	69.5%							65.1%		23
Flu Vacination Uptake	DoW&OD	Mar-18	*>= 70%*	78.6%									24
Discharge Summaries	MD	Aug-18	*>= 95%*	89.6%							88.1%		24

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	Aug-18		53.85									25
Emergency C-Section Rate	CN&DQG	Aug-18	<= 15.4%	13.8%							17.8%		25
Never Event: Incidence	CN&DQG	Aug-18	<= 0	0							0		26
Duty of Candour Breaches	CN&DQG	Aug-18		4							13		26
Stranded Patients	COO	Aug-18	<= 35%	53.3%							48.0%		27
Delayed Transfers of Care (DTOC)	COO	Aug-18	<= 3.3%	4.3%							3.0%		27
Medical Optimised Awaiting Transfer (MOAT)	COO	Aug-18	<= 40	92							471		28
Bank & Agency Costs	DoW&OD	Aug-18	<= 5%	12.2%							11.4%		28
Mortality: HSMR	MD	Jun-18	<= 1	1.08									29
Mortality: SHMI	MD	Dec-17	<= 1	0.96									29
Mortality: Deaths in ED or as Inpatient	MD	Aug-18		96							534		30
Mortality: Case Note Reviews	MD	Aug-18		40							178		30
Emergency Readmission Rate	MD	Jun-18	<= 7.9%	8.8%							8.9%		31

* 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	Aug-18	>= 100%	100.0%							70.0%		31
DSSA (mixed sex)	CN&DQG	Aug-18	<= 0	0							4		32
Complaints Rate	CN&DQG	Aug-18		0.7%							0.8%		32
Complaints: Response Rate 45	CN&DQG	Aug-18	>= 95%	42.9%							27.1%		33
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	Aug-18		1							6		33
Complaints Closed: Overall	CN&DQG	Aug-18		49							225		34
Complaints Closed: Upheld	CN&DQG	Aug-18		11							60		34
Complaints Closed: Partially Upheld	CN&DQG	Aug-18		27							105		35
Complaints Closed: Not Upheld	CN&DQG	Aug-18		11							60		35
Compliments	CN&DQG	Aug-18		22							93		36
Friends & Family Test: Response Rate	CN&DQG	Jul-18		26.8%							26.7%		36
Friends & Family Test: Inpatient	CN&DQG	Jul-18		95.6%							94.7%		37
Friends & Family Test: A&E	CN&DQG	Jul-18		88.0%							89.5%		37

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: Maternity	CN&DQG	Jul-18		96.4%							96.7%		38
Staff Friends & Family Test	CN&DQG	Jun-18		77.0%							77.0%		38
Diabetes Reviews	MD	Aug-18	>= 90%	73.3%							73.2%		39

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Jul-18	>= 90%	98.3%							98.5%		39
Dementia: Assessment	CN&DQG	Jul-18	>= 90%	100.0%							100.0%		40
Dementia: Referral	CN&DQG	Jul-18	>= 90%	100.0%							100.0%		40
Serious Incidents: STEIS Reportable	CN&DQG	Aug-18		25							88		41
Litigation: Claims	CN&DQG	Aug-18		6							24		41
Litigation: Key Risk Claims Rate	CN&DQG	Aug-18		100.0%							100.0%		42
A&E: 4hr Standard	COO	Aug-18	>= 95%	80.7%							83.0%		42
A&E: 12hr Trolley Wait	COO	Aug-18	<= 0	1							8		43
Cancer: 62 Day Standard	COO	Aug-18	>= 85%	78.2%							79.9%		43
Referral to Treatment: Incomplete Pathways	COO	Aug-18	>= 92%	84.4%							86.8%		44
Referral to Treatment: Incomplete Waiting List Size	COO	Aug-18	<= 22345	25274									44
Diagnostics: 6 Week Standard	COO	Aug-18	>= 99%	99.3%							99.1%		45
Outpatient Activity vs. Plan	COO	Aug-18	<= 1%	-3.4%							-3.4%		45

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Elective Activity vs. Plan	COO	Aug-18	+/- 1%	-7.4%							-7.4%		46
Elective Income vs. Plan	COO	Aug-18	+/- 1%	-3.0%							-3.0%		46

* 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	Aug-18	<= 2	4									47
Financial Controls: I&E Position	DoF	Aug-18	<= 1%	-3.3%									47
Cash	DoF	Aug-18	+/- 1%	-100.0%									48
Financial Use of Resources	DoF	Aug-18	<= 3	3									48
CIP Cumulative Achievement	DoF	Aug-18	+/- 1%	-4.1%									49
Capital Expenditure	DoF	Aug-18	+/- 10%	-33.8%									49
Financial Sustainability	DoF	Aug-18	<= 2	4									50
Sickness Absence Rate	DoW&OD	Aug-18	<= 3.5%	4.3%							4.1%		50
Appraisal Rate: Non-medical	DoW&OD	Aug-18	>= 95%	94.5%							94.8%		51
Appraisal Rate: Medical	DoW&OD	Aug-18	>= 95%	97.9%							97.6%		51
Statutory & Mandatory Training	DoW&OD	Aug-18	>= 90%	91.1%							91.4%		52
Workforce Turnover	DoW&OD	Aug-18	<= 13.94%	14.4%									52
Staff in Post	DoW&OD	Aug-18	>= 90%	89.8%							89.7%		53

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Stockport NHS Foundation Trust

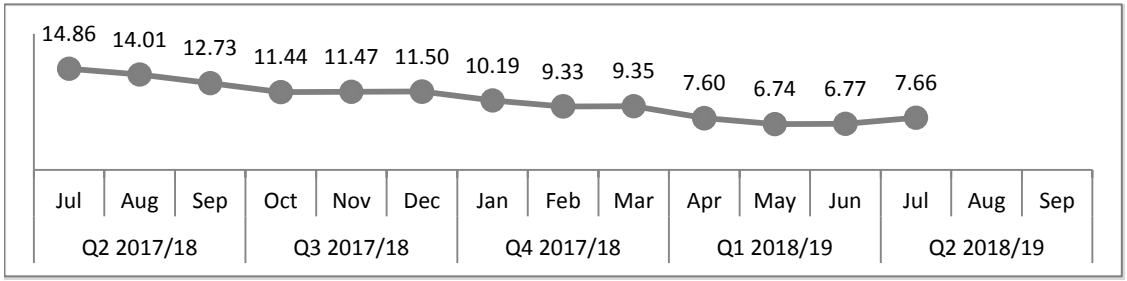
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	Aug-18	<= 0	1098							4728		53
Agency Spend: Distance From Ceiling	DoW&OD	Aug-18	<= 3%	13.0%							13.0%		54

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

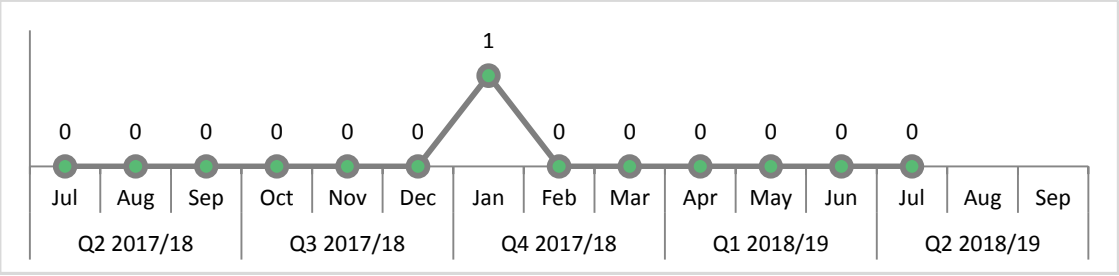
Indicator Detail

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



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

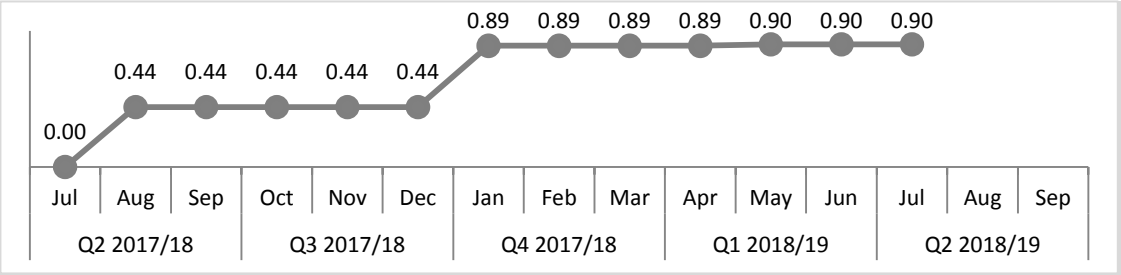
Jul-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care.
<=3 *	



Actions
- In July we have had no lapses in care identified- all the cases are still under investigation - A review of the new NICE draft guidance to combat drug resistant UTI's with the antibiotic pharmacists and Consultant microbiologist has been undertaken. Awaiting final guidance to be published - Further work will be undertaken with the new site coordinator team around isolation of patients following review and update of the isolation SOP - Following a Clostridium difficile investigation the case will be presented to the harm free care panel.

Indicator Detail

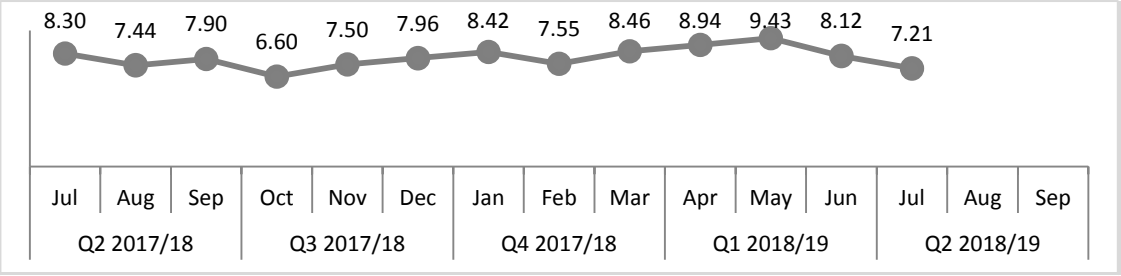
Jul-18	MRSA Infection Rate
0.90	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MRSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population The MRSA target remains zero for 2018/19



Actions

- In July there were zero cases of MRSA
- The target is monitored through the infection prevention group

Jul-18	MSSA Infection Rate
7.21	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population The MSSA infection rate is monitored as a whole health economy with no target.

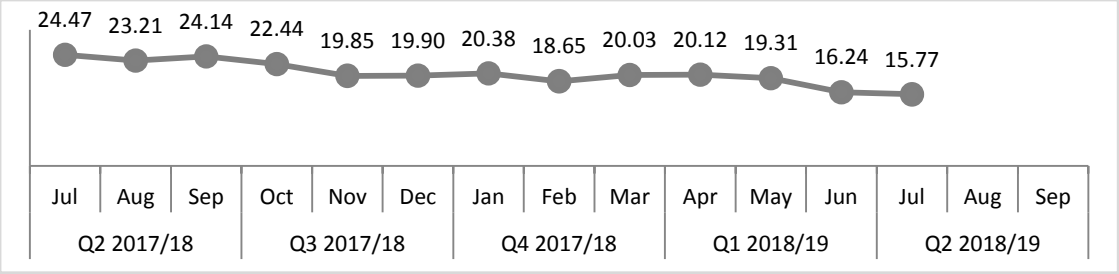


Actions

-The figures represented within this report are Trust acquired cases
- This is monitored through the Infection prevention group

Indicator Detail

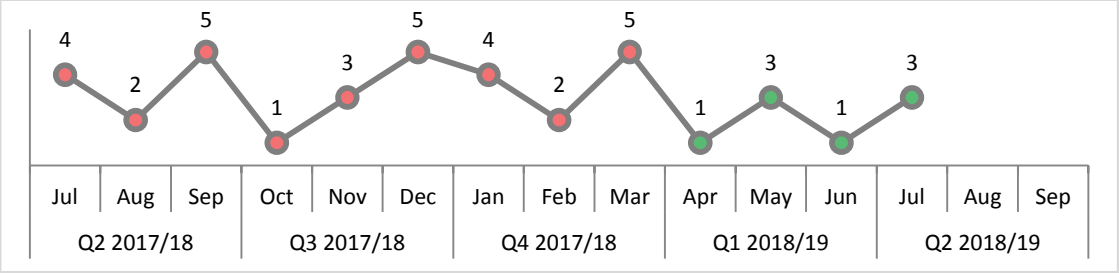
Jul-18	E.Coli Infection Rate
15.77	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections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



Actions

- The figures represented within this report are trust acquired cases
- A reduction plan has been developed collaboratively between the Trust, Health protection nurses and CCG.
- This plan will be monitored through the infection prevention group
- Discussions with the clinical director in laboratory medicine in regards to medical investigation of each case underway

Jul-18	E.Coli Infection Count
3	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target.
<=12 *	

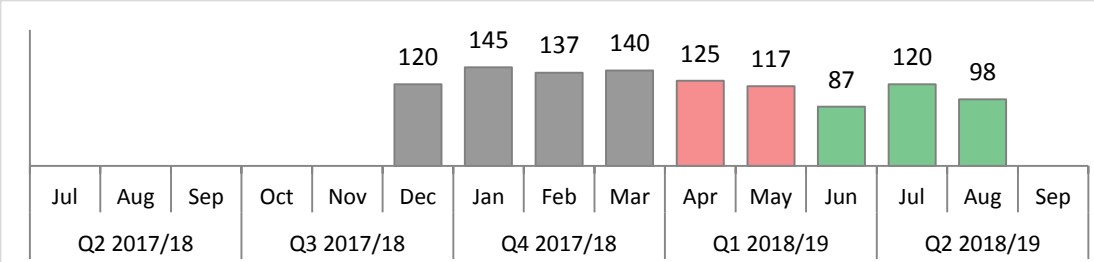


Actions

- The figures represented within this report are trust acquired cases
- This is monitored through the Infection prevention group

Indicator Detail

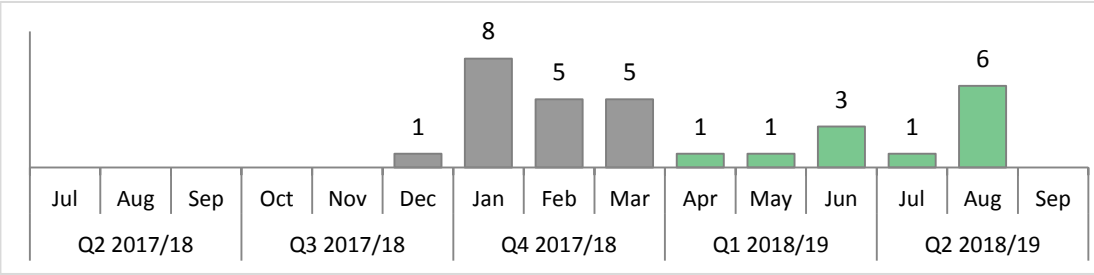
Aug-18	Falls: Total Incidence of Inpatient Falls
98	Total number of Inpatient falls
Target	Our Quality Improvement aim is to reduce in-patient falls by 10% compared to the total falls recorded in 2017/2018.
<=574 *	



Actions

As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 2018/19 we have introduced our patient mobility safety collaborative.
We are introducing a senior nurse review process for all falls, to identify themes and lessons learned.
We have seen a decrease in falls with the introduction of bay tagging. Good reporting practice has benefitted data analysis and allows a targeted approach.
The falls reported in August 2018 are currently under investigation by the business group and the level of harm may change as a result of the investigation outcome.

Aug-18	Falls: Causing Moderate Harm and Above
6	Total number of falls causing moderate harm and above.
Target	Our Quality Improvement aim is to reduce falls with harm by 25% compared to the total falls with harm recorded in 2017/2018.
<=13 *	

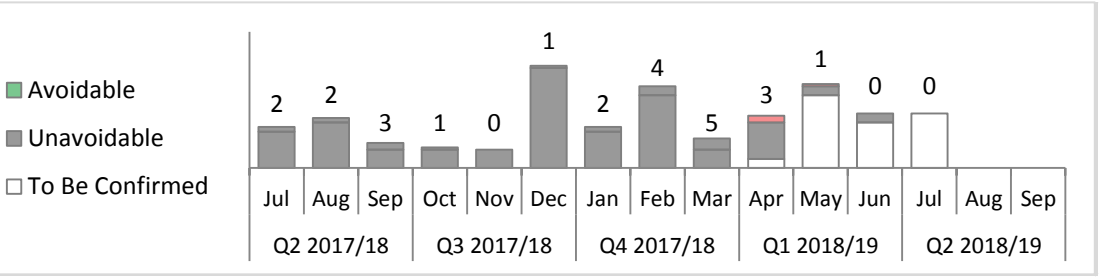


Actions

The total number of falls with harm for August was 6. One fall resulted in a fractured neck of Femur.
August 2018 has shown a rise in reporting falls with a moderate or above harm to the patient.
Each reported case is under investigation by the business group with an emphasis on lessons learned.
The introduction of the post fall proforma will help to understand what was happening in the clinical environment at the time of the fall. This will help to identify emerging themes and processes that can be targeted through quality improvement initiatives

Indicator Detail

Jul-18	Pressure Ulcers: Hospital, Avoidable Category 2
0	Total number of category 2 pressure ulcers in a hospital setting.
Target	We aim to reduce hospital acquired avoidable category 2 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July as category 2 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 4 *	

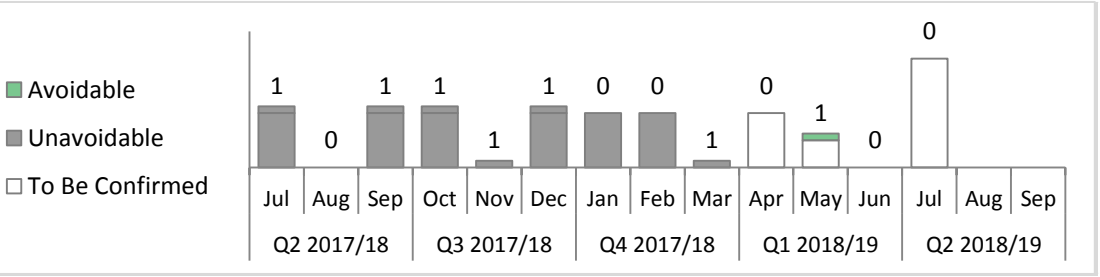


Actions

This month there has been a total of 6 category 2 pressure ulcers reported in the hospital. Avoidable = 0, Unavoidable = 0, TBC = 6. These will be reviewed by the harm free care panel in October.

- 284 staff have, now been trained in Purpose T pressure ulcer risk assessment tool.
- A gap analysis has been completed following the issue of NHS Improvement guidance in relation to the definition and measurement of pressure ulcers.
- A successful visit from NHS Improvement has taken place on the 14/8/18 as part of the NSTPP collaborative work that is progressing. Pilot site representatives had opportunity to feed back on the tests of change that they are currently working on and a third event has been attended on the 4/9/18 to consolidate learning about methods to scale and sustain change.

Jul-18	Pressure Ulcers: Hospital, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a hospital setting.
Target	Our aim is to reduce hospital acquired avoidable category 3 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July as category 3 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 2 *	



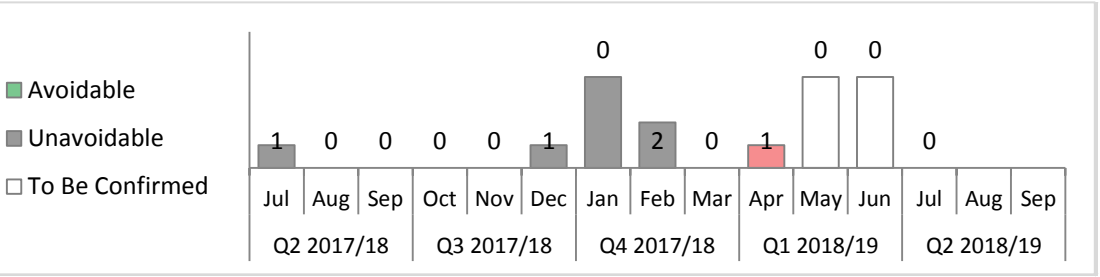
Actions

This month there has been a total of 4 category 3 pressure ulcers reported in the hospital. Avoidable = 0, Unavoidable = 0, TBC = 4 These will be reviewed by the harm free care panel in October.

- 284 staff have, now been trained in Purpose T pressure ulcer risk assessment tool.
- A gap analysis has been completed following the issue of NHS Improvement guidance in relation to the definition and measurement of pressure ulcers.
- A successful visit from NHS Improvement has taken place on the 14/8/18 as part of the NSTPP collaborative work that is progressing. Pilot site representatives had opportunity to feed back on the tests of change that they are currently working on and a third event has been attended on the 4/9/18 to consolidate learning about methods to scale and sustain change.

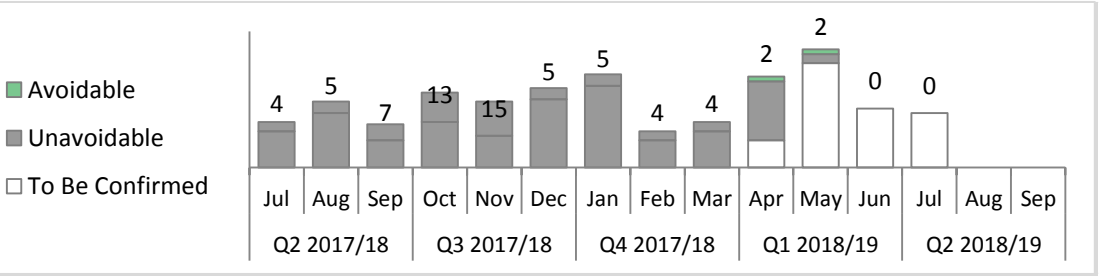
Indicator Detail

Jul-18	Pressure Ulcers: Hospital, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a hospital setting.
Target	Our aim to reduce hospital acquired avoidable category 4 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July as category 4 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 0 *	



Actions
This month there, have been no category 4 pressure ulcers reported in the Hospital.

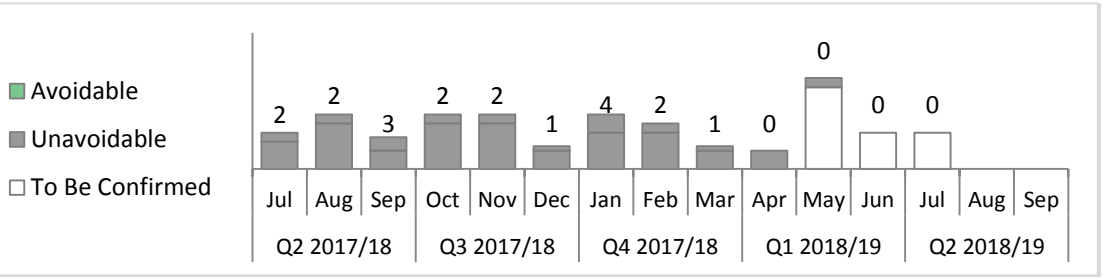
Jul-18	Pressure Ulcers: Community, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a community setting.
Target	Our aim to reduce community acquired avoidable category 2 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July as category 2 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 13 *	



Actions
This month there has been a total of 12 category 2 pressure ulcers reported in the community Avoidable = 0, Unavoidable = 0, TBC = 12. These will be reviewed by the harm free care panel in October - A gap analysis has been completed following the issue of NHS Improvement guidance in relation to the definition and measurement of pressure ulcers. - A successful visit from NHS Improvement has taken place on the 14/8/18 as part of the NSTPP collaborative work that is progressing. Pilot site representatives had opportunity to feed back on the tests of change that they are currently working on and a third event has been attended on the 4/9/18 to consolidate learning about methods to scale and sustain change. - A Pressure ulcer verification training package and draft competencies have been devised and being evaluated by Stepping Hill DN team as a test of change.

Indicator Detail

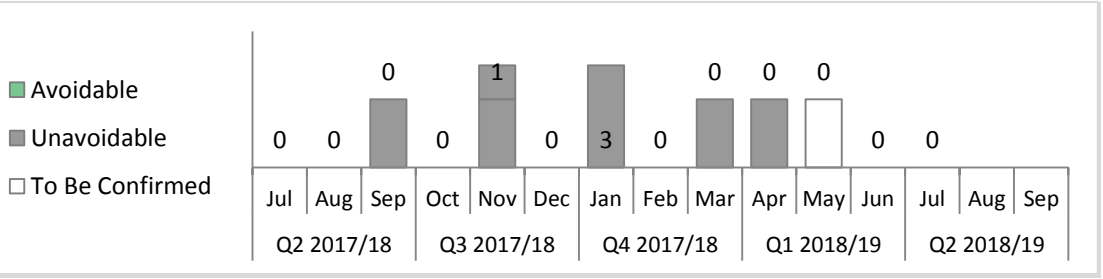
Jul-18	Pressure Ulcers: Community, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a community setting.
Target	Our aim is to reduce community acquired avoidable category 3 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July as category 3 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 3 *	



Actions

This month there has been a total of 3 category 3 pressure ulcers reported in the Community.Avoidable = 0, Unavoidable = 0, TBC = 3. These will be reviewed by the harm free care panel in October
- A gap analysis has been completed following the issue of NHS Improvement guidance in relation to the definition and measurement of pressure ulcers.
- A successful visit from NHS Improvement has taken place on the 14/8/18 as part of the NSTPP collaborative work that is progressing. Pilot site representatives had opportunity to feed back on the tests of change that they are currently working on and a third event has been attended on the 4/9/18 to consolidate learning about methods to scale and sustain change.
- A Pressure ulcer verification training package and draft competencies have been devised and being evaluated by Stepping Hill DN team as a test of change.

Jul-18	Pressure Ulcers: Community, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a community setting.
Target	Our aim is to reduce community acquired avoidable category 4 pressure ulcers by 50% by the end March 2019. The figure represented here relates to July 2018 as category 4 pressure ulcers that relate to August are not yet validated. Pressure ulcers are reported as either avoidable (where lapses in care were identified), or unavoidable (where no lapses in care were identified)
<= 1 *	

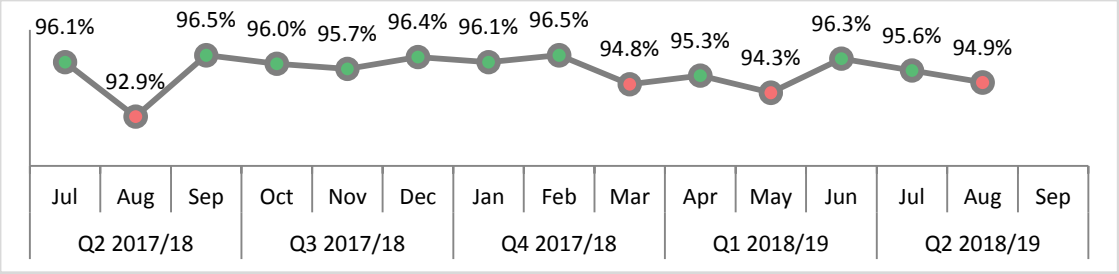


Actions

This month there, have been no category 4 pressure ulcers reported in the community.

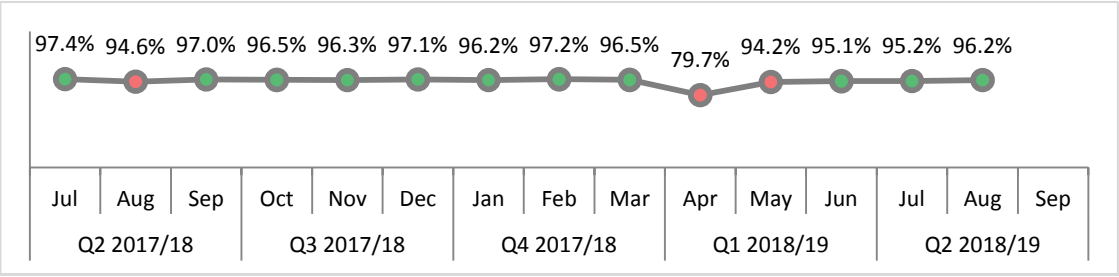
Indicator Detail

Aug-18	Safety Thermometer: Hospital
94.9%	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.
>= 95%	



Actions
This month saw a decrease in performance. Weekly safety thermometer data collection continues with validation meetings to monitor standards.

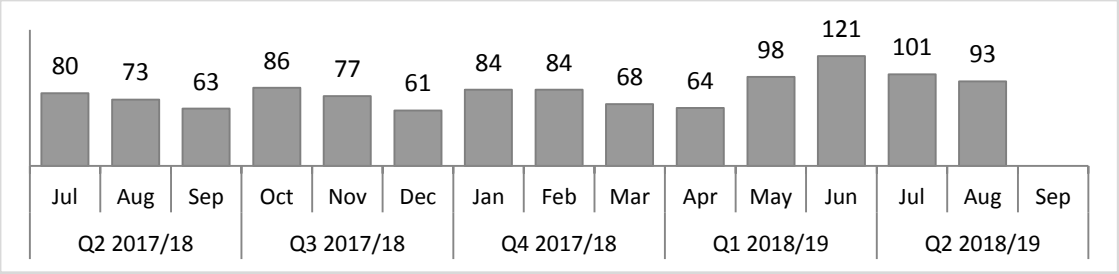
Aug-18	Safety Thermometer: Community
96.2%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that 95% of patients receive harm free care as monitored by Safety Thermometer.
>= 95%	



Actions
The target has been achieved in month.

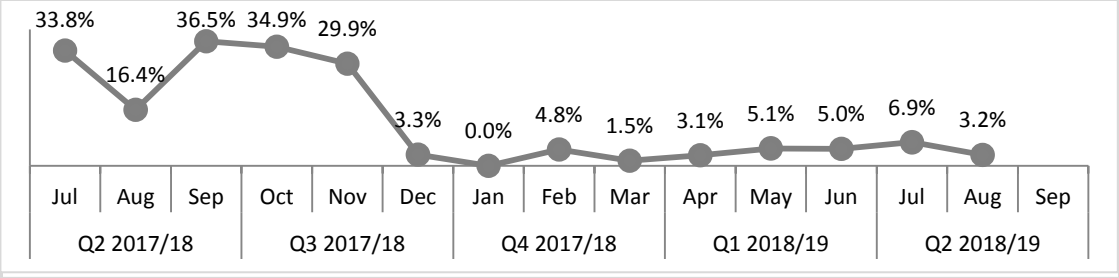
Indicator Detail

Aug-18	Medication Errors: Overall
93	Total number of Medication Errors.
Target	In August 2018, 93 medication errors were reported, which is a reduction from last month.



Actions
All medication incidents are reviewed weekly by a trust executive at the patient safety summit. In August, areas highlighted in the patient safety summit update include; - incidents and near misses where patients in our care have had medications prescribed on both the electronic system and a paper kardex at the same time - the importance of checking medications that are contraindicated with a patient's condition or other medication - the importance of the correct dose of paracetamol when a patient's weight is less than 50kg -the importance of checking expiry dates on medications

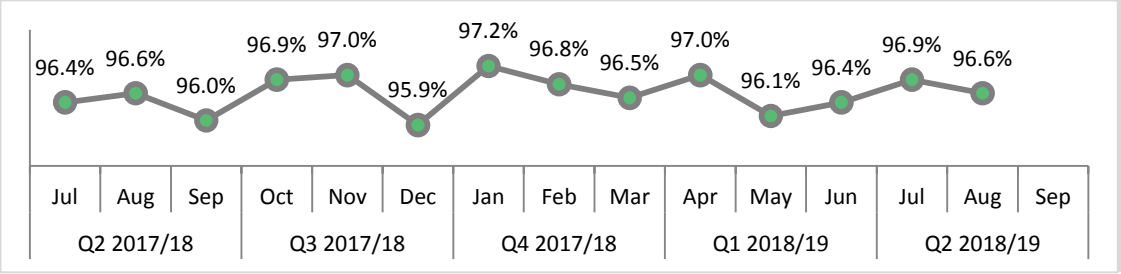
Aug-18	Medication Errors: Moderate Harm and Above
3.2%	The percentage of medication errors causing moderate harm and above.
Target	In August 2018, three medication errors were reported as incidents, where moderate harm or above had occurred. This is a reduction of 5 from last month.



Actions
The incidents reported are currently under investigation by the Business Groups. There has been a trend identified that incidents associated with anticoagulant therapy can cause harm. Anticoagulant incidents are now a standing item at the safer practice medicines group, and a representative from pathology has been invited to attend.

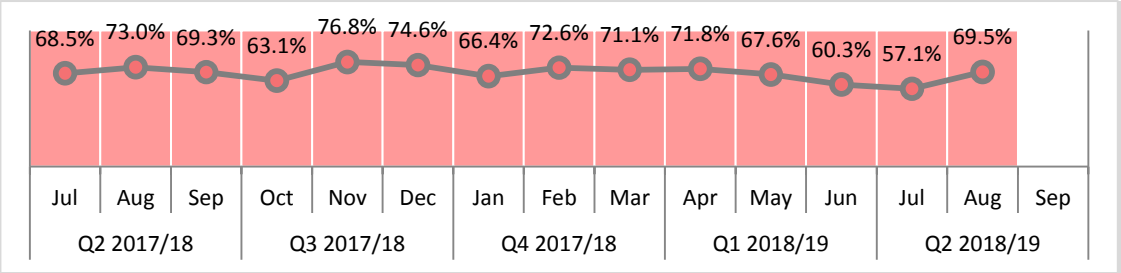
Indicator Detail

Aug-18	VTE Risk Assessment
96.6%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).
>= 95%	



Actions
The target has been achieved in month.

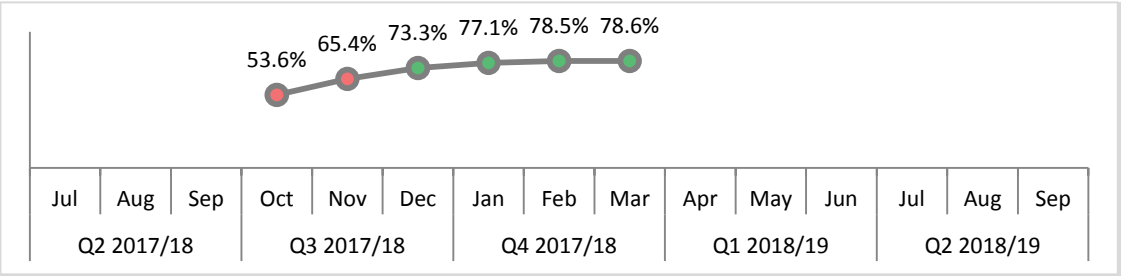
Aug-18	Clinical Correspondence
69.5%	The percentage of clinical correspondence typed within 7 days.
Target	The Trust failed to achieve the standard for clinical correspondence in August but have recorded an improvement in performance. The Integrated Care Business Group achieved the standard again, with 96.6% of letters being typed within the 7 day time-frame.
>= 95%	



Actions
The areas of most concern, in relation to volume and backlogs are: Medicine BG - up to 63.8% in August from 58.9% in July - Cardiology (10.5%) - Diabetes & Endocrinology (51.9%) Surgical BG - up to 65.3% in August from 48.8% in July - T&O (53.0%) - General Surgery (57.6%) W&C BG - up to 83.2% in August from 67% in July - Breast Surgery (56.6%) - O&G (66.6%)

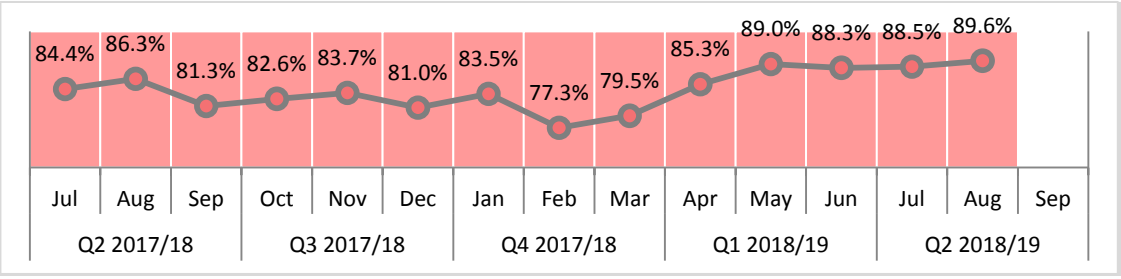
Indicator Detail

Mar-18	Flu Vacination 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 commence in September 2018.

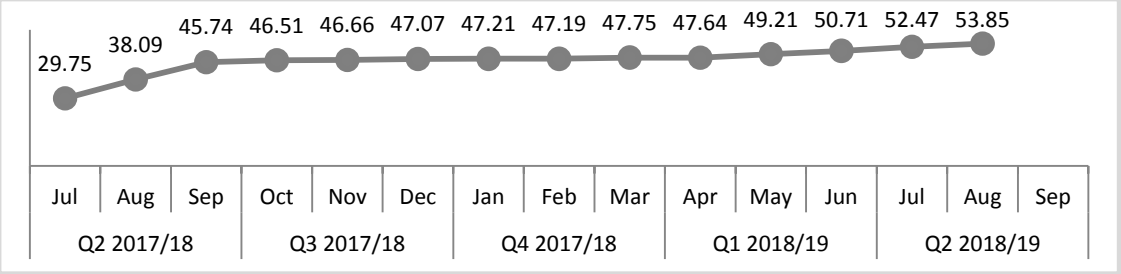
Aug-18	Discharge Summaries
89.6%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Performance against standard shows a small improvement in month. At Business Group level, S,GI&CC achieved 93.8%, and M&CS 91.2%. WC&D achieved their highest performance to date with 87.9%.
>= 95%	



Actions
Clinical Decision Unit (CDU) length of stay is being looked at to ascertain if all patients that attend the unit qualify for a HCR summary. Audit findings will be examined before any suggestions are clinically approved and implemented.

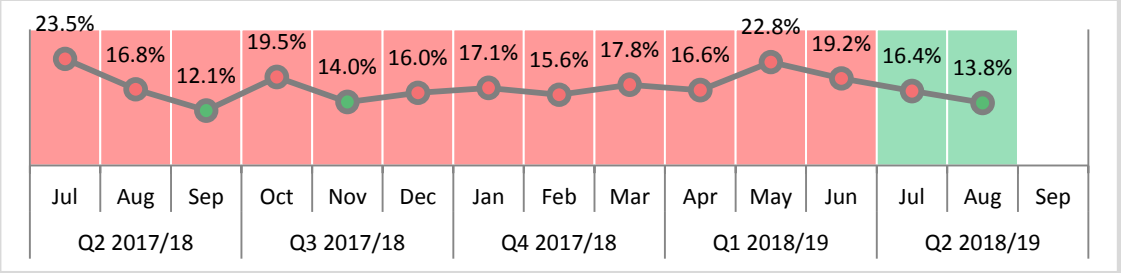
Indicator Detail

Aug-18	Patient Safety Incident Rate
53.85	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The patient safety incident rate continues to increase, in line with increased reporting.



Actions
The top 3 categories are Workplace stressors / demands Pressure ulcers Slips trips and falls Workplace stressors/demands refers incidents mainly related to staffing levels in wards and departments. All staff have been actively encouraged to report any staffing issues in order for both clinical and non-clinical managers to be aware of areas that require support. Pressure ulcer incidents remain in the top three categories reported and work continues to reduce the number of pressure ulcers that develop whilst under the care of our organisation for example the use of the Purpose T tool. There have been 70 incidents reported in relation to trips slips and falls; 64 of which resulted in low or no harm.

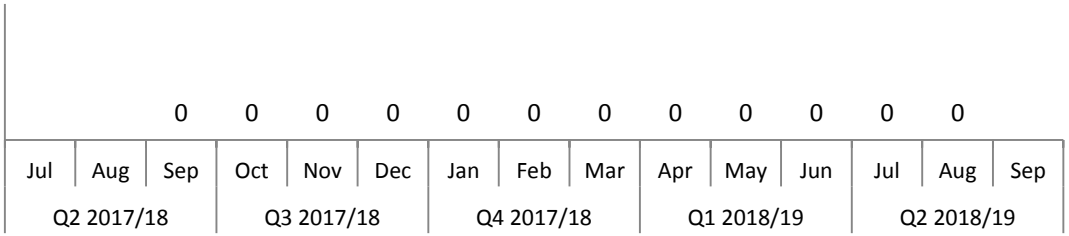
Aug-18	Emergency C-Section Rate
13.8%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	The emergency caesarean section target is <15.4%
<= 15.4%	



Actions
The target has been achieved in month.

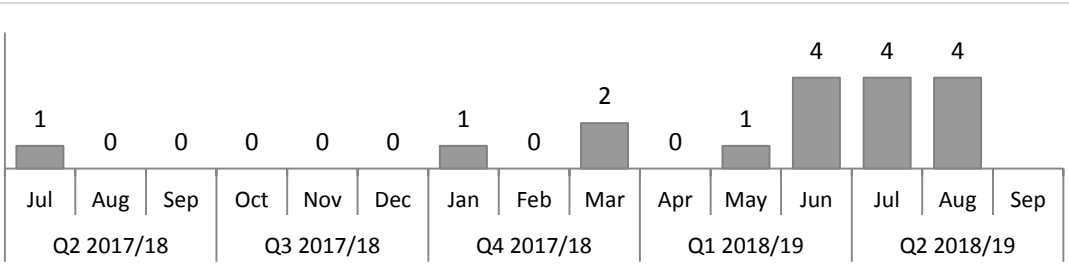
Indicator Detail

Aug-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 August 2018.
<= 0	



Actions
The last never event reported by the trust, was in July 2015. This was an incident of a wrong site interscalene block .

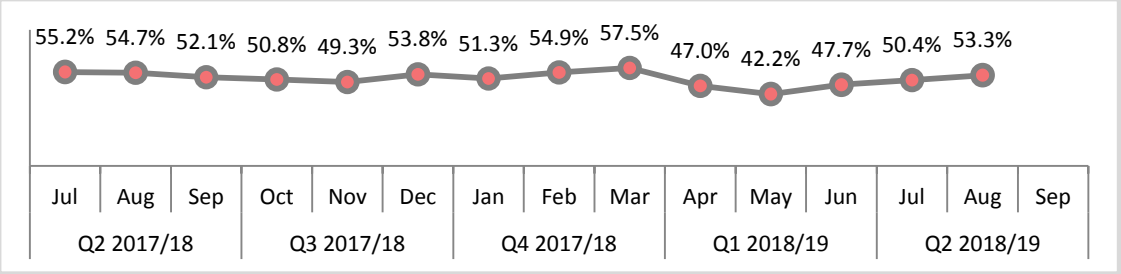
Aug-18	Duty of Candour Breaches
4	Total number of Duty of Candour breaches in month.
Target	In August 2018, out of the 24 incidents that required opening duty of candour, 4 were not completed within the 10 day timeframe.



Actions
The new duty of candour and being open policy has been approved and on the trust intranet. Training continues to be delivered to ensure staff are aware of the requirement. Duty of candour compliance is being monitored on a weekly basis.

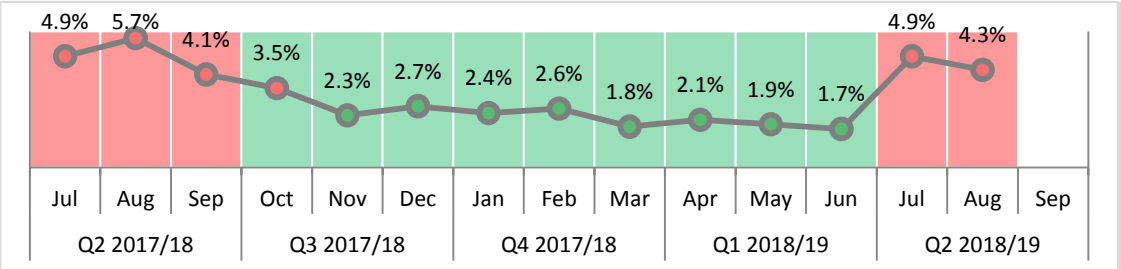
Indicator Detail

Aug-18	Stranded Patients
53.3%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The number and proportion of Stranded patients rose again in August.
<= 35%	



Actions
To improve the number and proportion of Stranded patients in Stepping Hill hospital, an innovative approach has been adopted to introduce a High Impact Team consisting of Primary Care clinicians working in dedicated ward areas to undertake the following: - Bring together clinicians from across the system to work collaboratively - Manage and reduce risk adversity at a ward level and support cultural change - Reduce stranded / super- stranded patients rates - Use the process to support the identification of themes and trends - Identifying gaps in commissioned services

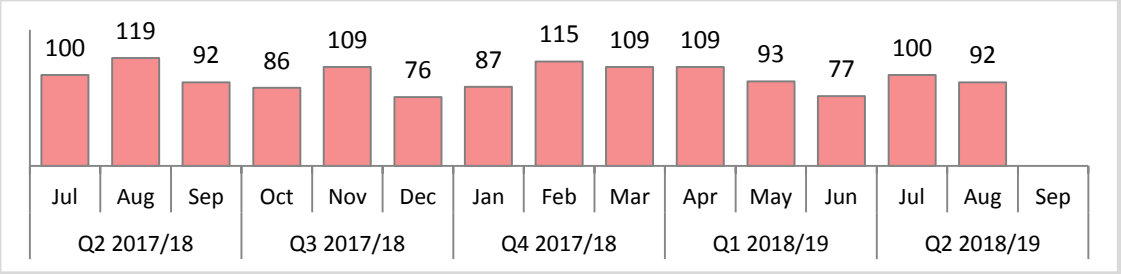
Aug-18	Delayed Transfers of Care (DTOC)
4.3%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	Performance improved slightly in August but is still above target
<= 3.3%	



Actions
Delayed Transfers of Care continue to be a key area of focus for the Integrated Transfer Team (ITT). The ITT undertake the following actions: - Daily reviews of patients requiring assistance to move to the next stage of their care. - Escalate delayed Out Of Area patients to their counterparts in other districts. - Work closely with the ward teams to ensure there are no delays in patients transfers.

Indicator Detail

Aug-18	Medical Optimised Awaiting Transfer (MOAT)
92	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The number of patients classified as Medically Optimised Awaiting Transfer fell slightly in August.
<= 40	

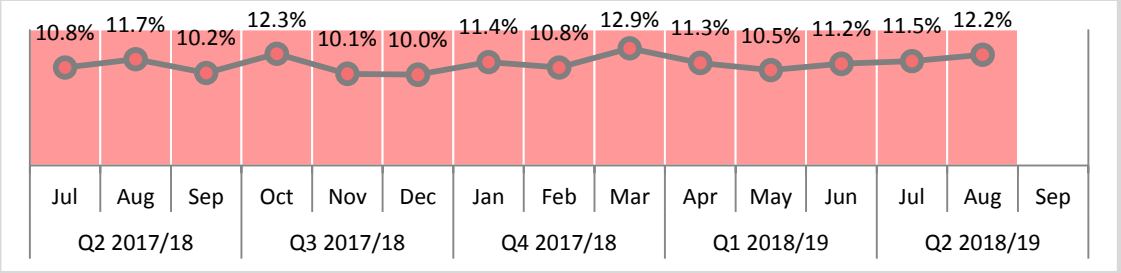


Actions

To ensure patients classified as Medically Optimised Awaiting Transfer are managed effectively, the Integrated Transfer Team, alongside the ward-based multidisciplinary teams take the following actions:

- Regular and active input to a Whiteboard Round on a control ward
- Undertake a Grand Round to review all patients under Enhanced Case Management
- Provide weekly input to the Super Stranded Grand Round

Aug-18	Bank & Agency Costs
12.2%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in August 2018 account for 12.22% (£2.446M) of the £20.023M total pay costs. This is a £278K increase from the position reported in July 2018 (£2.168M). The Medicine & CS Business Group bank and agency spend has increased by £77K from July 2018 to £908K in August 2018.
<= 5%	



Actions

The high spend areas are in the Medicine and Clinical Support business group, particularly at middle grade. There has also been an increase in non-clinical spend. Actions remain in place to reduce the level of spend and the current forecast for the end of the year is £11.1M, exceeding the agency ceiling of £10,534,000 for 2018/2019.

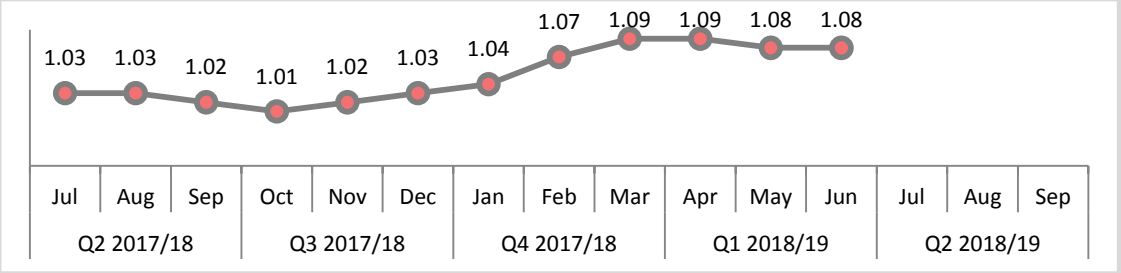
As the majority of the highest spend areas have reduced the issues leading to deterioration of the position relate to increases in consultant spend in Gastroenterology and Microbiology and also increases in non-clinical spend for safeguarding and Datix expertise.

Due to the lack of improvement in middle grade spend the following interventions have commenced:

• Substantial review of the middle grade rota to support out of hours urgent medical care to include further usage of non-medical roles.
• Increased challenge and scrutiny of all agency requests at the Establishment Control Panel and performance reviews

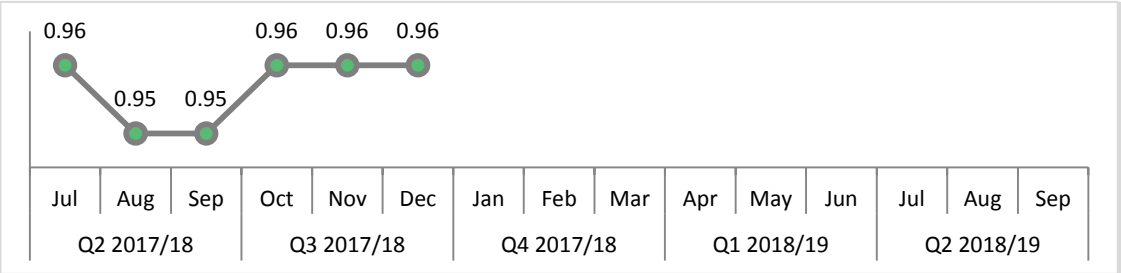
Indicator Detail

Jun-18	Mortality: HSMR
1.08	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	Sustained rise in HSMR is maintained.
<= 1	



Actions
This metric must be considered in the context of our SHMI mortality figure which gives positive assurance about our mortality performance. The main difference is the exclusion of patients coded as 'palliative care', which when take along with the high proportion of 'in hospital' deaths in Stockport (50% more than the national average) makes a considerable difference. This week we started an AQUA quality improvement project, looking specifically at our HSMR data, to better understand the result and consider what measures, clinical or coding will improve our performance.

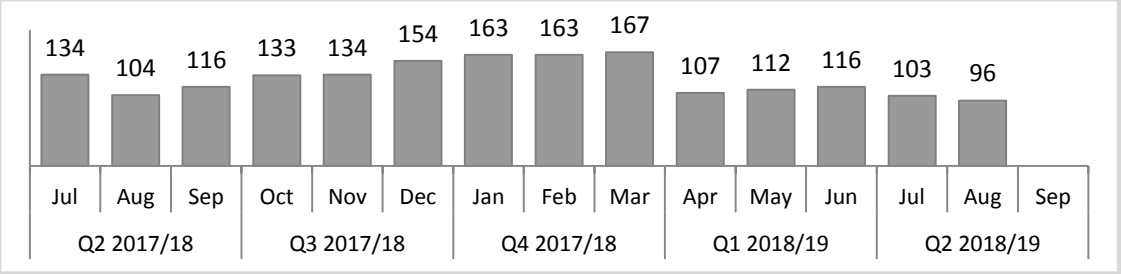
Dec-17	Mortality: SHMI
0.96	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	Sustained above average performance
<= 1	



Actions

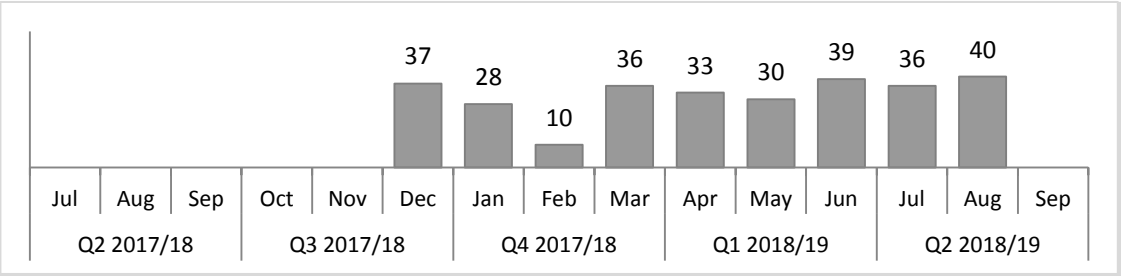
Indicator Detail

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



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

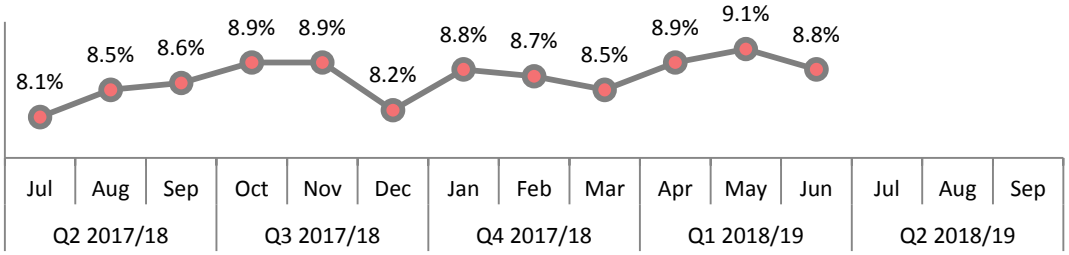
Aug-18	Mortality: Case Note Reviews
40	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	In August 40 case note reviews were undertaken, a completion rate of 40%. This exceeds the target of 30%. Since December that have been four serious incident investigations triggered for potentially avoidable deaths identified by learning from death reviews.



Actions
Significant progress has been made by the reviewers using the incident reporting system to log the reviews. We are satisfied with the number of reviews undertaken. Current focus is upon capturing family feedback, developing nursing LFD reviews, and on cascading the learning all our LFD reviews.

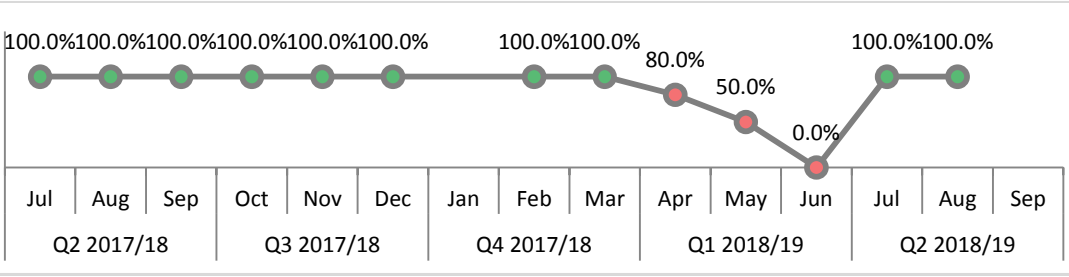
Indicator Detail

Jun-18	Emergency Readmission Rate
8.8%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	A continued focus of the enhanced case management program.
<= 7.9%	



Actions

Aug-18	Patient Safety Alerts: Completion
100.0%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	In August 2018, there were five safety alerts issued. There was one safety alert due for completion.
>= 100%	

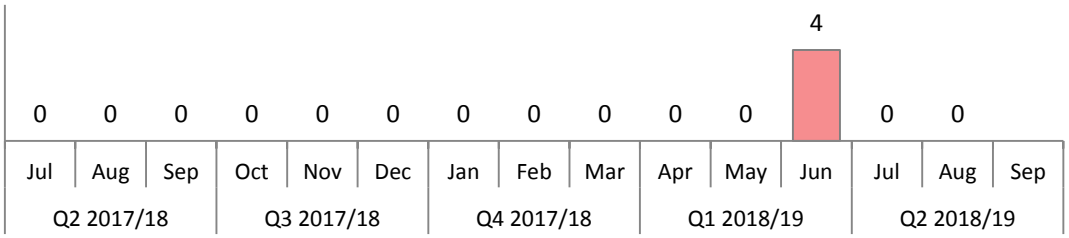


Actions

The standard operating procedure for responding to the Central Alerting System has been revised, in the line with a new process. The standard operating procedure is currently going through the consultation and approval process.

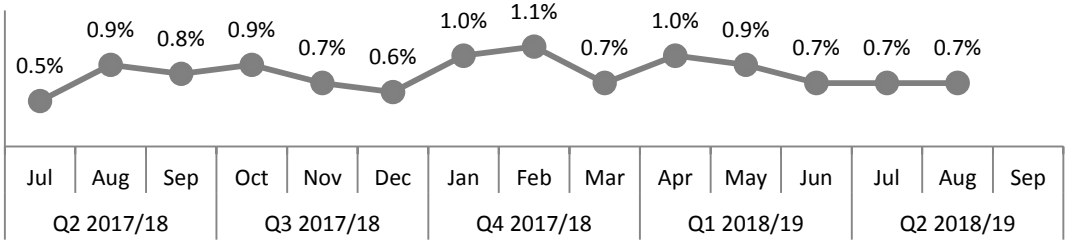
Indicator Detail

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



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

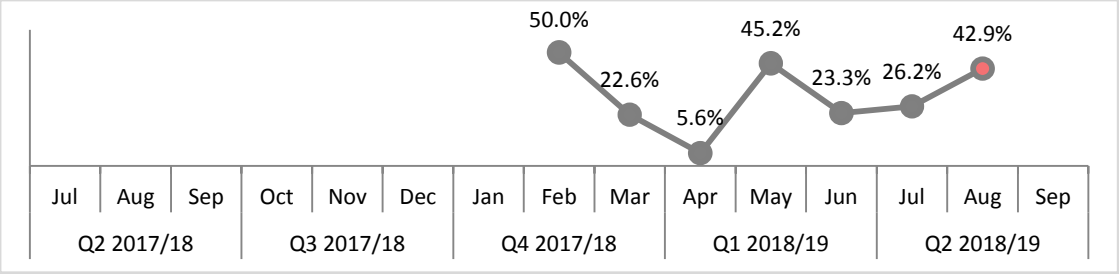
Aug-18	Complaints Rate
0.7%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	31 complaints were received in August 2018 (Integrated Care = 4 Medicine & CS = 9; Surgery GI & CC = 12; Women, Children and Diagnostics = 6; Estates & Facilities = 0)



Actions
The new complaints process includes identification of themes and trends that will result in resolution of concerns raised, with the overall outcome of maintaining the complaint rate under 1.5%. Whilst the number of formal complaint remains higher than is hoped, the number received year to date is showing a reduction on previous years. For the period of 01.04 - 09.09: 2016/17 - 334 2017/18 - 205 2018/19 - 189

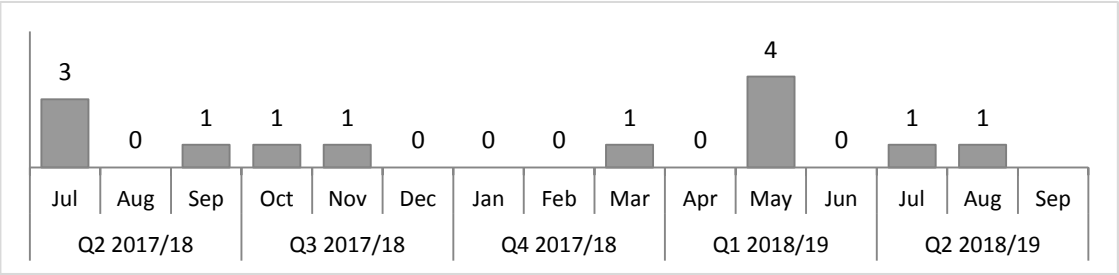
Indicator Detail

Aug-18	Complaints: Response Rate 45
42.9%	The percentage of formal complaints responded to within 45 days.
Target	In August 2018 40 responses were due out, 21 of which were responded to on time resulting in a 52.5% response rate. Integrated Care = 4 on time - Medicine & Clinical Support = 5 on time Surgery, GI & CC = 8 on time - Women, Children & Diagnostics = 4 on time
>= 95%	



Actions
The response rate is low due to increased scrutiny being placed on the investigation. The Trust is eager to improve the quality of responses to complaints in order to ensure the best possible outcome for the complainant. This includes ensuring that the Trust are open and honest when providing a response and the complainant is able to feel assured that a thorough investigation into their concerns has been conducted.

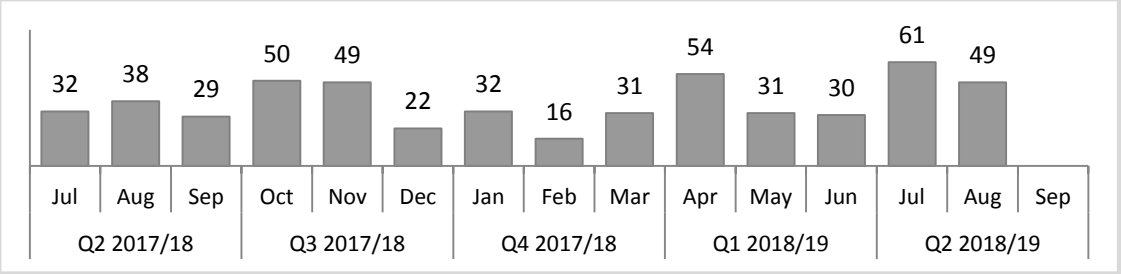
Aug-18	Complaints: Parliamentary & Health Service Ombudsman Cases
1	The total number of open Ombudsman cases.
Target	In August 2018 1 new referral was received from the PHSO.



Actions
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. Should an investigation be undertaken, relevant medical records and complaint file is provided to aid the PHSO with their investigation. On completion of the investigation, a draft report is produced. The Trust and the complainant are given the opportunity to provide comments. A final report is then received, this is shared with the relevant business group to address any actions/recommendations arising from the PHSO investigation. Where failing/shortcomings are identified, an action plan is produced to ensure learning. This is shared with the PHSO and the complainant along with a further response and any financial remedy imposed on the Trust.

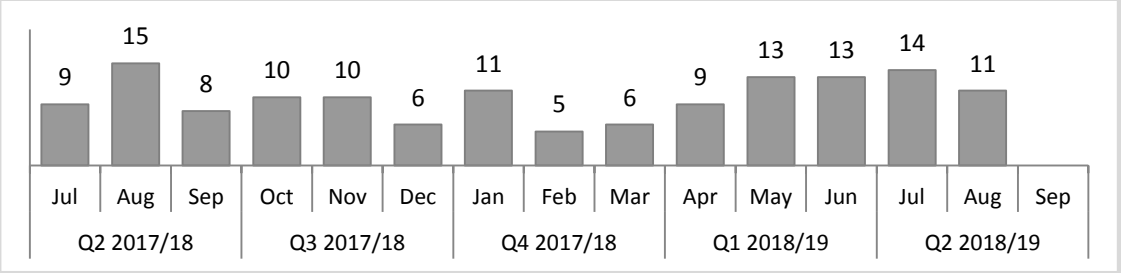
Indicator Detail

Aug-18	Complaints Closed: Overall
49	The total number of formal complaints that have been closed.
Target	In August 2018, 49 cases were closed: Integrated Care = 11 - Medicine & Clinical Support = 14 - Surgery, GI & CC = 17 Women, Children & Diagnostics = 7



Actions
The PCS team continue to monitor cases that are overdue and cases that due to respond and liaise with the BGs on a daily basis. PCS will also keep the complainant apprised of the current position. The Chief Nurse & Director of Quality Governance also receives monthly reports on cases in order to monitor cases that are overdue. A complaints review panel has also been formed. The meetings will be held bimonthly and will review a selection of closed cases and specifically focus on the investigation undertaken and the learning from the complaint.

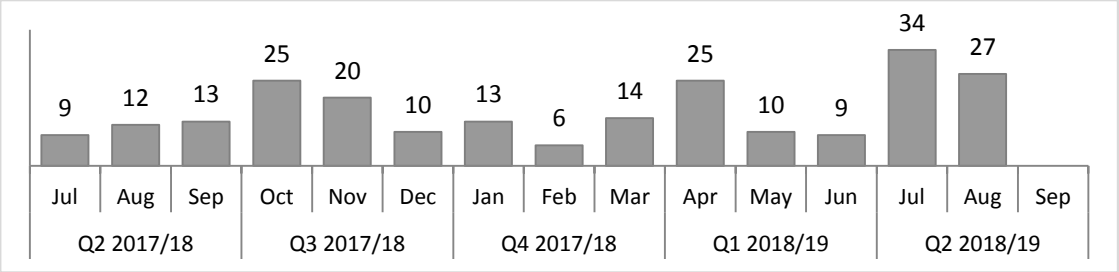
Aug-18	Complaints Closed: Upheld
11	The total number of upheld formal complaints that have been closed.
Target	In August 2018 the Trust reported that 11 complaints were upheld



Actions
The number of upheld complaints closed by business group were as follows: Integrated Care = 6 Medicine & Clinical Support = 3 Surgery, GI & CC = 2 Women, Children & Diagnostics = 0 Any learning identified during a complaint is shared with the complainant.

Indicator Detail

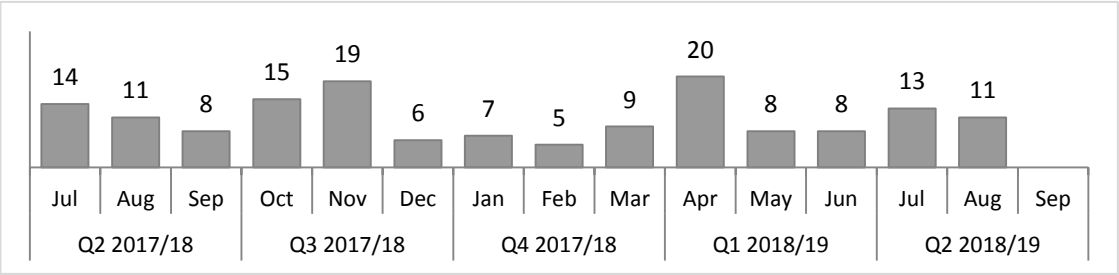
Aug-18	Complaints Closed: Partially Upheld
27	The total number of partially upheld formal complaints that have been closed.
Target	In August 2018 the Trust reported that 27 complaints were partially upheld



Actions

The number of partially upheld complaints closed by business group were as follows:
Integrated Care = 4
Medicine & Clinical Support = 9
Surgery, GI & CC = 10
Women, Children & Diagnostics = 4

Aug-18	Complaints Closed: Not Upheld
11	The total number of not upheld formal complaints that have been closed.
Target	In August 2018 the Trust reported that 11 complaints were not upheld

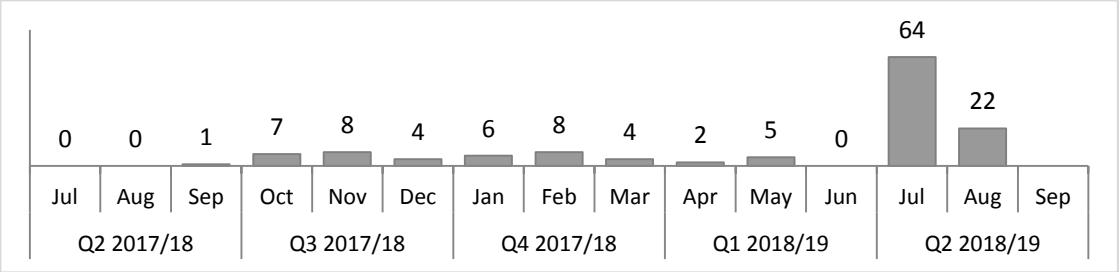


Actions

The number of not upheld complaints closed by business group were as follows:
Integrated Care = 11
Medicine & Clinical Support = 14
Surgery, GI & CC = 17
Women, Children & Diagnostics = 7

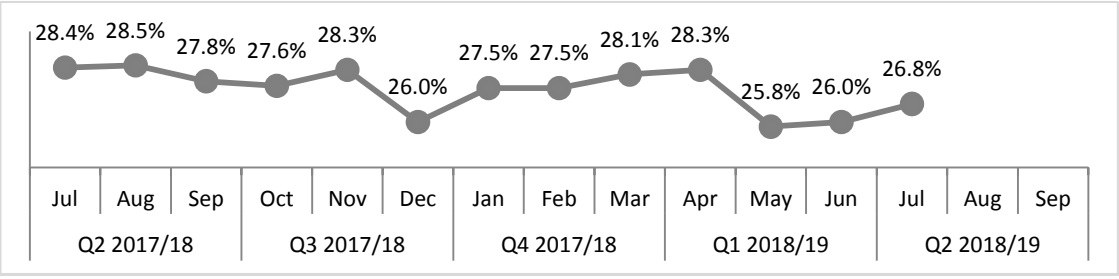
Indicator Detail

Aug-18	Compliments
22	Total number of compliments received.
Target	In August 2018, the patient and customer service team received 22 compliments from patients and their families. Integrated Care = 8; Medicine & Clinical Support = 6; Surgery, GI & CC = 5; Women, Children & Diagnostics = 2; Anonymous = 1



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.

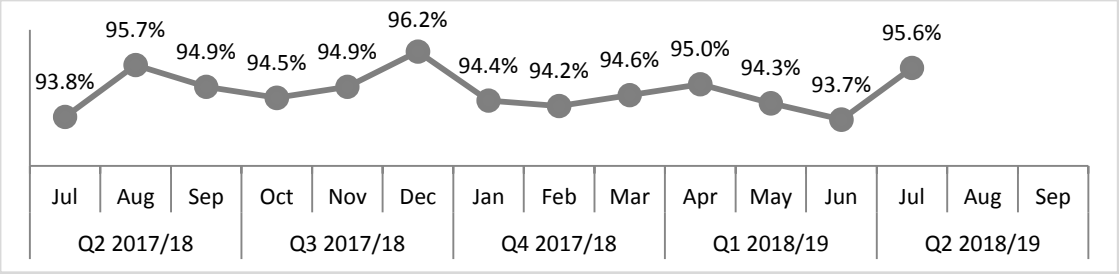
Jul-18	Friends & Family Test: Response Rate
26.8%	The percentage of eligible patients completing an FFT survey.
Target	The overall trust response rate for August 2018 for the Friends and Family test is 26%. There is no national indicator for response rate.



Actions
Patient voices continue to include patients attending the Emergency Department, Out Patients Department and parts of Community Services and this remains positively received. Patients contacted via landline are asked for their verbal feedback at the point of discharge, and comments are available to the business group for review and sharing with staff. Although there is no national indicator for response rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback. The business groups produce action plans for improvement which are monitored through the Patient Experience group and the Patient Experience Action group which meet on a monthly basis.

Indicator Detail

Jul-18	Friends & Family Test: Inpatient
95.6%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	There is no national indicator for the friends and family test.

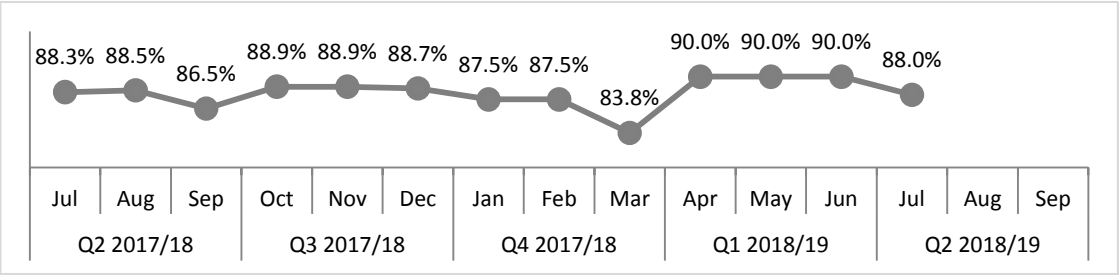


Actions

Positive comments in August 2018 across inpatient areas related to kind and considerate staff who treat patients with dignity and respect. There were also many positive comments relating to the professional behaviour of nursing staff. Negative comments continue to relate to the lack of staff however despite this the comments do acknowledge how hard the staff on duty are working. As a consequence the lack of staff meant that patients did not feel there was anyone to talk to about worries or fears.
Although there is no national indicator for response rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback.

The recruitment of Volunteers continues with a particular focus on ward helpers to offer emotional support to patients and assist the ward teams with tasks.

Jul-18	Friends & Family Test: A&E
88.0%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	There is no national indicator for the friends and family test.

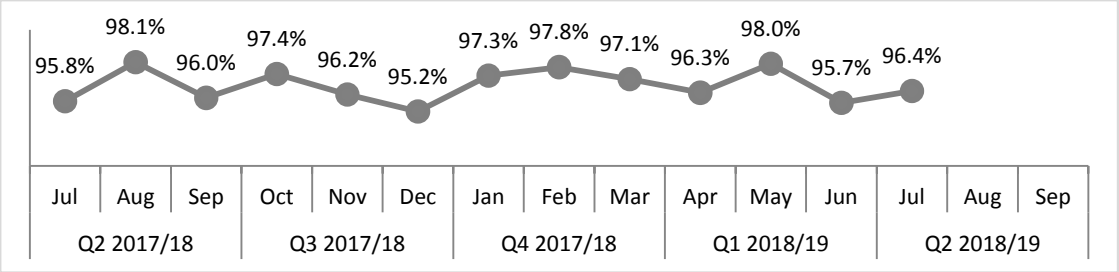


Actions

There were many positive comments in August 2018 for the Emergency Department centred on the excellent quality of care provided by professional, compassionate, caring staff who provide excellent care even when under pressure. Although there were many positive statements relating to not having to wait long, long waiting times continue to be the area with the highest negative comments.
Although there is no national indicator for response rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback.

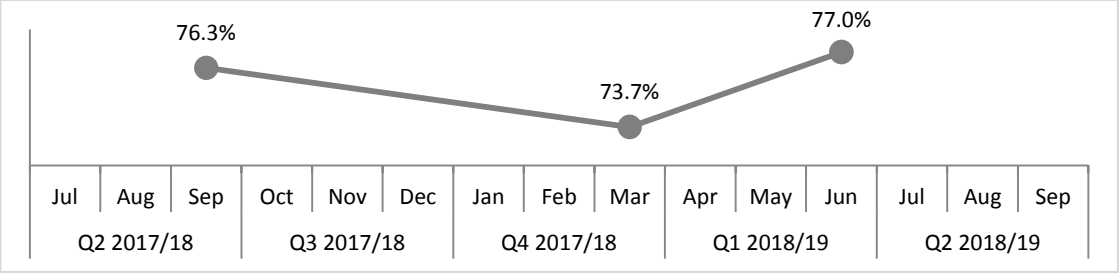
Indicator Detail

Jul-18	Friends & Family Test: Maternity
96.4%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	There is no national target for the friends and family test.



Actions
Positive comments for Maternity for August 2018 continue to be related to excellent, friendly and caring staff who delivered compassionate and competent care. Although the comments were largely positive there were some negative comments relating to lack of pain relief. Although there is no national indicator for response rate business groups, wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback. The monthly patient satisfaction surveys will be rolled out to Maternity and will include a question relating to pain relief.

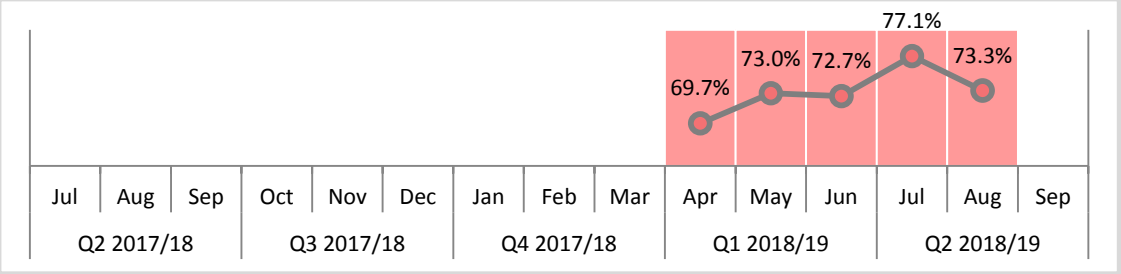
Jun-18	Staff Friends & Family Test
77.0%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The staff F&F Test is a quarterly survey that provides data on the likelihood that a) staff would recommend their Trust as a place to work and b) as a place to receive care to friends and family. The data we recieve is triangulated with staff survey and pulse survey to support delivery of the Culture and Engagement plan.



Actions
In Qtr.1 2018/19 58.8% of staff indicated that they were likely or extremely likely to recommend the Trust as a place to work. This is 9% higher than the 2017/18 Qtr. 4 survey. There has been a focus on engagement and health and well being which is having a positive impact on resilience and staff experience With regard to recommending the Trust as a place to receive care 77.0% of staff responding to the survey indicated that they were likely or extremely likely to recommend the Trust to friends and family with 3.7% saying that they were unlikely or extremely unlikely to do so.

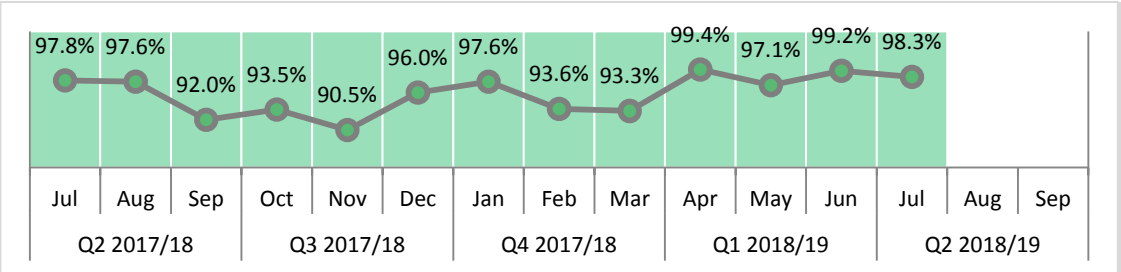
Indicator Detail

Aug-18	Diabetes Reviews
73.3%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	This new metric is still bedding in, but sustained improvements are shown.
>= 90%	



Actions
The diabetes team continue to prioritise the ward reviews, as shown in this performance.

Jul-18	Dementia: Finding Question
98.3%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target is >90%
>= 90%	

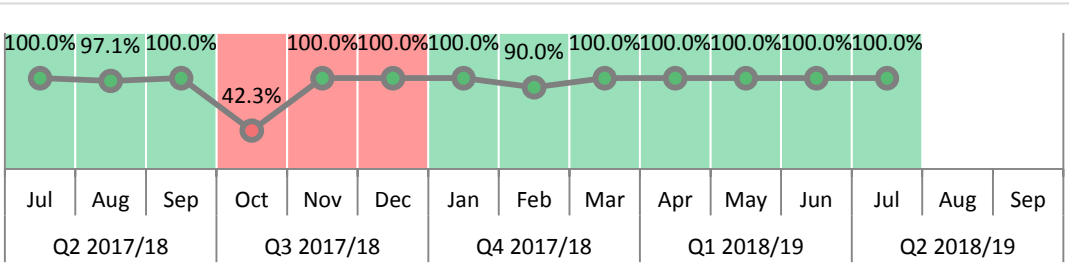


Actions
The target has been achieved in month.

Indicator Detail

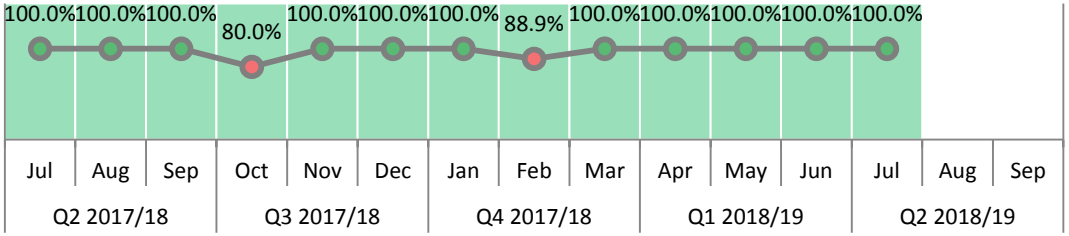
Jul-18	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target is >90%
>= 90%	

Actions
The target has been achieved in month.



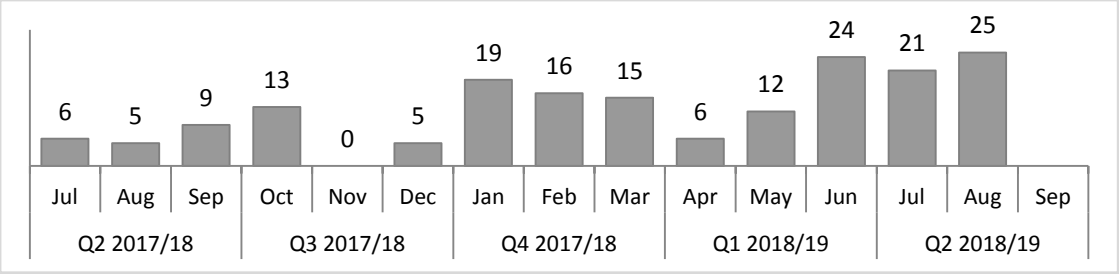
Jul-18	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target is >90%.
>= 90%	

Actions
The target has been achieved in month.



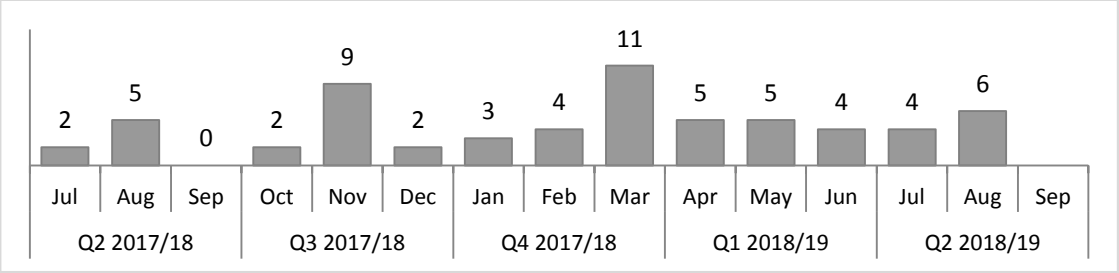
Indicator Detail

Aug-18	Serious Incidents: STEIS Reportable
25	The total number of STEIS reportable incidents.
Target	There have been 25 incidents reported via StEIS in August 2018. All Serious Incidents have been reviewed by the Chief Nurse & Director of Quality Governance and the Medical Director.



Actions
Investigations are underway in accordance with trust policy. In August there were; 10 cases of stage 3 pressure ulcers 2 cases of stage 4 pressure ulcers. 5 cases of potential suboptimal care 3 cases of a potential delay in diagnosis or treatment 2 cases of falls with potential sub-dural bleeds 1 case of a fall and fracture 1 case that waited over 12 hours from being clerked in the Emergency Department 1 case where there has been an allegation of assault CQC have been alerted to an incident where a patient was exposed to unnecessary radiation

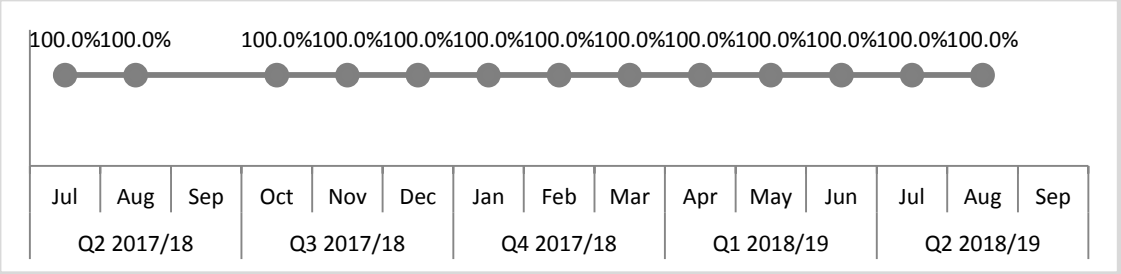
Aug-18	Litigation: Claims
6	Total number of claims opened in month.
Target	In August 2018, the trust received 6 litigation claims. 5 were potentially medical negligence claims. 1 was potentially an employment claim.



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

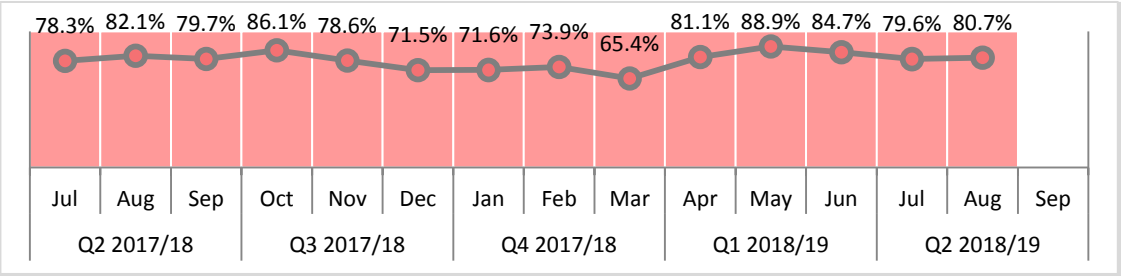
Indicator Detail

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



Actions
Key risk claims include those relating to; Obstetrics Slips, trips or falls Failure or delay in treatment Failure or delay in diagnosis. The two claims that were settled in month relate to, a failure to communicate and a delay in treatment.

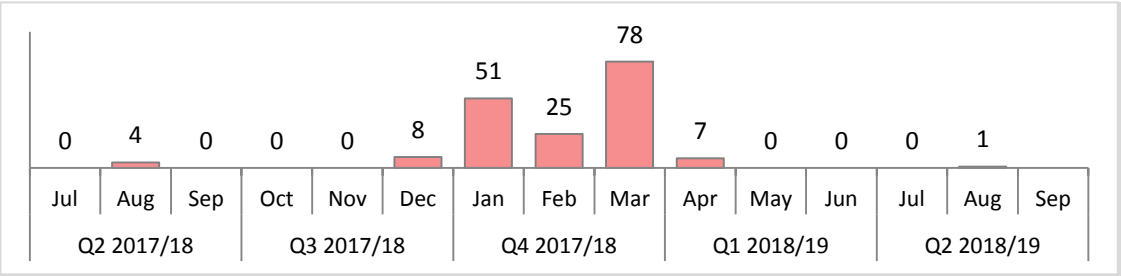
Aug-18	A&E: 4hr Standard
80.7%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance improved very slightly in August
>= 95%	



Actions
Performance against the 4hour A&E standard continues to be a challenge, with the following actions being taken: - Focus remains on overnight performance with a review of the staffing model and leadership in the department overnight. - Expediting patient discharges so they happen earlier in the day by supporting consultant-led whiteboard rounds, with particular focus on the specialty medical wards. - The timely and effective management of Stranded and Super Stranded patients through the introduction of the High Impact Team.

Indicator Detail

Aug-18	A&E: 12hr Trolley Wait
1	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	There was one 12 hour trolley wait in the month of August as a result of no bed availability.
<= 0	

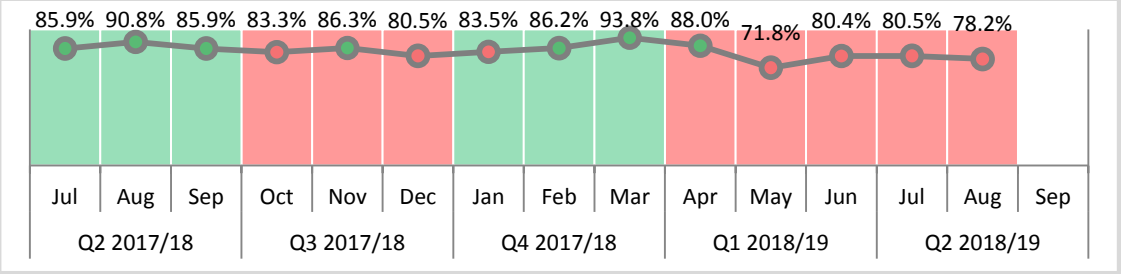


Actions

Work is ongoing by the Site Management Team and the Urgent Care Team to ensure all long waiting patients in the Emergency Department are cared for safely, this includes the following actions:

- the application of effective and time bound escalation procedures to ensure breaches of the 12hr standard are minimized.
- a focus on daily site management to ensure flow is maintained across the hospital.
- A refresh of the OPEL escalation framework to allow for effective whole-system escalation of issues.

Aug-18	Cancer: 62 Day Standard
78.2%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	Performance against the 62 day standard remains challenging. It should be noted that to month 5 of 2018/19, referrals for suspected cancer into the Trust have increased by 22.4%.
>= 85%	



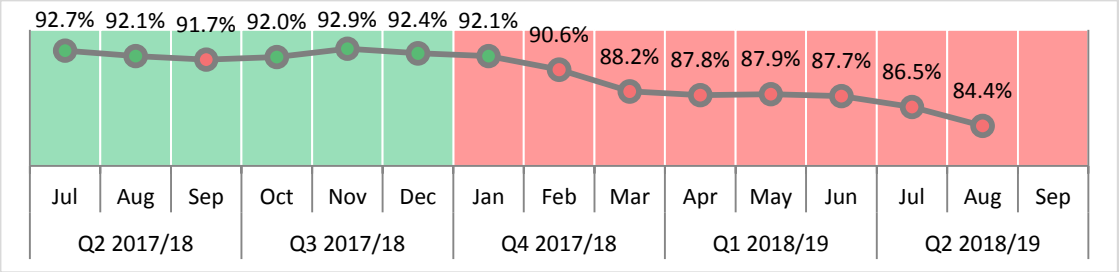
Actions

Services have been tasked with improving the proportion of patients seen for their appointment within 7 days.

A workshop is planned to take place in October with clinical and managerial representatives from each of the services to look at different ways of working that will facilitate achievement of the Faster Diagnosis Standard.

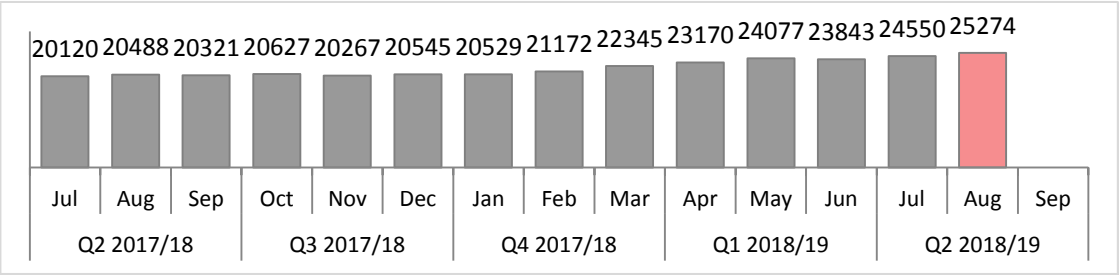
Indicator Detail

Aug-18	Referral to Treatment: Incomplete Pathways
84.4%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	Performance against the 92% Incomplete RTT standard continues to decline. The Trust has set a recovery trajectory of recovering compliance by the end of Q3.
>= 92%	



Actions
Recovery will be based on 4 themes, working collaboratively with Commissioners: - Referral/demand management - Increased activity - Data quality and validation - Discharge thresholds Progress of the impact is being tracked weekly via the various Trust PTL meetings.

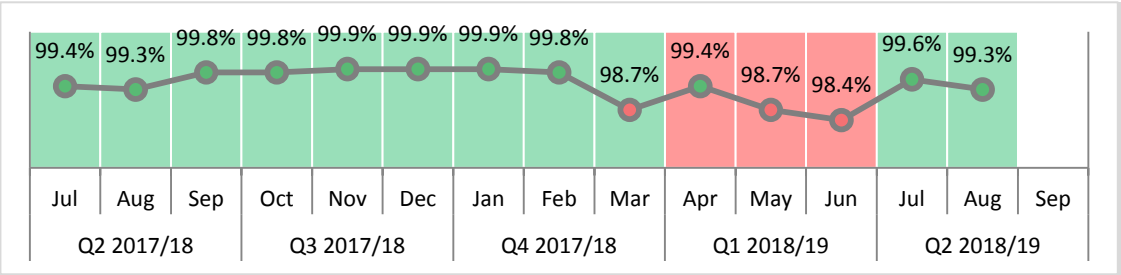
Aug-18	Referral to Treatment: Incomplete Waiting List Size
25274	The total number of patients on an open pathway.
Target	The Incomplete waiting list has increased by 10.7% from March 2108. There is a requirement to reduce back to March 2018 baseline figure by March 2019.
<= 22345	



Actions
Actions being taken are based on 4 themes, working in collaboration with Commissioners: - Referral/demand management - Increased activity - Data quality and validation - Discharge thresholds Progress of the impact is being tracked weekly via the various Trust PTL meetings.

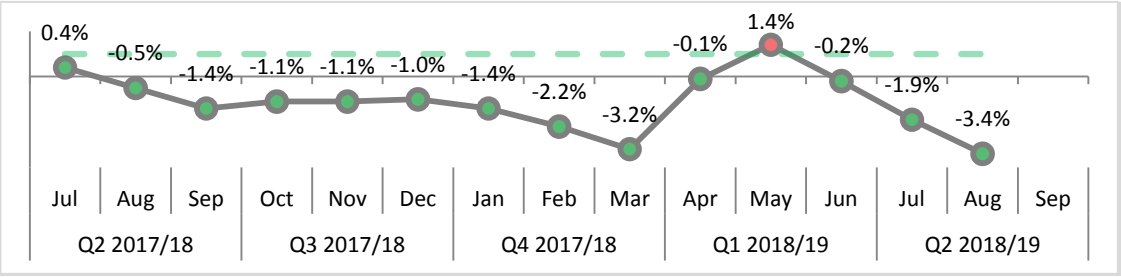
Indicator Detail

Aug-18	Diagnostics: 6 Week Standard
99.3%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust remained compliant with the standard in August, however it should noted that the Dexa scanner failed on a couple of occasions requiring repair.
>= 99%	



Actions
The occurrence of equipment failure will continue to be closely monitored and will trigger exceptional action as appropriate.

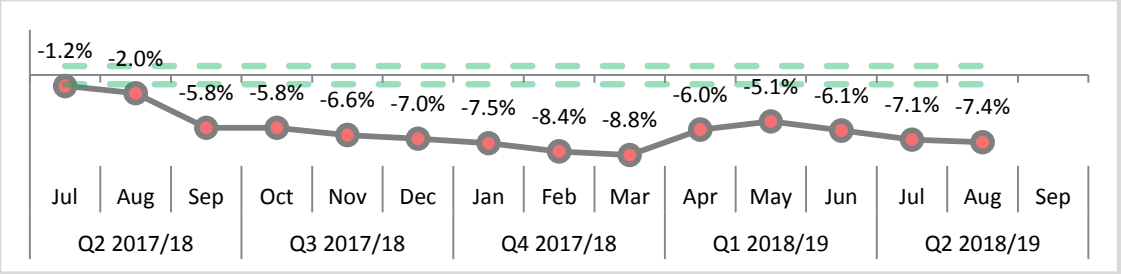
Aug-18	Outpatient Activity vs. Plan
-3.4%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Outpatient activity is under-plan in month. This is mainly being driven by under-performance in Ophthalmology and Orthodontics, Anticoagulation, fracture clinic and specialties within Women& Children Business Group.
<= 1%	



Actions
Work to maximise opportunity at Buxton & Cavendish Hospital is continuing and is part of the SLA negotiations with Derbyshire Community Health Services. Business Groups have developed activity recovery plans to address specialty level variances. Vacancies and sickness within the Outpatient nursing team is limiting Outpatient provision. Recruitment is ongoing.

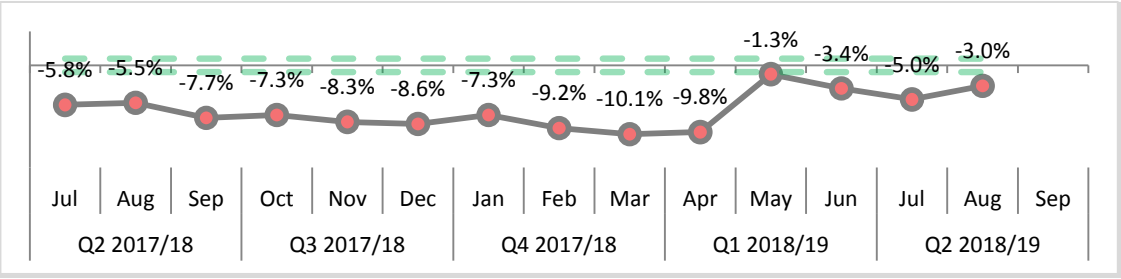
Indicator Detail

Aug-18	Elective Activity vs. Plan
-7.4%	The percentage variance between planned elective activity and actual elective activity.
Target	The Trust was 189 cases below plan in month. Whilst Urology shows an under performance in activity, income is favourable to plan due to case mix.
+/- 1%	



Actions
The Surgery Business Group is forecasting that they will recover the adverse activity position in ENT, Orthopaedics and General Surgery. Trajectory plans will be monitored via the regular Performance Management meetings. Other actions being taken within business groups include; - Embedding use of the new elective v plan tracking too - Creation of additional capacity in endoscopy and ophthalmology - Progressing recruitment of an additional Urology Consultant.

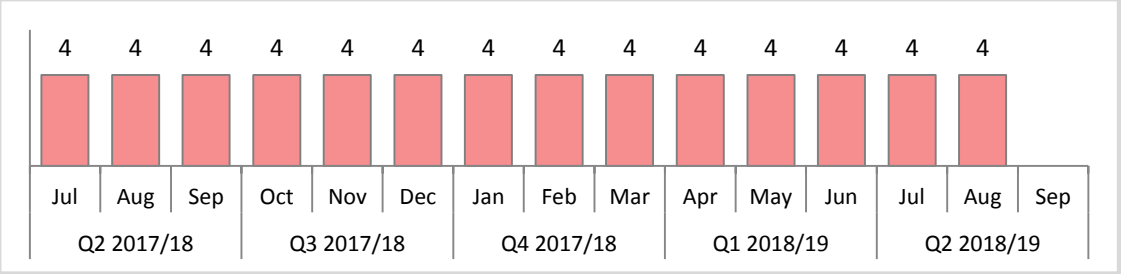
Aug-18	Elective Income vs. Plan
-3.0%	The percentage variance between planned elective income and the actual elective income.
Target	The Trust is adverse to plan at month 5. In month, this is primarily being driven by under-performance in day-case activity in Ophthalmology, Oral Surgery and Haematology.
+/- 1%	



Actions
Oral Surgery have additional sessions planned for September. Ophthalmology are looking to secure a locum Registrar and a locum Consultant to commence September. This will allow a flexible approach to job planning and increased theatre sessions. Substantive recruitment is underway.

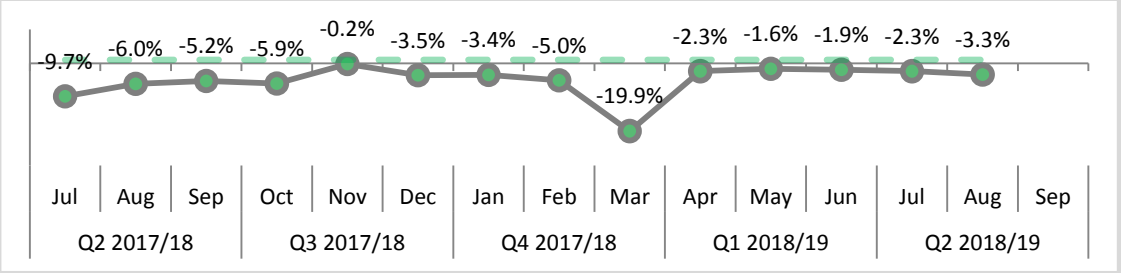
Indicator Detail

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



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

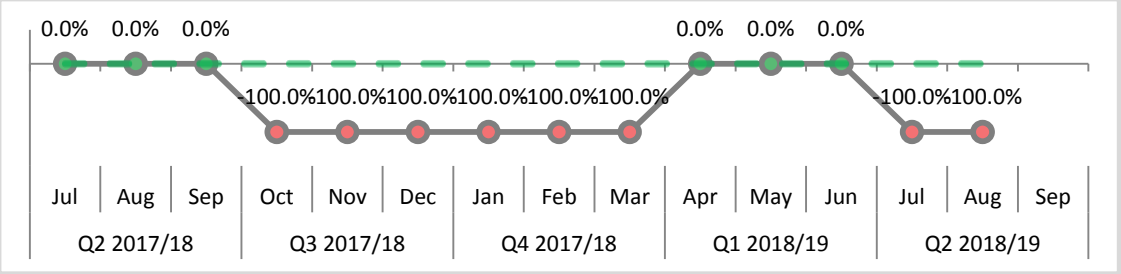
Aug-18	Financial Controls: I&E Position
-3.3%	The percentage variance between planned financial position and the actual financial position.
Target	The Trust has lost of £16.1m in five months, an average loss of £105,000 per day. The planned deficit was £16.7m so this is £0.5m favourable to plan. The Trust is reporting limited assurance on the delivery of this metric predominantly due to the CIP risk and the financial pressure of delivering operational challenges (winter escalation, cancer and RTT).
<= 1%	



Actions
As the Trust is favourable against the financial plan at this stage of the financial year, the Trust is scoring a 1 (best) under the NHSI use of resources (UoR) metric within the Single Oversight Framework. There are a number of risks which will need to be actively managed to assure the year end financial position, primarily delivery of the cost improvement programme.

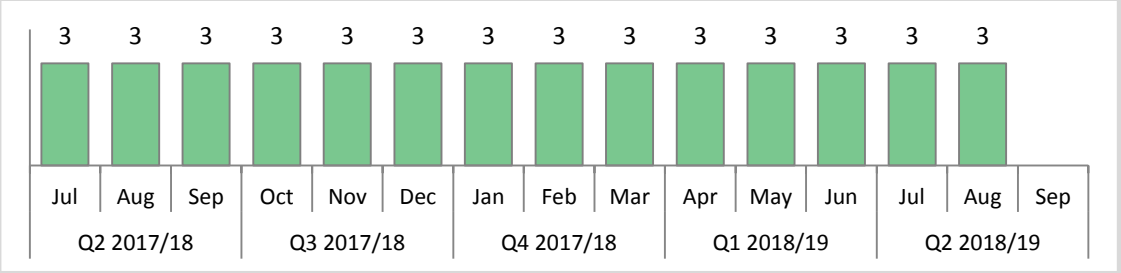
Indicator Detail

Aug-18	Cash
-100.0%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st August 2018 was £6.4m. The graph shows that the Trust has not accessed borrowing to August which is better than plan. In September the Trust has borrowed £2.3m, and the graph for this months begins to compare actual borrowing to planned levels. The forward risk is forecasted as a green, as the Trust has applied and received confirmation of revenue support from
+/- 1%	



Actions
In September the Trust now has a signed agreement to borrow £2.3m, and requested a further £2.6m in October. The planned level of borrowing to March 2019 is £24.7m. Cash is carefully managed and the requirement for a working capital support facility loan is continually being reviewed as part of the 13 week rolling cash flow forecast.

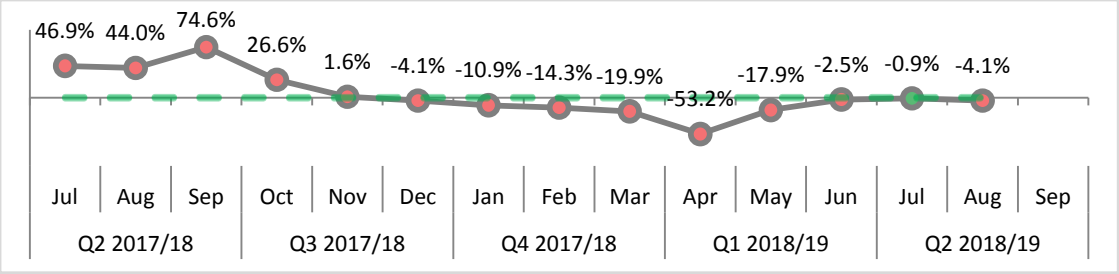
Aug-18	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering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

Indicator Detail

Aug-18	CIP Cumulative Achievement
-4.1%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is £0.1m behind the plan in the five months to August 2018 with £3.5m of savings transacted. The Trust has identified approximately £10.8m against the £15m target at this stage of the financial year. The Trust has agreed to identify £12m by the next Enhanced Oversight Meeting in September.
+/- 1%	

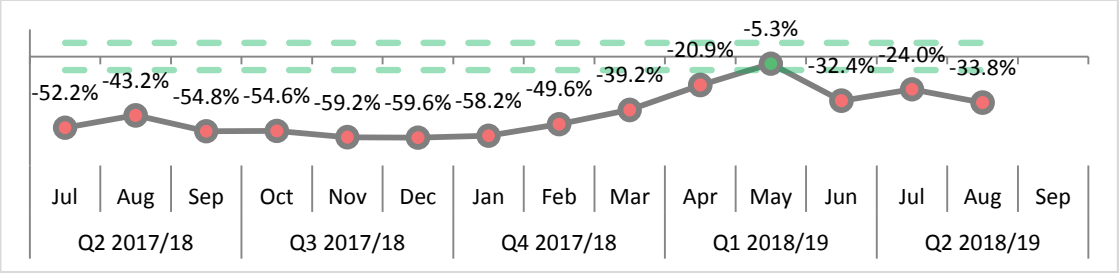


Actions

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. Recurrently only £2.9m of savings have been delivered against the £15m requirement.

Even with potential mitigation the Trust can only provide limited assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

Aug-18	Capital Expenditure
-33.8%	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 £3.0m have been incurred to date against a plan of £4.5m and so is £1.5m behind plan. This relates solely to internally funded equipment and estates schemes.
+/- 10%	



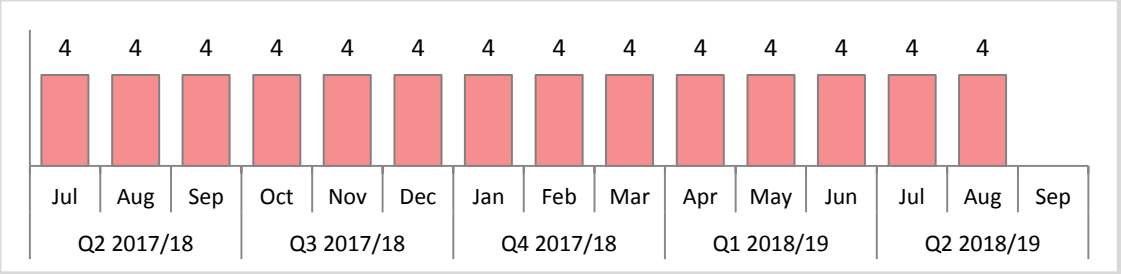
Actions

There is an equipment underspend driven by a reforecast of the gamma camera purchase from August to December, pending implementation discussions with the supplier. Estates maintenance and projects are also behind plan.

The full funding of Healthier Together schemes is fundamental to the delivery of the capital programme, but these are highly unlikely to be incurred in the current financial year, so as a result the Trust's capital plan will show a variance for the Healthier Together schemes later in the year.

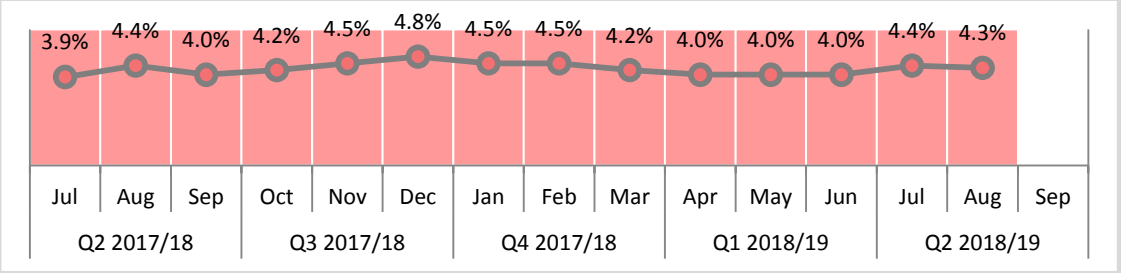
Indicator Detail

Aug-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

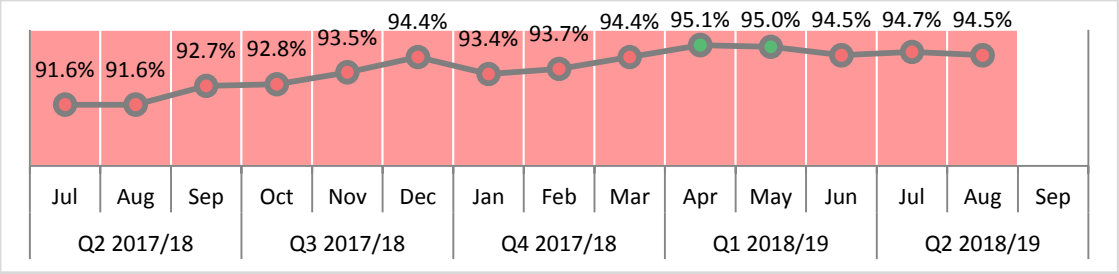
Aug-18	Sickness Absence Rate
4.3%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The unadjusted sickness absence figure for August 2018 is 4.30%; a decrease of 0.06% compared to the July 2018 figure of 4.36%. The sickness rate for comparison in August 2017 was 4.35%. The 12-month rolling sickness percentage for the period Sept 2017 to Aug 2018 is 4.32% (Sep 16 - Aug 17 is 3.96%).
<= 3.5%	



Actions
Top 3 reasons for absence are Anxiety/stress/depression, Back/musculoskeletal (including injury/fracture), and gastrointestinal problems. We have proactive wellbeing initiatives in place to support the top 2 reasons. The unadjusted cost of sickness absence in August 2018 is £485,291; a decrease of £3,638 from the adjusted figure of £488,929 in the previous month. The cost of the 0.8% above target is £90,286. This assumes a like for like replacement based on sample testing which demonstrates that an average replacement rate of 50% of shifts are covered; which is partially off set by increased agency cost. Return to work interviews are audited for compliance against our policy and proactive support for early returns include phased return and OH support.

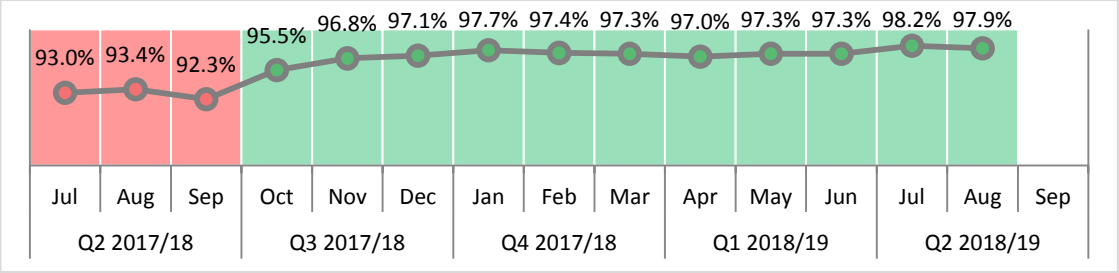
Indicator Detail

Aug-18	Appraisal Rate: Non-medical
94.5%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for August 2018 is 94.52%, a slight decrease from July's data which was 94.72%, and has dropped below target.
>= 95%	



Actions
The OD and learning team will continue to actively support the areas that are below 95% and address any key issues, such as data accuracy and one to one support for managers.

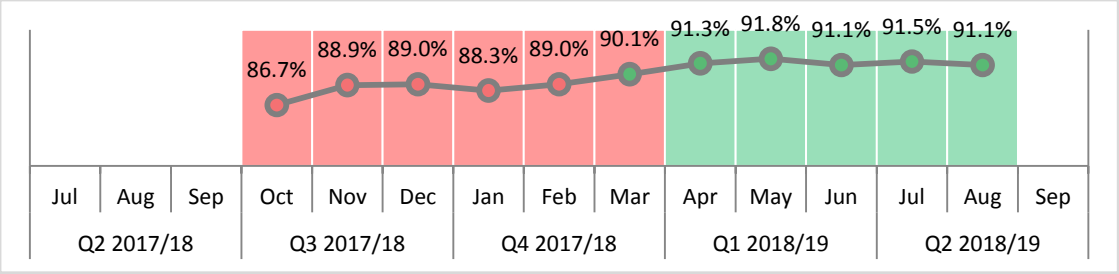
Aug-18	Appraisal Rate: Medical
97.9%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for August 2018 is 97.9%, above the Trust target of 95%.
>= 95%	



Actions

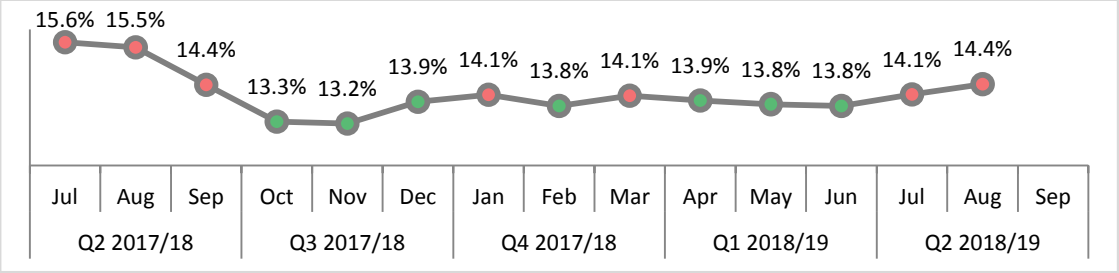
Indicator Detail

Aug-18	Statutory & Mandatory Training
91.1%	The percentage of statutory & mandatory training modules showing as compliant.
Aug-18	Statutory and Mandatory training has achieved the compliance standard in August 2018 (91.09%). This is due the commitment of staff to complete the core skills and the OD and learning team continue to offer diverse ways of completing the training.
>= 90%	



Actions
The team are continuing to support staff with the challenges they experience in accessing e-learning.

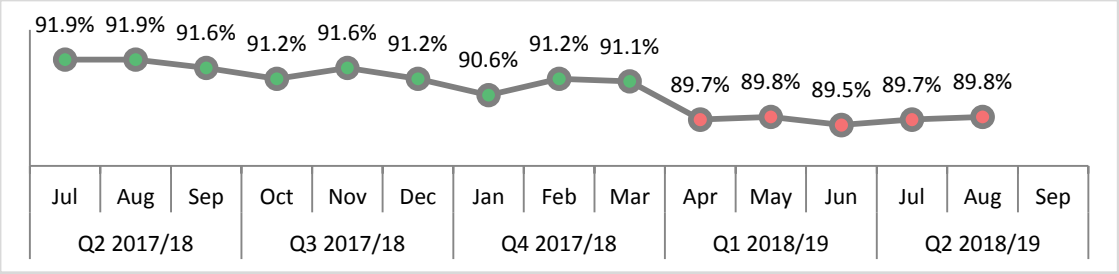
Aug-18	Workforce Turnover
14.4%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month unadjusted turnover figure for August 2018 is 14.39%. The adjusted turnover figure for August 2018 is 11.49%; which falls below the target. The top leaving reasons are: Retirement 16.28%, Relocation 15.95%, Work Life Balance/Dependents 15.45%, and Promotion 13.46.
<= 13.94%	



Actions
The registered nursing and midwifery adjusted 12-month turnover is 10.74%, a decrease of 3.27% from July. Work to progress the actions and interventions as detailed in the recruitment & retention strategy implementation plan are on-going, including the progression of the NHSI Recruitment and Retention programme against the 4 work streams i) Graduate Nurse scheme ii) Career Pathway iii) Top 10 turnover and iv) Retire & Return Programme.

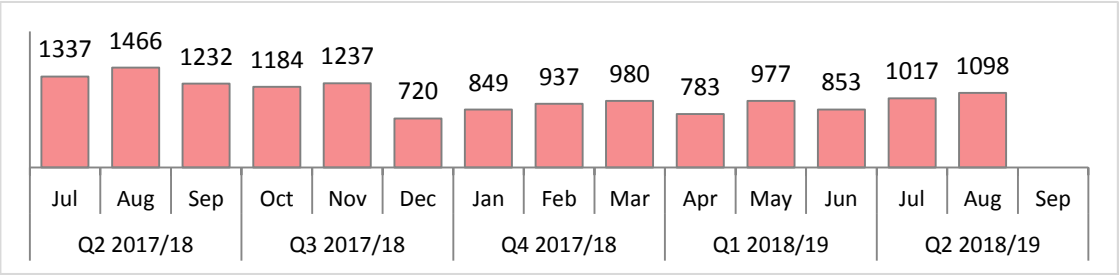
Indicator Detail

Aug-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 August 2018 is 89.76% of the establishment, which is an increase of 0.06% from 89.70% in July 2018.
>= 90%	



Actions
Work to progress the actions and interventions as detailed in the recruitment & retention strategy implementation plan are on-going. The Trust continues to face challenges in terms of recruitment in national shortage / specialist areas; significant work is being undertaken to look to improve our retention rates.

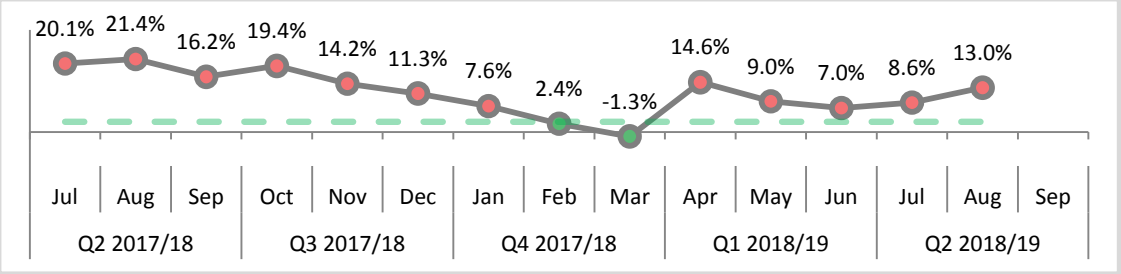
Aug-18	Agency Shifts Above Capped Rates
1098	Number of agency shifts above above the provider spend cap.
Target	There were a total of 1,098 agency shifts paid above the NHSI cap during the 5 week period from 30th July to 2nd September 2018. An average of 220 shifts per week, a reduction of 34 shifts per week compared to the previous month & a reduction of 74 shifts per week compared to the same period last year.
<= 0	



Actions
There was an average weekly reduction of 14 shifts in M&CS, 6 in Surgery, 11 in WC&D and 3 in Integrated Care. Changes to NHSI approvals and reporting have been implemented and work to ensure compliance with the revised arrangements is underway.

Indicator Detail

Aug-18	Agency Spend: Distance From Ceiling
13.0%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	A total of 209 shifts were paid at or above £100 per hour, requiring Chief Executive approval, which is an average of 42 shifts per week.
<= 3%	



Actions
A procurement exercise has been completed and establishes a tiered approach to our agency use within revised lower commission rates. With effect from 1st September, we have reduced our tier 1 cascade suppliers to 6 agencies where they have agreed to specific commission rates across several grades. It is anticipated that this will result in significant savings.

Safer Staffing Report

Aug-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 - All	Falls with Harm	Catheters & UTIs	New VTEs
AMU	4,092	3,792	3,348	3,294	3,720	3,125	3,069	3,316	92.7%	98.4%	84.0%	108.0%	1517	4.6	4.4	8.9	0	0	0	10
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	143	5.0	5.0	10.0	0	0	0	0
Short Stay Olders People's Unit	1,163	908	791	761	682	671	682	682	78.1%	96.2%	98.4%	100.0%	448	3.5	3.2	6.7	0	1	0	0
A3	1,423	1,348	977	1,082	1,023	902	682	737	94.7%	110.8%	88.2%	108.1%	720	3.1	2.5	5.7	0	0	0	0
A10	2,790	2,202	2,046	2,064	2,046	1,936	1,364	1,353	78.9%	100.9%	94.6%	99.2%	749	5.5	4.6	10.1	2	0	0	0
A11	1,581	1,229	1,628	1,508	682	643	682	869	77.7%	92.6%	94.3%	127.4%	816	2.3	2.9	5.2	3	0	0	0
A12	1,907	1,749	1,442	1,434	682	682	682	778	91.7%	99.5%	100.0%	114.1%	793	3.1	2.8	5.9	2	0	0	0
B4	1,209	751	605	953	682	682	682	682	62.1%	157.6%	100.0%	100.0%	488	2.9	3.3	6.3	0	0	0	0
B6	1,209	760	1,070	920	682	715	682	770	62.8%	86.0%	104.8%	112.9%	658	2.2	2.6	4.8	1	0	0	0
Bluebell Ward	1,209	1,101	2,077	1,933	682	671	682	550	91.1%	93.1%	98.4%	80.6%	667	2.7	3.7	6.4	2	0	0	0
C4	1,209	872	605	928	682	693	682	660	72.1%	153.5%	101.6%	96.8%	475	3.3	3.3	6.6	1	0	0	1
Coronary Care Unit	837	844	465	435	682	682	341	407	100.8%	93.5%	100.0%	119.4%	147	10.4	5.7	16.1	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,070	1,064	2,000	1,896	682	682	682	990	99.4%	94.8%	100.0%	145.2%	477	3.7	6.0	9.7	1	0	0	0
E1	1,952	1,343	2,310	1,932	1,023	814	1,364	1,364	68.8%	83.7%	79.6%	100.0%	907	2.4	3.6	6.0	1	0	0	1
E2	2,279	2,185	1,581	1,966	1,023	979	1,023	1,353	95.9%	124.3%	95.7%	132.3%	1020	3.1	3.3	6.4	0	0	0	0
E3	2,279	2,279	1,581	1,578	1,023	957	1,023	1,243	100.0%	99.8%	93.5%	121.5%	1028	3.1	2.7	5.9	2	0	0	0

Safer Staffing Report

Aug-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 - All	Falls with Harm	Catheters & UTIs	New VTEs
A1	1,442	1,382	1,209	1,059	1,023	902	1,023	990	95.8%	87.6%	88.2%	96.8%	803	2.8	2.6	5.4	0	0	0	0
B3	837	833	977	1,011	682	682	484	572	99.5%	103.5%	100.0%	118.2%	340	4.5	4.7	9.1	0	0	0	0
C6	837	717	977	959	682	682	682	671	85.7%	98.2%	100.0%	98.4%	498	2.8	3.3	6.1	0	0	0	0
D1	1,581	1,184	1,349	1,373	682	693	1,023	1,100	74.9%	101.8%	101.6%	107.5%	636	3.0	3.9	6.8	1	0	0	0
D2	1,143	1,046	977	947	682	671	594	594	91.5%	96.9%	98.4%	100.0%	446	3.8	3.5	7.3	0	0	0	0
D6	1,209	1,050	1,209	1,080	682	572	682	649	86.8%	89.3%	83.9%	95.2%	637	2.5	2.7	5.3	0	0	0	0
M4	1,568	1,418	1,674	1,536	682	616	1,023	1,067	90.4%	91.8%	90.3%	104.3%	624	3.3	4.2	7.4	1	0	1	0
SAU	1,814	1,562	977	905	1,023	902	682	682	86.1%	92.6%	88.2%	100.0%	486	5.1	3.3	8.3	0	0	0	0
Short Stay Surgical Unit	1,907	1,663	767	598	880	857	594	535	87.2%	78.0%	97.4%	90.1%	651	3.9	1.7	5.6	0	0	0	0
ICU & HDU	4,464	4,164	775	775	4,123	3,967	0	0	93.3%	100.0%	96.2%	na	345	23.6	2.2	25.8	1	0	0	0
Birth Centre	930	765	465	435	620	570	310	300	82.3%	93.5%	91.9%	96.8%	23	58.0	32.0	90.0				
Delivery Suite	2,790	2,633	465	353	1,860	1,860	310	280	94.4%	75.8%	100.0%	90.3%	192	23.4	3.3	26.7				
Maternity 2	1,628	1,523	930	915	620	620	310	240	93.5%	98.4%	100.0%	77.4%	476	4.5	2.4	6.9				
Jasmine Ward	930	930	465	465	620	620	0	0	100.0%	100.0%	100.0%	na	192	8.1	2.4	10.5	0	0	0	0
Neonatal Unit	2,325	1,890	0	0	1,628	1,302	0	0	81.3%	na	80.0%	na	348	9.2	0.0	9.2	0	0	0	0
Tree House	2,790	2,678	465	465	1,860	1,772	0	0	96.0%	100.0%	95.3%	na	374	11.9	1.2	13.1	0	0	0	0
	54,770	48,229	36,572	35,926	34,686	32,463	22,380	23,775	88.1%	98.2%	93.6%	106.2%	18124	4.5	3.3	7.7	18	1	1	12

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : August 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.	88.1% 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.	August 88.1% July 2018 89.1% June 2018 90%	The lowest RN staffing levels during the day were on Ward B4 at 62.1%. This has been supported by an increase in non-registered staff to 157.6%. . There are never less than 2 RN on duty. The plan going forward is for the business group to present to the Chief Nurse a plan to revise the establishment to have 2 RNs & 1 Registered Associate Nurse or Assistant Practitioner (band 4) on day duty rather than 2 RN and an additional non- registered band 2 nurse. The acuity audit undertaken summer 2018 indicates that the actual staffing versus acuity was 14.41% above required, which supports the potential for an establishment review incorporating a band 4 tier
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	93.6% of expected Registered Nurse hours were achieved for night shifts.	August 93.6% July 2018 94.3% June 2018 95.7%	The lowest staffing levels during the night were on E1 within the Medical business group at 79.6% which is sub-optimal. There were never less than 2 RNs on duty at any time to support safe staffing. The ward is working with the recruitment team to look towards recruiting band 4 staff for day and night duty to support safe staffing and are actively engaged with recruitment and retention initiatives.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	98.2% of expected Non-registered hours were achieved for day shifts.	August 2018 98.2% July 2018 99.7% June 2018 100.1%	The lowest non-registered staffing levels were on the delivery suite at 75.8%. RN levels were 94.4% to support safe care. Staffing levels are closely monitored at 4 hourly intervals throughout the 24 hour period and staff are redeployed to assist from other areas to support activity when required. If safety cannot be assured a maternity diver t is implemented Unregistered staffing deficit caused by planned annual leave and sickness. Low rate of fill noted on nhsp as only staff with experience of working in a maternity area can fill the CSW 66 shifts advertised.

Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	106.2% 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 RN shifts.	August 2018 106.2% July 2018 108.8% June 2018 109.8%	The lowest staffing levels during the night were on maternity 2 at 77.4%. Staffing levels are closely monitored at 4hrly intervals throughout the 24hr period and staffs are redeployed to assist from other areas to support activity if needed. Unregistered staffing low rate of fill noted on staffing proformas for August 2018. Vacant shifts covered by remaining staff and thus a significant deficit was not noted in the clinical setting.

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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Winter Plan Update		
Report of:	Improvement Director (UEC)	**Prepared by:**	Jayne Wood

REPORT FOR UPDATE

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

Summary of Report

This paper presents an update on the system winter plan.

The Board of Directors are asked to:

- Note the winter bed capacity requirements and progress in delivery
- Note that finalisation of the system winter plan is on-going with local health economy partners
- Note that a fully costed plan will be provided to October Board together with a monitoring plan and system escalation plan
- Note the ongoing development of the winter monitoring plan

Attachments:

Annex 1 – Trust Bed Reconciliation
Annex 2 – Winter Schemes

This subject has previously been reported to:

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

1. EXECUTIVE SUMMARY

The Trust's Winter Plan 2018/19 is being developed as part of a wider Local Health Economy (LHE) plan to identify capacity and interventions to address anticipated increase in emergency activity.

The Winter Plan for 2018/19 has a significant focus on increasing acute inpatient capacity to meet expected emergency demand but also on maximising ambulatory pathways, reducing bed occupancy levels and optimizing neighbourhood deflection/management schemes. The system is also in the process of implementing the Urgent and Emergency Care Delivery Plan, supported by the North East Commissioning Support Unit (NECs). The advice and input of North East Commissioning Support (NECs) has been sought to strengthen our system winter plan and escalation response. It is intended that the UEC Improvement programme and business as usual work in tandem with the winter plan to assist us in meeting the national requirements of reducing the numbers of stranded patients, reducing Delayed Transfers of Care (DTOCs), maximising patient streaming in ED and enabling early discharge.

The impact of the proposed schemes once agreed will be tracked internally and monitored formally via the Urgent and Emergency Care Delivery Board (UECDB). The process currently ongoing to finalise the plan has included an initial system-wide workshop. However, as the indicative financial impact and cost of proposed schemes totals exceeds the £1.7m winter funding identified which is composed of £1.1m (SRG funding, ED consultants, primary care access etc) from the CCG and £0.6m from internal resources, a further prioritsation process has started with a Commissioner review. A Provider response has been requested and is now being completed.

In line with national guidance, the additional funding available to CCGs in 2018/19 is to be utilised to enable health systems to fund and plan in a way that improves ED performance. Over the next 2 weeks a final plan will be developed and agreed within the funding envelope available. The plan will be approved by UECDB and presented to October Board.

2. INTRODUCTION AND BACKGROUND

For the Stockport system this winter there are 4 documents being produced:

- A detailed system winter plan which is supported by:

- A monitoring document
- A detailed bank holiday plan
- A system OPEL escalation plan with supporting action cards

- The **system winter plan** document is being co-produced by Stockport FT, Stockport CCG, SMBC, Pennine Care and Viaduct, Mastercall and NWAS.

- The **monitoring plan** will contain expected impact on ED performance with associated measureable metrics so that performance can be tracked by UECDB and after winter a robust evaluation can be undertaken to enable lessons learned and inform plans for future years.

- The **bank holiday plan will cover the two weeks around Christmas and New Year** to enable a collaborative approach to re-start the system between Christmas and New Year and after New Year as well as providing a rapid response to escalation and response to OPEL triggers.

- The **OPEL escalation plan and action cards** will be finalised after testing at a System Table-Top exercise

As outlined earlier there will continue to be a focus within the Trust on improving patient flow at all stages of the pathway for those patients who are admitted. Operationally and for winter preparedness, based on our own analysis of the key factors affecting urgent care flow. These are predominantly:

1. Acute Medical Unit occupancy - the lower the occupancy, the better the performance
2. A decongested Emergency Department with flow so the system can perform to a high standard. Fast flow through to specialty assessment areas is essential
3. Discharges earlier in the day, 10 by 10 and 33% by midday
4. Performance against the "new world" targets.
5. Effective management of influenza and respiratory conditions that peak over winter months which can, if not treated by the appropriate specialists, result in extended periods of time in hospital.
6. Stranded patients – the lower the number the better the 4-hour performance
7. Effective deflection schemes, rapid neighbourhood response, effective support by the ITT for complex discharges and SMBC to provide packages of care and placements.
8. Sufficient bed capacity to admit those patients who require it – in the Trust and Community.
9. Effective management of frail patients through a Frailty Unit

In addition, based on the experience of 2017/18 in terms of bed occupancy, the requirement for emergency admissions and the fact that on most days up to 30 patients were requiring beds first thing every morning with the resultant effect that overcrowding has on 4-hour performance, a proportionate amount of beds will be opened within the Trust and escalation areas staffed, subject to the availability of nursing, medical and AHP teams to cover the beds. A task and finish group has been established and the process to enable this has commenced. This plan reconciles to the operational plan submitted to NHSI and is shown in Annex 1.

An internal contingency plan is also being developed if the above plans do not enable SFT to cope with additional demand. This includes consideration of cancellation of elective work (and the associated consequences) and use of additional short term bed capacity. If however, pressure becomes extreme consideration would also need to be given to cancellation of training, non-urgent meetings, annual leave, non-emergency surgical work and outpatient work. This will be balanced with the associated risks and consequences.

3. HOW HAS WINTER PLANNING AND PREPAREDNESS CHANGED FROM 2017/18

Planning was started earlier this year and the plan developed collectively with full engagement of all system partners. This has proved to be extremely challenging in terms of the complexity of the Health Economy, overlap between commissioned services, overlap between proposed schemes, the current position of the SNC Programme and the absence of central winter monies at the time of writing.

There are a number of developments that have taken place and opportunities that have arisen during 18/19 that will help to maintain performance during winter for example, the improvement work that has been undertaken by the new Delivery Director and Improvement Director (UEC) supported by North East Commissioning (NECs). Standards have also been agreed internally as part of the "new world launch" in the Trust on 21st August.

These standards and other key metrics will be assessed as part of the winter monitoring plan through the comprehensive governance systems in place across the Stockport system by individual Providers and Commissioners as well as the Stockport Neighbourhood Care Programme Board and ultimately the Urgent and Emergency Care Delivery Board.

A very detailed System Bank Holiday Plan covering the two weeks around the Christmas and New Year period is being produced to ensure a collaborative approach to "Home for Christmas", delivery of ongoing performance and a system re-start between Christmas and New Year and after New Year. The plan format and content has been tested over the August Bank Holiday with "a perfect 3 days". This will be modified for Christmas and New Year from lessons learned.

The system escalation document is nearing completion which contains the agreed OPEL triggers at all levels for the Trust as well as revised action cards for system partners at all levels. A Table Top exercise to test the triggers and response and is planned to ensure all stakeholders are confident in its application, that actions are specific and enable de-escalation as rapidly as possible.

In terms of opportunities, the ED reconfiguration and streaming capital scheme commenced on plan on 13th August. On completion of the main scheme before Christmas some additional clinical cubicles will be available in ED. The department will also be able to introduce enhanced streaming in an Urgent Treatment Centre (UTC) model which will increase the number of patients seen as ambulatory ill. On completion of the second phase at the end of February an additional 4 majors cubicles will be created. This scheme will also free-up the space occupied by the current CDU. This will have 2 key benefits as it will enable the creation of a TDU (Trauma Decision Unit) from January 2019, subject to staffing. Move of orthopaedic patients to TDU will also free up space in the new CDU created by the scheme and hence will also contribute to a decongested ED. Finally, an additional £367k of capital has been obtained, following a bidding process from national funds to support ED and flow through the hospital.

4. PROGRESS TO DATE

Winter schemes have been submitted by all partners and have been categorised across 4 key themes:

1. Wider system preparation including - the "stay well" philosophy
2. Home first – encompassing deflection and management of patients out of hospital
3. In hospital – which includes the "front door" and also patient flow within the hospital
4. Discharge and recovery

Initial prioritisation has been undertaken by the system winter planning group at the winter workshop in August. Commissioners have since grouped some of the schemes together under a theme. For example, *Weekend Support to Care Homes* to encourage integrated solutions. They have requested that providers work in collaboration to provide *one* proposal for such schemes.

The attached document (Annex 2) outlines the commissioner view and response to the winter schemes that have been submitted. This document clarifies what is already funded and indicates those areas commissioners have agreed are a priority for the 18/19 winter plan budget. The schemes that have been identified by commissioners as priorities exceed the available budget and therefore further prioritisation will be required. To maximise resilience of the whole system across winter 2018/19 commissioners need to ensure:-

1. Full mobilisation of existing commissioned capacity;

2. Delivery of pre-existing 2018/19 plans, in particular the bed capacity plan jointly agreed prior to submission to NHSI and the implementation of the Urgent Care Improvement Plan;

3. This will then be further supported by the additional schemes that have been prioritised thought the winter planning process.

5. RISKS & ASSURANCE

Key Risks:

- The availability of resources within the Trust and from partners to fund the desired schemes
- The availability of national funding – and if available the ability to utilise it effectively with a short lead time
- Maintaining support from system wide stakeholders to deliver actions for admission avoidance and timely discharges of medically fit patients.
- Financial risk of incurring additional expenditure above the £1.7m.
- Securing sufficient staff numbers to provide adequate levels of acute care in all of the additional capacity areas within the Trust.

Assurance:

Assurance can be provided to the Board that a rigorous process has been and is continuing to be undertaken in the development and agreement of a robust winter plan noting that no assumptions of effectiveness nor reliance is being placed on schemes that have not been proven, are new or otherwise untested, even if currently funded. Assurance can also be provided that the trust is progressing internal plans to open additional capacity and implement internal schemes. However, in terms of the availability of a fully costed winter plan, at this stage only low levels of assurance can be provided at the time of writing as the schemes have yet to be finalised within the financial envelope. However there is work ongoing to ensure that a fully costed plan will be available for presentation to the October Board meeting.

6. RECOMMENDATIONS

The Board of Directors are asked to:

- Note the winter bed capacity requirements and progress in delivery
- Note that finalisation of the system winter plan is on-going with local health economy partners
- Note that a fully costed plan will be provided to October Board together with a monitoring plan and system escalation plan
- Note the ongoing development of the winter monitoring plan

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Report to:	Board of Directors	**Date of Meeting:**	27 September 2018
Subject:	Quality Improvement Plan – 7 Themes – Quarter 1 Update 2018/19		
Report of:	Chief Nurse and Director of Quality Governance	**Prepared by:**	Deputy Chief Nurse Business Change Manager

REPORT FOR INFORMATION / ASSURANCE

Corporate objective ref: 2a 2b	**Summary of Report** The Board of Directors are asked to note progress against the 7 themes from the Quality Improvement Plan for quarter 1, 2018/19 The high level progress is below:
Board Assurance Framework ref:	
CQC Registration Standards ref:	Responsive Well led Effective Safe Caring
Equality Impact Assessment:	☐ Completed ☒ Not required

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

Attachments:

This subject has previously been reported to:

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

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1. Introduction

1.1. The Board of Directors are asked to note the progress and assurance against the 7 themes from the Quality Improvement Plan for quarter 1, 2018/19.

2. Background

2.1. In March 2016 and October 2017, the Trust was rated at 'Requires Improvement' by the CQC. The Quality Improvement Plan implemented in April 2018 describes the steps we plan to take to ensure that our patients receive consistent, high quality care and our ambition is that the pride taken in delivering care to our patients helps us become the employer of choice in the region.

2.2. The CQC rated the Trust as 'requires improvement' overall, but also as 'inadequate' for safety in Medicine and Urgent and Emergency Services and as 'inadequate' in well led for Urgent and Emergency Services. The delivery of our Quality Improvement Plan, underpinned by good governance and staff development, will ensure that the changes made are sustainable, and that those outstanding can be delivered in agreed timeframes.

2.3. This report provides an overview of the progress made in Quarter 1, 2018/19 against the Quality Improvement Plan.

3. Progress to Date

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

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

3.2. The table on the following page displays the progress for quarter 1 2018/19 against the seven themes. A summary has been provided against each theme as to where it is up to against the plan. The key for the status is as follows:

Summary	Description
✓	On-track
✓	Off-track, but recoverable
✓	Off-track, not recoverable

4. Conclusion

4.1. Each theme has made significant progress. There are 4 themes on-track and 3 themes off-track but recoverable. The themes which are currently off-track will be rectified in quarter 2 as far as possible.

5. Recommendations

5.1. The Board of Directors are asked to note the progress and assurance against the 7 themes from the Quality Improvement Plan for quarter 1, 2018/19.

6. Progress Against Seven Themes, Quarter 1 2018/19

Area	Context Within Quality Strategy	Update Narrative
High Quality Safe Care Plan 		The Safe High Quality Care Action Plan has been created in response to areas of concern relating to patient safety. The concerns have been noted externally by the Care Quality Commission (CQC) and NHS Improvement and have also been recognised by the Trust. **Areas of progress:** ✓ • The Safety and Quality Leadership Group continues to drive improvement • Start of the day meetings have commenced with senior operational teams to support priority setting and delivery **Areas of concern** ✓ • Storage of medical records • Patient Flow
Reducing Unwanted Variation in Clinical Practice 		Reducing unwanted variation in clinical practice focuses on three areas: **7 day working** ✓ • Each Outline Business Case has been through the process of peer challenge and feedback • National 7 day survey completed and shows that the Trust is compliant against the trajectory for 3 of the 4 priority clinical standards (>90% compliance in CS5, CS6 and CS8) and has made an 18% improvement in clinical standard 2 (85% compliance in CS2) compared to last year's survey • All Clinical Standard 2 breaches in the survey was reviewed clinically and lessons shared in the implementation meeting • Categorisation levels of care audits have been completed in ward areas to provide a snapshot of consultant's reviews that may be required at the weekend under standard 2 and 8

		Getting it Right First Time [GIRFT] ✓ • The GIRFT recommendations from the 10 specialties that have been through the review process and have been incorporated into the in-house Service Review process • The actions and outputs from the reviews have been monitored by the Programme Management Office through the Service Review Steering Group • The next wave of GIRFT reviews are being prepared by the clinical teams with support from colleagues in Business Intelligence **ACE Accreditation** ✓ • ACE was launched successfully in April 2018 • 7 ward accreditations completed by end of Q1 with 6 planned in Q2 • Scoping for Community, Maternity, Paediatrics and Theatres accreditation has commenced with a timeline for implementation by Q2
Urgent Care Delivery ✓		To improve the provision of Urgent Care across the Stockport System, focusing on four key workstreams; Pre-admission, Attendance & Assessment, Admission & Management and Discharge. The programme is initially focused on delivering the improvements aligned to the GM Improvement Plan. However this forms the basis for the longer term delivery of the Stockport Urgent Care Delivery Board work plan. Projects have been established with a "check and challenge" session booked for July 2018 with the Senior Responsible Officers to present the first phase of their programmes to their peers and stakeholders. This will determine the next phase of the programme.
Safety Collaboratives ✓		Safety collaboratives focusing on five areas: **Pressure ulcers – AIM** ✓ **Aim**: *Achieve 50% reduction in avoidable stage 2,3 and 4 PU in acute and community settings by March 2019 [max avoidable PU in acute = 22; max avoidable PU in community = 55]* • **Acute:** 6 avoidable pressure ulcers recorded in Q1, [with 0 recorded in June 2018] • **Community:** 4 avoidable pressure ulcers recorded in Q1, [with 0 recorded in June 2018] **Falls** ✓ **Aim**: *Achieve 10% reduction in all inpatient falls by March 2019*

		Achieve 25% reduction in falls with moderate and above harm by March 2019 • 382 total falls in Q1 compared to 416 in Q4 [2017/18] • 5 falls with moderate or above harm in Q1 compared to 15 in Q4 [2017/18] **NEWS2** ✓ **Aim:** *NEWS2 introduction for improvement in March 2019* • Training has been scoped and training needs analysis for AIMS has been completed • The policy has been approved • Scoping for implementation plan is in progress **Nutrition** ✓ **Aim**: *Achieve 100% compliance with MUST screening tool by March 2019* • The baseline for Q1 has been established at 52% using the accreditation results • Plans are in development to ensure appropriate screening • Establishment of robust data collection **Discharge** ✓ **Aim:** *Review of the discharge planning process and establish baseline and target for improvement by March 2019* • AQuA programme has commenced • Scoping to determine the metrics is underway and will be determined in Q2 • Progress against SAFER for Medicine and plan for rollout across Surgery in Q2 • Scoping for the behind the bed boards to include EDDs
Quality Improvement Initiatives ✓		The quality improvement initiatives focus on promoting improvements in the quality of care and treatments Eight quality improvement initiatives have been established. These will utilise the AQuA methodology and all form part of the recent cohort. The next steps will be to agree the baseline, targets and plans 1. IV Referrals 2. Cardiac Arrests 3. Palliative Care 4. Effective Management (LOS) 5. Safer Discharge

		6. Reducing variable care reviews 7. Learning from Death 8. Fractured Neck of Femur Pathway
Safe Staffing ✓		We aim to ensure safe staffing and a reduction on reliance on temporary staffing through a series of schemes associated with recruitment and retention **Recruitment programme – reduce vacancy rate** ✓ • The quarterly vacancy rate has consistently remained circa 174 working time equivalent [WTE] for Registered Nurses • Alternative workforce pipelines have been explored; including the associate nurse programme, international recruitment, as well as a focus on graduate nurse recruitment. The vacancy figures however are not yet reducing as hoped • Business group and centrally coordinated recruitment is now embedded. Multiple recruitment events are attended over the Manchester and Stockport region • An average of 180 WTE Registered Nurse temporary workers per month over this quarter have been utilised to support safe staffing • Flexible working contracts have been encouraged to help attract staff. • A pilot to recruit nurses with a relocation package incentive in traditionally hard to recruit areas has been funded and 4 WTE have been attracted with this new initiative **Retention Programme – Reduce Turnover Rate by 1.5%** ✓ • The Itchy Feet programme, launched in March 2018, where staff can approach Corporate Nursing staff to look for career development opportunities is evaluating well. So far, 22 registered and non-registered nurses have been helped by this scheme and have chosen to stay within the Trust • There has been a particular emphasis in supporting Graduate Nurses with: a 'yellow badge' scheme; senior nurses to buddy staff; keeping in touch events and drop in sessions • The Retire and Return Policy has been re-launched • The HR team are working with the top 10 turnover areas to identify themes and trends to support the teams and reduce turnover **Percentage Turnover [WTE] [Full Staff Group]** **Period** | **Jan** | **Feb** | **March** | **April** | **May** | **June** **2018** | **14.18%** | **14.17%** | **15.37%** | **15.00%** | **14.68%** | **15.04%**

		Improved efficiencies in e-rostering against a range of measures ✓ • In May 2018 an e-rostering clinical lead, (band 6), was employed on a fixed term 12 month secondment to review the e-rostering practices • 'Establishment Genie' have provided an in-depth review of 7 wards and 3 departments to look at their e-rostering practices and assist with providing revised rosters to help enable wards to maintain safe staffing levels; whilst also embracing new associate nurse band 4 role • 6 deep dives have been undertaken by the e roster lead which has highlighted areas of sub optimal e roster practice. This has been fed back to the business groups for action. • E-roster re-training is planned for October 2018 to ensure more solid foundations in rostering practices • Improved 'grip' is being implemented, ensuring there are plans to cover the wards with a band 6 or 7 on each shift to support junior nurses on days; improved practice on utilising Health Roster to avoid the NHSP cascade system and reviewing declared versus actual staffing levels • Finance are supporting with resetting rosters to ensure that the rosters are credible so that tools and rules can be reset. The rostering policy needs to be refreshed which will be a key priority for the next quarter. **Development of a suite of measures with NHS Professionals** ✓ • A detailed NHSP report is reviewed at the monthly temporary staffing meeting. • A suite of measures in this report are the Chief Nurse, with the Matrons and Business groups ensuring accountability and transparency of issues • Key issues are reported to the Workforce Efficiency Group (WEG) • The Trust participates in the North West Client User Group meetings where a review of agency and NHSP strategic financial and qualitative objectives and outcomes are scrutinised and acted upon
Quality Faculty ✓		The establishment of a quality faculty will encourage the sharing of best practice and enable the delivery of high quality compassionate and continually improving care • Training of the Transformation Team in Quality Improvement techniques has been initiated to support the development of the Quality Faculty • A portfolio of projects has been identified, with additional projects to be scoped • Plans are in place to develop the Quality Faculty with support from the Programme Management Office and the Transformation Team

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Report to:	Board of Directors	**Date of Meeting:**	27 September 2018
Subject:	Report of the Liverpool Community Health Independent Review		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Chief Nurse

REPORT FOR INFORMATION / ASSURANCE

Corporate objective ref:	SO2a, SO3a-c, SO5a-b	The report of the Liverpool Community Health Independent Review published January 2018 identified widespread failings in the provision of community services at the Liverpool Community Health NHS Trust. The investigation was initiated following whistleblowing concerns raised by staff and subsequent concerns highlighted in the CQC report and a Quality, Safety and Management assurance review carried out by Capsticks Solicitors. Detail on findings are added within Appendix 1 along with a Stockport NHS Foundation Trust position statement and consideration of any further action or assurance that may be needed to learn from the report. The gap analysis shows a number of areas where work is in progress or planned.
Board Assurance Framework ref:	SO2, SO3, SO5	
CQC Registration Standards ref:	9, 11, 13	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:

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

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INTRODUCTION

The Board of Directors are asked to note the assurance provided by the gap analysis within the report.

BACKGROUND

A review of Liverpool Community Health services published in January 2018 identified significant failings in care quality and the identification of an inexperienced management and director team. The review also examined the role of the external bodies responsible for overseeing the Trust.

Following the publication of the Independent review in to Liverpool Community Health Services, Stockport NHS Foundation Trust considered the areas identified as issues within the report. This is to provide assurance for the Board of Directors, that all aspects within the report have been given due consideration and that internal processes are in place within the organisation to demonstrate that systems and processes are in place against the areas of concern raised.

AREAS OF CONCERN HIGHLIGHTED.

The areas of concern highlighted by the review team related to;

- Patient harm, clinical care and the capability and competence of staff working together in effective teams
- Organisational culture demonstrating shortcomings specifically with poor communication, team working, intolerance and a blame culture
- Poorly developed clinical governance systems with poor data analysis leading to a lack of learning from incidents
- Recruitment delays compounding short staffing problems and increased pressure on services
- Human resources processes that were found to be ineffective with poor systems and processes for investigations
- Patient safety incidents reported to the board of directors did not demonstrate scrutiny or an open approach to learning
- A committee structure that did not have clear two way communication
- Clinical governance processes were not in place
- Poor medicines management processes
- There was a focus on the cost improvement programme and savings were addressed by reducing staffing number in the main

RISK & ASSURANCE

Stockport NHS Foundation Trust has embarked upon the journey of improvement and has in place a robust risk assurance and clinical governance framework. All incidents of moderate harm and above, including near misses, medication incidents and staffing incidents are reviewed weekly at the executive lead patient safety summit. Since January 2018 the organisation has seen a significant improvement in the number of incidents reported and a reduction in the level of harm associated with incidents. The clinical governance paper shares the updated wider learning and themes from all reported incidents claims and complaints and is reported to the Clinical Governance group, quality committee and the board of directors.

The trust has engaged with the NHS improvement collaborative for the recruitment and retention of staff and this is led by the assistant chief nurse for workforce, who has direct links with the human resources team. Staffing levels are monitored on a daily basis by the business group matrons with daily reporting to the chief nurse and director of quality governance and the deputy chief nurse. The staffing data is included in the integrated performance report received by the board of directors. Stockport NHS Foundation Trust has developed its workforce strategy which supports the human resources processes and additionally the recruitment and retention strategy.

The integrated performance report provides significant assurance to the board of directors, of a wide range of data and metrics related to quality, performance and finance. These data are reviewed and received at the quality governance group and quality committee through the trusts governance processes.

There is a robust plan for the cost improvement programme with executive approval of the quality impact assessment to ensure the plans are appropriate and measured in their approach.

The trust have developed a quality improvement plan to support the organisation on the journey of improvement and this is monitored via the committee structures and progress reported to the Board of Directors.

5. CONCLUSION

The independent review of Liverpool Community services identified significant shortcomings in care provision, culture and leadership and costs savings that affected the quality of care being provided. Of note for the Board of Directors, the Government made a statement in the House of Commons which outlined the intention to review the 'fit and proper person' test with a view to consideration whether it should be extended in its scope and effect and that restrictions could be introduced for secondments and similar where there are queries about conduct of affected individuals. The outcome of this review is awaited.

6. RECOMMENDATIONS

The Board of Directors are asked to note the assurance provided by the gap analysis within the report.

Finding subject	**Finding detail/context**	**Stockport NHS Foundation position**	**Monitored by:**	**Action Lead**
A. CIP QIA p2,3,	1. Grossly deficient QIA of CIP. 2. Ill-considered, overambitious CIP measures (cost control through significant staff cuts and vacancy freezes). 3. No Clinical engagement on the design or implementation of improvement programme. 4. Ongoing quality and safety impact of staff reductions were not evaluated or monitored.	1,3,4 QIAs RAG rated, reviewed and reported to F&P. 2. CIP development process includes validation by project team and clinical lead, confirm and challenge meeting, clinical lead sign off, independent QIA review and reporting via F&P	Finance and Performance committee Quality Governance group People and Performance committee	Kaye Wiss
B. Staff welfare and wellbeing p3,	1. Staff demoralised due to cuts. 2. Not listened to and disengaged. 3. Sickness absence increased. 4. Staff subject to a climate of fear, insecurity and bullying making them reluctant to speak up. 5. Increase sickness absence from work related stress. High levels of stress particularly in Prison staff. 6. Staff working long hours with insufficient breaks. 7. Staff survey showed a worsening position.	1,2,3,6,7 Staff survey, F&F test results, 2. Meet the executive engagement sessions. 2. Executive Leadership walkabouts. 2. Freedom to speak up guardian and champions. 3. Robust sickness absence management policy, supported by reasonable adjustment policy. 3. Health & wellbeing strategy and workforce health & wellbeing staff group. 4. Robust bullying and harassment policy, cohort of mediators trained, freedom to speak up guardian. 5. Stress management policy, supported by stress risk assessment process and staff counselling service. Resilience toolkit Coaching Listening events and focus groups based on Health and Well being Celebration event with awards based on health and well being	People and Performance Committee	Emma Stimpson

C. Patient harm **p3, 4**	1. Increase in patient harm incidents (including falls and pressure injuries) and avoidable harm caused. Areas most affected were district nursing, intermediate care, community dentistry and healthcare in HMP Liverpool. 2. Significant harm caused to patients due to inadequate experience and capability to manage new Prison service. 3. Failure to act on indirect indications of harm i.e. increased complaints re staff attitude and communication. Work on this was said to be ongoing with little additional assurance. 4. Increase in claims and inability to defend due to incomplete actions by managers, lack of robust control and monitoring of action plans and interrogation of governance and quality.	1.Falls collaborative interventions have been reviewed, targeted work is underway with areas reporting higher numbers of falls on a monthly basis. 2. Targeted work on reducing pressures in progress across the acute and community settings. 3.Monthly patient experience report which contains complaint themes and actions taken. 4. The number of claims have increased in2018/19 compared to 2017/18. However, the successful defence of claims has also increased. Action plans for all investigations are monitored through the governance teams and recorded on the incident reporting system. An increase in the use of audit to ensure the actions are embedded has also been introduced.	Quality Governance Group Quality Committee	Helen Howard/Helen Kershaw
D. Clinical and Corporate Governance systems/process **p3,**	1. Failures in mandated reporting of serious incidents – some reporting discouraged. Incidents regularly downgraded in importance. 2. Lack of assurance in the Serious Incident report papers presented to Assurance Committee and TB. 3. Poor Investigation of incidents and deaths.	1. NRLS reports a healthy reporting culture and no underreporting. 2. Delays in reporting serious incidents are irregular – monitored internally and by CCG. 3. Investigations into incidents is robust with oversight by executive leads. Significant work has been completed on learning form deaths and mortality meetings with oversight by the medial director. 4. Six monthly Audit of SUI action closure.	Quality Governance Group Quality Committee	Helen Kershaw

	4. Action planning for improvement absent/invisible, not followed through or followed up. 5. Governance systems failed to identify deviation from necessary standards to correct/improve. 6. Learning from incidents and serious incidents not used effectively or shared for wider learning. 7. Lack of coherent communication from the frontline of service delivery to TB. 8. Sufficient data to identify trends and themes but analysis was poor. 9. Learning from deaths not reviewed or used to inform healthcare system reform. 10. Deaths in custody did not feature on performance dashboard reported. 11. Failure to find root causes of incidents leading to recurrence of similar events and/or staff blamed. 12. Poor quality minutes of the Assurance Committee meant inability to track issues raised and responsibility for actions. 13. TB minutes showed little appreciation or questioning around repeated incidents, underlying causes and no correlation with repeated incidents and complaints or staffing levels.	5. Oversight monitoring in place via: Clinical audit, Policy audit, External reviews, SUI and incident monitoring, Duty of Candour, Risk register review, CQC assessment, NICE and National guidance, New procedures. 6,8 Lessons identification and sharing via: Patient safety summit updates, Monthly risky business newsletter. Trends are identified in the quarterly trends analysis paper. 7. Incidents and SI investigations are reported to Trust Board via the IPR and in more details in the quarterly governance report. 9,10 Mortality processes to compliment the Learning from deaths reviews Numbers of LFD's are reported via the IPR. Any LFD that identifies concerns with care is escalated to the Medical Director and an appropriate level of investigation is undertaken. HM Coroner will also be informed 11. The trust has adopted the NHSI just culture guide when reviewing SI investigations. Executive Directors or their deputies review each SI investigation to ensure root causes are identified 12 All Trust committees and groups minutes with action logs. 14,15 Trust committee structure reviewed from March 2018 to strengthen accountability and oversight. (Governance Framework) 16.Internal audit actions are tracked to closure. Trust Clinical audit outcomes		

	14. Trust committee structure lacked clear escalation between groups, attendance inconsistent and multiple meeting names for same group was confusing. 15. Meeting structure failed to hold staff to account for delivery of action from safety incidents or risk assessments. 16.Failure to act on an Internal Audit of Trust Clinical Audit arrangement – recommendation not accepted on the belief that they were the responsibility of management teams. 17. Inconsistent application of Trust Governance processes (Dentistry, HMP operated outside mainstream governance).	showed improved compliance outcomes. 17.Annual Governance and Risk management audit of core Governance activities e.g. minuted governance meetings, risk register review, incident and SI reporting, action tracking.		
E. Leadership/ Management issues p11, 12	1. Focus on becoming a FT and on CIP achievement. 2. Poor HR practices in Nursing and HR management. 3. Serious shortcomings in leadership of HR and Nursing Depts. 4. Lack of leadership at senior and middle levels. 5. Safety concerns and themes escalated to Board had some evidence of redress actions identified but no evidence of effective action taken to improve practice. 6. Lack of management training and	1. Not applicable, organisation already FT. 2. See F below. 3. See F below. 4. Leadership development programme, supported by talent management strategy. 6,8 Leadership and management training programme available for staff. 4,6 Nursing Leadership facilitation and support available. 6. Current and future training delivery plan for leadership and management training has been identified and collated into a Leadership Strategic Approach document. This work included a multi-mode analysis including capacity and demand, gap analysis, organisational	Quality Governance Group Quality Committee People & Performance committee	Emma Stimpson

	poor leadership. 7. Excessively top-down management. 8. Clinical Leadership poorly developed at senior/Exec levels. 9. Non Exec Board members lacked expertise to challenge. 10. Failure of leadership replicated in the organisation resulted in failure to get a grip on governance and quality improvement. 11. Lack of senior and Exec presence in HMP. 12. Lack of professional responsibility at senior level, insufficient expertise and inadequate infrastructure to manage services.	analysis, and determination of the skills and behaviours required of leaders and managers at Stockport. Leadership development programme based on Quality improvement and compassionate leadership Human Factors for leaders Advanced Psychology skills Coaching skills and full Coaching programme Culture and Engagement group formed to provide assurance		
F. Human Resource Dept and Processes p3	The HR Department was chaotic. HR managers failed to follow Trust procedures; inadequate in communicating to staff subject to arbitrary disciplinary processes. Individuals suspended for prolonged periods of time, with no apparent rationale or process for resolution. Recruitment had been outsourced; numerous delays in recruitment, more than 3 months for a single	1. ER case log maintained and reviewed. 2. Board reports include ER activity. 3. IO training provided. 4. Policy training for managers. 5. Process for suspension which provide challenge for alternative options. 6. Policy review group for staff side involvement. 7. ER meetings to discuss cases and ensure consistency 1. Recruitment KPIs in place 2. Recruitment performance included in board reports	People and Performance Committee	Emma Stimpson

	post. Clinicans not involved in the vacancy review panel process. Service Managers describe merely receiving an email advising whether or not a vacancy had been approved for recruitment. Consistent accounts that whistleblowing or raising concerns was discouraged and that staff who raised concerns were ostracised by their manager / leader and later let down by HR.	3. ECP has nursing and medical membership. 4. ECP outcomes formally communicated in a timely fashion 1. Policy in place to facilitate whistleblowing 2. Freedom to speak guardian in post 3. Significant communications from FTSG to raise awareness. 4. FTSG drop in sessions 5.HRBM / HRA Support and Promotion of the Policy 6. F2SUG Reporting to PPC / BoD / JNCC / EMG (update on trends & learning)		
G. Service acquisition p3	1. Trust expansion of geographical area covered and service type – expanded community services acquired and Prison healthcare services. 2. Staff integration difficulties, sub-culture conflicts affected staff re-deployment and worsened staff morale. 3. Poor system integration eg. incident reporting and investigation. 4. No attempt to integrate Prison service with Trust with Trust clinical Governance systems. 5. No regular monitoring and reporting back to the main governance framework. 6. The Prison Partnership Board	Stockport NHS Foundation Trust has an integrated community and acute services with integrated governance to support all services. 2. Full integration of community services within the Trust. 3. Community services utilise Trust wide approach to incident reporting and investigations.	Quality Governance Group Quality Committee	Margaret Malkin/ Emma Stimpson

	was mainly operational rather than quality focused, RR not reviewed and managers struggled with unfamiliar data.			
H. Clinical care Capability	1. Staff training and supervision inadequate. 2. Staffing levels inadequate. 3. Skill mix inadequate. 4. Staff had little time for clinical and management supervision preventing reflective practice and learning. 5. Low mandatory training compliance.	2, 3 Nursing System framework in development. 2,3 Monthly report on staffing vacancies and due starts locations. 2,3 C events based on vacancies and predicted vacancies. 2,3 Safer staffing figures reported monthly for all adult inpatient areas. IPR monitoring – published on NHS Choices. Staffing benchmarks are taken from the model hospital dashboard. 2,3 Staffing risks are identified with mitigation actions. 2,3 Staffing levels are reported to Trust Board. Skill mix review undertaken bi-annually for adult inpatient areas. Maternity (birth rate plus) and Paediatrics undertake annual skill mix reviews. The Shelford acuity model is used for adult inpatients, emergency portal, Children and young people. 1. Mandatory training reported monthly and is currently above the compliance rate of 90%	People and Performance Committee Bi annual strategic staffing report to Trust Board	Helen Howard/ Pauline Enstone
I. Clinical standards	1. Evidence based standards not uniformly applied. 2. Action plans significantly hampered by: -Failure to identify actual root causes.	1.Systems in place for cascade and response to NICE, National guidance/inquiries, Royal College reports etc and reported at an appropriate level within the trust. 2. Audit and monitoring in place for some	Quality Governance Group Quality Committee	Tina Harkin/ Helen Howard/Helen Kershaw

	-Lack of time-trend analysis and thematic analysis. -Plans based on process actions unrelated to patient outcome. -Failure to follow up whether actions undertaken/completed. - Lack of evaluation of whether actions from incidents/themes have been successful. 3. Failures in clinical assessments, screening, poor care planning, record-keeping and communication led to messages not being received/acted upon within MDT 4. Staff ignorance of policies and procedures.	clinical assessments eg observations, VTE, documentation audits. 4. Communication of policies via local meeting updates and Policy briefings.		
J. Culture and leadership p3, 9,	1. Lack of openness and transparency impacting Duty of Candour. 2. Failure to learn from events. 3. Reactive culture. 4. Failure to act on serious patient safety markers ie care planning, poor reporting – exposing poor reporting culture. 5. Instead of 'just culture' staff worked in a culture of blame, punishment, disbelief and fear. 6. 'Scoping meetings' where incidents and actions were discussed and reviewed, described as interrogation and frightening experience – staff felt	1. Duty of Candour system in placed monitored internally and by CCG. 4. Monthly monitoring of Quality metrics via IPR, QSIS and ACE 3,5,7 Trust has a People strategy in development. 40 Cultural Ambassadors across all key services. Culture and engagement groups Monthly Pulse surveys in clinical areas New starter listening events Values based meetings, training and documentation Behaviour Framework implemented based on key values Teams Charters developed across clinical and support services Positivity Boards developed and exhibited Resilience toolkit introduced	Quality Governance Group Quality Committee People and Performance Committee	Helen Kershaw/ Tina Harkin/Emma Stimpson

	blamed, anxious and stressed. 7. Poor focus on values for staff behaviour. The culture was one of not reporting failure.			
K. Teamwork and communication p8	1. Failures in communication, teamwork, intolerance and a culture of blame. 2. Significant failures in MDT working. 3. Poor communication leading to inconsistent and flawed handovers within teams, across agencies and across management and leadership at all levels. 4. Staff lacked time for adequate handovers, training and time for good record-keeping and documentation. 5. Staff lacked time reflect, learn and review performance and clarity of own and organisational objectives. 6. Inconsistent time for training, supervision and appraisal. 7. Team members not aware of clear goals in complex care management. 8. Care goals not agreed with or communicated with patients. 9. Breakdown in MDT working – 'us and them' attitude between clinicians and others prevented any constructive approach to learning from safety incidents and risk reduction.	3. SBAR handover model and tool in use. 4. Recruitment and retention strategy supported with detailed implementation plan. 4. Documentation audit completed quarterly- results Q4: - Comparison of previous Trust wide results has shown an increase in compliance with standards - Items where <50% compliance achieved was for clinician's professional identification number, clinician's designation and any deletions and alterations signed. 5, 7, 9 Team Development model is applied in some areas of the trust – supports the effective functioning of goals (ie objectives), roles, processes and relationships (including MDT working) in teams.	Business group quality boards Quality Governance Group Quality committee	Emma Stimpson/ Helen Howard

L. Pressure Damage p6,7	1. Failure to act (for more than 2 years) on reported themes and causes leading to preventable pressure damage ie. record-keeping, documentation, assessment, wound care, supervision, equipment, training and communication – added to by staffing problems. 2. Underlying causes of incidents not addressed (staffing levels, competency, training, skill mix). Instead the word 'reinforce' compliance with above themes was regularly used in TB papers. Appraisal and supervision were highlighted as a shortcoming of staff undertaking them but not in relation to the time allotted to do them. 3. District nursing teams not undertaking timely risk assessments or follow up and not using a preventative framework for pressure damage. Delay in receiving pressure relieving equipment.	Stockport NHS Foundation Trust is part of the NHS Improvement collaborative to support prevention of pressure damage. Progress is being made across the hospital and community settings with Harm free care panels chaired by the Deputy Chief Nurse are well established to review and determine if there has been any contribution to harm caused. This work is being reported through the governance framework and progress monitored via the QSIG.	Quality Strategy Improvement Group Quality Governance Group Quality Committee	Helen Howard
M. Falls p7, 8	1. Although focused work undertaken to reduce falls, falls risk assessments were irregular leading to poor care planning in bed based services. 2. Falls audit showing 37% compliance with care planning lack of staff knowledge and retention after training showed the same themes 6 months later following	All patient safety incidents of moderate harm and above, including near misses are reported and reviewed via the Datix incident reporting system. These incidents are reviewed weekly at the patient safety summit and the level of investigation determined. A safer mobility collaborative has been established with targets for falls reduction in place. The actions of the collaborative	Quality Strategy Improvement Group Quality Governance Group Quality Committee	Helen Howard

	high risk incidents. Also failure to investigate incidents due to incomplete records. An update report to the Assurance committee was never produced. Failure to report falls with serious harm as SUI.	are reported monthly through the QSIG.		
N. Medicines Management	1. Lack of policies and SOPS. 2. Non-compliance with policy including inappropriate storage temperatures, omission in administration, lack of administration checks, lack of medicines reconciliation. 3. Failure to undertake control drug register audits and weekly balance checks.	1,2,3 Stockport FT has a comprehensive suite of policies and SOP's and demonstrates good compliance in relation to the storage and administration of medicines. Controlled drug audits are captured monthly and reported through governance framework. Progress has been made with the monitoring of drug fridges with a mechanism for electronic recording being piloted.	Medicines Optimisation Group Quality committee	Paul Buckley
O. Records and Record-Keeping.	1. Vital records missing leaving patients vulnerable. Failure to reconcile records leaving previous medical intervention unknown-8 years of prescription charts and ECG found in a cupboard (not scanned to complete the patient record). 2. Lack of reliable track and trace system for documentation. 3.Breach of records management retention periods.	1-EVOLVE used to scan new episodes, have historic episodes in file, but tracked on PAS. Procedure in place to search for missing records. Regular audits for availability of records in clinics completed with evidence of good compliance. 2-PAS used for tracking of records. 3-Records management group in place. Business groups have been asked to review the records they store in health records storage and remove as appropriate. Health records have to keep their records even when scanned due to licence. Records are stored also in individual wards	Business Group Quality Board Finance and Performance Group	Joanne Edwards

		and departments not just health records. Procedure document for the retention, storage and destruction of documents in place –covers Goddard and all relevant points.		
P. Commissioner/NHSE/SHA/TDA/CQC oversight.	1. Inadequate oversight and assessment of risk by CCG. 2. Inadequate impact assessment and decision to reduce contract income whilst maintaining same level of service. 3. Failure to identify concern over the challenges of a new service type – Prison service. NHSE monitoring failures. 4. TDA raised concerns but reversed its assessment for unknown reasons. 5. CQC did not identify concerns until MP alerted to the problems. 6. Above failures contributed to by reconfigured organisations coming to terms with new roles and not communicating effectively – however above insufficient to account for the missed opportunities to intervene.	Quarterly CCG contract and performance meetings Quarterly CCG quality meetings Stockport Improvement Board CQC regular engagement meetings	As previous column	

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Trainee Experience		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR INFORMATION & ASSURANCE

Corporate objective ref:	S06 S04
Board Assurance Framework ref:	C8,10, 15,16,17,18
CQC Registration Standards ref:	12, 18
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

In June 2017, HENW raised some concerns about trainee experience working in the emergency department and in the care of acute medical admissions. As a result of these concerns, the trust has been under GMC 'enhanced monitoring' for the past 18 months. Considerable focus upon training has resulted in improvements in trainee experience over the past year. Feedback direct from trainees, and via HENW has been largely positive.

Our new cohort of trainees began in the trust in early August. Within 3 weeks concerns were raised relating to a number of problems with 'out of hours' medical provision.

This report summarises the concerns raised, and our resultant actions. The response to these concerns has been prompt and has led to a considerable improvement in the trainee feedback.

HENW will be undertaking a further external review on October 4th. The board are recommended to take note of the concerns raised, but to take assurance that our response this has been rapid and proportionate.

Attachments: Appendix 1 – Action plan

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 Concerns have been recently been raised by some of trainees about the adverse experience 'out of hours' in our organisation. For some these concerns have been sufficient to raise concerns about patient safety.

2. BACKGROUND

2.1 The trust is under 'enhanced monitoring' from GMC following concerns raised by Health Education North West, during a site visit in spring 2017. The trust response to these concerns has been well received, and feedback from HENW has suggested that progress towards the lifting of 'enhanced monitoring' has been good. HENW will be carrying out a further site inspection on October 4th.

Our new cohort of trainees began work with us in August. Within three weeks of starting, concerns were being raised by some of the trainees about their experience, predominantly during 'out of hours work'.

These concerns have been taken seriously. This report outlines the concerns raised and how we have responded.

3. CURRENT SITUATION

Our current cohort of trainees began work with us on 1st august. Within three weeks, Dr Baxter - our Director of Medical Education, began to receive adverse feedback from some trainees. He immediately recognised that these were not simply the 'usual grumbles' of a new group of trainees finding their feet, and were a source of concern. Of particular concern was that some trainees went as far as to describe times where patient safety was compromised. Dr Baxter immediately arranged to meet with our trainees, and escalated his concerns to the Medical Director.

Concerns raised related to a number of issues;

- **Overwhelming demands upon the 'i bleep' system –** 'i – bleep' is the system used to log jobs 'out of hours' that require medical attention across the organisation. This system is designed to facilitate effective allocation and prioritisation of tasks.

- Concerns were raised that the numbers of jobs on the system were of a magnitude that made the task undeliverable by the available staff 'out of hours'– and so – at times, compromising patient safety.

- **Trainee medical handover –** The acute medical team is extremely busy out of hours, both managing admissions and reviewing patients with outstanding or new issues on the wards. Critical to efficient functioning of this team is the trainee handover between shifts.

- Concerns were raised that this handover was poorly located (distant from the majority of the work), poorly coordinated, and as a result trainees were starting their shifts without the required information to 'hit the ground running'.

- **Foundation doctor ward support –** New admissions to the hospital continue day and night. Ensuring that each new patient is reviewed by a senior trainee, means that the senior trainee (ST3+) spends most of the night in the Emergency Department (ED), or Acute Medical Unit (AMU). One of our junior doctors (foundation doctors) is allocated to provide medical cover the in-patient medical wards – with support from the ST3+ doctor as required.

- Concerns were raised that this trainee was at times feeling isolated and unsupported.

- **Poor registrar support of junior trainees –** Junior trainees (foundation doctors and ST1 / ST2) are extremely reliant upon the support that they receive from more senior (ST3+) trainee. Most of these shifts are filled by 'internal' trainees, who generally offer great support. Some shifts are filled by consultant staff.

- Concerns were raised about the variable support offered by some ST3+ trainees, with particular concerns raised over the performance of one locum registrar.

- **Poor consultant support –** Ultimate responsibility for out of hours medical provision falls to the consultant physician 'on call'. As well as offering a senior review of medical decisions, it falls to the medical consultant to support the management team in addressing staffing shortfalls.

- Concerns were raised about one consultants failure to support a critical staffing shortage.

Initial response.

These concerns were identified extremely quickly. The Medical Director and Dr Baxter, cascaded the concerns to the Training Leads, Clinical Directors and Associate Medical Directors.

Action

At all levels, trainees were met with, offered support and more detail was sought around the specific concerns raised. There was an immediate increase in senior support and 'visible presence' of senior leaders both 'in' and 'out of hours'.

A number of specific actions were immediately put in place to ensure that patient safety was not compromised, and a more formal action plan was developed within a week (see appendix 1) of the concerns coming to light.

- **Improving the environment of handover –** the AMU office was cleared to improve the space, additional plasma screen added to assist with handover.
- **Improving the structure of handover –** Clarification of the structure and process of handover has been ensured.
- **Clarification of roles –** Clear 'job cards' have been developed, such that each trainee understands their role, who they support, and who supports them.
- **Two additional 'safety huddles' –** two safety huddles have been introduced, one at 6:30 pm and one at 2 am. These offer the junior trainees an opportunity to informally discuss cases of concern with the ST3+ doctor, without needing to 'bleep them'. This is of particular help where they have multiple small areas of concern requiring advice.
- **Recruitment of a trainee cohort into the next AQUA program –** This project will specifically consider how we organise our 'out of hours' services.
- **Addressing behaviour issues.** The specific concerns relating to the performance of one ST3+ locum, and one consultant have been managed with the individuals concerned.
- **Restructure of trainee allocations –** A greater allocation has now been directed at the in-patient medical wards, to ensure that the 'I bleep' tasks can be managed

Feedback.

As a result of the changes implemented, we have seen a dramatic reduction in the number of 'i bleep' jobs logged on the system.

Current feedback suggests that the measures put in place have had an immediate effect. Examples of the feedback are below;

‘Last night no jobs when they came on. Super support from the CMT and ST3+ .’

‘2.am huddle worked really well.’

‘We met about 15 FY1s yesterday evening with a member of the iBleep team - generally pretty positive feedback.’

"It feels much safer today and manageable."

‘Last 2 weeks have been so much better."

These immediate actions have certainly led to short term improvements of benefit to our current cohort of trainees. The Medical Leadership groups (CD’s and AMD’S) are considering more significant restructuring of our approach to out of hours provision in the longer term.

4. RISK AND ASSURANCE.

4.1

This adverse experience early in their jobs, may still be reflected in the feedback given to HENW when they visit. We are confident that we have been responsive to these concerns, and feel that this should reflect positively in the feedback.

We remain optimistic that the overall assessment of training will see the GMC enhanced monitoring being stood down after the HENW visit.

5. CONCLUSION

5.1 ‘Out of hours’ medical provision can be challenging to get right, but ensuring that the medical cover is sufficient to meet the demand is critical to patient safety.

Our new cohort of trainees, who started in August, raised concerns about our ‘out of hours’ provision of medical care.

The Medical Education Team, Clinical Directors and Associate Medical Directors have been extremely responsive to these concerns. Immediate actions put in place appear to have addressed the patient safety concerns, and significantly improved trainee experience.

Further discussions continue about what more can be done to improve our out of hours medical provision.

6. RECOMMENDATIONS

6.1 The Board of Directors is recommended to:

- Note the concerns raised by our current trainees, but take assurance that our response has been rapid and proportionate.

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Handover / Out Of Hours Action Plan

Action	Department Responsible	Lead	Deadline
Move Night Time Handover to AMU 7 days a week	Acute	KB/HC	17/09/2018
Clear Doctors' office on AMU to create more space	Acute	KB/HC	14/09/2018
Move plasma screens on AMU to doctors' office	Acute	KB/HC	14/09/2018
Provide some overnight refreshments in the handover office.	Acute / GIM	KB/HC	14/09/2018
Display poster for Night Time Handover Process	GIM	RB/ NK	17/09/2018
Introduce Safety Huddles at 6.30pm and 2am 7 days a week	Acute / GIM	HC/RB	17/09/2018
Create Watts app Group with all Junior doctors on the on call with CD/AMD oversight	Acute / GIM	HC/RB/PH	17/09/2018
Update Roles and responsibilities of the On call grades	Acute	KB / NK	17/09/2018
Change Twilight FY1 from ACU cover to General ward cover after 5pm	Acute / GIM	KB/ NK	12/09/2018
Introduce a Weekend Handover Clinic for Medical Registrars between 4-5pm	GIM	RB/NK	01/11/2018
Develop a Proforma to capture handover details	Acute	HC	30/09/2018
Introduce a quarterly out of hours forum	Acute / GIM	KB	01/11/2018
Review the process of managing gaps on general medical on call	GIM	RB / NK / SR / JC	30/09/2018
Address vacancies in medical on call middle grade and SHO grade rota	GIM	RB / NK / SR / JC	01/12/2018

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Update on Staff Survey 2017 and Culture & Engagement Plan		
Report of:	Interim Director of Workforce & Organisational Development	**Prepared by:**	Head of Organisational Development & Learning

REPORT FOR APPROVAL

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

Summary of Report

- This report is to update Trust Board on the progress against the actions arising from the staff survey 2017
- A Trust Culture and Engagement Plan (CEP)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.
- Delivery against this plan is led through the Culture and Engagement Group, reporting in to the People & Performance Committee.
- The People Strategy has Culture and Engagement and Learning and Development as two key priorities.

Attachments:

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 The purpose of this report is to inform Trust Board of progress against the Staff Survey 2017 priority actions and of the Culture and Engagement Plan which aligns to two of the five key priorities in the developing Stockport People Agenda.

2. BACKGROUND

2.1 The Board considered the outcomes of the 2017 Staff Survey and agreed four priority actions:

1. Giving feedback about changes made in response to reported errors – Datix systems have been reviewed and upgraded to include feedback on consequent changes.
2. Identifying training and development needs in appraisal – Appraisal processes and training have been revised to strengthen PDPs and links to the annual Training Needs Analysis process.
3. Reporting experience of physical violence - additional support is available for staff that have been subjected to aggression from patients or relatives.
4. Taking positive action on health and wellbeing – a growing range of staff wellbeing provision is led and promoted by the Trust Culture and Engagement Group.

2.2 These actions have been added to the CEP - a medium term plan to support the continued development of a broader Culture & Engagement agenda relating to contributing factors to the Trust culture and values and includes: Equality, Diversity and Inclusion (EDI), Workforce Wellbeing and Leadership Development in recognition that these are all key elements of creating a engaged and motivated workforce.

3. CURRENT SITUATION

3.1 The Trust's Culture and Engagement Group, chaired by our Head of OD and Learning has developed a medium term C&EP for the Trust which includes EDI, Workforce Wellbeing and Leadership Development – all key factors in an organisation's culture and levels of active engagement.

3.2 The People Strategy includes Learning and Development and Culture and Engagement as two of its five key priorities. The Culture and Engagement Plan will be aligned to these priorities and will support successful delivery of the Education, Resourcing and High Performance priorities.

4. ENGAGEMENT

4.1 The People Strategy provides a 3 – 5 year plan to create the workforce we need to deliver the Trust's Vision and Strategy. The culture we create through engaging with our workforce and how we lead our workforce is a key factor in our ability to successfully deliver the Trust's strategy and to provide safe and high quality care.

4.2 The current plan includes a wide range engagement channels in addition to our annual staff survey including; Friend and Family Test, Proud to Care, Care Opinion, Freedom to Speak Up, New Starter Forums, and Listening Events.

4.3 The Medical Engagement Scale (MES) survey has been developed in partnership with 'Engage to Perform'. The survey is for Medical staff to complete and will be analysed alongside the Staff Survey feedback.

4.4 Schwartz Rounds are being introduced to the Trust. These are meetings that enable staff to share and reflect on the emotional and human aspects of caring for others. The 'Schwartz Rounds' will be held as monthly meetings based on a variety of topics for an hour, with refreshments provided. At each Round a trained facilitator will introduce a panel of speakers who will tell their individual stories and then the discussion will be opened to the audience to share their thoughts and responses. The aim is not to problem solve, identify solutions or highlight issues that need escalating, but to listen and reflect on shared work experiences. Schwartz Rounds will be launched on the 4th October with the first panel title *'The Little Things'*.

4.5 Celebrating Stockport; continues to grow with three good practice/celebration events having taken place (December 17, March and July 18); staff have been commended internally, regionally and nationally for their commitment to patients and community of Stockport. The 'Thank You' cards are now implemented with Chief Executive support. Team Member of the Month has been in place for four months with diverse winners, including HCA's, Procurement Manager and Porters. The Cultural Ambassadors have developed Change Pledges and Positivity Boards with teams and continue to promote the Trust as a positive place to work.

4.6 The Culture & Engagement agenda is supported throughout the Trust by a team of 48 Culture Ambassadors. In addition to their substantive roles, they represent their teams at regular Ambassador groups and by representatives at Culture & Engagement Group, and cascade key messages and outputs from the CEP back to their teams.

4.7 In addition, the Trust Wellbeing and EDI strategies are incorporated into the overarching CEP.

5. A CULTURE PLAN

5.1 All of the above provide rich sources of data and intelligence about the prevailing culture in the organisation. The data can be used to inform our Leadership Development; help us to understand what is working well and why, enable change systems and make improvements to our working environment.

5.2. To develop a framework that enables the Trust to gather and analyse the wealth of data gathered via a wide range of engagement activities across the Trust, and make sure that we apply that learning to make positive changes, we are working with the support of NHSI and the Kings fund to introduce a Culture Programme. This is a programme that has been used in other Trusts to effectively capture these diverse sources of data and intelligence, analyse them, and effectively track resulting actions. The programme has 3 phases: :

- Phase 1: Discover - diagnose cultural issues
- Phase 2: Design - develop collective/compassionate leadership strategy to address the issues
- Phase 3: Deliver – Create a plan to implement changes

5.3 The programme provides dedicated resources and tools to support the assessment process and the plans will align to the 2018 staff surveys results and inform the overarching CEP. Although still in the early stages of planning, it is estimated that this process will take between 12 and 18 months to be fully implemented.

6. CONCLUSION

6.1 The Trust has developed a CEP to support the delivery of the staff survey outcomes and additional key areas that support a positive staff experience and enable motivated and engaged staff to deliver safe, quality and effective care.

7. RECOMMENDATIONS

7.1 The Committee 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.

7.2 Progress against the CEP should be monitored by People and Performance Committee on a quarterly basis.

7.3 The Board is asked to note the progress against the key areas of improvement based on the 2017 Staff Survey results.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Medical Appraisal and Revalidation Board report		
Report of:	Medical Director	**Prepared by:**	Kelly O'Gara, A&R coordinator

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** Annual Board of Directors report for Medical Appraisal and Revalidation.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	

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

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Glossary

RO:	Responsible Officer
MAL:	Medical Appraisal Lead
ARC:	Appraisal and Revalidation Co-ordinator
AOA:	Annual Organisational Audit
PReP:	Premier IT (appraisal IT system)
GMC:	General Medical Council
ASG:	Appraisal Support Group
CD:	Clinical Director
ESR:	Electronic Staff Records
NHSE:	NHS England
CHKS:	Clinician Level Indicator Programme (CHKS Provide this report)
NCAS:	National Clinical Assessment Service
SPA:	Supporting Professional Activities
HEENW:	Health Education England North West

Introduction

- Stockport NHS Foundation Trust has an established process for the annual appraisals of doctors. The process is in place to ensure that all doctors employed by the Trust provide sufficient and relevant information and evidence towards the GMC revalidation process.
- As at the 31st March 2018 the Trust had a total number of 315 connections on the GMC, this is broken down to 185 consultants, 80 Staff Grade, SAS and specialty doctors, 36 Temporary/short term contract doctors, 14 other doctors with a prescribed connection. All HEENW trainees are appraised via the relevant deanery.
- A total of 23 recommendations to revalidate occurred within the 2017/18 financial year. Of these a total of 6 deferrals were made, this is broken down to 2 with an ongoing process, 4 due to lack of supporting evidence. The maximum deferral timeframe used within the Trust was 9 months. No non-engagement recommendations were made.
- As at the year end the Trusts Medical Staff appraisal rate was at 98.73%.

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.
The GMC requirement is that all doctors licenced to practice within the UK revalidate once every 5 years. At present the Trust is currently within the second cycle since the process began in 2012. All doctors within the Trust must provide satisfactory evidence through appraisals in order for the RO to make a positive recommendation.
Provider organisations have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations 1 and it is expected that provider boards / executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Purpose

NHS England requires each Responsible Officer (RO) to provide a full annual report to their organisations Board of Directors, or equivalent. The report should detail the compliance of all Trust connections with the Appraisal and Revalidation Process.
NHS England require a statement of compliance to be completed by the organisations Chief Executive or Chairman, following the Annual Report **Statement of Compliance** (for the chief executive or chairman, or executive if no board exists, to sign a statement of the organization's compliance to the Responsible Officer Regulations and submit to their higher-level responsible officer no later than **28 September 2018**).

Governance Arrangements

The Deputy Medical Director currently holds the position of Responsible Officer for the Trust. The RO currently has the support of the Medical Appraisal Lead (MAL) and Appraisal and Revalidation Co-ordinator (ARC). The MAL and ARC meet on a weekly basis to discuss the current position in regards to appraisals progress. The RO also meets with the ARC on a weekly basis to discuss impending revalidations and also any relevant issues in regards to the appraisal process and or progress.

Reports are run on a monthly basis from the ESR system to show all new medical staff and also leavers where appropriate. This information is then used to ensure that the doctors have a connection via the GMC to the RO and that details are added to the PreP system for appraisal progress. Prior to a doctor becoming connected to the Trust and RO-RO Transfer of Information form is sent to the previous organisation to request details on previous appraisal dates and also any outstanding GMC issues.
A quarterly report is taken from GMC connect to show the Trusts active connections, this is offset against an ESR report to ensure that all connections are still employed at the Trust. The GMC connection figures are also compiled along with appraisal compliance figures; this is then sent each quarter to NHS England.

Medical Appraisal

PreP Revalidation

The Trust currently uses the web-based software PreP for appraisal and revalidation purposes. PreP allows each doctor of the Trust to have an individual secure account, where relevant documents can be added I support of their yearly appraisal. This system allows doctors to uploaded and input information onto and Input form which will then be sent to the appraiser. Following an appraisal meeting the appraiser is able to complete and output form containing details from the meeting. PreP allows the RO to view completed appraisals to ensure a high standard is met.

Appraisal and Performance data

Table 1: Summary of the information provided to NHS England for the 2017/18 Annual Organisational Audit (AOA):

Grade	Number of connections	Completed Appraisal (1A)	Completed Appraisal (1B)	Approved incomplete or missed (2)	Unapproved Incomplete or Missed (3)	Total
Consultants	185	49	133	1	2	185
Staff Grade, Associate Specialist, Specialty Doctor	80	16	63	1	0	80
Temporary/Short Term Contract	36	5	29	1	1	36
Other	14	2	11	0	1	14
Total	315	72	236	3	4	315

Table 2: Summary of each individual department's appraisal rates as at 31st March 2018

		1A	1B	2	3
Community Healthcare	1		1		
Corporate Services	6	2	4		
Intergrated Care	43	9	31	2	1
Medicine and Clinical Support	88	16	68	1	3
Surgery GI and Critical Care	116	30	86		
Women, Children and Diagnostics	61	15	46		
Total	315	72	236	3	4

Table contents

Number of connections – this is the total amount of registered medical professionals whom have Stockport NHS FT listed as their GMC connection.
1A: A doctor who carried out an appraisal meeting between 1st April 2017 and 31st March 2018, of who can agree to the following 3 statements:

A meeting of which was within the 3 months preceding the appraisal due date.
An appraisal summary signed off within 28 days of the appraisal date.
The entire process occurred between 1st April and 31st March.

1B: A doctor who carried out an appraisal meeting between 1st April 2017 and 31st March 2018, and who has achieved at least one of the above requirements.
2: A doctor who did not carry out an appraisal meeting between 1st April 2017 and 31st March 2018. The reason for missing the appraisal has been agreed in advance by the RO.
3: A doctor who did not carry out an appraisal meeting between 1st April 2017 and 31st March 2018. The reason for missing the appraisal has not been agreed in advance by the RO.

AOA Comparator Report – published by NHSE

A report to compare the Trusts AOA submission for revalidation responses, against those from designated bodies of a similar sector, and also all designated bodies in England:

2017/18 AOA Indicator SECTION 2 (Cont): Appraisal		**Your organisation's response**	**Same sector: DB's in sector 99**	**All sectors: Total DB's 834**
		Completed appraisals (Measure 1a & 1b)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 - 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	182 (98.4%)	92.0%	92.7%
2.1.2	Staff Grade, associate specialist, speciality doctor	79 (98.8%)	88.4%	88.9%
2.1.3	Doctors on Performers Lists	N/A	71.4%	94.7%
2.1.4	Doctors with Practising privileges	N/A	66.7%	93.0%
2.1.5	Temporary or short-term contract holders	34 (94.4%)	77.2%	82.8%
2.1.6	Other doctors with a prescribed connection to this desiganted body	13 (92.9%)	63.9%	87.1%
2.1.7	**Total number of doctors who had a completed annual appraisal**	308 (97.8%)	88.3%	91.3%

2017/18 AOA Indicator SECTION 2 (Cont): Appraisal		Your organisation's response	Same sector: DB's in sector 99	All sectors: Total DB's 834
		Approved Incomplete or missed appraisal (Measure 2)		
2.1	Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 - 31 March 2018	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	1 (0.5%)	4.9%	4.3%
2.1.2	Staff Grade, associate specialist, speciality doctor	1 (1.2%)	7.9%	7.5%
2.1.3	Doctors on Performers Lists	N/A	28.6%	4.8%
2.1.4	Doctors with Practising privileges	N/A	33.3%	5.5%
2.1.5	Temporary or short-term contract holders	1 (2.8%)	17.2%	11.2%
2.1.6	Other doctors with a prescribed connection to this desiganted body	0 (0%)	18.5%	9.8%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	3 (1.0%)	7.8%	6.1%

2017/18 AOA Indicator SECTION 2 (Cont): Appraisal		Your organisation's response	Same sector: DB's in sector 99	All sectors: Total DB's 834
		Unapproved Incomplete or missed appraisal (Measure 3)		
2.1	Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 - 31 March 2018	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	2 (1.1%)	3.1%	3.0%
2.1.2	Staff Grade, associate specialist, speciality doctor	0 (0%)	3.8%	3.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4	Doctors with Practising privileges	N/A	0.0%	1.5%
2.1.5	Temporary or short-term contract holders	1 (2.8%)	5.6%	6.0%
2.1.6	Other doctors with a prescribed connection to this desiganted body	1 (7.1%)	17.5%	3.1%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	4 (1.3%)	3.9%	2.7%

Appraisers

The trust currently has 36 trained Appraisers; each receives a PA value dependant on their level as detailed below:
11 Super appraiser 0.75 PA carry out 12-15 per year, attend Appraisal Support Group (ASG) and complete the Quality Assurance Process
23 Appraisers with a 0.25 PA carry out 6-8 per year, attend ASG.
1 appraiser currently receives 0.5 PA for 10 appraisals per year, and ASG
The trust undertakes an Appraisal Support Group (ASG) twice a year; these are led by the Medical Appraisal Lead. Appraisers are aware of the expectation to attend at least one per year. The ARC makes a note of all attendees on a master database; from this appraisers are provided with a certificate of which can be uploaded to their own appraisal for supporting information. ASG packs are sent out 2 weeks prior to the meeting date; within the ASG discussions take place in regards to the PreP system, appraisee allocation, NHS England updates and any other matters of current importance.

Quality Assurance

Appraisee

Appraisees have an individual responsibility to ensure they participate in the yearly appraisal process. The PreP system will send out automated emails at 12 weeks prior and again at 11 days prior to the due date. Along with these automated emails the ARC will send out personal messages to individuals for upcoming due dates with missing meeting dates. Trust supporting information (Datix, Training, CHKS) is uploaded by the ARC to the individual PreP accounts 2 months prior to the due date; this information is also emailed to the relevant individual and their appraiser.

Appraisal input forms should be submitted to the relevant appraiser 2 weeks prior to the meeting date; this then allows the appraiser to review all information uploaded, contact the relevant clinical director and also return the input form is changes are required.

RO/Trust

Once the appraisal meeting has taken place the appraiser will complete an output form detailing discussion which have taken place, this form is then directed to the appraisee for a final sign off. When an appraisal is fully completed and signed off the RO will receive notification via email, from this the RO checks all output forms and PDP's. These are then scored and ranked into one of five categories (Excellent, Good, Moderate, Poor, Unacceptable). A formal peer review takes place on a yearly basis, this process is carried out using the EXCELLENCE Tool. A group of super appraisers will review appraisals using this tool and provide feedback to the MAL and RO. The selection of appraisals in which the EXCELLENCE Tool is used are selected using the RO scoring and also a random group taken from PreP.

Appraiser

Upon completion of an appraisal the appraisee will have the opportunity to complete a feedback questionnaire of which the system will generate. This feedback is then sent to the appraiser on a yearly basis to be included within their own appraisal. Appraisers are also provided feedback with the ASG meetings, along with 1:1 meetings on a yearly basis with the MAL.
The RO and MAL will offer additional support and training if an appraisal review shows that standards are not being met. If standards do not improve following additional support the role may be removed from the appraisal pool.

360 Feedback

The ARC will coordinate the 360 feedback for all doctors who have a connection to the Trust. The 360 feedback must be completed once within each 5 year revalidation cycle. The system used is to collate the feedback is Edgecumbe, this system interlinks with PreP allowing the appraisee to view their completed reports directly on PreP. Each doctor must invite a minimum of 17 patients, 6 colleagues at peer level and 6 colleagues at a junior or support level to complete the questionnaire. The system will not allow a report to be generated until this minimum number has been reached. The appraisee must also print and distribute a minimum of 17 patient questionnaires, once returned the questionnaire must be returned to Edgecumbe via email or post. Once received Edgecumbe will produce an electronic report detailing all responses. Both reports are viable to the appraiser and appraisee and viewable on PreP ready for reflections. Certain groups of doctors are exempt from the 360 patient feedback, due to a lack of or no direct patient contact i.e. Histopathologists. In certain individual cases the Trust's RO has the discretion to reduce the minimum required numbers for feedback. This amendment would be based on individual circumstances and must also be confirmed in writing by the RO.

Access, Security and confidentiality

Appraisal portfolios inclusive of input and output documents are held on the PreP appraisal system. PreP is secured electronically and can only be accessible by the individuals personal GMC number and password. Old appraisal documentation either from the Trust or a previous organisation are held within secure electronic P-Files on a secured shared drive. In some cases where a paper appraisal would have been completed prior to the electronic system, these are held securely within Medical HR in lockable cabinets under the doctors individual name.

All Trust doctors are aware that patient identifiable information must not be included within their portfolio. Supporting information provided by the ARC is anonymised prior to the upload onto PreP, Appraisers are also aware to check for any identifiable information within the system. An Appraiser can only view information on their appraisee for that specific cycle, they will not be able to view another doctor's or any previous appraisals they have completed.
The Responsible Officer and ARC are able to view information uploaded and entered onto the PreP system. The MAL and Clinical Directors are able to view output forms and PDP information; however the CD can only view information relevant to their department.
During the 2017/18 financial year no breach of confidentiality has been identified in relation the PreP system or appraisal process.

Clinical Governance

Revalidation Recommendations made for the financial year 2017 – 2018.

Within the year a total of 23 recommendations were made by the RO. Out of the 23 revalidations 6 required a deferral to be made, 2 for ongoing issues, and the remained for insufficient evidence provided. One particular individual required deferment for a second time, and another individual left the Trust prior to recommendation.
Note: recommendation of deferral is not a negative action. The most common reason is to ensure that recommendations are made only when the RO is satisfied there is sufficient supporting information provided. The deferral may be for between 3-12 months at the discretion of the RO.

The table below details when the recommendations took place:

Require Recommendation	23
Within 1 month of due date	11
Within 2 months of due date	9
Within 3 months of due date	
Within 4 months of due date	2
Left Trust prior to due date	1

Recruitment and Engagement background checks

The Trust's recruitment team ensure that all pre-employment checks are undertaken in accordance with NHS employment check standards and in line with all legal, statutory and good practice guidance requirements.

These meet six standards for:

- Verification of the doctor's identity
- Their right to live and work in the UK
- Professional registration and qualification checks
- Employment history and reference checks
- Disclosure Barring Service check (DBS) formally known as CRB
- Occupational health checks.

In relation to revalidation, all newly appointed medical staff must complete the Revalidation Entry Form. This is then cross referenced with GMC Connect to clarify the previous RO and also their new connection to the Trust. The ARC will contact the previous RO to obtain information in relation to previous appraisals. Any doctor who has HEENW listed as the previous RO must directly provide their ARCP information.

Monitoring Performance

The performance of all doctors employed by Stockport NHSFT is managed through Trust processes according to Trust policies such as the 'Policy and Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental staff' and the Harassment and Bullying Policy'.
Concerns can be raised by patients or other staff members; from SIs, Learning form Deaths reviews or referrals to the coroner; or from the GMC
Concerns may be managed informally or formally within the Business Group; or may be escalated to the Responsible Officer. A decision will be taken as to whether a formal investigation process is required; and consideration given to immediate action such as restricted duties or exclusion. If a Case Investigation is required, a Case Manager is appointed (usually the RO); and a Case Investigator appointed from a group of appropriately trained individuals. A report from the Case Investigator will be considered by a Decision Making Group (the Executive Medical Director; Director of Workforce and the RO), who will decide on further action if required. The RO is responsible for informing the GMC if required.
In cases where there are concerns about capability; NCAS will be involved
If there are concerns about doctors working at Stepping Hill but not employed by the Trust; then the RO will discuss the concerns with the doctor's RO (the Dean for trainees; locum agencies where appropriate; or the Higher level RO for GPs
There are regular meetings with the Director of Workforce and Head of Medical Workforce to discuss 'Doctors in Difficulty; and the Director of Medical Education is involved for any trainees.

Responding to Concerns and Remediation

The Trust's Policy for remediation of medical and dental staff is available on the Intranet. In the year April 2017-2018; there has been 1 disciplinary hearing for a doctor (resulting in a 1st written warning); and 1 formal NCAS assessment.

Risks and Issues

Some concern about the funding of SPA time to support appraisers. This has been escalated to the COO to discuss with BG Directors

The contract with our current IT system for appraisal (Premier IT) comes to an end in 2020.

Board/Executive Team reflections

Improvement Plan and Next Steps

- Recruit and train more appraisers by October 2018
- Increase the number of ASG meetings to every 4 months
- Ensure an increase in number of appraisals where the meeting takes place before the appraisal due date; and the output form is completed within 4 weeks
- Implement 'best practice' from the Peer Review process with Christie and East Cheshire
- To start to look at alternative IT systems in preparation for a procurement exercise next year

Conclusions

The board report requires Chief Executive Sign off by the 28th September 2018.

Recommendations

The Board is asked to approve the report.

Appendices

The Christie
NHS Foundation Trust

Three-way Peer Review - Appraisal and Revalidation

Summary report August 2018

This report provides an overview and summary of a peer review exercise to appraise processes for medical appraisal and revalidation undertaken June - August 2018 across three NHS Designated Bodies: East Cheshire NHS Trust, Stockport NHS Foundation Trust and The Christie NHS Foundation Trust.

Objectives

- A developmental and learning opportunity, with reviews undertaken by those who understand the issues and constraints.
- To provide an independent appraisal of how each organisation undertakes appraisal and revalidation of the doctors connected to them.
- To allow sharing of good practice.
- To move towards a consistent model of the recommendation process any concerns or areas to review and improve.
- To provide assurance to Responsible Officers of the systems they have in place
- To share learning and if appropriate, to identify areas for future collaboration.

Process

The Responsible Officers at three NHS trusts within a reasonable geographical locality and of fairly comparable size had discussed and agreed to participate; three participants avoided reciprocal arrangements and broadened the potential for shared learning. The process would involve the Responsible Officers, appraisal leads and appraisal and revalidation coordinators at each organisation.

The peer review followed the suggested framework from NHS England; the joint medical director of NHS England North was briefed and there was commitment to compile a summary report and share learning at a future RO/Lead Appraiser Network event.

A start up meeting was used to agree the arrangements, time scale and a minimum data set of information from each team to be shared prior to the peer review on-site visits.

The 3 way process entailed:

The Christie to review East Cheshire

East Cheshire to review Stockport

Stockport to review The Christie

The information shared in advance of the visits included:

- Appraisal and revalidation policies
- Team structure
- The last completed annual report to Board of Directors and AOA
- Revalidation process; submissions and deferrals with reasons
- Description of QA processes and outcomes
- Any issues encountered or significant learning events in the past year

Each on site visit comprised a 2 hour meeting' team to team', allowing time for the reviewers to pull together preliminary feedback that was shared at the visit, and subsequently written up as a report for each organisation.

The process ended with a joint meeting of the three participating teams, the conclusions from which are described in this report. This enabled reflection on the process and learning for each organisation, discussion of the key findings and also identified some areas where the teams agreed to work together.

Outcomes

1. All teams found the exercise to be extremely interesting and valuable to all organisations; each learned from the other two. Practice was reviewed and questioned in some detail but in a format that promoted open discussion and reflection.

2. The reviews provided significant assurance for each designated body: there were no concerns identified.

3. Areas that were picked up for individual teams to consider included:
    - Need to review policy where current practice has changed from that described
    - Clarity on timeframe in which reciprocal appraisal arrangements are avoided
    - How appraisal for 'fellows' / specialty doctors might incorporate an educational appraisal approach
    - How refresher training for appraisers might be offered and how often
    - Ensure clear Trust policy for how each revalidation recommendation is considered and reached, and documented (particularly where doctors are new to trust and/or UK)

4. Examples of good practice included
    - RO visits to doctors working at sites away from main trust so familiar with individuals and their working environment
    - Appraisal – revalidation newsletter to all doctors
    - RO reviews all patient feedback then sends to individual doctors with a personal comment and recognition for good care
    - Formal refresh/update training for appraisers
    - RO looks at and scores each appraisal output (see QA below)

5. The following areas promoted further discussion in the whole group in the final meeting
    - Pros and cons of different electronic systems: two trusts were about to change or had changed in year, and the third not happy with present system. Interestingly, the co-coordinators tended to maintain independent Excel spreadsheets alongside the electronic systems for peace of mind. Capture of scope of practice was discussed: at present none of the teams maintain a database with updated details for each doctor but it was felt to be a good idea given diversifying of portfolios.

- There were examples of a shared RO-lead appraiser role: this was feasible with a smaller organisation and here the medical director role was separate - however worked closely with the RO. None had formal provision for a named 'deputy' RO in event of extended absence of the RO: options might be to RO train another individual or consider a reciprocal arrangement between trusts, but this would need to be formally approved by Board.
- QA of appraisals: all had struggled to arrive at a consistent but not excessively labour intensive process. All felt that the ASPAT was not practical and even the Excellence tool required some adaptation. One team had adopted a simple overall scoring for every appraisal on 5 point scale from inadequate through poor, adequate, good and excellent and the other two teams liked the approach adopted. This was a two part process and then the lower scored could be reviewed in detail using the Excellence tool for structured feedback to appraiser.
- Feedback to appraisers: variable rates of appraise feedback although usually positive and alerts the team to a concern. Sharing examples of good v poor summaries was valuable and welcomed by appraisers, but it was difficult to fully anonymise within the group. There was potential to share anonymised examples between the teams across Trust for future appraiser discussions.
- Revalidation decision-making: one RO had a fixed approach that doctors working less than 12 months in the trust were deferred. Others were more flexible depending on robustness of information available to them: so if recently transferred but satisfactory MPIT and evidence including a recent appraisal (last 3 months) would recommend. If new to UK and NHS would defer for a year to ensure robust appraisal and assurance no concerns. Documentation of decision-making varied but needs to be in place in case of future challenge.

Areas for further collaboration

It was agreed that the three teams would work together on the following:

- Collaborate on a standardised QA process for appraisal summaries and PDP
- Share anonymised examples of good and poor outputs
- To set out how decisions to recommend or defer are made in different circumstances and the documentation to capture this
- Explore joint refresher training opportunities for appraisers and also case investigators/case managers to reduce costs
- Consider reciprocal arrangements for a named reserve RO in case of unforeseen circumstances at a Trust

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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Annual Report – Adult and Children's Safeguarding		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR ASSURANCE

Corporate objective ref:	2a, 2b
Board Assurance Framework ref:	SO2
CQC Registration Standards ref:	9, 11
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

This Annual Report describes the activity of the Adults and Childrens Safeguarding teams during 2017 – 2018.

The Board of Directors are asked to note the report and the information it provides.

It is important to note that significant progress has been made during Q1 2018 – 2019 in relation to raising the profile of Safeguarding at the Trust which will be reflected in the 18/19 Annual Report.

Attachments: Annual Report – Adult and Children's Safeguarding

This subject has previously been reported to:

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

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Annual Children's & Adults Safeguarding Report 2017-18

Foreword

I am delighted to present the 2017/2018 annual report for safeguarding adults and children. You will see throughout the report that much has been achieved to ensure that vulnerable adults and children in our care are safe and well cared for by a kind and compassionate workforce.

This annual report covers a period of time where there were significant changes in leadership for our Trust. We are responsible for ensuring that the most vulnerable in our care are protected by ensuring that our workforce has the skills and knowledge to recognise their responsibilities and carry these out in practice.

Whilst much has been achieved over the last year, on-going challenges of course remain and ways to tackle these challenges will form part of our 2017/2018 work plan. Our priority as ever, remains the welfare and safety of those most vulnerable in our care.

Our safeguarding teams continue to support our staff through their expertise and knowledge and deliver training to enable our staff to take on this increased responsibility.

Alison Lynch
Chief Nurse and Director of Quality Governance

1. Introduction

Stockport NHS Foundation Trust is committed to safeguarding all vulnerable patients who access services across the Trust – this commitment is from the Board to frontline staff. The Chief Nurse & Director of Quality Governance is the Executive Lead for Safeguarding supported by the Deputy Chief Nurse and relevant business group Directors and Associate Nurse Directors.

This report provides a summary of the activities of the children's and adults teams across the Trust and demonstrates to the board and external agencies how Stockport NHS Foundation Trust discharges its statutory duties.

The 2017/18 annual report includes:

- An overview of the national and local context of safeguarding.
- An overview of the areas of practice included in safeguarding within the Trust
- An update on safeguarding activity within 2017-18 including progress made in strengthening safeguarding practice and outcomes.
- Assurance that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding.
- An overview of any significant issues or risks with regard to safeguarding and the actions being taken to mitigate these.
- A briefing on the challenges and work to be addressed by the Safeguarding Team in 2018/2019.

It is proposed that the Safeguarding Annual Report will be changed in-line with the revised safeguarding reporting structure, which includes a half yearly and quarterly reporting process.

2. Safeguarding Children

Safeguarding children within the organisation has noted a number of developments and challenges. There continues to be an increase in activity in many areas of safeguarding children but in particular the complexity of case management and the continuing stream of learning reviews and Serious Case Review activity. Within the Safeguarding Children's Team there have been persistent pressures with changes in staff, team structure and vacancies. During this time period there has been a new change in Named Nurse coming into post at the end of March 2018. The following safeguarding children report reflects the hard work of the Trust.

Serious Case Reviews (SCR)

Previously it has been noted regarding the increase in Serious Case review activity which has continued into 2018. An overview of the current active and ongoing cases has been summarised in the table below.

9 month old baby who drowned in the bath	SCR in early stages	Final report is in draft form awaiting review prior to publication.	Commissioned by East Cheshire Safeguarding Children Board
6 month old baby who sustained a significant head injury caused by shaking.	SCR in progress	Chronologies have recently been submitted to the Independent Author. Police Investigation current.	Commissioned by Stockport Safeguarding Children Board
7 month old who died following a possible overlay.	SCR in early stages	Chronologies have recently been submitted to the Independent Author. Police Investigation current.	Commissioned by Stockport Safeguarding Children Board

Work over the 2017-2018 has focussed on ensuring actions within the plans are implemented & active dissemination of learning through a variety of means within the Trust and in multi-agency settings with Stockport Family colleagues. This has also included ensuring serious case review themes across Greater Manchester being shared to a number of staff groups for consideration within current practice.

In the SCR's there was active health involvement including midwifery, health visiting, and acute neonatal care in two of the cases. The 9 month old baby was resident in a neighbouring Borough and our involvement includes midwifery only.

Of note all of the reviews involved babies less than one year. This replicates themes which have emerged from the analysis of national serious case reviews. It has been a consistent feature of national serious case reviews that a large proportion of those conducted relate to infants and babies under one year old, reflecting the particular vulnerability of babies. The NSPCC[1] reports that in England and Wales, under-1s face around eight times the average risk of child homicide with those less than 3 months of age being the most vulnerable. Any learning implemented by the Trust must therefore acknowledge the vulnerabilities of this age group and the impact a new-born can place on a family and especially where the care-giver

[1] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/
[2] Ofsted 2011. Ages of concern: learning lessons from serious case reviews

is known to have experienced trauma. There is also a need for practitioners to consider the causes of the parental behaviours, the content and context of quality assessments with a coordinated approach to secure a sustained support network.

The reviews have been conducted by independent authors; panels made up of senior representatives from each organisation. Practitioners involved in each case were given the opportunity to take part; being offered to attend the Serious Case Review practitioner events so they can share their views of what it was like to work with the families and the difficulties presented to them. It is also an opportunity for staff to share their experiences of where working practices went well so this can be reflected in the reports. It is important to remember that "abuse and neglect rarely present with a clear, unequivocal picture (Munro 2011[2]) and this kind of work is never simple and straightforward.

All the children's cases were unique; their stories meriting a full review and understanding of what can make good practice more likely. Work over this last year focused on ensuring the actions within the plans are implemented and the dissemination of learning through a variety of means and with the help of our Stockport Family colleagues. We have a duty to the children and families involved to ensure that we learn from their stories.

Safeguarding Children Supervision In Health Visiting and School Nursing

	2017-2018
No of staff requiring supervision (Health visitors & School Nurses)	245
No of staff supervised within timescale	201 (83%)
No of staff supervised from previous month	19
No of staff not supervised within timescale	22

This last year has continued to focus on the revised model of safeguarding supervision, spending longer on those cases that are presenting the most difficulties for practitioners. This enables quality reflection, learning and development which are transferrable skills to other cases within the caseload. The necessity for quality safeguarding supervision was a theme to emerge from local and national SCR's and this year has seen this embedded into practice. The model continues to develop and evolve and will be reviewed by health and children's social care colleagues to review its effectiveness and impact on complex case management.

Safeguarding supervision is offered widely across the Trust; acute and community services. The Trusts Safeguarding Children Supervision Policy is currently under review and will incorporate amended ways of working to meet the needs of the service and demonstrate improvements within outcomes.

[3] Eileen Munro, Effective Child Protection, Second Edition: Sage Publications

Midwifery

Safeguarding Midwifery Supervision

Midwifery Supervision – April 2017 – March 2018	
Midwifery Champions (4 sessions required per year)	57%
Community Midwives (4 sessions required per year)	39%
Acute Midwives (1 session required per year)	85%

Within Stockport NHS Foundation Trust Community Midwives are required to attend safeguarding supervision sessions four times a year and hospital based staff are required to attend one formal session per year. The sessions are either delivered on a one to one basis or using a group format.

This model of midwifery supervision has become embedded within practice over recent years and the uptake of supervision has improved greatly, with an opportunity to continue to improve. This model provides the opportunity for complex safeguarding cases to be discussed by Community Midwives during a one to one supervision with the Named Midwife for safeguarding and vulnerable groups. Acute staff receive the supervision in group format when they attend the public health study day and additional supervision is also provided if required when they are/have been involved in a safeguarding case or caring for vulnerable woman.

Community Midwives with high caseload numbers of vulnerable women/ safeguarding concerns are allocated time every month to have protected time to focus on their complex families and attend safeguarding supervision sessions with the Named Midwife for Safeguarding and Vulnerable Groups.

The Maternity Information System (MIS) helps staff identify safeguarding concerns/ vulnerable families. When a woman contacts the maternity triage department the MIS is checked and if there are safeguarding risks identified this prompts staff to access the woman's central file where the full details are recorded.

Court Reports

	2017 - 2018
No. of Court Reports Produced	85

Court report activity has continued to increase in volume and is comparable with last year's figures (71). Practitioners have been supported to produce high quality, evidence based reports which show the families' strengths and difficulties. These are often produced with very tight timeframes in order to comply with the court order.

The Vulnerable Children's Team have introduced a new court report template to assist practitioners in completing the reports to a very high standard. All reports are quality assured by the team prior to submission. This has shown to be extremely effective and efficient. The team provide an essential quality assurance service for practitioners which has been extremely well received. The use of the new template will be audited and included within the Safeguarding teams audit programme for the future work programme.

Child Protection Case Conferences Activity

Child Protection Conferences	2017-2018
No. of Initial Case Conferences	271
No. of Review Case Conferences	462

Child protection case conference activity has increased immensely within the last report period. This has had a significant direct impact on frontline practitioners to produce a high standard quality report and ensure that there is health representation at Case Conferences; there is a noted 39% increase in Initial Case Conferences and 44% increase in Reviews when compared to last year. This can be reflected within the current figures for children who are subject to child protection in Stockport at 327, compared to 239 children subject to a child protection plan in Q4 2016/17.

MARAC (Multi-Agency Risk Assessment Conference for high risk Domestic Abuse Cases)

MARAC is a multi-agency risk assessment conference where high risk domestic abuse cases are heard. Professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan. They are held twice a month and health is represented at the panel by a member vulnerable children's team and named midwife for safeguarding.

MARAC	2017 - 2018
No. of Cases	439
No. of Children	575

MARAC has discussed more cases and children this year than previous years; there is a significant increase in the cases that have been heard at MARAC at 42% and a total of 27% increase in the number of cases that include children. Over this last year training and supervision has aimed to increase practitioner confidence in the use of the MARAC referral and demonstrate professional curiosity when treating victims of domestic abuse; this work is ongoing and is to be embedded within the acute training offer for frontline practitioners within the training plan for 2018 / 2019. Domestic Violence and Abuse is one of the four thematic priorities identified by Stockport Safeguarding Children and Adult Boards in their shared strategic plan 2017-2020.

Child Sexual Exploitation (CSE)

Stockport: MASE (Multi- agency Sexual Exploitation)

MASE is a multi-agency forum developed to co-ordinate care planning for young people at risk or involved in child sexual exploitation. MASE meetings are planned to take place monthly however there has been a significant reduction in the amount of meetings that have taken place due to a noted reduction in referrals. The meeting is chaired by an Independent Reviewing Officer with specialist responsibility for Child Sexual Exploitation at the Safeguarding Children Unit. Health is represented to inform the risk assessment around these vulnerable children; information is sought from a range of health partners i.e. GP's, school nursing, hospital, Looked after Children team. This process is currently under review and once clarified will be clearly reflected in the Child Sexual Exploitation guidance.

MASE	2017 - 2018
No. of Cases	56

The planning and risk assessment around children at risk of or those who have been sexually exploited is partially co-ordinated through the MASE process. There have been a noted 23 fewer cases referred to MASE this year due to a reduction in Social Worker referrals.

The health practitioner who is allocated to "The Aspire team" has supported staff throughout the organisation with training and raising awareness. One of the key messages is about using the right language to ensure that there is an understanding of our roles and consideration about vulnerable children. Learning from SCR's have highlighted the impact of childhood trauma as a result of experiencing CSE and the mental health impact into adulthood and parenting impacting on adverse childhood experiences.

The organisation has participated in the 'It's not okay' campaign, a week of activity and awareness raising to tackle CSE; agencies collaborate under Project Phoenix (Greater Manchester response to tackling CSE) aims to educate young people and their carers on the warning signs of CSE, how to stay safe and how to get help. The health practitioner from the Aspire team, a school nurse and a safeguarding children's nurse manned a stall within Treehouse to support the CSE week of action and provide information and resources for patients, carers and staff. Additional opportunities to update staff were completed by attending safety huddles, team meetings, and sharing relevant documentation and guidance.

A number of training sessions have been offered throughout the organisation for staff which have included presentations for the midwifery practitioners at public health study days, and bespoke packages for community practitioners.

Safeguarding Children Training

Safeguarding Children's Training	2017-2018
Level 1	90%
Level 2	86%
Level 3	85%

The training compliance figures for Level 1 & 2 training figures have continued to be

maintained across the organisation. Level 3 training is offered to all clinical staff working with children/families who potentially contribute to assessing, planning, intervening and evaluating the needs of a child/young person.

Particular focus has been to ensure level 3 practitioners have access to the required level of high quality training through a blended approach alongside the SSCB multiagency programme. At level 3 practitioners have been trained in classroom sessions and two large conferences with multiagency speakers looking into detail regarding physical abuse. Training of this type is evaluated well; attendees reporting that they felt more confident about their involvement in safeguarding children and the importance of having up to date knowledge around the more recent learning from SCR's. Volunteers are also trained in safeguarding children.

The safeguarding the unborn child course was developed and is now on the training programme at the SSCB which I facilitate with a practitioner from the SSCB, it has received excellent reviews and is multi-agency.

Level 3 compliance reporting is currently under review to ensure that there is a consistent approach throughout the organisation.

Causes For Concern

	2017 - 2018
No. of Cause for Concern forms received	2687

The number of causes for concern generated by acute hospital staff continues to remain high. This year has seen a slight increase in comparable activity from the previous year. Whilst the amount of causes for concern generated around children and their carers (where appropriate) is good evidence that staff are aware of their safeguarding responsibilities it becomes as important to evidence that this is actually making a difference to children's outcomes.

Each of the cases noted above are individually triaged and assessed by the Paediatric liaison nurse and safeguarding specialist nurse team members. The forward plan is to ensure that 16-17yr old emergency department attendances are also reviewed as part of this process and appropriate / relevant action taken to safeguard the patient accordingly.

A previous three phase cause for concern audit was completed, which tracked the journey of the child to identify areas for improvement within working practices and stream line processes. Also aiming to maintain and improve Trust standards for safeguarding children and young people. Each stage of the cause for concern has been audited:

- when a safeguarding concern is identified and form generated
- detailed overview of health visitor/school nurse practice on receipt of the cause for concern
- With the support of Stockport Family colleagues; assessment of the impact the cause for concern has had on children's social care practice and on the child/family.

The outcome of the audit has raised the need for a review of referrals processes into Children's social care and the request for early help interventions. Currently the team are reviewing the processes and developing working streams with the IT department to make this as electronic as possible so the transfer of information is seamless.

Child Protection Medicals

The Local Authority has a duty under section 47 of the Children Act 1989 to investigate if there is reasonable cause to suspect that a child who lives, or is found, in the area is suffering, or is likely to suffer, significant harm. As part of this duty the Local Authority makes enquiries when they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare. In cases of suspected physical abuse the Local Authority request a child protection medical by the Pediatrician which is supported by the Safeguarding Children Team.

	2017-2018
No. of Child Protection Medicals	113

This year there has seen a decrease of 24 Section 47 Child Protection Medicals compared to last year. Over the year it is noted that on average the department receives around 9 requests per month. Further audit reviews around this area will continue into the next financial year focusing upon the appropriateness of referrals, the quality of Child Protection reports and the outcomes for the child / young person. The Named Doctor for Safeguarding children will be able to triangulate the outcomes and formulate developments work streams accordingly. Further work streams are currently underway as a partnership approach to review developments in the non – accidental pathway and incorporate this in multiagency learning which will be reported to the Safeguarding Children's Board.

Midwifery Update

Perinatal Mental Health Provision

For women with current or previous significant mental health conditions, appointments are now offered in the Obstetric led perinatal mental health (PMH) clinic. Our new IAPT Perinatal Nurse and Named Midwife for MH are present at this clinic. Referrals to Wythenshawe's Specialist Perinatal Psychiatry outpatient service and the new GM CMHT are offered which enables multidisciplinary care planning to be provided. This service has been audited within the last 12 months with positive findings.

The service offers a community focused approach, for women with significant mental health issues the Named Midwife for MH is offering midwifery case holding including extended postnatal visiting. This continuity is also facilitated by an Assistant Practitioner who is now allocated 2 days a week to work with families known to the service or who develop new symptoms in the postnatal period.

Access has also improved for those with mild to moderate conditions; a new Amber clinic based within Stockport Family provides direct contact with Named Midwife for MH via a professional or patient directed referral.

Links with the Infant Parent Service have strengthened over the past year; the service lead who is a Clinical Psychologist now provides the named midwife for mental health with supervision on a regular basis. Collaborative working with Health Visitors to promote parent and infant health continues, with recent public health displays rolled out across Stockport.

Community midwifery teams have been trained to use Patient Health Questionnaires – PHQ-9 & GAD-7 to assist in the diagnosis of acute perinatal illness.

Professionals are present within GM strategic clinical networks, CCG Task group meetings, local perinatal pathway and voluntary sector meetings.

Future work will include strengthening the links with the RAID team concerning inpatient review, developing a more robust referral system and further work to promote service uptake to eliminate perceived barriers.

Teenage pregnancy

All teenagers under the age of 17 years old are referred to our Young Parents Midwife (YPM), 17 and 18 years of age are referred if there are additional concerns, if there are no additional needs they are still offered the service. The YPM case holds throughout the antenatal and postnatal period and supports the generic community Midwives with the teenagers which they are case holding. The YPM meets weekly with the Family Nurse Partnership (FNP) and during term time holds antenatal sessions at Moat House School, she also facilitates young parent's antenatal education at the hospital.

There is currently a PGD being devised for a contraceptive to be administered in the immediate postnatal period for women to help prevent recurrent pregnancies within a short period of time.

STATS
Court reports = 19
Case conference reports = 56

Family Nurse Partnership (FNP)

The FNP in Stockport was successfully established and working to full capacity by the end of 2016. It is recognised that it has been well implemented and accepted as part of the integrated Stockport Family Service. The year 2016 -2017 has seen a number of changes within the team after a stable first 18 months.

The new team is now taking shape under the leadership of the new Supervisor with the key focus in recent months to work toward a period of stability following many changes. In particular, working on induction of new team members, team building and prioritising supervision and both team / personal learning. Through this we have been able to focus on quality programme delivery to achieve optimum outcomes for our clients despite being in a period of transition.

Currently we have 61 families enrolled on the programme. We had capacity for 69 due to a nurse vacancy and maternity leave. This has increased to 94 due since our new nurse started in March. The team is therefore still in a period of recruitment as new nurses work towards building a caseload. It is through the dedication and skill of the nurses that we have maintained excellent client engagement during this period of change with no clients disengaging in caseloads that have been transferred from nurses that have left and our overall attrition rate is below the 40% recommendation at 38.4%

Stockport continues to have high levels of complex vulnerable young parents comparative to the programme national data. Although Stockport may be seen as an affluent area, the reality of working with such young, vulnerable families is stark. The Family Nurses report the delivery of the programme to families with high levels of vulnerability to be one of the most challenging aspects of their work and therefore this forms the rationale for the theme of this

annual review. High levels of vulnerability ultimately present many challenges for outcomes and therefore work around breastfeeding rates and subsequent pregnancies will be a key focus in the next 12 months. Despite the complex vulnerabilities of the clients a key highlight are our smoking rates which fall from 42.3% at intake (programme average 30.5%) to 26.9% at 12 months (programme average of 40.8%).

It is through the FNP model of supervision that nurses can receive support for their most complex clients. We continue to prioritise supervision and access support from the Named Nurse safeguarding Children and the Vulnerable Children's Team. We utilise our tripartite and psychology supervision to further support us with this challenging work. We recognise that it is through collaboration with other agencies that we can achieve outcomes for our clients. Moving into the next 12 months we would like to continue our work in building relationships with other agencies and seek out further opportunities for shared learning within Stockport Family.

We also plan to further our work around the use of ASQ (Ages and Stages Questionnaire – an assessment tool) in FNP (Family Nursing Partnership). Work around the Local Impact Study will be a key focus and initial data from this work is encouraging and will generate some interesting discussions around 'School Readiness' moving forward. We are confident that following a period of stability combined with a continued commitment to delivery of the FNP programme and learning our dosage and outcome data will improve.

Service Provision and Developments in 2016 / 2017

- The implementation of Stockport Family (April 2016) where health visitors, school nurses and midwives will continue work within an integrated model to keep children safe from harm is an exciting opportunity to work more collaboratively and proactively. Continued specialist training around restorative practice has been available for staff and very useful to help encourage staff to work with families rather than for or without, crucial with work in safeguarding children and influencing change. There have been noted developments in the working partnerships with partners which have demonstrated effective outcomes for families. Stockport Family is currently collating these experiences from families to support practice developments.
- A number of safeguarding policies are under review to integrate local and national guidance. Policies / pathways will be monitored as a standing agenda item on both the Safeguarding Children operational group as well as the Trust Safeguarding Group.
- The Failure to Present SOP has been developed and embedded within the school nursing service.
- The Child Protection Information Sharing project (CPIS) has been implemented in the Emergency Department, on the Children's Ward and also within maternity on delivery suite. CPIS enables practitioners to review each child's vulnerability status according to whether the child is subject to a child protection plan, is a Looked after child or an unborn child subject to a CP plan). Midwives are also advised to check the CPIS system if a woman presents to the unit and is not booked to have her maternity care at Stockport Foundation Trust. As the year has progressed more areas in the country have now so the information can be accessed immediately.
- Paediatric nursing, medical staff and community staff have been supported to produce high quality chronologies for suspected fabricated illness cases.
- Safeguarding midwifery champions have been reviewed and identified to implement the safeguarding messages and support staff in midwifery. Euroking stats system now available to identify high risk cases.
- There was a week of action around child sexual exploitation; messages were tweeted by the Trust's communication team; school nurses played an active part in the response and worked with GM police and their multiagency colleagues. This also included the acute

hospital, whereby a stall was manned within the children's treehouse by the safeguarding children's team and the health representative form Aspire to provide resources for families and staff.

- A Safeguarding Children level 3 Conference was delivered to cover Physical abuse. This was well received by staff across the organisation and evaluated well.
- Safeguarding supervision is well embedded into the Family Nurse Partnership programme; evidence is available in the case studies presented to the advisory panel that safeguarding always underpins the assessments
- Partnership safeguarding supervision with childrens social care partners has continued to be integrated within practice. The supervision offers an additional supervision function for cases which are complex, to offer safe environment for reflection and enhance understanding of multiagency knowledge, perspective roles and responsibilities.
- A School Nurse continues to be seconded to work in The Aspire Team. Her role within the team is assessing the health needs of those vulnerable children exposed or at risk of child sexual exploitation.
- A health practitioner continues to be seconded to work in the Multi Agency Safeguarding and Support Hub (MASSH).

Safeguarding Children Future Focus

Policies, Procedures and Pathways

Over the coming months the team will be reviewing all of the policies and procedures to ensure they are in line with local and national changes. There will be new developments of ways of working to integrate within the pathways for front line practitioners which will be disseminated throughout the organisation accordingly. Key area documents and legislative changes will be reflected accordingly.

Serious case Reviews

The wider Safeguarding Children's Team to incorporate the named Midwife for safeguarding and vulnerable group and the named nurse for looked after children will continue to contribute and participate within multi-agency serious case reviews and learning reviews. The safeguarding team's key objectives will be to ensure the findings form the reviews and the noted learning points will be embedded in all training packages and disseminated to departments ensuring there is transferable learning for areas and services that were not directly involved in the reviews. This will extend to reviews that have been completed outside of the Local Authority area to share regional and national findings.

Neonatal Unit

One of the key themes in 2 of the current serious case reviews is they were both babies that had identified needs and spent a significant amount of time within the neonatal unit both here at stepping hill hospital but also at a regional centre. Further work is to be completed to develop pathways within the neonatal unit for babies that are transferred into the unit and robust discharge planning procedures which reflect and consider safeguarding. The safeguarding team will continue to support the unit and identify any learning needs and ensure they are addressed accordingly.

Safeguarding 16-17 year olds

From April 2018 the safeguarding children's team has started to review all Emergency department attendances for 16-17yr olds in the context of the definition of a child. This has already demonstrated an increase in demand on the team, however there is a need to review

the process and safeguarding team offer to this cohort of patients. The team plan to develop a pathway for the review of presentations and admissions for the 16-17 year old cohort of patients within the organisation. A further piece of work will be undertaken to scope and identify any key areas of increased activity to develop and deliver bespoke training sessions. A series of audits will be completed to capture this detail.

Safeguarding in a Multiagency Forum

There is a need to develop and review a meeting matrix to plan and map the health representation requirement at an extensive amount of meetings within the organisation and also within Stockport family, the safeguarding children's board and the local council just to note a few. It is essential that we consider how health can be best represented at these safeguarding forums which have now extended to include transitions between children and adult safeguarding children boards and the complexity of safeguarding i.e. trafficking, modern day slavery, female genital mutilation, organised crime, radicalisation and extremism etc.

The safeguarding team will continue to work closely with multi-agency colleagues to contribute to multiagency audit streams to identify learning and embed actions. This will incorporate our contribution to the "Stockport Family Practice Week" which will include completing a number of audits throughout the service and ensure senior service leads gain a clear insight and understanding of working with practitioners on the frontline. This will include the leads attending a number of meetings, completing visits, and engaging with the practitioners. This will in turn inform practice and highlight areas that require development and support but also to showcase the areas that are demonstrating best practice.

The team will also continue to work in partnership with children social care colleagues for any proposed inspections and ensure Trust staff are advised and supported to participate in any inspection requests as required.

Training

The wider safeguarding children's team plan to review and develop a safeguarding children's programme for training delivery. It is essential that the current safeguarding training provision is reviewed to ensure there is a wide range of sessions available for all relevant practice areas with a strong theme and focus upon, "Think Family", impacting parental presentations, domestic violence and abuse, neglect, sexual abuse, 16-17yr olds and Looked After children.

It is however imperative that the noted work streams above are clearly linked with the work which is ongoing at the safeguarding children's Board as well as other directives such as the recommendations form NICE guidance, the areas for learning from serious case reviews and domestic homicide reviews as well as changes in key documentation and legislation such as the newly released Working Together to safeguard Children 2018.

Stockport Safeguarding Children's Board is currently in the process of recruiting a training and development manager which will be essential for the team to maintain links and to develop key working relationships so practice can be shared and to aid with the continuity of the key messages across the Stockport borough through the multiagency training programme.

There is also a need for the team to review the level 3 training programme and data collection system to secure a more efficient and streamlined process is developed to collate and record training compliance across the organisation. This will be reflected accordingly in the Safeguarding Children's Training Strategy and ensure that staff have their relevant

safeguarding training attached to their staff record.

Neglect

The Safeguarding Children's Team will remain as core members within the development of the neglect strategy for the safeguarding children's board. It is essential that health are clearly represented within its development which will ensure that we are fully appraised of the developments to aid in effective dissemination across the organisation. The safeguarding team will ensure that this is fully reflected in training and policy.

Develop IT Systems and Electronic Referral Pathways

The safeguarding children's team plan to develop the functionality of the safeguarding children's microsite. This is to ensure the key documents are easy to locate and access for front line practitioners. It will be essential to review the current design and ensure that all irrelevant documents are archived / removed.

Other developments include the use of electronic communication pathways within health to ensure the children's and young people's emergency department notifications are reviewed and sent out of the organisation to the relevant record case holders in a timely manner. This will also incorporate the development of processes on how to raise a safeguarding concern within the organisation.

It will be essential for the team to engage with the Multi Agency Safeguarding & Support Hub (MASSH) with the integration of a new electronic referral process method within the acute organisation to ensure this is safe and secure but also allows for the safeguarding children's team access to the information for quality assurance and review purposes. Working pathways are currently ongoing to work alongside Stockport council to ensure this functionality can be achieved.

The IT development team plan to assist the safeguarding team in developing our recording systems so figures and data can be retrieved efficiently. This will support the collation of data regarding the team's activity and note the team's activity to monitor demand.

Audit

The safeguarding children's team are in the process of developing a Safeguarding Children's Audit programme that will be monitored via the Safeguarding children operational group. Outcomes will assist the team to form an insight into the needs of the service and how outcomes for children, young people and their families can be improved. Findings will be action planned accordingly.

Safeguarding Children's Supervision Review

The safeguarding children's team within the community have a robust model of safeguarding supervision which is monitored monthly and reported to the safeguarding group as well as platforms within the health component of Stockport family to maintain oversight of KPI's. Further developments are to be considered for the safeguarding supervision offer trust wide so all relevant cohorts are captured and compliance is monitored. This will be reflected accordingly within the Safeguarding Children's Supervision Policy.

Multi Agency Risk Assessment Conference - MARAC

There has been a need to review in detail the current safeguarding children's team contribution to the MARAC function and the current service demand and pressures. As noted within the paper there has been a significant increase in the amount of cases heard at conference at an increase of 42%. This work is currently completed by a clinical member of staff to secure the family detail and assess the risk indicators and also ensure the relevant health partners are abreast of the concerns to ensure they can practice effectively and also safely. The safeguarding children's team will be reviewing the need and submitting a business case to secure the administrative support for this work stream which at this time can equate for approximately 80-90% of a clinical nurses time. It has been noted on initial review that a large amount of the tasks are administrative and at this time the team do not have a admin member of staff to complete this task. The findings from the annual review and the noted increase in demand will be reflected within the report.

In addition there is a need to review the current training provision regarding this topic area. The team plan to review this in detail and place a specific focus on the impact on the child / young person and unborn child.

Healthy Young Minds (HYMS) & The Mental Health Trust

The safeguarding team will aim to continue to work closely with the HYMS service and the Mental Health Trust to maintain working relationships and focus on key areas such as the transition from 16yrs of age, mental health presentations and management pathways, and the developments of communications regarding parental impacting behaviours.

Midwifery Future Focus

FGM

A Scoping exercise is to be undertaken within the Trust of FGM training provided to relevant staff groups relating to the recognition, prevention and management of female genital mutilation in order to ensure that a robust training offer is made to relevant staff groups and compliance is monitored. A training proposal will then be submitted to the Trust Safeguarding Group to address any concerns highlighted.

All FGM cases are currently reported to the national database by the Governance Lead of the Women, Children's and Diagnostic Services Business Group. During 2018/2019 Business Groups will be asked identify a lead reporter for the national database and input cases when required with support from the named Trust Lead if required.

Looked after Children (LAC)

Background

At the time of reporting Stockport have 370 Looked After Children of which 124 are placed outside Stockport. As a service we are responsible for coordinating health assessments for Stockport children placed out of area. In addition, Stockport needs to provide services for Out of area children living in Stockport. As part of the responsible commissioner guidance, the placing authority can be asked to pay; Stockport has introduced this system which provides its own challenges. A GM finance agreement across the CCGs means that the trust cannot directly charge GM areas for the assessments completed; currently Stockport CCG pays for this element of funding.

In addition to Stockport's own LAC, approximately a further 500+ LAC from other local authorities reside here. The estimate of this number is due to the notification process when a child moves. Although there is a statutory requirement for notification this is still not an accurate reflection of numbers placed in Stockport from other local authorities. There is an effective online reporting system in place with the local authority which has resulted in a significant improvement in accuracy.

The availability of placements for children from other areas is mainly due to the 40 plus residential units that have been granted planning permission in Stockport. These homes are operated by a number of independent providers and are regulated by Ofsted. The young people residing in these units are some of the most vulnerable and challenging and often access multiple services across organisations including health. In addition to the regulated homes there is an increasing number of 16+ accommodation which increases the demand on the LAC team and on services at a time of transition.

A comprehensive action plan was put in place following CQC inspection in December 2014; this provided a framework to address service improvement. The 9 recommendations specifically relating to LAC have been addressed and are continuing to be embedded. These actions have been monitored as part of the overall CQC action plan. Working with the Local Authority the team continues to work in partnership, strengthening the good outcome at the OFSTED inspection in 2017.

As part of the safeguarding self-assessment required by the CCG an audit tool has now been completed to measure provider compliance specifically relating to LAC.

Resources

The Foundation Trust is commissioned to provide a dedicated resource for Looked after Children which sits alongside universal services. Together these fulfil the aim of reducing inequalities and ensuring Looked after Children's health needs are met, in accordance with statutory guidance.

The Foundation Trust delivers the service using a combination of skill mix to deliver the service outlined within the service specification and to meet the expectations within statutory guidance. The specialist LAC team meets the requirements when benchmarked against the intercollegiate framework (2015).

The development of skill mix within the team was part funded from the CCG, to support care leavers; with the additional funding being generated from the implementation of PBR.

Equalities

Looked After Children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect.

The vision across Stockport is that Looked after Children will access universal health services in the same way as other children and young people. Additional needs will be met through targeted interventions and specialist services. Furthermore, children and young people who are cared for by any Local Authority, but living in Stockport, will receive the same opportunities to access health services within the borough irrespective of their originating CCG. It should however be acknowledged that this can cause difficulties due to commissioning arrangements for these children within some services.

Assurance

Stockport NHS Foundation Trust

- Provide a dedicated resource for LAC which works alongside universal services.
- There is an on-going quality assurance process in place to ensure all health assessments meet the required standard. Stockport has adopted the GM model which is being used consistently in Payment By Results (PBR).
- The specialist LAC health team have been proactive in managing the KPI requirement alongside difficulties encountered with a maternity leave, redeployment and long term sickness within the service. Although the timeliness was not always achieved, there are detailed exception reports and action plans reflecting the multiple factors influencing the delivery of these KPIs. The action plan can be found in appendix 2.
- These reports are monitored by the C,F &D Quality Governance committee and the Trust Safeguarding group. From a multiagency perspective performance is also visible at ILAC board in the key issues report provided by the multi-agency Health and Wellbeing Steering group.
- Changes in School Nurse and Health Visitor commissioning arrangements means that the Local Authority now have responsibility these elements of the service.

Health Visiting, School Nurses & LAC Team KPI Targets for LAC 1st April 2017 to 31stMarch 2018	**Target**	**Actual**
Percentage of children between the ages of 0-5yrs, for whom you are commissioned to provide a service, who, on becoming looked after have received a minimum of twice a year Review Health Assessments, in line with the requirements in the national statutory guidance on promoting the health and wellbeing of looked after children	92%	68%
Percentage of children over 5 years for whom you are commissioned to provide a service who on becoming looked after have received a minimum of 1 annual review health assessment in line with the requirement in the national statutory guidance on promoting the health and well-being of looked after children.	92%	59%
Percentage of Initial Health Assessments for Looked after Children completed within statutory timeframe of 28 days since coming into care	95%	41%

It is recognised that the KPI performance is less than it should be. To provide better oversight and context to some of the challenges, a new reporting template has been implemented. This year's Q1 in appendix 3 shows an improvement across all areas.

This reporting in conjunction with the action plan aims to provide strengthened assurance to support continued improvement.

Risks

Funding

There continues to be uncertainty around the implementation of the national tariff and how this will impact on future income.

There is no consistent way in which PBR is being implemented with CCG's locally and nationally choosing to implement the tariff arrangements as they see fit. Income from this may be problematic due to a finance agreement across GM to not cross charge. The CCG is currently underwriting this cost. This will be an ongoing problem until the directors of finance review their agreement, at which time the funding arrangements for the commissioned service will need reviewing to take in to account the impact of any decision made. This would need to be considered as part of any service review.

The action plan in Appendix 2 identifies capacity issues in providing adequate numbers of clinics for IHA's. The foundation trust continues to provide extra clinics in response to demand and permanent arrangements will need agreeing as part of any service review.

Service Delivery

- Service development remains a challenge due in part to on-going service redesign and cuts to services across the economy. Improvements to processes are developed through the Multiagency Health and Wellbeing Steering Group which, in turn, reports to the Integrated LAC board.

- There is a planned programme to seek opinions of young people with regard to their experience of health assessments; however this has not yet been achieved due to capacity within the service.

- Implementing the care-leaver resource to extend the provision within the LAC service has proved challenging. This year has seen a reduction in staffing due to a maternity leave, 2 members of admin staff on long term sickness and a redeployment which significantly impacted on the team's ability to implement additional work. The service has now restructured its administration roles and is moving forward in terms of performance and development.

- The LAC team need to use EMIS to capture the increasing demands on service. It needs to evidence both the nature of the work and the requirements from the team. By ensuring the correct templates are developed to support reporting for commissioned services and PBR activity, a true reflection of the work carried out by the team can be captured which in turn can support future service planning.

Number of Health assessments completed

01/04/17-31/03/18	Stockport	OLA	Total
IHA	144	49	193
RHA	162	178	340

- The table illustrates the impact that other local authorities placing children in Stockport has on service provision. It should be noted that the health assessment is only one part of the service provided. With the focus purely being on this statutory element the complexity in working with these young people is often missed. There are large numbers of children and young people for which our services support who never have a health assessment in part due to placement moves and changes in legal status.

Progress and next steps

There is a specialist looked after children health team service specification in place. The team strive to deliver best practice and review this as new guidance is published. There are processes in place to ensure that the Designated Professional's roles and provider services work together to meet the health needs of LAC in accordance with statutory guidelines.

Health profiling data is being collected for all children at the time of their health assessment. This is a collaborative piece of work with public health and initial findings will be reported on this reporting year. A template has been developed to ensure key areas are recorded to enable the needs of LAC living in Stockport to feed into the JSNA, benchmark service provision and inform future commissioning.

There is an ongoing programme of audit which will continue to evidence improvement. With a continuous quality assurance programme using the GM assurance tool there is an annual overview for both RHAs and IHAs to identify themes and focus for improvement.

The Named Nurse LAC has continued to provide a 'Drop in' session for support and advice for young care-leavers at Café Zest. This has enabled the capturing of views and experiences from young people on their access to services across health and listening to what matters to them. The team offer advice and consultation to the Care leavers personal advisors including joint visits as appropriate. The final RHA has been adapted into a care leaver summary; this document is provided at the time of transition and provides information to support the young person through to independence.

Alongside a formal training programme LAC updates are provided as requested. This has been provided at team meetings or on a one to one basis. Messages from research and learning from serious case reviews are integrated into development days and service updates.

There is a need to monitor the financial implications for the trust following non-payment of PBR from GM CCGs in response to the directors of finance agreement. This will be considered further as part of a planned service review.

3. Adult Safeguarding

During 2017–18 there has been increased focus on the function of Adult Safeguarding within Stockport NHS FT. Changes in Trust leadership at a senior level have led to a restructure of the governance processes allied to Adult Safeguarding with greater clarity and a clearly defined structure for reporting to Board via the Trust Safeguarding Group to the Trust Quality Committee.

The Trust Safeguarding Group meets on a bi- monthly basis and is chaired by the Chief Nurse.

There are some aspects of adult safeguarding that remain a challenge and require ongoing work and development – these will be described later in this report.

The Trust has a duty to comply with national and local policy, in particular working with social care in terms of the Care Act and Section 42 enquiries and with our commissioners in order to ensure compliance with contractual standards.

Adult Safeguarding is particularly focussed around “Adults at Risk” - Care Act 2014 - an Adult at Risk is a someone aged 18 or above who :

(a) has needs for care and support
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Stockport Safeguarding Adults Board

It is a statutory requirement of each local authority that a Safeguarding Adult Board is established within the Borough. Although not a statutory partner on the Board the Trust is represented by Deputy Chief Nurse, deputised by the Named Nurse Adult Safeguarding. Attendance is recorded and the Trust was represented at 5 out of the 6 meetings held over the year.

There are 9 sub–groups of the Board and the Board has recognised the pressure that this puts on partner agencies to attend and is undertaking a review of the sub-groups.

Adult Safeguarding Team

The adult safeguarding team comprises of the following staff

1 WTE Named Nurse for Adult Safeguarding

1 WTE Specialist Nurse for Adult Safeguarding

Training Compliance

There are three areas of training that sit under adult safeguarding
Prevent
Adult Safeguarding
Mental Capacity Act and Deprivation of Liberty Safeguards Awareness

The compliance levels for each of these are as shown below

Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness)	84.14%
Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness)* *This is now added to all clinical staff which has lowered compliance level as explained further in the report	18.98%
Safeguarding Adults	87.42%
Mental Capacity Act and DoLS	91.96%

During the summer months of 2017 there was an increased focus on “tool box training “for Deprivation of Liberty Safeguards, whilst a band 5 nurse was seconded into the safeguarding team, this was well received by ward staff and increased staff confidence at that time.

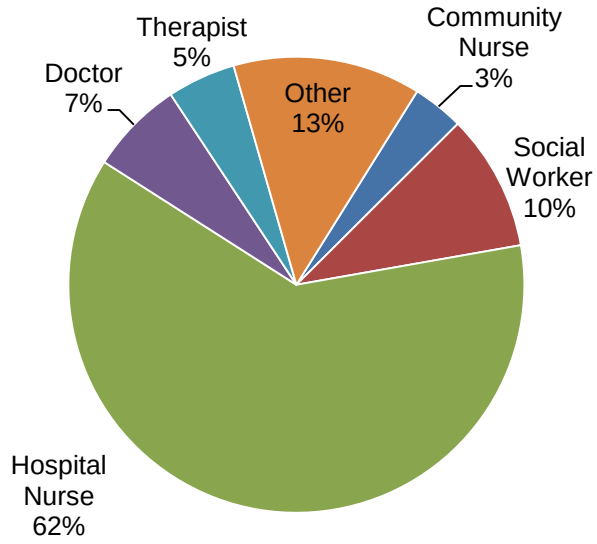
Safeguarding Alerts Raised by Trust Staff to Safeguarding Team

2016/17	Year End
Concerns Raised	356 (last year 464)
Referred to Adult Social Care (ASC)	216 (last year 268)

These are the concerns known to the Adult Safeguarding Team, the numbers may be higher as occasionally alerts are sent directly to ASC and the team are not informed.

All known concerns / alerts are logged onto a database by the team. The highest numbers of alerts are generated, as would be expected, by ED staff however other areas are now showing an increase in reporting concerns which is reflecting increased awareness across all areas. Nursing staff remain the highest reporting group.

Q1 to Q4 Reporter Role



When an alert is raised against the Trust an incident report is completed and the business group is asked to investigate. In reality this number of reports should be higher, however there is has been less compliance in reporting incidences where there have been lapses of care and patients have sustained significant harm e.g. where patients develop category 4 pressure ulcers. With the implementation of regular structured Harm Free Care Panels this number is likely to increase as the panel chairs ask the question “is this a safeguarding issue?”

46 alerts were raised against the Trust, these came from a variety of sources including, Trust staff, care homes, social care and some directly from CQC, 35 of these incidents were reported to Adult Social Care.

Type Of Concern	Number
Discharge Planning	20
General Care	6
Pressure Ulcer Damage	6
Medication related incident	1
Catheter management	1
Staff behaviour / attitude	4
Fall	2
Unexplained bruising	2
Missed fracture	2
Assault by other patient	1
Theft	1
Total	46

Not all of these alerts were managed via formal safeguarding processes but through the Trust incident management process.

The Trust has a good record of reporting and investigating these types of events via the incident reporting system and feedback is given to Adult Social Care of the outcome of these investigations via contact meetings with the team leader in Adult Social Care.

Some of the safeguarding concerns raised with the safeguarding team require the application of statutory safeguarding duties in accordance with legislation (Care Act 2014) and Stockport Multi-

agency Safeguarding Policy and Procedures and these do go through the formal safeguarding procedure, at the present time Adult Social Care hold responsibility for setting up strategy meetings and case conferences. This may change in the future and the responsibility passed over to the safeguarding team.

Other concerns require a different response and preventative interventions such as urgent re-assessment of care needs which can prevent escalation to safeguarding.

HM Coroner has requested that where it is known that a person who has died is the subject of an open safeguarding investigation that the death is reported to the Coroner. The safeguarding team receive a list from the Bereavement Suite to check on a daily basis if we are aware of any open safeguarding in order to ensure Coroner's Office is informed.

Adult Social Care reporting systems in Stockport do not currently give us the reports back that we would like in respect of how many alerts raised by staff go onto investigations and outcomes of these, this has been an ongoing issue with no change in the position.

Although raising concerns demonstrates that staff are aware of their safeguarding duties it should be recognised that the reason for raising a concern is to reach a good outcome for the person involved, or in some cases others who may be affected e.g. in a care home. Making Safeguarding Personal (MSP) is a person-centred and outcomes focussed approach and we are working with the Stockport Safeguarding Adult Board looking at how we can apply the principles of MSP in our practice within the Trust.

MCA/DoLS

The Trust (the Managing Authority) made a total of 374 applications for authorisations of Deprivation of Liberty Safeguards in 2017/8. In 2016/7 we made 213 applications. This represents a 75% in year increase in workload in relation to DoLS.

Due to a backlog in the Local Authorities (the Supervisory Bodies) the majority of DoLS applications are unauthorised, over the year 22 patients received their assessment by the Supervisory Body and the DoLS were authorised – the previous year 39 were authorised.

Where DoLS breach, i.e. the urgent application has been made but the assessments have not been undertaken, staff now report this via the Trust incident reporting system and are advised that they must treat the patient under the principles of the Mental Capacity Act whilst they remain in our care and lack capacity around their care and treatment.

SSAB are aware of this backlog as it is reported via the Board meetings. Stockport is not the only Supervisory Body the Trust makes applications to and the problem is not unique to Stockport.

Prevent

Prevent is one of the 4 key principles of the CONTEST strategy, which aims to stop people becoming terrorists or supporting terrorism by being drawn into radicalisation. The Health Service is a key partner in Prevent and the principles of this national strategy apply to all parts of the NHS including charitable organisations and private sector bodies which deliver health services directly or indirectly to NHS patients. It refers to anyone with whom the Trust has contact - staff, patients or visitors.

There has been one Prevent referral made by the adult safeguarding team in 2017/8. Nationally health services are low referrers with 6% of national referrals coming from a health source.

The Trust is represented on the Stockport Channel Panel, hosted by the Local Authority, by the Named Nurse Adult Safeguarding. This is where people who may be at risk of radicalisation are discussed and plans put in place to support them.

Stockport is not a priority area for Prevent therefore we receive indirect support from the Regional Prevent Coordinator, quarterly forums are held for Prevent leads with a requirement to attend two per year.

We have a quarterly requirement to report into NHS England on our performance related to Prevent, the report includes training figures, attendance at Channel Panel and referral information.

The training requirements for the Trust will change in 2018/19 in line with recommendations from NHS England and CCG to mean that all Trust staff require level 2 basic awareness of Prevent and that **all** clinical staff will require Level 3 training (as opposed to selected groups of staff previously in ED, children's services and community).

Domestic Abuse

When there is a homicide related to domestic violence the Trust is asked to provide any information we may hold on contacts with the victim and perpetrator in order to inform a Domestic Homicide Review – this is a requirement of NHSE.

Since 2011 and the introduction of the statutory requirement to undertake reviews by NHSE in total there have been 9 domestic homicide reviews in Stockport, up until the end of March 2018 . During 2017 /18 the Trust adult safeguarding team had significant input into two of these reviews, one of which became a Safeguarding Adult Review following review by the Crown Prosecution Service and is ongoing.

Domestic Violence and Abuse is one of the four thematic priorities identified by Stockport Safeguarding Children and Adult Boards in their shared strategic plan 2017-2020.It is recognised by the SSAB that there is a need for a multiagency preventative approach to domestic abuse and there is now a multi-agency steering group in Stockport taking the lead on domestic abuse. The Trust is represented on this group by the Named Nurse Adult Safeguarding.

There has been a need to review in detail the current Adult Safeguarding Teams contribution to the MARAC function and the current service demand and pressures. As noted within the children's report there has been a significant increase in the amount of cases heard at conference of 42%. The research required to be undertaken prior to attendance at this meeting is undertaken by a clinical member of staff, as is the "flagging" of victims on the ED systems in order to ensure that staff are aware that this person is at high risk of domestic violence if they present at ED. A large amount of the tasks associated with MARAC could be assigned to an administrative role and at this time the team do not have an administrator that can carry out these tasks.

Self-Neglect

Stockport Safeguarding Adults Board (SSAB) established an Early Help and Prevention sub-group to agree, implement and review an annual work programme to meet the objectives of the SSAB A key area of work of this group will be self-neglect, since the implementation of the Care Act 2014 this has been recognised as a safeguarding concern.

Self-neglect is another of the SSAB's thematic priorities. An all age neglect strategy has now been ratified by both safeguarding boards, the Trust have had input into the development of this document via the safeguarding teams, and this will need review and translating into a practice document for Trust staff.

Safeguarding Adults Reviews (SAR)

SSAB has a duty to commission a Safeguarding Adults Review (SAR) when an adult at risk in Stockport dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The SSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. SSABs are free to arrange for a SAR in other situations where they believe that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

Multi-agency panels are held on a regular basis, chaired by the head of safeguarding in the local authority, to determine if a case meets the criteria for a SAR. The Trust is represented on these panels by the Named Nurse Adult Safeguarding.

Up until March 2018 the Trust has had input into 5 SAR's, 2 of which required a full IMR – one of these was a combined SAR/SCR – an action plan has been developed from this case.

The Trust also had significant input into a single agency health review commissioned by the SSAB where it was recognised that there could have been better partnership working between the Trust, Pennine Care and the patients GP. An action plan has been devised by the author of the review that requires Trust review and implementation.

Learning Disability

There is a KPI in place for completion of Reasonable Adjustment Risk Assessments and Care Plans by clinical staff – 75% of patients admitted should have these in place, compliance with this requirement slipped in the latter quarters of 2017 /18 with compliance dipping to 52% in Q4. This was discussed at the Trust Safeguarding group and measures put in place by the safeguarding team and the business groups to address this.

A Confidential Inquiry into the deaths of People with Learning Disability (CIPOLD) carried out in 2010 – 2012 discovered that the median age of death for people with learning disabilities (65 years for men; 63 years for women) was significantly less than for the UK population of 78 years for men and 83 years for women. Men with learning disabilities died, on average, 13 years sooner than men in the general population, and women with learning disabilities died 20 years sooner than women in the general population. Overall, 22% were under the age of 50 when they died. These findings along, with the Mazars report, mean that all Trusts are expected to participate in the review of the deaths of all patients aged 4 and above who have a learning disability via the LeDeR project.

The Trust has two trained reviewers, the Named Nurse and the previous Specialist Nurse for Adult Safeguarding, who form part of a team of reviewers in Stockport.

In 2017/18 we had 11 deaths of people with Learning Disabilities in the hospital setting – all were reported to LeDeR.

Assurance

There are quarterly assurance meetings held with Stockport CCG, jointly with the leads from Children's safeguarding, where we review our position against contractual standards. From these meetings, and

using the standard framework documentation, we formulate a working action plan against which our progress is reviewed over the year. The Trust now has an internal assurance group set up to meet prior to meeting commissioners to address issues and actions within this framework

Adult Safeguarding Future Focus

Policies, Procedures and Pathways

Over the coming months the team will be reviewing all of the policies and procedures to ensure they are in line with local and national changes. There will be new developments of ways of working to integrate within the pathways for front line practitioners which will be disseminated throughout the organisation accordingly. Key area documents and legislative changes will be reflected accordingly.

NHS England Adult Safeguarding App is in the process of being downloaded onto Trust IT equipment in order to be available to all staff.

Pocket guides for MCA and DoLS are in the process of being delivered to all Trust clinical staff.

Training

There have been significant improvements in training compliance, however staff at operational level are not always clear about their roles and responsibilities related to the Mental Capacity Act (MCA) , including Deprivation of Liberty Safeguards (DoLS) and also a recent clinical services review has indicated that not all staff may be fully aware of their safeguarding responsibilities.

This indicates a need to review the current training provision to ensure that the right training is being delivered to the right groups of staff in a way that will enable them to implement this in their practice. For some time now we have been awaiting the publication of an Intercollegiate Document that outlines the training requirements for different staff groups. We cannot wait for this any longer, as we need to progress this work, therefore following discussion with the Designated Nurse in the CCG who has had sight of the draft document, training will be reviewed in line with the Bournemouth National Competence Framework for Safeguarding Adults that this document is aligned to.

The Trust needs to review the provision of restraint training to staff and undertake a training needs analysis to ensure that all staff are trained at the level required for their role and are confident and competent in this area.

Prevent Level 3 training figures are showing as significantly below target as we have added this competency to all patient facing clinical staff's roles. The target is to achieve a level of 85% compliance by end of March 2019. This currently stands at 38% since the addition of this to role profiles, although this training is available as e-learning we will look at providing face to face sessions for those staff who find it difficult to undertake e-learning.

Microsite

The Safeguarding Adult's Microsite is under review and is being updated to ensure that the most up to date documents and resources for practitioners throughout the organisation are available and readily to hand. This is a challenge as at present it is dependent of the named Nurse and Specialist to undertake this task rather than it being an administrative function.

Mental Health

The safeguarding team have now taken on responsibility, with support from Chief / Deputy Chief Nurse, for ensuring that the Trust is compliant with requirements of the Mental Health Act in terms of policies, procedures and staff awareness of application of the Act therefore a training programme will need to be developed to meet this need. Development of SLA with Pennine Care FT in relation to MHA is in progress.

Learning Disabilities and Autism

A regular programme of training needs to made available to staff. There are also a number of key reports that require review and analysis to determine what the Trust needs to do to in order meet recommendations described within these reports.

Safeguarding Supervision

A plan to develop a model of adult safeguarding supervision requires development, at present this is not a statutory requirement as in children's safeguarding but is good practice.

Domestic Abuse

MARAC – the Emergency Department (ED) has taken the responsibility for attendance at MARAC meetings, however attendance has been inconsistent due to pressures in the department. As described above we need to review the Trust contribution to the MARAC process.

The current provision for domestic abuse training is incorporated into adults and children's safeguarding; this needs further development and joint working with the adults and children's teams. Workforce development is part of the multi-agency Domestic Abuse Steering Group agenda, however we may need to review the training provision for our own staff particularly those in ED and community.

Self-Neglect

The adult safeguarding team will remain as core members within the development of the all-age multi-agency neglect strategy. It is essential that we maintain this engagement in order to ensure that we are fully appraised of the developments to aid in effective dissemination across the organisation and translation of the strategy into a working document for our staff, particularly those based in ED.

Prevent

With the addition of the level 3 competency to all clinical staff profiles our compliance is now low and work will be required by each business group to develop a trajectory to meet the year-end target of 85% compliance. This will be monitored at the Trust safeguarding group.

SSAB

The team continues to support the work of the SSAB .There are a number of Safeguarding Adult Board Subgroups requiring Trust representation and input, attendance at these is to be determined

Assurance

The CCG GM assurance document is a work in progress, the Trust has now established an internal assurance group to monitor our actions and progress these.

Appendix 1

Definitions:

Serious Case Reviews / Multi agency learning

There are various ways in which we review cases where there have been incidents relating to the safeguarding of a child; the table below highlights the current cases.

- A multiagency learning review is commissioned by the Safeguarding Children Board's Learning and Improvement Panel. The learning could be to share good practice or to consider where actions and multiagency responses could have been done differently in order to protect the child. Practitioners are invited to the review so that learning is more likely to be embedded in future practice

- A Domestic Violence Homicide Review is commissioned where there has been a homicide within a relationship

- A Serious Case Review is commissioned where a child has died or been injured as a result of abuse/neglect or where there are concerns that agencies have not worked together to safeguard the child

Safeguarding Children supervision

Supervision within safeguarding relates to the requirement for all practitioners who are responsible for managing a caseload where vulnerable families/children have been identified. Supervision will consider any risks and strengths within the family and help practitioners to formulate an action plan to increase resilience and reduce risk thereby improving outcomes for children. Health Visitors in Stockport are supervised on their most vulnerable families every 12 weeks and school nurses every term (see Appendix 2).

Court reports

Court reports are produced at the request of a judge at a legal hearing where legal procedures have been initiated to protect the child

MARAC (Multi-Agency Risk Assessment Conference for high risk Domestic Abuse Cases)

MARAC is a multiagency risk assessment process which in Stockport and in Tameside and Glossop is chaired by the Police; health representatives attend and contribute the relevant health information known about each case; taking actions away where appropriate.

Causes for concern

Causes of concern can be generated by any hospital practitioner who has identified a concern about a child; whether that is relating to the adult caring for the child or about the child. The largest proportion of causes for concern are generated by staff in the Emergency Department and sent through to social care directly if an immediate response is required. They are copied to the paediatric liaison service (part of the safeguarding children team) which ensures the relevant community worker get the information in a timely manner.

Child protection medicals

Child protection medicals are undertaken as part of a joint social care/police and health investigation (Section 47 of The Children Act 1989) where a child presents with a suspected non-accidental injury. The medical examination is always undertaken by a paediatrician.

Looked after children

'Looked after children' refers to those children who are given accommodation away from their families at the request of their parent and those in care as a result of a legal care order. Children more rarely can be made subject to an order but remain at home. Their health needs are significantly higher than a child who is not looked after.

MAPPA (Multiagency Public Protection Arrangements) a panel that meets to manage violent and sexual offenders

Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism.

Version	Date
1	
2	03/07/2018
3	

Appendix 2

Action Plan – IHA/RHA

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Jane Hancock
Position:	Named Nurse Looked after children
Tel:	0161-217-6964
Email:	janehancock@nhs.net

Status Key	
1	Not complete / no progress reported / timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
IHA					
For IHA to be completed within 28 days of a child coming into care as per statutory guidance. Needs of the child are prioritised.	For appointments to be allocated on receipt of new into care notification. Letter to go to SW with date emphasising importance of keeping the apt. LAC team to send letter to SW, team manager and team admin. JH to monitor DNAs and report Via health steering group and ILAC board. Appointments are allocated as the best fit for the child's requirements. To monitor impact and provide narrative for all children seen outside of timescale. For LAC team to prioritise the coordination of IHA's.	Jane Hancock		Key actions complete. Need to continue to monitor Nurse/admin time required alongside the impact of last minute changes (movements and availability) June 2018. This action is now ongoing Data provided via quarterly exception reports. June 2018. Monthly analysis now provided alongside the quarterly reporting. New April 18 KPI.docx New May 18 KPI.docx	

	To provide time and costings for clinics to contribute towards service review and additional clinic costings. March 2018				
The CCG will continue to monitor demand and on-going requirements for additional clinics. Designated LAC Dr to review requirements and feed into service requirements.	Stockport FT will continue to provide additional clinics as required CCG will look at ongoing funding for this via quality board. OOA requests have a significant impact on the ability to plan	.Jane Hancock/ Kelly Curtis/ CCG	July 2018	Clinic data provided to CCG via KPI quarterly reporting. Analysis of cost of additional clinics and funding request has now gone to the CCG. This will be considered as part of the service review. June 2018 Formal service review will now take place at a later date. KPI monitoring is now recording numbers of Stockport and Out of area children separately to help monitor impact of demand.	
To monitor performance for children placed out of area escalating concerns where appropriate via the CCG.	CCG monitoring the quality of IHA in conjunction with the Designated Doctor.	Erika Houston /Liz Newby/ Sue Gaskell		Designated Drs have devised a letter to send with those not meeting the required standard. Process need confirming for returns/re requesting additions for those not meeting quality standard June 2018	
To provide a quality IHA which meets the quality standard, regardless of who is completing the assessment.	Review use of IHA For Designated Drs to provide training and oversight of IHAs completed by less experienced members of the team. Obtain feedback from Social care and other areas requesting the assessments.		July 2018	In response to providing a quality assessment alongside minimising duplication, a new IHA template has been devised. This has been adapted from other areas and the changes they have made, alongside the requirements from the quality assurance template. It provides prompts and information to standardise the information recorded. Audit the new paperwork is planned October 2018	

RHA					
School Nursing will improve the timeliness of completion of Review Health Assessments to meet the KPI requirements.	<u>School Nursing</u> Lists of RHA's due will be sent monthly to generic inbox, team leaders and managers for oversight. A pathway is in place to monitor the use of a seconded post. This impact will be reviewed on a monthly basis. LAC caseload oversight will feature as part of 1:1 supervision with managers. Reasons for breeches will be established and any themes addressed. Group supervision has been set up for School Nurses. Themes and issues identified in these sessions will be used to inform and improve practice.	Jane Hancock/ Team Leaders Jane Hancock/Lynsey Beacon/ Maura Appleby Team Leaders Jane Hancock/ Team Leaders Jane Hancock/ Team Leaders / School Nurses	Commenced April 2018 Pathway in place. Monthly monitoring in operation. July 2018 July 2018 Dates set June 18th/ 8th October/ 15th January/ 23rd April		
Health Visiting will improve the timeliness of	<u>Health Visitors</u> Lists of RHA's due will be sent monthly to generic	Jane	Commenc		

completion of Review Health Assessments to meet the KPI requirements.	inbox, team leaders and managers for oversight. LAC caseload oversight will feature as part of 1:1 supervision with managers. Reasons for breeches will be established and any themes addressed.	Hancock/ Team Leaders Team Leaders Jane Hancock/ Team Leaders	ed May 2018 July 2018 July 2018		

Appendix 3

	Health Visiting, School Nurses and LAC team KPI Targets for LAC 1st April 1st 2018 to 31st June 2018		**Q1 2018**
HV	Percentage of Stockport children under the age of 5yrs, for whom you are commissioned to provide a service, who receive Review Health Assessments every 6 months in line with statutory guidance. 11 out of 16 completed within timescales.	Target Actual	92% 69%
	Percentage of children under 5yrs placed by other local authorities, for whom you are commissioned to provide a service, who receive Review Health Assessments every 6 months in line with statutory guidance. 7 out of 10 completed within timescales.	Target Actual	92% 87%
	Total number completed within timescales 18 out of 26	Target Actual	92% 69%
SN	Percentage of Stockport children over the age of 5yrs, for whom you are commissioned to provide a service, who receive Review Health Assessments every 12 months in line with statutory guidance. 31 out of 33 completed within timescales.	Target Actual	92% 94%
	Percentage of children over 5yrs placed by other local authorities, for whom you are commissioned to provide a service, who receive Review Health Assessments every 12 months. 14 out of 18 completed within timescales.	Target Actual	92% 78%
	Total number completed within timescales 45 out of 51	Target Actual	92% 88%
LAC Team	Percentage of Stockport children over the age of 5yrs, for whom you are commissioned to provide a service, who receive Review Health Assessments every 12 months. 4 out of 8 completed within timescale	Target Actual	92% 50%
	Percentage of children over 5yrs placed by other local authorities, for whom you are commissioned to provide a service, who receive Review Health Assessments every 12 months. 7 out of 7 completed with time scale. Total completed within timescales 11 out of 15.	Target Actual	92% 100%
	Total of over 5's completed within timescales 56 out of 66.	Target Actual	92% 73% 92% 87%
LAC Team IHA clinics	Percentage of Initial Health Assessments for Stockport Looked after Children which are completed within statutory timeframe of 28 days 22 out of 35 completed within timescales.	Target Actual	95% 63%
	Percentage of Initial Health Assessments for other local authorities Looked after Children placed in Stockport which are completed within statutory timeframe of 28 days. 11 out of 19 completed.	Target Actual	95% 58%
	Total number completed within timescales 33 out of 54%.	Target Actual	95% 61%

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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	The Trust Strategy		
Report of:	Director of Support Services	**Prepared by:**	Hugh Mullen

REPORT FOR APPROVAL

Corporate objective ref: Strategic Objective Number 1	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to seek approval of The Trust's Strategy. The Consultation with our staff and external stakeholders will be launched on the 1st of October for a period of 3 months.
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:

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

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NHS
Stockport
NHS Foundation Trust

Refreshed Trust Strategy:
A New Strategic View

2018-2022

Consultation Document

This version includes comments from Colin Wasson, Alison Lynch, Paddy Fox and Helen Bennett

1. EXECUTIVE SUMMARY

This is the strategy for the future of Stockport NHS Foundation Trust. It describes the intended place and role of the Trust in the local and regional health and social care system as well as the Trust's updated vision, mission, priorities, aims and objectives in place to achieve.

The purpose of this document is to self-determine for Stockport FT the strongest possible strategy for the local population and the Trust. There are significant services that we are incredibly proud of that we will continue to develop. Where there are further developments required we will work with our community and our partners to support better patient care.

The Trust provides the full range of district general hospital services for children and adults across Stockport and the High Peak, as well as community health services for Stockport. As an associate teaching hospital, we are also proud to provide excellent facilities to support doctors in training, student nurses, trainee nurse associates and allied to health professionals for the future. We aim to be an employer of choice that provides great training and is a fun place to work.

The Trust's vision, mission, priorities, aims and objectives will guide the organisation over the medium term and help its decision making. The successful delivery of these priorities, and the strategic objectives which support them will be a guide for the success of the organisation. The Trust's strategy is:

- The Trust will continue to meet the needs of the local population while maintaining high quality clinical services and financial sustainability.
- In practice this means we remain committed to delivering all clinical services expected from a DGH, either directly or through collaboration with our partners.
- We will drive Stepping Hill Hospital as a specialist Healthier Together site providing elective and non-elective inpatient surgery & actively support clinical service provision links.
- We are ready and equipped to take a strong role in the South East sector of GM and with East Cheshire
- We are committed to the integrated agenda of Stockport Neighbourhood Care to deliver seamless care services, between primary, secondary, mental health and social care to the population of Stockport.

To deliver this strategy the trust has refreshed our enabling strategies, not least provided greater clarity on how we will deliver clinical services in the future. Our clinical leaders advocate seamless care, alongside partner organisations in our community that wraps around the needs of our patients, to enhance the quality of life for individuals.

The Trust recognise that the delivery of the strategy is both critical and challenging. As we aspire to excellence throughout the organisation we will support colleagues to make the changes that are required. We believe that we can deliver the strategy and implement the transformation programme.

Working together we will provide safe, high quality, integrated care to people through a range of excellent, accessible health and social care services.

2. INTRODUCTION AND PURPOSE OF THIS DOCUMENT

The aim of this document is to ensure clarity of purpose and outline the direction of travel of the Trust for the organisation's workforce, our partners and the Board of Directors.

The strategy provides the vision for the future of Stockport FT. It describes the intended place and role of the Trust in the local and regional health and social care system as well as the Trust's updated vision, mission, priorities, aims and objectives in place to achieve.

The purpose of this document is to self-determine for Stockport FT the strongest possible strategy for the local population and the Trust. There are significant services that we are incredibly proud of that we will continue to develop. Where there are further developments required we will work with our community and our partners to support better patient care.

It has patients at the core of everything that we do; this has not changed. Our dedicated workforce is crucial to delivery of the strategic and operational work programmes; this has not changed.

For the Trust to succeed it is crucial, both within the Trust, and through established partnership relationships, that our collective purpose is aligned. We must work together with external health and social care organisations in ways which:

- contribute to the improved health and wellbeing of the population;
- reduce avoidable admissions to hospital; and
- secure further efficiencies and increases in productivity.

The new strategic approach for the Trust is one of cohesion and cooperation.

3. THE TRUST WITHIN OUR COMMUNITY

3.1. THE TRUST

The Trust provides the full range of district general hospital services for children and adults across Stockport and the High Peak, as well as community health services for Stockport. As an associate teaching hospital, we are also proud to provide excellent facilities to support doctors in training, student nurses, trainee nurse associates and allied to health professionals for the future. We aim to be an employer of choice that provides great training and is a fun place to work.

Our main hospital is Stepping Hill which receives around 500,000 patients every year, with in addition community services delivered through 24 health centres and people's homes.

We also run specialist units including the Devonshire Centre for neuro-rehabilitation, the Bluebell palliative care ward at The Meadows and Swanbourne Gardens respite facility for children and young people with severe disabilities.

We are the second largest employer in Stockport, with approximately 5000 highly-skilled, committed and award-winning employees. Our annual budget is circa £300 million.

As a Foundation Trust we have a Board of Governors who are the voice of the local community, the majority of whom are elected from our public membership.

We are now one of four specialist centres, as part of the Healthier Together decision, for emergency and high risk general surgery in Greater Manchester.

3.2. OUR POPULATION

Health and Wellbeing in and around the Stockport and High Peak areas

Health inequalities - Stockport
Overall, Stockport is similar to the national average for deprivation (access to resources and opportunities), although it includes some of the most affluent areas and least deprived in the country. It also has some of the most deprived areas. While the length of time people can expect to live (life expectancy) has improved in all areas of Stockport over the past 20 years; marked inequalities (differences) still remain. We are the 5th most polarised local authority in England.

The main causes of death are heart disease, cancer and respiratory (lung) disease, which together make up three out of every four (75%) deaths. These diseases link strongly with poor lifestyle choices, such as smoking, excess alcohol, poor diet and not living an active life. There are also inequalities that are linked with mental wellbeing in Stockport. Reducing inequalities in health is a key priority for Stockport.

Health inequalities – High Peak
The health of the people of High Peak is generally better than the England average. Deprivation levels are low and life expectancy for men is higher than the average for England. However rural deprivation is often hidden by traditional indicators, so there may be more deprivation that people are able to measure.

Health inequalities – Tameside and Glossop

The life expectancy for men and women in Tameside and Glossop remains below the average for England. As with Stockport, some of the lowest rates of life expectancy are found in the most deprived wards (areas) in the borough.

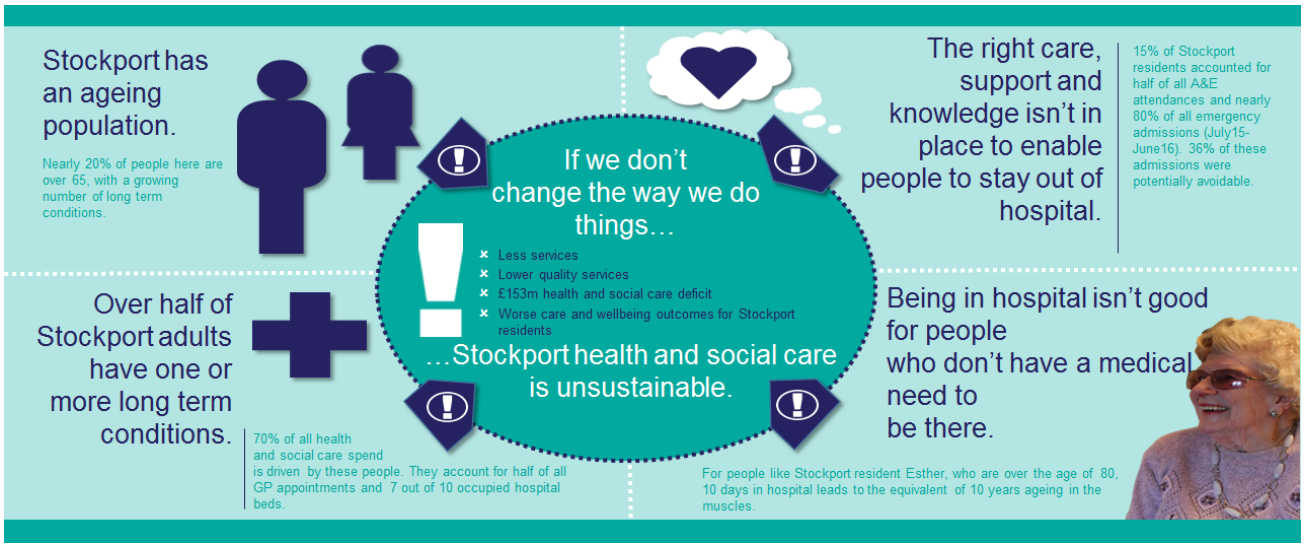
An ageing population, and increasing levels of long-term health conditions
People's health is generally improving, but the demand for NHS services continues to rise. Many people are now living with one or more long-term conditions (e.g. asthma, diabetes, dementia), and so they need more NHS care. All of the boroughs (areas) served by the Trust are experiencing a population that is ageing, and this group of people is expected to become increasingly older. Often older people need more health care than younger people.

This increased need for NHS care is happening at a time when the range and type of medical care is developing very fast. This means that we are able to treat people who in previous generations would have died or been handicapped. But often these new treatments are costly.

3.3. OUR COMMUNITY

As part of the Stockport Together partnership, we are at one of the most exciting and transformative points in our history. The partnership brings Stockport's providers of primary and secondary health and social care services together, as part of a formal alliance, to deliver integrated services closer to people's homes.

This graphic gives an overview of our population and some of the key population needs.



The Trust also sits within the sustainability and transformation plan footprint of Greater Manchester and will be part of future development towards an Integrated Care System; a devolved health and care system.

4. YOUR HEALTH. OUR PRIORITY.

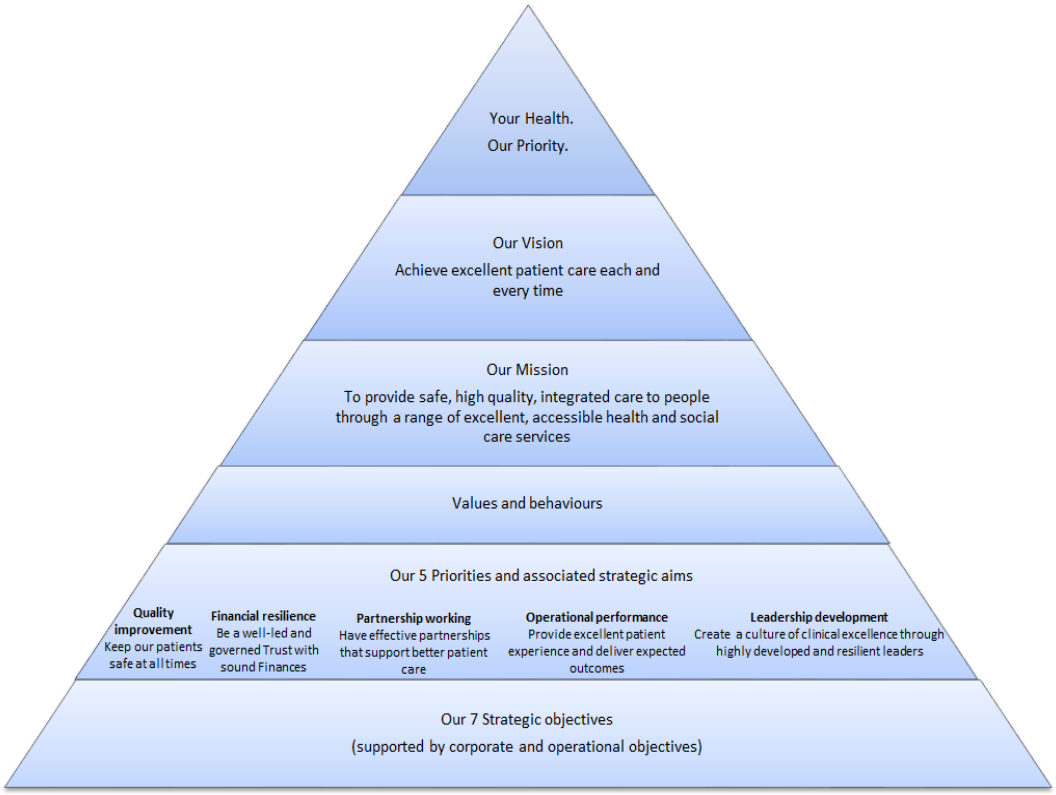
As part of reviewing the Trust's strategic position, an exercise was undertaken to review and update some of the Trust's corporate information. Refer to Figure 1 also. The updates carried out were as follows:

- **Brand statement:** An overall succinct message used on materials that remains unchanged
    - Your Health. Our Priority.
- **Vision:** The ambition for our organisation
    - Achieve excellent patient care each and every time.
- **Mission:** The purpose of the Trust
    - To provide safe, high quality, integrated care to people through a range of excellent, accessible health and social care services.
- **Strategic priorities and associated aims:** The main priorities of the Trust
    1. Quality improvement: Keep our patients safe at all times;
    2. Financial resilience: Be a well-led and governed Trust with sound finances;
    3. Partnership working: Have effective partnerships that support better patient care;
    4. Operational performance: Provide excellent patient experience and deliver expected outcomes; and
    5. Leadership development: Create a culture of clinical excellence through highly developed and resilient leaders.
- **Strategic objectives:** A small set of longer term objectives based on the aims
    - Refer to Appendix 11.1 for a list of the recently approved 7 strategic objectives.
- **Corporate objectives:** these sit under the strategic objectives for the 12 months ahead
    - Refer to Appendix 11.1 for a list of the recently approved objectives for 2018/19.
- **Values and behaviours:** These were identified as still relevant and therefore were not identified for review. These values and behaviours remain as; Quality and Safety; Communication; and Service. Please refer to the Appendix 11.2 for further information.

It is important to underline that staff are encouraged to live and breathe the values through demonstrable safe, high quality, compassionate care and support an environment that is fit for purpose and offers a positive experience. We pride ourselves on excellent service that is effective, efficient and encourages innovation.

As part of the consultation exercise on this document the Board of Directors are keen to receive feedback on the updated areas in Figure 1 in order that staff have an opportunity to influence the final version.

Figure 1: Our Vision, Mission and Statements

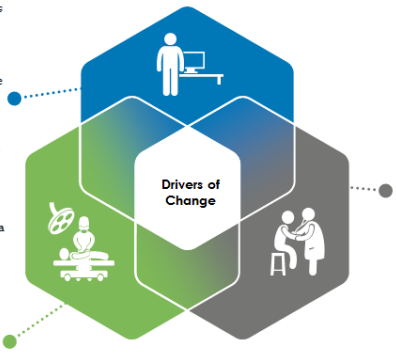


5. WHY WE ARE REFRESHING OUR STRATEGY: DRIVERS OF CHANGE

In 2017/18 the Board of Directors requested a review of the Trust's Strategy which was approved in 2015. This was to take into account a number of significant changes that it was believed would undoubtedly impact the Trust. These changes were; internal changes; local and regional changes; and national policy changes.

Internal Position

- **Quality Agenda:** The Trust recognises that following our CQC review in 2016 and report in 2017 improvements were required.
- **Operational Performance:** Not hitting targets for A&E, Cancer, 18 weeks etc
- **Financial Recovery**: The financial challenge for the Trust remains and has worsened since the 2014/15 position.
- **Leadership Changes:** The retirement of the Chief Executive, Chief Nurse and Chair, as well as HR Director leaving in 2017.
- **Collaboration:** In 2016 as the GM STP developed, it became clear that as part of the STP our ability to make large scale service change which effected services outside our direct footprint needed to be undertaken in a far more collaborative way.
- **Integrated care:** In 2017 Stockport Together was accelerated via a formal agreement with partners of Stockport Metropolitan Borough Council (SMBC), Stockport CCG, Viaduct/GP federation and Pennine Care to become Stockport Neighbourhood Care. This required the Trust to take a much more integrated view of our community service provision.



Local and Regional

- The Healthier Together (HT) decision in 2016;
- East Cheshire talks which began in 2017: East Cheshire are being formally reviewed by Cheshire and Merseyside STP. The outcome of this is unknown however it is likely to have a significant impact on the Trust in relation to services currently provided on the Macclesfield site;
- Greater Manchester Combined Authority Theme 3 work streams gathered pace in 2017: Standardising acute hospital care across majority of services, especially surgical but also paediatrics, obstetrics, respiratory and cardiology. To note that the Orthopaedics, Paediatric and Benign Urology transformational management leads are from the Trust. In addition, Pathology (clinical element) and Radiology (clinical element) are underway;
- Greater Manchester Combined Authority Theme 4 work streams progressed in 2017: These are corporate functions creating an NHS-led multi-agency solution in areas such as finance, HR, procurement and IM&T in the first phase and
- Shared services: in addition to the GM work across back office functions the Trust has undertaken an options appraisal with SMBC under the Stockport Together plans. The Trust will then assess working with the council and areas of the GM work streams.

National Policy Changes

- Primary Care Five Year Forward View 2016;
- Encouraging Trusts to work together (not in competition) to reduce costs, resolve issues of sustainability of some services;
- Development of new models of services/care, for example Multi-specialty Community Providers (MCPs), Primary and Acute Care Services (PACS) or Accountable Care Organisations (ACOs);
- An extremely challenging financial settlement for both the NHS and local authorities;
- Development of Sustainability and Transformation Plans (STPs);
- Emergence of formal devolved Integrated Care Systems and Integrated System working;
- NHS Five Year Forward View Delivery Plan 2017;
- Refreshing NHS plans for 2018/19; and
- The principles of the One Public Estate Initiative.

The new strategic view has been developed to meet the opportunities provided by these factors.

6. HOW WE HAVE DEVELOPED A NEW STRATEGIC VIEW

Taking into consideration the factors described above, the Board of Directors have developed a new strategic view via Board meetings, reviewing the significant changes that have occurred since 2014/15 and updating the Trust's vision, mission, priorities and objectives. The information received from the staff consultation exercise in 2017 has also been taken into account.

This strategy provides the vision for the future of Stockport FT. The purpose of this document is to develop the strongest possible strategy for the local population and the Trust.

There are significant services that we are incredibly proud of that we will continue to develop. Where there are further developments required we will work with our community and our partners to support better patient care.

The intention is that this consultation document will be shared with internal and external stakeholders to obtain their input. This will include clinical and non-clinical colleagues. Once feedback is received from our stakeholders the Board of Directors will formally reconsider the document and its content.

All detailed service changes and the impact of all strategic development programmes will be explored in a supporting clinical services plan, which will underpin this strategy.

In addition, in order to ensure that all corporate developments align, the Board of Directors have requested that the following enabling and supporting strategies (in no particular order) are reviewed by the responsible Executive Director to ensure planning congruence;

- Quality governance framework;
- Risk management strategy and associated framework;
- Patient experience strategy;
- Quality Improvement Plan;
- Nursing, midwifery and allied health professionals strategy;
- Dementia strategy;
- We are developing a Patient Experience Strategy
- Digital strategy;
- Estates strategy;
- Financial strategy;
- Organisational Development strategy
- People strategy; and
- Communications strategy.

7. THE TRUST STRATEGY

As described, the Board of Directors have developed the following new strategic view in terms of the internal and external environment and our role in that changing environment.

The Trust's new strategic view has patients at the core of everything that we do; this has not changed. Our dedicated workforce is crucial to delivery of the strategic and operational work programmes; this has not changed.

The Trust's strategic priorities will guide the organisation over the medium term and help its decision making. The successful delivery of these priorities, and the strategic objectives which support them will be a guide for the success of the organisation. The Trust's strategy is:

- The Trust will meet the needs of the local population while maintaining high quality clinical services and financial sustainability.
- In practice this means we remain committed to delivering all clinical services expected from a DGH, either directly or through collaboration with our partners.
- We will drive Stepping Hill Hospital as a specialist Healthier Together site providing elective and non-elective inpatient surgery & actively support clinical service provision links.
- We are ready and equipped to take a strong role in the South East sector of GM and with East Cheshire
- We are committed to the integrated agenda of Stockport Neighbourhood Care to deliver seamless care services, between primary, secondary, mental health and social care to the population of Stockport.

7.1. THE TRUST STRATEGIC PRIORITIES

The Trust has agreed five strategic priorities. These represent the strategic aims of the organisation over the medium to long term and will be used to guide the Trusts decision making. These objectives are:

- **Quality Improvement:** Keep our patients safe at all time
- **Finance Reliance:** Be a well led and governed Trust with sounds finances
- **Partnership Working:** Have effective partnerships that support better patient care
- **Operational performance:** Provide excellent patient experience and delivery expected outcomes
- **Leadership Development:** Create a culture of clinical excellence though highly developed and resilient leaders

Given these strategic priorities, the Trust has taken the strategic view that the following areas are critical to focus on and vital to continue to develop detailed plans:

- Reliance and Improvement (getting the basics right)
- Delivering clinical services that service the needs of our local population
- Stockport Neighbourhood Care
- Healthier Together implementation
- Trust's role in the GM STP and emerging Integrated Care System

7.2. RESILIENCE AND IMPROVEMENT (GETTING THE BASICS RIGHT)

The Board of Directors have underlined the need for the organisation to focus on getting the basics right by building on the fundamentals across the organisation.

Getting the core elements of our clinical and non-clinical activities right is essential in order for us to realise our vision of: achieving excellent care each and every time. We continually drive towards a culture of articulating expectations and ensuring accountability and compliance.

The Trusts ability to 'get the basics' right is a key determinant of our ability to drive a longer term strategic vision for the Trust. We have made good progress on this aspect, which we consider critical.

There are significant services that we are incredibly proud of that we will continue to develop. Where there are further developments required we will work with our community and our partners to support better patient care.

7.3. CLINICAL SERVICES THAT SERVE THE NEEDS OF OUR POPULATION

The Trust will continue to meet the needs of its local population by delivering high quality, high performing and sustainable clinical services. This will require both clinical and non-clinical services

within the Trust to continue to transform to know and unknown opportunities and threats. Continued active engagement with our partners in the local and regional care community will help to mitigate potential future threats.

As stated earlier the Trust is committed to:

- The Trust will meet the needs of the local population while maintaining high quality clinical services and financial sustainability.
- In practice this means we remain committed to delivering all clinical services expected from a DGH, either directly or through collaboration with our partners.
- We will drive Stepping Hill Hospital as a specialist Healthier Together site providing elective and non-elective inpatient surgery & actively support clinical service provision links.
- We are ready and equipped to take a strong role in the South East sector of GM and with East Cheshire
- We are committed to the integrated agenda of Stockport Neighbourhood Care to deliver seamless care services, between primary, secondary, mental health and social care to the population of Stockport.

There are a number of improvements anticipated to our clinical services moving forward which the Trust will need to respond to internally. These include:

- **Urology:** The confirmed transfer of specialist Urology Cancer to the Wythenshawe and Christie sites.

- **Neuro-rehab:** There is consensus to move to a single provider model. Our service provided at the Devonshire is therefore anticipated to transfer to another provider however this is subject to approval and confirmation through formal GMCA governance processes;

- **Breast surgery:** The clinical model is not yet developed but we will need to continue to align to a screening site (currently East Cheshire) and there is potential that surgical services could move to a larger hub; and

- **MSK & Orthopaedics:** The likely direction of travel is to consolidate high volume arthroplasty work on a number of hub sites with highly specialist work such as reconstruction, in designated centres. Given our current service we would aspire to be one of the hub sites.

- **Pathology:** The Pathology programme has identified the need for greater consolidation within GM. The Trust have expressed a desire to be an early adopter of any consolidation to mitigate risks

- **Radiology:** The procurement of a new GM wide PACs system is the primary focus for the radiology programme. This is a seen as a key enabler to further transformation.

Other significant programmes in earlier stages of development are: Paediatrics; Obstetrics; Cardiology; Respiratory; and Critical Care & Anaesthetics.

Additionally, a number of internal programmes are already underway which include:

- The use of national tools such as GIRFT and the Model Hospital to undertake detailed service reviews to understand actions taken to ensure future sustainability

- Bed Reconfigurations: A key opportunity for the Trust to reconfigure and reduce in bed stock by c.74 beds outside of any service reconfiguration / changes.

- Continued progress towards delivery of 7 day working which is expected to be in place by 2020

7.4. STOCKPORT NEIGHBOURHOOD CARE

The Board of Directors are committed to working with our local partners to deliver the Stockport Neighbourhood Care (NC), formally known as Stockport Together. This new model of care will be fundamental to future financial sustainability.

The Stockport NC vision is: to provide a joined up, high quality, sustainable, modern and accessible health and care system. This aligns to our corporate Trust vision, mission and priorities.

The new model of care addresses the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport. To this end, there are a range of approaches to support the health and wellbeing of the 85% of the local population without chronic health needs, and intensive, highly integrated approaches for the 15% of the population with chronic health needs who are most at risk of a hospital intervention or long term care. In other words, we are segmenting the care needs of the population and differentiating interventions.

The four key underpinning concepts within the Neighbourhood Care business cases are:

- Invest £19.7m recurrently over the next four years largely in those 'out of hospital' areas that benchmark as either low or very low; primary care, community, social and mental health care;
- Implement a new fully integrated 24/7 neighbourhood based model of health and social care built from and led by General Practice which is based on the best available evidence and with an emphasis on validated prevention activities that will create the capacity and capability (in both primary and community care alternatives) to deliver the right care/support in or close to people's homes rather than in hospital;

- Train and develop a well-resourced, motivated, empowered and flexible workforce integrated across health and social care with the right skills, experience and attitude to deliver this new joined up model of care; and
- As a by-product of delivering the right care and support to people, we plan to realise, with partners, financial savings based on cost reduction of £22.4m by 2020/21.

In 2017/18, through agreement with our partners, a formal Alliance agreement was put in place and an Alliance Provider Board was established. This agreement enables us to provide an MCP service within a vehicle we have called Stockport Neighbourhood Care, this is our model of integration designed to provide services as a national MCP vanguard site.

The fundamental centre of the MCP is that it is based on the GP registered population and is primary care led. Providers and commissioners in Stockport have agreed that an Accountable Care Trust is the preferred organisational form through which this will be provided. In 2018/19 to 2019/20 we will continue to develop the necessary governance requirements to move forward with this transaction in collaboration with partners.

The focus in 2018/19 will be the implementation of the operational service models as part of Stockport Together business cases approved by the Board of Directors in June 2017. The emphasis will be to deliver the benefits articulated by the whole system working of the Stockport NC specifically these programmes/ business cases are:

1. Active recovery;
2. Crisis response;
3. Enhanced case management;
4. Neighbourhood models and GP home visiting; and
5. Outpatients.

7.5. HEALTHIER TOGETHER IMPLEMENTATION

The Board of Directors are committed to the implementation of the Healthier Together decision.

In the South-East Sector, the hub site was confirmed as Stepping Hill Hospital, Stockport partnered with Tameside Integrated Care Trust as a non-hub site.

Across Greater Manchester's four sectors, detailed planning continues for the implementation phase arising from the Healthier Together model.

The scope of Healthier Together includes a range of services including, directly: Medicine, Diagnostics, Anaesthetics and Critical Care, Emergency Medicine and, indirectly, a series of other services that are co-dependent with these. The principal focus of the changes, however, is the reorganisation of General Surgical services such that each sector has one identified 'hub' site which will be the centre for high risk elective and non-elective surgery, linked to one or more non-hub

sites, providing a wide range of lower risk, planned services and having a critical role in the reception, assessment and, where necessary, the transfer of unplanned patients. The underpinning principle is that sector general surgical services should be provided by combined teams of clinicians in 'single services'.

Preparation for the implementation of Healthier Together (now under formal Theme 3 governance) is anticipated to progress early 2018/19 subject to access to national capital funding and agreement of revenue costs at a sector level. Locally we will continue to progress implementation. The transfer of high acuity surgical activity from Tameside is now anticipated to be in 2019/20.

7.6. THE TRUST'S ROLE IN THE GM STP AND EMERGING INTEGRATED CARE SYSTEM

The Board of Directors are committed to aligning our activities with that of the GM STP and the emerging Integrated Care System.

We are now part of the formal Greater Manchester Sustainability and Transformation Partnership (STP) and every proposed change must be considered in a collaboration context. The business focus going forward is cohesion and cooperation, no longer competition and commerce.

In 2018/19, all STPs nationally, will be taking an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs are expected to:

- Ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners;

- Work with local clinical leaders to implement service improvements that require a system-wide effort for example: implementing primary care networks or increasing system-wide resilience ahead of next winter;

- Identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;

- Undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate; and

- Take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners.

The Trust will be required to respond to this system wide approach.

We aim to embrace the challenge that is to contribute to single system planning that encompasses CCGs and NHS providers. The system plan is expected to align key assumptions on income, expenditure, activity and workforce between commissioners and providers.

The Trust recognises that it is important that our current Stockport locality plans reflect GM developments in Themes 1 and 2 which focus on: communities, health and well-being and social care. We will proceed on this basis until such a time that a single system operating plan comes into force.

As it stands, the development of future acute service provision under the scope of Theme 3 and Theme 4 will fundamentally impact the Trust and services delivered from the Stepping Hill site over the next 2-3 years.

The Trust is committed to supporting neighbouring trusts and care economies. The trust is ready and equipped to take a strong role in the South East sector of Greater Manchester and with East Cheshire.

8. ENABLING STRATEGIES

To enable the Trust to impliment its strategic priorities there are a number of enabling strategies that support this overarching docment. These are:

- Clinical Services Strategy
- Quality Improvement Plan
- People Strategy
- Digital Strategy
- Estates Strategy
- Finance Strategy

8.1. CLINICAL SERVICES STRATEGY

The Trust has a rolling programme of undertaking 'Deep Dive' reviews with its clinical services to understand their current position and define future direction. These deep dives combined with further engagement and discussion across services to ensure alignment are forming the basis of the Trusts clinical services strategy. The table below outlines examples of current services and the type of opportunity that relates to each service. This may be:

- **Sector:** The service has an opportunity to have a increased role in the neighbouring and wider health economy.
- **DGH:** The service will be delivered in a robust and sustainable model within the DGH.
- **Collaborate:** we will look to collaborate with other organisations to ensure a robust and sustainable service is provided.

Additionally, each example service has been prioritised to outline the immediacy of the opportunity. This will be used to produce a coherent delivery plan to be implemented over the next 3-5 years.

PRIORITY	***SPECIALTY***	***OPPORTUNITY***
1	ORTHOPAEDICS	Sector
1	GENERAL SURGERY	Sector
1	OLDER PEOPLE	DGH (Stockport NC)
1	UROLOGY	Sector
1	OBS & GYNAE	DGH
1	PAEDS	Sector
1	DIAGNOSTICS	DGH
1	PHARMACY	Expand commercially
1	ENT (Paeds)	DGH or collaborate
1	CRITICAL CARE	DGH
2	RESPIRATORY	DGH
2	OPHTHALMOLOGY	Sector
2	HAEMATOLOGY	Collaborate

3	STROKE	Sector
3	GASTRO	DGH/ sector
3	NEURO-REHAB	Collaborate
3	BREAST	Collaborate
3	ORAL SURGERY	Collaborate

There is an on-going work to further develop the approach for these examples. To should be noted that there are specialities not listed in the examples above that will be engaged as part of the on-going strategy development.

8.2. QUALITY IMPROVEMENT PLAN (STRATEGY)

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

The CQC rated the trust as 'requires improvement' overall, but also as 'inadequate' for *safe* in Medicine and in Urgent and Emergency Services, and as 'inadequate' in *well led* for Urgent and Emergency Services. Our status with NHS Improvement is that of a Trust challenged for quality, performance and finance in September 2017.

The dedication and efforts of all our staff has led to many improvements since the CQC reports were published in March and October 2017.

Quality Improvements include:

- Consistent approaches to reporting incidents, with a significant and sustained increase of 20% in reporting – leading to a greater opportunity to share immediate lessons learned and embed safer practice
- 60% improvement in the reporting of 'no and low harm' incidents – demonstrating an evolving safety culture and a passion to get things right
- Reduction in the number of complaints received and in those returned where the complainant did not feel the complaint was resolved
- Reduction in pressure ulcers, especially across surgery and critical care, although we did not achieve our stretch trajectory
- Introduction of our ward accreditation scheme – Accreditation for Continuous Excellence (ACE), resulting in immediate improvements in MUST scoring compliance
- Achievement of our 'no lapses in care' target for C-difficile cases that are healthcare acquired

- Every ward has a nurse on every shift who has up to date Basic Life Support training, meaning we are assured that our wards and departments have the right staff with the right skills on duty to respond if a patient were to suddenly deteriorate.
- In our Emergency Department we have improved patient experience by ensuring that privacy and dignity for patients who attend in an emergency is maintained.
- Introduction of a new Quality Governance Framework where assurance is monitored from 'ward to board'.

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

The Board of Directors are committed to provide full support, leadership and apply focus and rigour to ensure the delivery of the plan. The Board of Directors intend to ensure continuous focus on creating the conditions that allow staff to do their job well by removing blocks to success and making sure we are managing any risks to delivery.

Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. We know that the Clinical Commissioning Group, Greater Manchester Health and Social Care Partnership, Local Authority, Health-Watch, NHS Improvement, NHS England and others will play a key role in scrutinising assurance processes to ensure they are sufficiently robust.

A core facet of the Quality Improvement Plan is the engagement of frontline staff in the improvement journey, with everyone being able to influence and contribute and feel empowered to change and improve. We know that when our clinical, non-clinical support staff and managers work together then our patients get the best care possible.

We continue to listen to our staff; making the most of their enthusiasm, expertise and knowledge and signalling a common purpose and priority for the organisation that is owned by everyone whether front-line staff providing direct patient care, human resource teams, staff working in information management and technology, estates and facilities, or finance and quality governance.

Delivery at pace

The Board of Directors is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation.

Our plan will help us to:

- improve quality and safety
- reduce variation and patient harm
- ensure every member of our staff has access to and has undertaken core learning and appraisal

- ensure all CQC Must Do actions and concerns are fully addressed and become the way we provide care for every patient every day
- act smart in the way we use our resources and prioritise safety and quality improvement to gain maximum impact
- work in conjunction with partner organisations to improve quality and safety for our most vulnerable patients

8.3. PEOPLE STRATEGY

The Trust has a workforce of circa 5,000 staff, all of whom are focussed on meeting the needs of our patients. The health and wellbeing of our staff remains vital however, it is clear that improvements can be made. Issues are in the main due to the capacity and capability problems the Trust has, and the difficulties the Trust experiences in recruiting to some key posts such as nursing and medical staff posts.

Despite these issues, staff are rightly proud of what they achieve for patients, are committed to meeting the needs of patients and are doing great work. However, there is always work to be done to improve the working lives of staff, reduce staff sickness rates, address vacancy rates and reduce staff turnover.

There is significant focus on recruiting hard to fill vacancies that are being covered by premium cost agency locums. The Trust continues to have some success both domestically and internationally. There are significant controls in place to manage the agency spend which is currently being reviewed and will face a further reduction in the future.

Having the right numbers and staff with the correct skill set is crucial to the efficient and effective operation of the Trust. The time taken to train staff, the challenging changing landscape and the scale of the exercise, mean that workforce planning for the Trust is a complex issue.

There will be an underpinning aligned People Strategy developed in 2018 to expand upon areas outlined here along with mitigation plans and plans for the need for greater partnership working and skills development across health and social care. The working draft details workforce priorities of; wellbeing, culture, leadership, recruitment and retention, temporary workforce and workforce transformation. Essentially, these will be explored as follows;

- Wellbeing: We will continue to reduce sickness absence due to musculoskeletal reasons or mental health and improve staff attendance;
- Culture: We will continuously improve equality, diversity and inclusion for our staff. We will continue to develop values-based processes and the Trust culture of care where staff feel empowered to raise concerns, innovate and continuously improve. We will support staff experiencing change in the organisation to improve retention and enhance staff experience;
- Leadership: We will support the development of leaders and managers and ensure our staff have the skills to carry out their roles now and are developed to take on new roles in the future to enhance patient care;

- Recruitment and retention: We will recruit the right people with the right skills and deploy them to meet organisational demand. We will recruit to vacant posts and use workforce planning and skill-mix methods to deliver the specified care models; and
- Temporary workforce: We will continue to reduce agency usage and spend and increase the use of bank workers to fill temporary staffing gaps.
- Workforce transformation: We will transform our workforce so that it can continue to be responsive to the needs of our patients now and in the future as demand and complexity increase.

As a Trust we value our people and recognise they are our greatest asset. Our overall aim is to develop our staff, give them clear career pathways, provide them with the leadership, skills and knowledge they need to deliver the care our patients need now and in the future, to support their wellbeing and to recognise and value their diversity.

8.4. DIGITAL STRATEGY

Over recent years the Trust has invested heavily in developing a strong IT infrastructure on the hospital site (networking/server/PC/wireless mobility) to provide the necessary platform on which clinical technology has been introduced. We have an excellent record of developing in-house and identifying a wide range of external clinical solutions already in place for secondary care, such as Electronic Medicine Management and Prescribing and is either paper light or paperless in many areas including the emergency department. Currently the Trust can be described as being at the high end of digital maturity when compared with the majority of Trusts. The last HSCIC National index position rated the Trust as 44th across the country in terms of digital maturity.

In addition, work continues on the Acute EPR system (InterSystems- TrakCare) in readiness for go live. This go live will provide the necessary platform from which the implementation of a full paperless clinical record can be achieved in future rollouts.

Given the above experience, the Trust is in a good place to realise technology enabled benefits in the future. It will be important to ensure that all implementations are supported by real business and process change in order to drive out such benefits.

In line with the Stockport Neighbourhood Care strategy during 2017/18, the Trust completed implementation of phase 1 of its Community EPR (EMIS WEB) programme to be fully aligned to primary care who all use EMIS WEB. This is now concentrating on introducing clinical functionality within the system to support paper light and mobile working practices across the range of community services. This is a major enabler of the Stockport Neighbourhood Care Programme. We are now investing in a shared domain across the care economy to support multi-disciplinary teams wherever they are located in the community.

The Trust is working to mobilise the community staff to be more agile and responsive to patients closer to home. How the Trust uses digital platforms to communicate with and offer support to patients and their families is constantly under review.

Maintaining and continually investing in the technical IT architecture of the Trust will be an essential requirement for the future to protect our patient and staff data. Although the Trust is currently in a strong position, investment will enable the Trust to effectively manage ongoing and ever present cyber security threats.

Sharing patient data across Health and social care organisations to support ongoing patient care across organisational boundaries is an ever increasing requirement. This includes data sharing across both Stockport to support the Stockport Together agenda and Greater Manchester, particularly by means of the GM Shared Health and Care Record. Protecting this data is of upmost importance to the Trust and with the introduction of GDPR, greater emphasis has been and will continue to be placed on the management and control of data flows respecting information governance protocols. We will use the Health and Care Record to facilitate Healthier Together working with Tameside for general surgery implementation.

A key area of work is to replace the trust's outdated Telephony system and replace it with a VOIP Unified Communications solution which will enable the transformational changes and new ways of working, required to support new models of care. Work is underway to procure a new system and once implemented, this will be a vital enabler for the increased levels of agile working which the Trust is eager to embed.

Agile working for some staff will be essential in future whereby technology enables them to work seamlessly anywhere in a Trust, community or council setting or from home. Other aspects of the digital office include video-conferencing to enable virtual meetings, tele-health and supporting hot desk facilities throughout the Trust to enable more efficient use of the estate.

Part of our strategy is to consider opportunities for shared services both with Greater Manchester and as part of Stockport Neighbourhood Care. In Stockport this may include procurement and implementation of shared infrastructure.

Providing accurate information and analysis to support direct service delivery has always been a key priority for the Trust. With the recent organisational changes, the information department has aligned itself more closely to business groups, transformation projects and the performance and monitoring function to support key decision making. Building on this model, the implementation of a comprehensive data warehouse and the implementation of Business Intelligence tools including Tableau are key priorities for the Trust. Both developments will reduce the time analysts spend on processing data and allow them more time to undertake true analysis which adds value and insights to the information produced, enabling improved decision making within the Trust. This has led to greater involvement of clinical coding in our theatre transformation programme.

8.5. ESTATES STRATEGY

The Estate Strategy sets out the Trust's vision for the future of its estate and the opportunities that our hospital site and community facilities present for us as an organisation, for our staff and for our patients. Our commitment to excellence and quality recognises the crucial role that the physical environment plays in delivering first class services.

It looks to the future, taking a long-term view of how the estate will evolve, but also acknowledges the issues and challenges that we face right now and seeks to identify practical steps that will help us to manage operational pressures while we plan for the future. We will always need to make short term decisions about our facilities, responding quickly to changing circumstances or new initiatives, but a coherent long-term plan will give us a consistent framework for those decisions and help us to maximise the benefits from investment.

At this stage the strategy focuses primarily on the Stepping Hill Hospital site, its challenges and opportunities, but it does so in a wider strategic context that includes the Trust's specialist and community centres and the need for much closer partnership working in Stockport and across Greater Manchester.

The potential site development scenarios are underpinned by evidence and a clear rationale but are intended to stimulate debate rather than present definitive solutions.

The case for change is a compelling one. The scale and extent of the significant estate issues in terms of coherence, efficiency, risk, compliance, backlog maintenance, obsolescence and fitness for purpose seriously impact on the Trust's commitment to deliver high quality services now and in the future. The opportunities, however, to strategically develop the site into a modern, flexible and future-proofed site are significant and present valuable opportunities to the Trust at this time.

8.6. FINANCE STRATEGY

The financial resilience and sustainability of the Trust is a concern and priority for the Board of Directors. Along with ensuring that financial control measures are in place and adhered to, the Trust will deliver financial efficiency through transformation change in the provision of health care and influence the provision of primary and social care. The Trust must provide the best value for everyone pound spent and therefore the Trust's leaders pledge to spend resources in the right way in order to meet the priorities and objectives of the Trust.

These challenges are not exclusive to the Trust. Overall, the NHS has been facing significant financial pressure in recent years. With an ageing population and increasing demand, there is need for the health and social care partners to continue to evolve to meet these challenges. There is likely to be minimal financial income growth over the next five years and therefore there will be an on-going need to deliver high quality services in a cost-effective way working in partnership.

The Trust has an underlying deficit for 2018/19 of £51m, in line with historical performance, the Trust is planning a cost improvement plan of £15m (c15%) and therefore the Trust is planning a deficit of £36m. In the coming five years, the Trust will have to make significant in-roads in delivering efficiencies on a sustainable basis to reduce the overall deficit position.

As part of the financial recovery plan and as a key element in planning for the overall cost improvement programme, a service review programme is being led by the operational teams and is supported by representatives from finance, PMO, workforce, performance and information. The

outputs of each of the service reviews are grouped into the themes namely; efficiency and quality, procurement and finance and workforce. The service review programme brings together performance data and financial benchmarking with intelligence in the system provided by clinical teams, supported by operational managers, to identify the key actions required to be taken to ensure the future financial sustainability of services.

All aspects of the estate, infrastructure and equipment will be continually reviewed to ensure it is fit for purpose and safe, so services can be delivered in the most effective and efficient way. The Trust investment and replacement programmes are risk-based and deliver clinical and safety priorities.

The Medium Term Financial Plan is available.

9. DELIVERING THE STRATEGY

9.1. GOVERNANCE

The Trust recognise that the delivery of the strategy is both critical and challenging. The workforce is under considerable pressure and the requirement to balance multiple priorities can be difficult without clear direction.

The Trust also believe that it has adequate capacity to deliver the strategy and to support and develop the programmes of work that will fall out of this document. However, the Trust does recognise that this capacity may not be position correctly or have been given the necessary direction to deliver as required.

Therefore, the Trust, will as part of its implementation approach, review and revise the governance of its programme, project and transformation capacity to ensure that it is most appropriately aligned to the work that is a priority for the Trust.

It is important that a clear methodology for providing assurance to the Trust board, external regulators and other stakeholders using the Board Assurance Framework.

9.2. TRUST OPERATIONAL PLAN

The Trust produced a yearly operational plan which outlines the Trusts intended position for the following year. This outlines the key activity, financial, quality, workforce and transformational plans. This document in effect is the delivery plan for year one of the Trust strategy and therefore is a key enabler of successful delivery.

The Trust has key challenges to overcome in terms of addressing some of its performance issues and financial sustainability which deteriorated in 2017/18. The Trust has been subject to Enhanced Oversight measures since October 2017 for both the financial performance and the operational performance for Urgent Care. We maintain that our system wide approach to transforming the way we deliver services in Stockport supports the system wide challenge of financial balance.

9.3. KEY RISKS

RISK	RAG RATING	MITIGATION
Focus is placed on place and regional programmes at the expense of internal opportunities	16	Trust to have a strong internal focus with a strategy that reflects the organisational ambition
The Trust is reactive to internal and external shocks and changes rather than proactively directing	16	Trust to have a clear strategy and steps to deliver this which will include engagement and drive towards place and regional programme's

The Trust is unable to make sufficient progress on financial performance	20	Trust to have a clear financial strategy with required savings targets. All strategic options for creating financial sustainability to be considered
The Trust is unable to rectify its operational performance issues (i.e. A&E) and/or complete its quality improvement journey	20	Trust to have a clear and supported operational and quality improvement strategy that aligns with the Trust overall strategy
The Trust is required, or attempts, to resolve all issues in year one but doesn't have the required capacity or capability	16	The Trust to make clear the timings of developments and if required push actions into year 2-5
The Trust overestimates its relative position with potential partners and doesn't lead discussions	16	Trust to clearly consider potential partnerships and alliances with other Trusts as part of its strategy and proactive engage in conversations

10. APPENDICES

10.1.STRATEGIC AND CORPORATE OBJECTIVES (APPROVED FEBRUARY 2018)

Strategic Objective 1	To achieve full implementation and delivery of the Trust's Refreshed Strategy 2018/22
Corporate Objective 1a	To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy
Corporate Objective 1b	To lead the annual operational planning cycle in line with NHSI guidance
Strategic Objective 2	To deliver outstanding clinical quality and patient experience
Corporate Objective 2a	To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy
Corporate Objective 2b	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.
Strategic Objective 3	To strive to achieve financial sustainability
Corporate Objective 3a	To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.
Corporate Objective 3b	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.
Corporate Objective 3c	To review and monitor a revised performance management framework

Strategic Objective 4	To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including; a. Stockport Together/ Stockport Neighbourhood Care/ Integrated Service Solution b. Healthier Together c. Theme 3 & 4 Programmes (GM Health & Social Care Partnership)
Corporate Objective 4a	i. To implement the new integrated service solution model of care working with our key partners ii. To realise the financial and non-financial benefits of the Stockport together business cases iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate
Corporate Objective 4b	To progress with planning for the realisation of the Healthier Together decision in line with GM defined timescales and investment
Corporate Objective 4c	To progress work streams relating to a)Theme 3 and b) Theme 4 in line with the GM Transformation Strategy
Strategic Objective 5	To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements (non-financial)
Corporate Objective 5a	The Trust will complete an independently assessed Well Led Review by 30 September 2018
Corporate Objective 5b	The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018
Corporate Objective 5c	The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan
Corporate Objective 5d	The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week
Strategic Objective 6	To develop and maintain an engaged workforce with the right skills, motivation and leadership

Corporate Objective 6a	To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum
Corporate Objective 6b	To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement
Corporate Objective 6c	To develop programmes of work to ensure the Health and Wellbeing Strategy is embedded across the trust and supports all staff in improving their health and wellbeing, delivering an environment where staff wellbeing is integrated into day-to-day practices
Corporate Objective 6d	To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage
Strategic Objective 7	To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality
Corporate Objective 7a	To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience
Corporate Objective 7b	To refresh the Estates Strategy based on the six facet survey and master planning information
Corporate Objective 7c	To manage investment relating to the Trust's capital programme relating to; i. Medical equipment ii. IT iii. Estates

10.2. VALUES AND BEHAVIOURS

Stockport NHS
NHS Foundation Trust

Demonstrating our values-based behaviours

Values	Values statements	Expect to see	Do not want to see
Quality and Safety	We deliver safe, high quality and compassionate care	I put patients first, recognising there is a patient behind everything I do. I always follow the Trust's practices, guidance and protocols. I take pride in the way I do things and take responsibility for my performance. I share my knowledge and offer practical support to help and develop others. I learn from mistakes when things go wrong and build upon successes.	I put my own interests or those of my service area first. I make excuses for my poor performance and look to blame others. My actions put the Trust at risk. I am inflexible and do not offer support to others.
	We ensure a clean and safe environment for better care	I do everything in my power to protect those who use our services from avoidable harm. I act immediately to raise any genuine concerns which may adversely affect patients, public or staff. I take pride in our surroundings and my appearance. I observe the confidential nature of information and circumstances. I demonstrate responsibility for my own, as well as others' wellbeing.	I act in a way that puts my personal or others' wellbeing at risk. I hide issues, do not share with the team and/or escalate issues to others. I demonstrate no interest in improving patient services.
Values	Values statements	Expect to see	Do not want to see
Communication	We treat our patients, their families and our staff with dignity and respect	I treat others as I would wish to be treated and challenge inappropriate or poor behaviour. I ask whether patients and others have everything they need, respond with kindness, carry out the things I can do, or find someone who can. I consider the needs and views of others and respect their opinion even if it is different from my own. I value other people's time by being punctual, responding to requests for information and queries promptly and delivering on commitments. I am accessible, approachable, professional and say thank you to colleagues for a job well done.	I ignore, judge, am rude to, or humiliate people. I am insensitive or dismissive to the needs of others from different cultures and backgrounds, or who have different views. I consider the patient as an inconvenience. I criticise other people or services without consideration of the impact on the reputation of the Trust or abuse my position or authority. I am often late for appointments, arrive unprepared or don't turn up; and often require chasing for agreed work and actions to be completed
	We communicate with everyone in a clear and open way	I introduce myself, welcome and listen to others, and show an interest in what they have to say. I use clear and plain language and check people's understanding. I involve others in decisions that affect them, give them information, and keep them informed. I engage with patients and colleagues to identify and resolve complaints and concerns. I am honest about my point of view and what I can and cannot do.	I am not always open and transparent about motives. I make assumptions without listening. I talk over people and do not allow them to express their opinions. I use unnecessary jargon or do not adjust my language to suit the person or situation. I hide behind email and take issues above colleague's heads without talking to them first.
Values	Values statements	Expect to see	Do not want to see
Service	We provide effective, efficient and innovative care	I strive to do the right thing, first time, every time and learn from mistakes to develop better and safer services. I look for solutions and encourage people to share their ideas, rather than accepting that nothing can be done. I embrace change and continually look for ways to improve how we work, putting forward and trying out new ideas. I offer, encourage and act on feedback as a way of learning and improving. I look for opportunities to develop and learn from those around me – and attend all relevant training and development for my role.	I do not raise concerns when noticing inefficiency in others, practices or systems. I am wasteful with Trust budgets, equipment or other resources. I am complacent about the services we provide and stand in the way of change. I say no without considering different options.
	We work in partnership with others to deliver the right care, in the right place, at the right time	I embrace involvement and work collaboratively with others in the patient's best interests. I consider the needs of other teams and partner organisations when carrying out my role. I try to help whenever possible, even when it's not my role. I offer to participate where my skills and experience will be of value, in and outside my service area.	I create barriers to collaborative working, intentionally or otherwise. I exhibit high levels of self interest and resist change. I am negative about other teams and partner organisations.

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Stockport
NHS Foundation Trust

Estate Strategy

September 2018

Table of Contents

1 Executive summary

1.1 Introduction

This draft Estate Strategy sets out the Trust's vision for the future of its estate and the opportunities that our hospital site and community facilities present for us as an organisation, for our staff and for our patients. Our commitment to excellence and quality recognises the crucial role that the physical environment plays in delivering first class services.

It looks to the future, taking a long-term view of how the estate will evolve, but also acknowledges the issues and challenges that we face right now and seeks to identify practical steps that will help us to manage operational pressures while we plan for the future. We will always need to make short term decisions about our facilities, responding quickly to changing circumstances or new initiatives, but a coherent long-term plan will give us a consistent framework for those decisions and help us to maximise the benefits from investment.

At this stage the draft strategy focuses primarily on the Stepping Hill Hospital site, its challenges and opportunities, but it does so in a wider strategic context that includes the Trust's specialist and community centres and the need for much closer partnership working in Stockport and across Greater Manchester.

This short paper briefly outlines:

- Proposed guiding principles to underpin the estate strategy, its objectives and the benefits it is expected to deliver
- Drivers for change, a view of clinical priorities and 'core activities', linked to the estate
- Operational, tactical and strategic planning timescales, reflecting the tension between short term imperatives and long term vision
- High level analysis of the current estate, building condition and backlog maintenance
- Possible scenarios/concepts for site development and an 'end state' to initiate debate
- Proposed next steps, including a process of engagement and consultation with staff and with external stakeholders

This summary is drawn from a much more detailed draft estate strategy document with supporting analyses, which will be developed in full subject to the Board's approval.

1.2 Guiding principles, objectives and benefits

Development of this draft estate strategy has been informed by a set of guiding principles and objectives. The estate strategy will:

- Facilitate delivery of the Trust's strategy, core values and objectives, in line with the Trust's Clinical Strategy, by providing an estate that is appropriate, safe and cost effective
- Take a long term view (20+ years), explore wider opportunities but recognise the tension between short/medium term imperatives and longer term vision
- Improve and sustain the quality of the environment for patients, staff and visitors in the short, medium and long term
- Deliver a flexible, agile strategy and high level masterplan informed by understanding of key drivers and impact of change, clear strategic rationale and future adaptability
- Provide a framework for operational and tactical decisions and managing strategic change in a way that targets investment and maximises benefit from scarce resources, identifying priorities and core activities

- Seek to optimise use of existing facilities where fit for purpose and VFM but also improve utilisation, efficiency and suitability and minimise risk, disposing of unfit buildings
- Develop a clear plan that improves site coherence, accessibility, flows and wayfinding
- Support effective recruitment and retention of staff by creating a high quality working environment
- Provide tools for delivering sustainable development and carbon reduction initiatives and monitoring delivery of the strategy through performance metrics

Developing the strategy is an iterative process and the document itself will be a statement at a point in time but remain 'live'. A clear set of guiding principles and objectives will continue to inform development of the strategy as it evolves. This estate strategy will continue to be refined and iterated on a regular basis going forward from this point.

1.3 Strategic drivers, clinical priorities and core activities

1.3.1 Strategic drivers

The need to manage pressing day to day issues is a crucial operational driver but the estate strategy will need to respond to significant strategic drivers including:

- Collaboration and partnership – Stockport Together and Healthier Together, a sustainable system, new models of care, shifting the balance to achieve better patient outcomes
- The Trust's primary focus, its core activities, the role of an acute hospital and the impact of demographic change on services and capacity
- Significant changes in areas such as urgent care, older people's services, planned care, outpatient and other ambulatory based care
- Recruitment and retention of high quality staff as critical success factors
- The impact of technological advances and new working practices

The estate will need to respond to these drivers and facilitate transformation over short/medium and longer term in a way that is sustainable and appropriate.

1.3.2 Clinical priorities and estate response

The estate strategy will need to respond to the Trust's clinical priorities, including:

- **Emergency care** - the ED is undersized and poorly configured. The STP Wave 4 Emergency Campus bid will begin to address, as will the Healthier Together commercial case for ED reconfiguration, but the Trust will also need to plan for longer term expansion of all its emergency care services, including vital clinical support services such as diagnostic imaging
- **Beds** – the number, types, location and mix of the Trust's current acute bed stock is inappropriate and suffers from poor adjacencies and access. The quality and functionality of the bed stock is poor, particularly in medicine. There is a clear need to consolidate and improve short term and relocate/reconfigure longer term as part of a coherent site plan, reflecting key adjacencies and models of care. The HT commercial case will act as one enabler
- **Outpatients** – currently out-patient services are delivered in diffuse, outdated, inefficient and poor-quality accommodation. Services are desperately in need of consolidation, considering the implications of Stockport Together

Estate planning and strategy will need to reflect the overall direction of travel and new models of care consistent with collaborative working - many existing buildings are simply not

fit for purpose. Necessary improvements in these areas, including the short term, need to be mindful of the longer term estate strategy to avoid problems of the past, for example, ensuring adequate expansion space for the future, avoiding isolating particular service provision when co-locating services would be more efficient and effective and ensuring that each development at the very least does no harm to future strategic developments and at best enables future developments to deliver optimal value for money through development synergies.

1.3.3 Core activities

In line with the Estate Strategy objectives, the strategic drivers and agreed clinical priorities, an analysis of the Trust's 'core' and 'non-core' activities, appropriate to its role, and what this analysis means for the estate is one of the building blocks of a coherent site development plan. For example:

- What is 'core' to the role of Stepping Hill as an acute hospital – clinical services and clinical support, for example ED, diagnostic imaging, acute beds, surgery, some outpatients, etc.?
- Conversely, what constitutes 'non-core' clinical, clinical support or non-clinical support?
- Can non-core services be relocated away from the hospital site or to areas of the site not required for core services now or in the future?
- How will more efficient, technology-enabled patient care and working practices, including agile working, impact on this analysis over time and act as an enabler?

This graphic, peeling away the layers of a 'strategic onion' to reveal the core, illustrates the point and offers a starting point for debate.

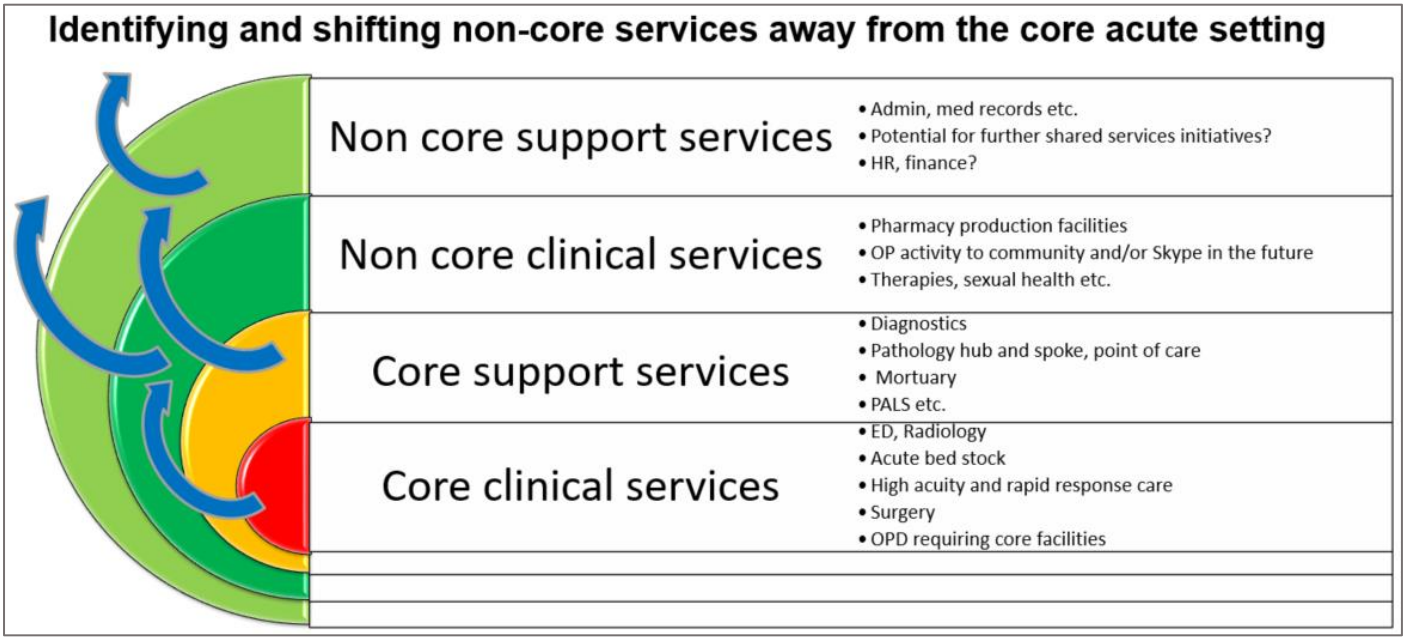


Figure 1. Conceptual shifting of care away from the core acute setting

1.4 Operational, tactical and strategic timescales

There is an inevitable tension between immediate, short term needs, longer term aspirations that are ambitious but realistic and the tactical decisions on how to get there. These are the proposed timescales for considering site development:

- **Operational** - within next 2 years (some things much sooner)
- **Tactical** – within 5 years
- **Strategic** - over next 15-20 years, but 20+ years is not a particularly long timescale for large scale strategic investment

There is uncertainty about future funding, and this is obviously a concern, but this should not constrain the strategic vision for the estate, reflecting the Trust's ambitions.

We need to be realistic about what can be achieved right away, some things will take time, but short-term planning needs to take account of the longer term vision.

A clear strategy will act as a blueprint that allows the Trust to develop and prioritise off the shelf solutions consistent with the strategic direction, acting as 'oven ready' projects that can exploit funding opportunities that may well arise and plug in without compromising the longer-term site development plan.

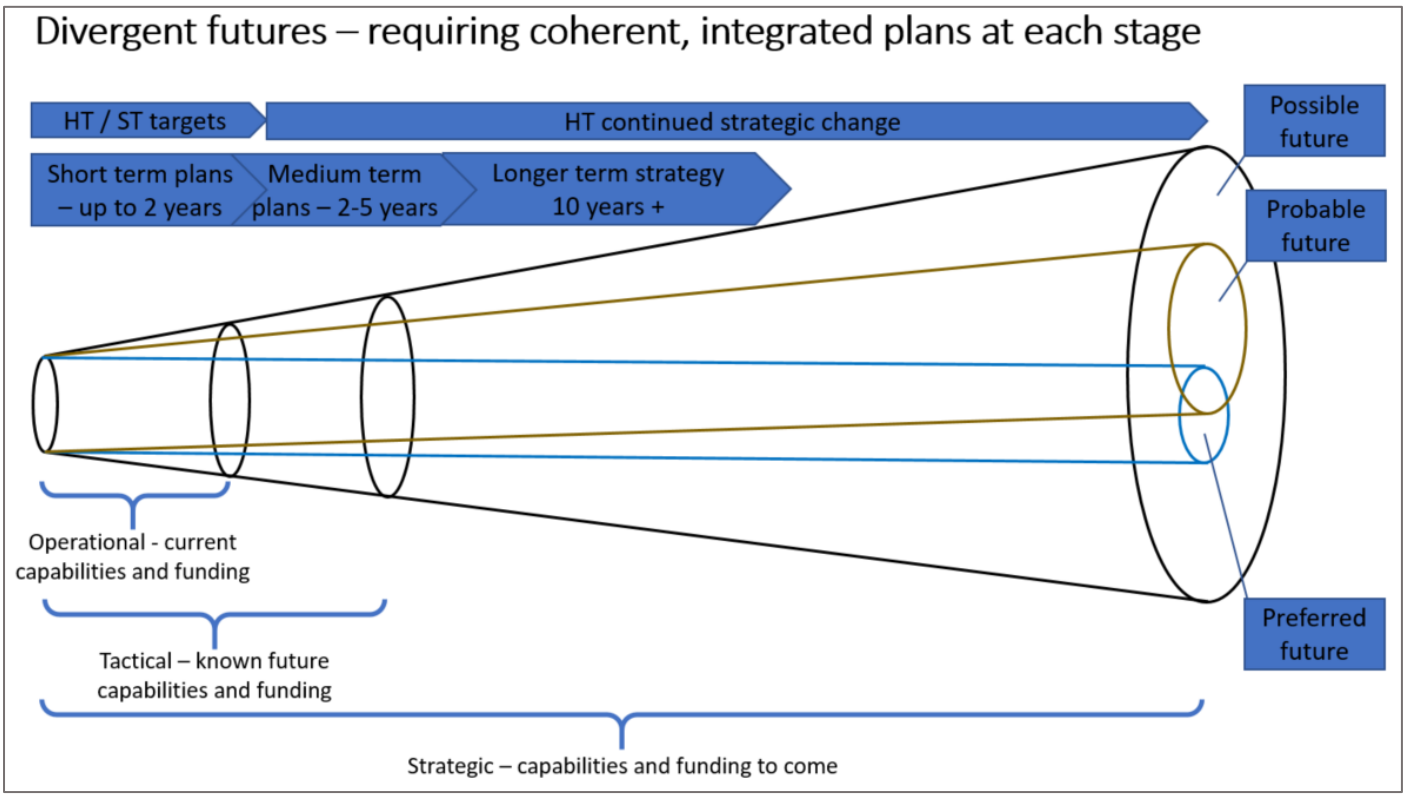


Figure 2. Strategic vision in the context of future possible technologies and funding streams

1.5 Site analysis

This section provides a high-level overview of the current estate, the current location of services and a summary of estate condition and backlog maintenance based on the most recent six facet survey, commissioned by the Trust.

1.5.1 High level overview of the current estate

- Hard site boundary – no room for expansion
- Scattered buildings, many low rise, consuming the whole site, and many buildings no longer fit for purpose
- The long walkways, poor adjacencies and inefficiency are legacies of the original hospital and years of piecemeal development

- Clear need for a masterplan and longer-term view on how the estate should support the clinically led strategic direction
- Rationalisation, development and phasing will be a complex exercise but there is a way forward

1.5.2 Current location of services

These site plans show the overall distribution of services and, in order to illustrate the level of fragmentation, the distribution of outpatient and ambulatory care type services in multiple locations.

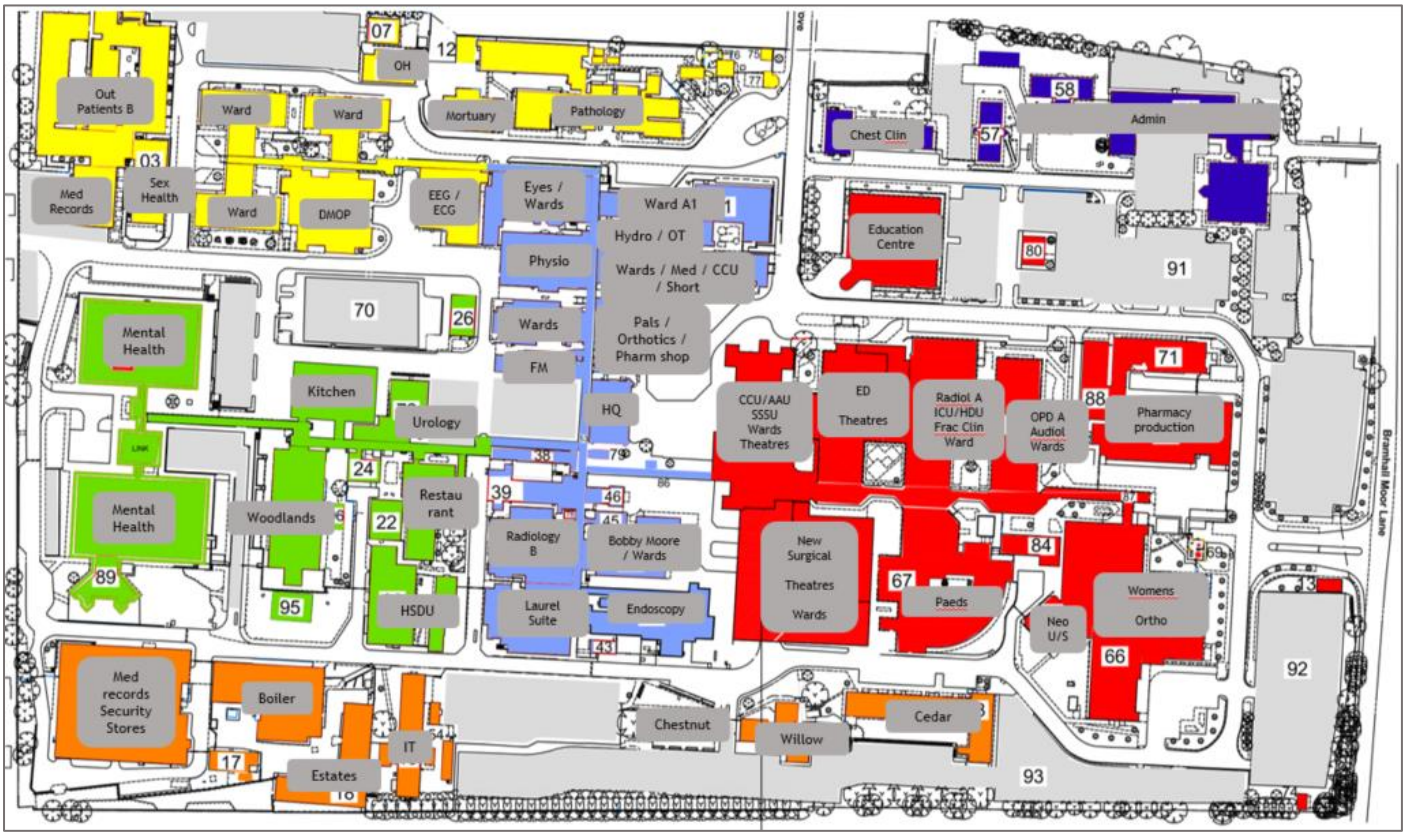


Figure 3. Map of current Stepping Hill Hospital site

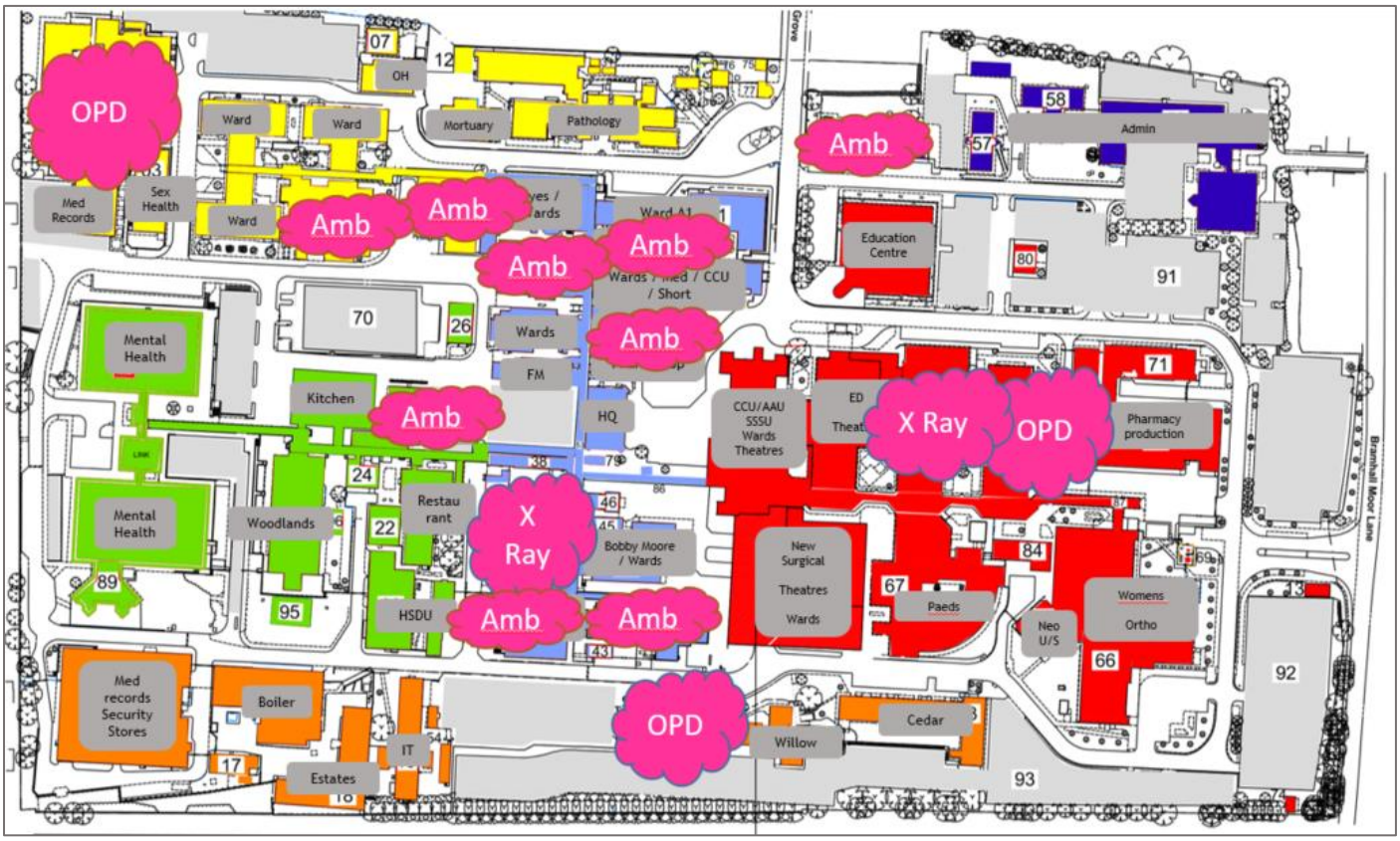


Figure 4. Map of Stepping Hill Hospital identifying disparate ambulatory and out-patient based services

1.5.3 Estate condition

This summary is based on the most recent six facet survey and analysis of building condition.

As previously noted, there is a core of newer buildings in generally better condition, which can act as the functional heart of the hospital as it is redeveloped. These analyses of suitability, condition and backlog maintenance costs reinforce this concept and also highlight very clearly the buildings, and zones of the hospital estate, in the worst condition and presenting the most obvious opportunities for site clearance and greater efficiency.

Whilst the condition of the buildings does not represent the primary driver for the estate strategy, the condition of the buildings will be considered in any assessment of funds utilisation to bring such buildings back towards a Category A condition. A number of buildings are functionally poor and are not considered capable of supporting modern healthcare services and it is therefore uneconomic to continue to support these buildings in terms of backlog maintenance.

As a long term strategy which identifies the phasing and timing of demolition of such buildings is further developed, such buildings should be maintained to the minimum to provide adequate care and services in anticipation of the strategic redevelopment of those services.

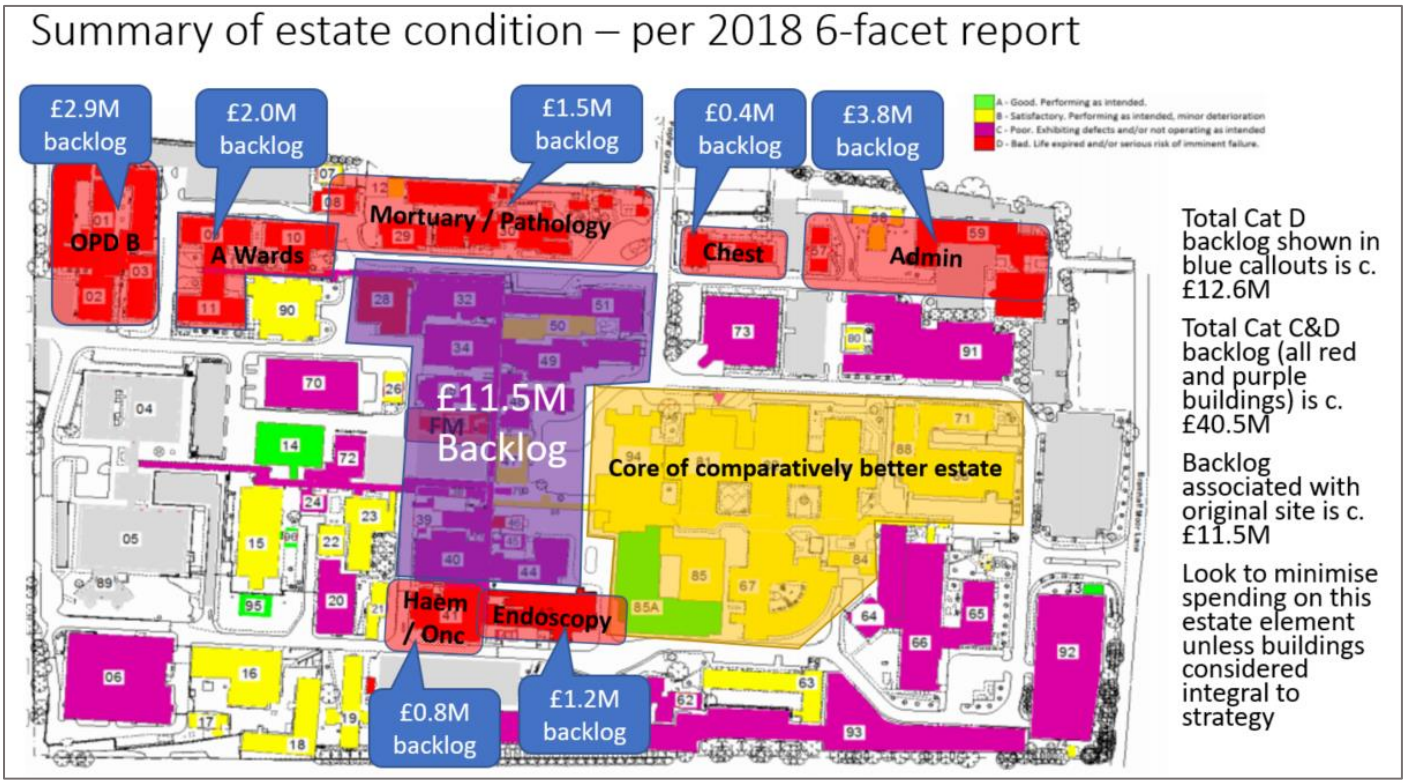


Figure 5. Summary of Stepping Hill site backlog maintenance issues

1.6 Developing the core

There is a core of newer buildings, in better condition generally, that consolidates key services to an extent and maps onto the functional core of the acute hospital. This is therefore a good starting point for a site development and investment strategy.

The estate strategy needs to reflect and focus on these core services - what Stepping Hill needs to deliver as an acute hospital - and also consider alternatives for 'non-core' services.

In terms of developing the site and improving utilisation, it is also known that certain buildings will be vacated in the future, for example the Pennine Care mental health services relocation planned for 2021, which will also create opportunities.

Adopting the core/non-core principle has advantages in that it:

- Makes a virtue of identifying how care can be delivered closer to home, avoiding unnecessary visits to or stays in hospital
- Delivers quantifiable benefits from vacating elements of the site and allows a coherent development strategy to emerge

1.7 Site development scenarios

Bringing all of these elements together, including current planning for projects like the Wave 4 bid and the Healthier Together Commercial Case, enables us to develop a number of potential scenarios that offer a vision of a much more coherent, effective and efficient Stepping Hill site that will be fit for the future.

These scenarios are based on the analysis to date, views on clinical priorities and fixed points identified, and are therefore underpinned by evidence and a clear rationale, but they are conceptual. These concepts are intended to stimulate debate about the way forward rather than present definitive solutions at this time. It is proposed that the conceptual plans shown

here are developed in detail through a comprehensive engagement exercise with all relevant internal and external stakeholders to the Trust. The next iteration of this Estate Strategy will therefore develop a preferred direction of travel for the long-term redevelopment of the Stepping Hill site in conjunction with its other facilities and responding to the Trust's developing clinical strategy.

Some key clinical issues associated with the current site as well as a high-level analysis of site activities are summarised in Figure 6 below.

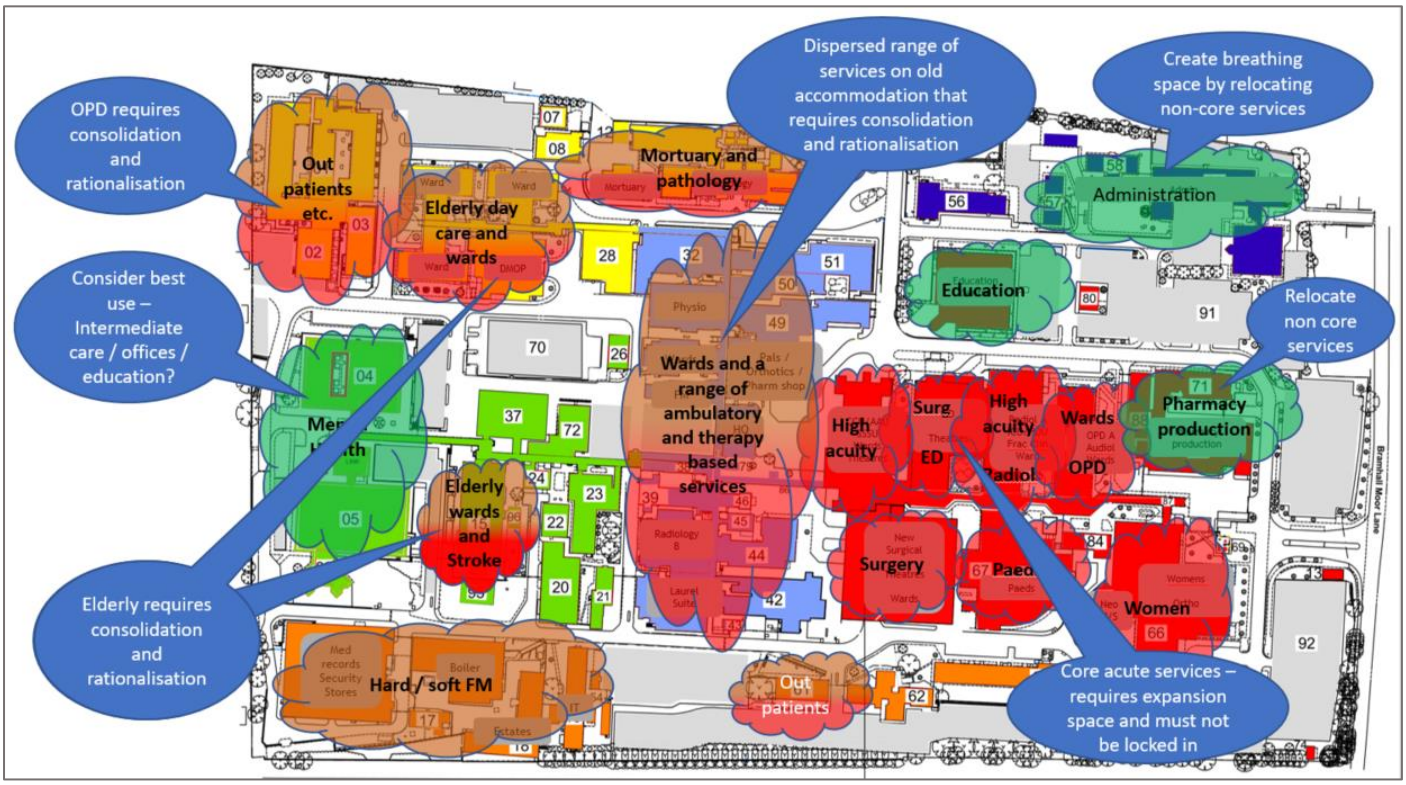


Figure 6. Key clinical issues and high-level analysis of activities at Stepping Hill Hospital

The current Wave 4 bid to develop and support emergency care at the hospital, develops an Urgent Treatment Centre close to the current Emergency Department (ED) whilst also developing needed retail facilities and additional car parking requirements. Additionally, a range of other facilities are planned in the short term to support clinical activities including a 4th CT scanner, enlargements to the Clinical Decision Unit (CDU) and further urgent treatment facilities and developing options for an Essential services Laboratory (ESL) to support point of care and rapid turnaround pathology support to emergency care.

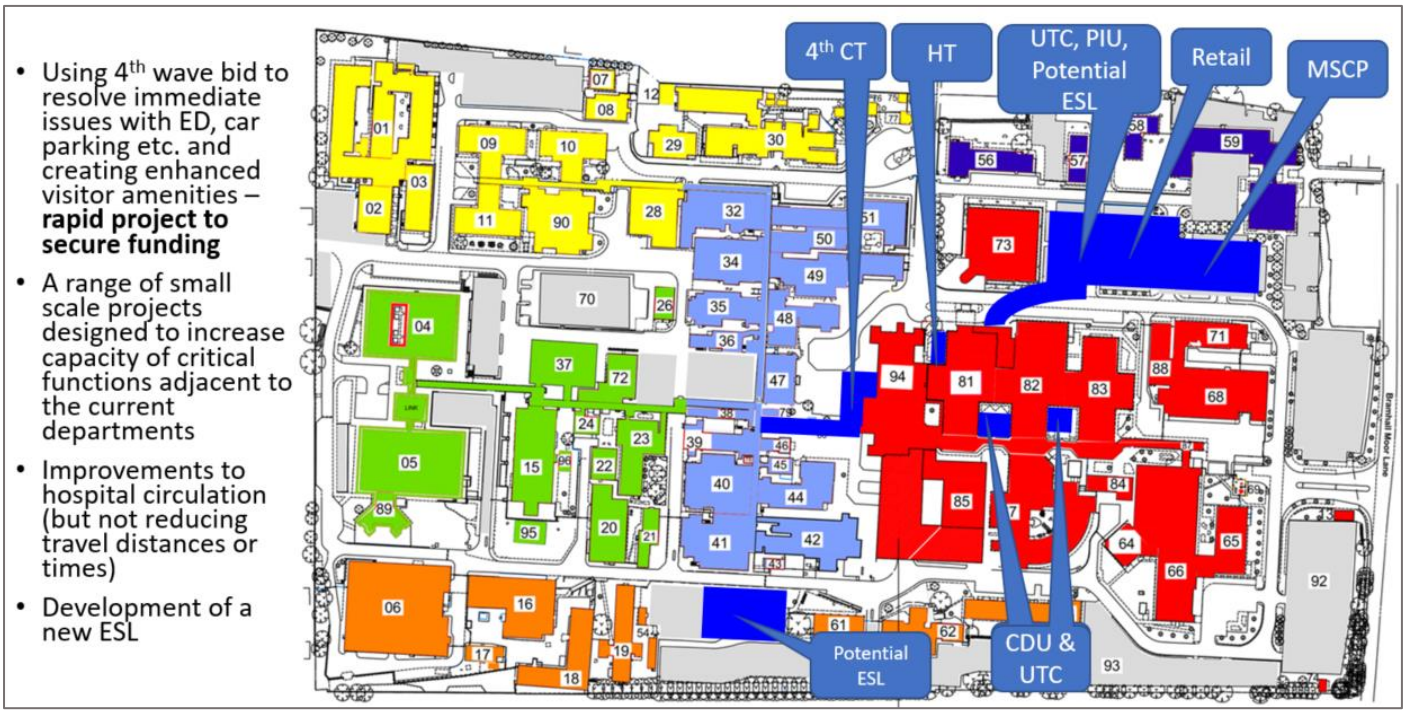


Figure 7. Summary of short-term projects associated with the current Wave 4 funding bid

The planned developments associated with the Wave 4 bid above will be considered alongside the developing long-term estate vision, a key principle being to ensure that there are clear alignments and synergies between Wave 4 and future long-term developments. Some adjustments to ensure those synergies are expected and a conceptual scenario for the development of the whole site is shown in Figure 8.

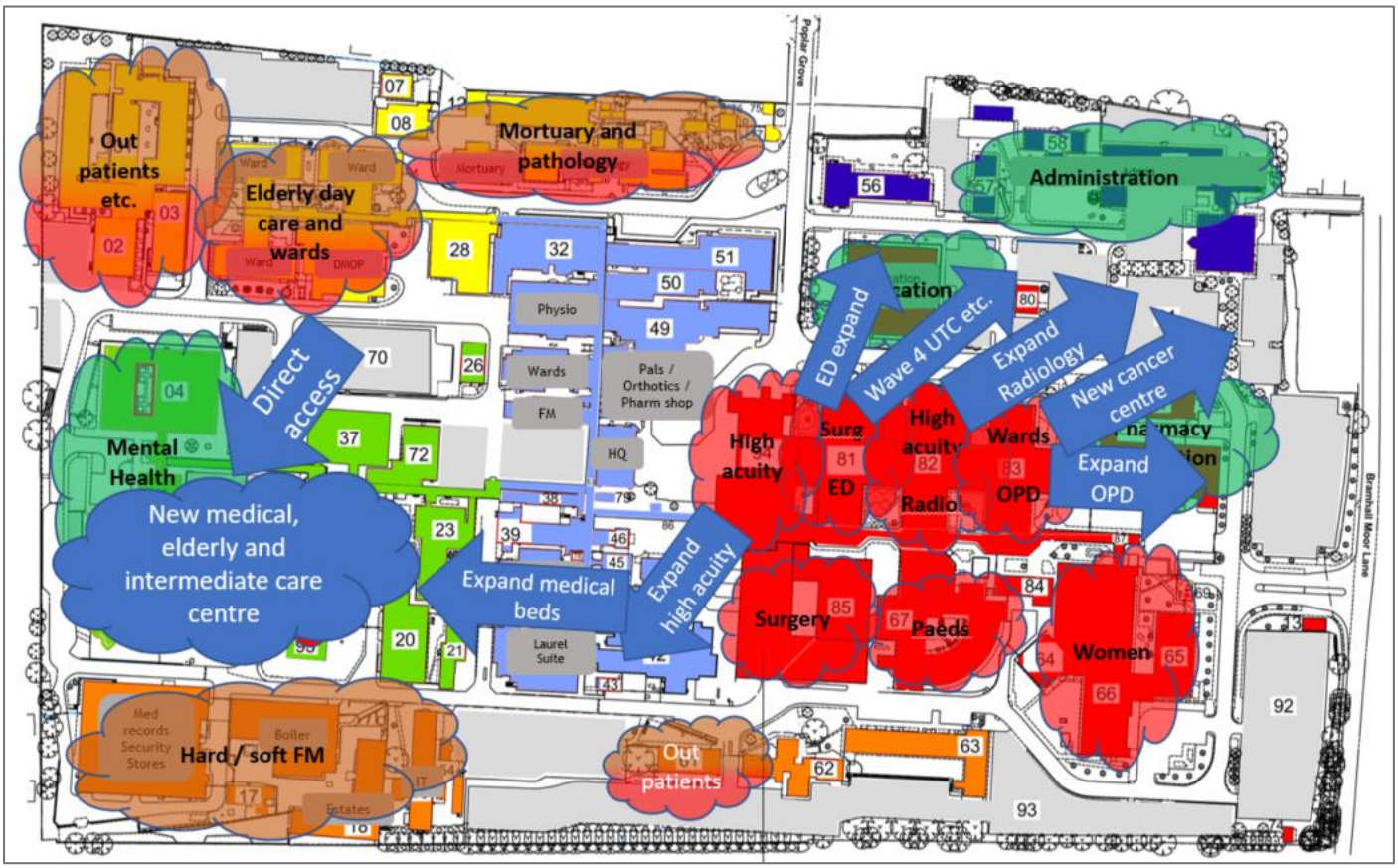


Figure 8. Conceptual development of the Stepping Hill site

The draft conceptual vision for Stepping Hill Hospital will include building on the core acute services provision facilities by

- Establishing future requirements for Emergency Care and associated diagnostics and support, ensuring synergies between those and the developed UTC
- Consolidating out-patient and other ambulatory services on site to be supported by enhanced diagnostics and laboratory facilities
- Developing radiology and diagnostics as both a supporting and patient facing service
- Developing a new Cancer centre which will consolidate current cancer services which are delivered in aging and functionally poor facilities across the site
- Developing a new Endoscopy service with close associations to the current surgical facilities, utilising common support facilities and developing synergies wherever possible
- Creating additional high acuity accommodation adjacent to the current similar accommodation
- Developing and replacing the current medical bed stock where functionally poor and physically remote from other supporting services. Creating a graduated medical care facility which places patients in medically appropriate accommodation from high acuity care through to general care requiring acute facilities and establishing the potential for the site to effectively and economically support additional step up / down facilities on site, as appropriate, as part of this graduated or intermediate care model

The above principles are shown as a high level conceptual vision in Figure 9 below.

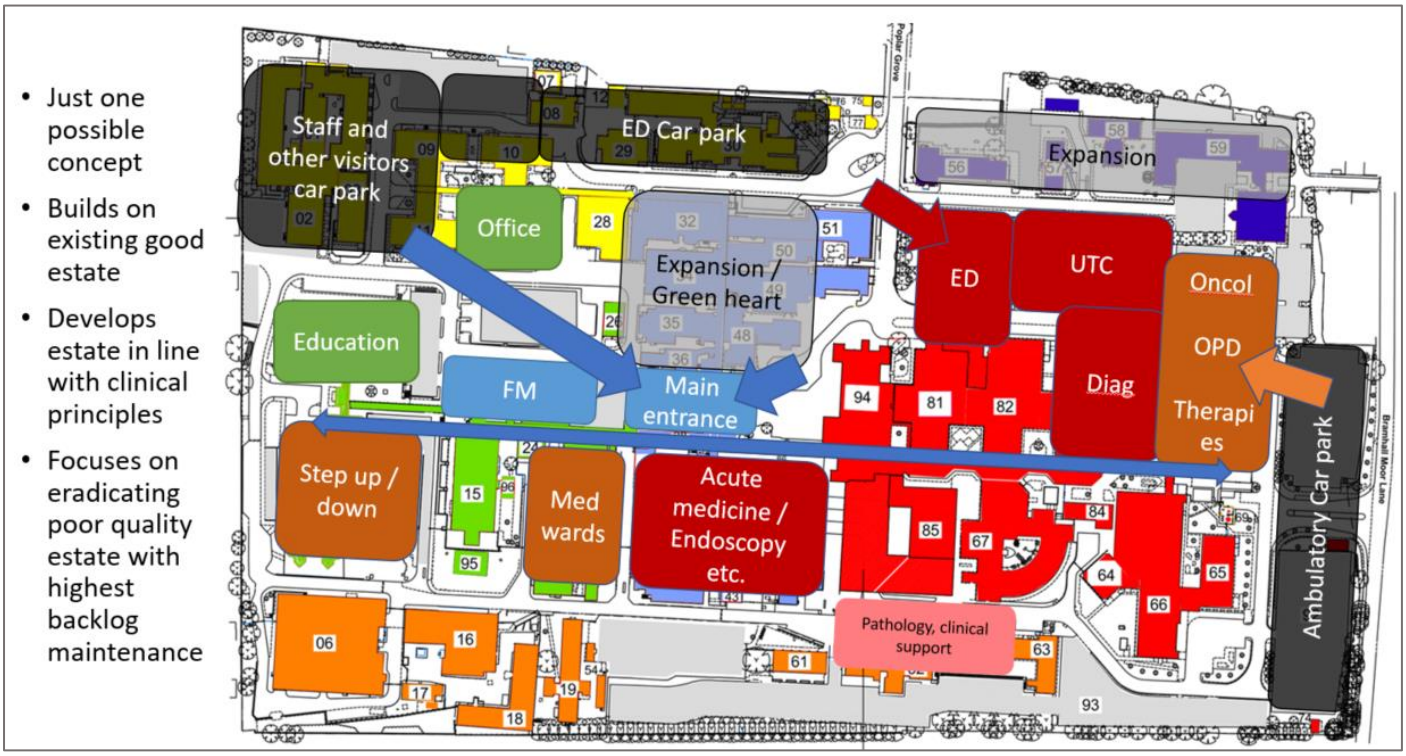


Figure 9. Conceptual high-level vision for Stepping Hill Hospital

The conceptual vision comprises:

- Creation of a clear car park strategy which locates parking to the periphery of the site and clearly designates between parking for emergency, ambulatory, staff and visitor parking, located to optimise flows around the site and to allow ease of access to associated care facilities

- Developing and clearing outdated, inefficient and functionally inadequate buildings as part of the clinical strategy for future care provision on the site, creating space which can be an asset in terms of enhanced public realm and also creating future expansion space for service provision beyond the timescale set for this current long-term strategic estate vision
- Developing an enhanced entrance strategy which will incorporate a new main entrance but also create clear separate entrances to key clinical service groups such as Cancer care, OPD and other ambulatory care, visitor access and emergency access

1.8 Conclusion and next steps

This paper summarises the key elements of the Trust's emerging draft Estate Strategy and its supporting analyses, setting out a potential vision, or blueprint, for the future of its estate and the opportunities that it presents.

It takes a long-term view of how the estate could evolve, but also acknowledges the issues and challenges that we face in the short term and seeks to identify practical steps that will help us to manage operational pressures while we plan for the future.

At this stage the draft strategy focuses primarily on the Stepping Hill Hospital site, its challenges and opportunities, but it does so in a wider strategic context that includes the Trust's specialist and community centres and the need for much closer partnership working in Stockport and across Greater Manchester.

The potential site development scenarios are underpinned by evidence and a clear rationale but are intended to stimulate debate rather than present definitive solutions.

The case for change is a compelling one. The scale and extent of the significant estate issues in terms of coherence, efficiency, risk, compliance, backlog maintenance, obsolescence and fitness for purpose seriously impact on the Trust's commitment to deliver high quality services now and in the future. The opportunities, however, to strategically develop the site into a modern, flexible and future-proofed site are significant and present valuable opportunities to the Trust at this time.

The Board is asked to consider the key messages and proposed approach outlined in this paper and to approve further development of the draft Estate Strategy to establish a clear strategic direction for the Trust's estate, a coherent long-term plan and a consistent framework for decisions that will help us to maximise the benefits from investment.

2 Introduction and overview

2.1 Introduction and context

This draft Estate Strategy complements our other Trust Strategies, and those of our partners, and begins to address the challenges set by Delivering the Forward View: NHS planning guidance 2016/17-2020/21, Lord Carter's Review on operational productivity and performance as well as commissioner-led local estates strategies. It sets out our ambition of a consistently high-quality estate to support all our services and to respond to the changes envisaged by whole system programmes such as Healthier Together and Stockport Together.

Ensuring a safe and appropriate environment, maintaining our facilities and delivering excellent services is the core of what we do, and must continue to do, in the management of our estate. Much of this work takes place 'behind the scenes', but a positive experience of Stockport NHS Foundation Trust services depends on these being delivered efficiently and effectively.

Much has changed in the wider landscape and we have seen greater emphasis on partnership and collaboration across the health and care system, with work progressing on a Sustainability and Transformation Plan for the NHS across the whole of Greater Manchester, the development of commissioner led local estates strategies, and deepening relationships with other partners, including local councils that commission and provide social care.

A review our own estates strategy is therefore timely, to take account of these wider developments, which support and enhance the direction set out in 2016. This edition of the draft strategy has been updated to reflect the progress we have made and to adapt to changes affecting the Trust itself, its partners and the wider health and care system.

The estate strategy tells the story about how we are using our buildings to change the way we deliver services, in particular how we are planning to use our estate to support the Trust's continually developing Clinical Care Strategy. This clinical strategy sets out how we intend to deliver more complex and specialist care in the community, effectively joined up with all health and social care service provision as part of Stockport Together. We are responding to the challenge of a growing and ageing population and increasing service user expectations at a time of continued financial pressures.

Everything we do is about delivering excellent healthcare. To do this we need to have the right buildings in the right places to ensure that all who use our services have a good, positive experience of their care, and that we support all our staff by providing a consistently high-quality working environment.

At this stage, this document is still considered a draft Estate Strategy, albeit one that brings together a substantial amount of information to describe the current position and establish a direction of travel for the future. Further work is being undertaken to develop and confirm the Trust's Clinical Care Strategy and also to quantify the impacts of Healthier Together and Stockport Together to ensure that the estate is able to respond effectively to these key strategic drivers.

The format of this draft Strategy follows that recommended by the Department of Health in reviewing the overall use of the estate, occupancy costs, service and organisational constraints, and capital investment decisions and is broken down into the following main themes:

2.1.1 Where are we now?

We have analysed the current position and performance of the Trust in order to establish a baseline against which development planning can take place. This shows that progress has been made since the previous strategy to create a firm foundation for service delivery, but we recognise the need to forge stronger links between estate planning and operational service planning and ensure that there are up to date, coherent data about the estate to allow proper analysis of performance.

2.1.2 Where do we want to be?

A review of estate requirements is needed to support emerging service delivery strategies along with the environmental and estate performance criteria to be developed and monitored. There will be a much stronger emphasis on ensuring that estate delivery aligns more closely to service requirements and Trust aspirations, reflecting clinical priorities and changing models of care. We will seek to develop a more coherent estate and high-level masterplan, consolidating and rationalising space across clinical and non-clinical uses and improving adjacencies, flows and wayfinding. We will also administer the estate more effectively, which will include data/finance management and setting of clear performance related targets to reduce cost and increase income. Ongoing monitoring and management of resources will help support those improvements already made with the sustainability of the estate.

2.1.3 How do we get there?

We will use the information and objectives from the preceding stages to reach initial conclusions and develop a series of realistic and feasible options for the future estate. This will include a clear understanding of emerging local strategies based on close collaboration, a level of clinical engagement to ensure relevance and help to build local ownership, the development of a data collection and recording system, including more refined customer feedback processes, which will aid performance management and allow informed benchmarking of the estate against our peers and comparators. The ongoing development of the Trust's estates team and the supply chain supporting it will also be important if the Trust is to deliver successful estate related outcomes that flexibly and properly support operational service requirements, both known and those yet to be developed.

This draft Estate Strategy makes a clear statement at a point in time but will not be a fixed document. It will evolve and adapt to the changing requirements of the Trust and its partners and stakeholders and will be updated regularly to maintain its relevance. Future directions in healthcare, innovation and development, as well as changes within the Trust itself and the environment in which it operates, cannot all be known or predicted with any degree of certainty. A long term estate strategy such as this must therefore remain responsive to change so that it continues to meet the Trust's needs and those of the people it serves.

2.2 Objectives

At a high level, the core objectives of this Estate Strategy, in line with the Trust's wider clinical and organisational strategies and those of its partners, are to:

- Provide a modern, functional estate that is fit for purpose and will support the strategic vision, within an affordable capital and sustainable revenue investment plan
- Develop a coherent site master-plan that will consolidate and rationalise the use of space, improve adjacencies, flows and wayfinding to 'make sense' of the estate
- Reduce the overall estate backlog condition, maintenance and life cycle liabilities along with improving space utilisation and satisfying capacity requirements

At a strategic level this document is not about creating a detailed list of specific estates issues, tasks and projects, although these will follow along with clear programmes of work to deliver the changes required. The strategic remit is much broader and far reaching in its scope, drawing on the development of potential scenarios, and a vision of the future, to create an adaptable, flexible strategy. That strategy will need to take account of the transformational changes taking place locally, regionally and nationally and the dramatic advances in the use of technology in healthcare.

The Estate Strategy deliberately, and necessarily, takes a long-term view and it is therefore a plan for the future, responding to the many changes, challenges and uncertainties that future will bring. However, it also recognises the tension between that long-term perspective and more immediate short and medium term demands and requirements that must be addressed.

The objectives that we have set out will ensure that the Estate Strategy supports the strategic objectives of the Trust by providing a plan to enable the estate to develop. It will:

- Provide a clear, positive statement to public and staff on the Trust's plans to maintain and improve services and facilities, in line with delivering national, regional and, local strategies for healthcare
- Support the Trust's operational plan, clinical strategy, work force and development strategy, sustainability plan, finance plan and IM&T strategy
- Provide safe, secure and high-quality healthcare facilities that complement and support provision of high quality care
- Ensure the Trust's estate is used efficiently, coherently and strategically to support future clinical and corporate requirements
- Ensure a flexible, fit-for-purpose and sustainable estate for future delivery of healthcare

In terms of quantifiable benefit, the success of the Estate Strategy will be measured by:

- Continual improvement against Estates Performance Indicators – identifiable improvements in key facet indicators, space utilisation, functional stability, quality, adaptability and environmental management
- Reduction in backlog maintenance liability
- Capital receipt for any land disposal for reinvestment, where this appropriate and consistent with the Trust's overall strategy
- Patient-led Assessment of the Care Environment (PLACE) – measurable improvements in care environment quality standards
- Premises Assurance Model (PAM)
- Staff, patient and visitor feedback

2.3 Guiding principles

Development of the Estate Strategy will be informed by a set of guiding principles, acting as a frame of reference. These are that:

- The estate strategy exists to facilitate delivery of the Trust's strategy, core values and objectives – it does not have a life of its own and does not start with the estate
- It takes a long-term view, explores wider opportunities but recognises the tension between short/medium term imperatives and longer-term vision
- The objective is to deliver a flexible, agile estate strategy and high-level masterplan informed by understanding of key drivers and impact of change, clear strategic rationale and future adaptability
- The quality of the estate does not drive the strategy but it needs to respond to the physical condition of the estate when developing solutions

- Development of the strategy is an iterative process – not all the answers will be in place and a sense of ownership needs to be created
- It seeks to optimise use of existing facilities where fit for purpose and VFM
- The strategy establishes long term vision and framework for consistent decision making, prioritising investments to maximise benefit from scarce resources

> *'A well-thought-out estate strategy is essential to the provision of safe, secure, high-quality healthcare buildings capable of supporting current and future service needs. An estate strategy cannot be developed in isolation. Rather, it is an integral part of service planning.'*
> (Developing and Estate Strategy, NHS Estates, 2005)

2.4 Policy context for the estate

2.4.1 The Five Year Forward View (5YFV)

The 5YFV sets out a vision for the future direction of the NHS, describes three improvement opportunities: a health gap, a quality gap and a financial sustainability gap. It proposes a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services and of health and social care.

Within the constraints of the requirement to deliver financial balance across the NHS, the main 2017/18 national service improvement priorities for the NHS are:

- Improving A&E performance
- Strengthening access to high quality GP services
- Improvements in cancer services (including performance against waiting time standards) and mental health

In order to deliver these and the wider goals, work will be focused on accelerating service redesign locally through Sustainability and Transformation Partnerships.

The traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised and co-ordinated health services that patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems and networks of care not just organisations. Care outside of the hospital environment needs to become a much larger part of what the NHS does and services need to be integrated around the patient.

While there are few explicit references to the estate in the 5YFV, by proposing new models of care there will be varying degrees of impact on the NHS estate. Given the emphasis on expanding and strengthening primary and out of hospital care it will not be possible for the NHS to achieve its vision without changes in the estate.

2.4.2 The Carter Review

Lord Carter issued the findings of his review "Operational productivity and performance in English NHS acute hospitals: unwarranted variations" in February 2016. The review set the context for the NHS to deliver 2-3% savings per annum, requiring major improvements in efficiency, productivity and quality to bring about this change. The review identified an unwarranted variation in costs across seven key resource areas, including Estates and Facilities, which can make a significant contribution. The following recommendations are particularly relevant:

Recommendation 6 – all trusts' estates and facilities departments should operate at or above the median benchmarks for the operational management of these functions by April 2017;

with all trusts having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost-effective manner.

Recommendation 7 – all trusts' corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020.

2.4.3 Naylor Review – NHS Property and Estates: why the estate matters for patients

The NHS estate is vast; it is worth tens of billions of pounds and the size of a small city. It costs over £8 billion each year to run with NHS providers spending around £2.3 billion on capital investment to maintain and improve the estate and infrastructure.

Lack of focus on the importance of the estate as an enabler of high quality care in recent years prompted the Secretary of State for Health, in 2016, to commission Sir Robert Naylor to conduct an independent review and make recommendations on the options available to realise better value from NHS property, and deliver Department of Health and Social Care targets to release £2 billion of assets for reinvestment and to deliver land for 26,000 homes.

The Government has responded (The Government response to the Naylor Review – January 2018), agreeing with the primary conclusion that the NHS must manage and use its estate more efficiently and strategically, whether by selling land and buildings that are no longer needed for delivery of clinical services, or using the land to develop new services or to provide housing.

The Government's vision is of an efficient, sustainable and clinically fit for purpose estate, one where the NHS:

- Provides a modern estate equal to delivering the vision of the 5YFV and new models of care
- Ensures local strategic estates planning reflects changing delivery models
- Aligns with current and future clinical service strategies, for the benefit of patients, local communities and partners in the Sustainability and Transformation Partnerships (STPs) and, in time, Accountable Care Systems (ACSs)
- Proactively takes steps to maintain its assets and reduce backlog maintenance
- Replaces what cannot be cost-effectively maintained and releases what it no longer needs, maximising receipts which can be reinvested into new premises and new services
- Understands the cost of its estate, with comprehensive, accurate and comparable information underpinning estates-related decision making
- Draws on expert advisers where it needs to, but builds its own capabilities to become an effective informed client on estates matters

In summary, the actions to support the Government's vision are to:

- Build capability and capacity in strategic estates planning and management.
- Invest in estates transformation and align it with a wider sustainability and transformation agenda by providing £3.9 billion of additional capital by 2022/23 including:
    - £2.6 billion to support STP estates transformation plans, in addition to £425 million announced earlier this year
    - £700 million to tackle critical maintenance issues and support turnaround plans in struggling trusts
    - £200 million to support efficiency programmes, allowing more time and money to be directed to patient care

- Enable local NHS organisations and STPs to take a more strategic approach to estates planning and management by:
    - Allowing NHS organisations to retain receipts from land sales, on condition that they are reinvested in the NHS estate to deliver local priorities and STP strategies
    - Requiring STPs to regularly update their estates strategies, to "futureproof" the estate so that it accommodates the requirements of changing clinical service strategies and supports STPs' visions for local clinical excellence and financial sustainability
    - Encouraging NHS providers to give greater prominence to estates matters in Board discussions
    - Encouraging STPs and NHS providers to work with local government and other public-sector organisations as part of the One Public Estate programme
    - Supporting the NHS to develop surplus land for NHS staff and other residential housing
    - Supporting the NHS to realise £3.3 billion of additional capital from the disposal of surplus land

2.5 Structure of the draft strategy

This first section has set out the context, objectives and guiding principles of the Strategy. The following sections:

- Provide an overview of the Trust and the development of this draft Estate Strategy
- Describe the Trust's current estate, including the condition of its buildings and performance on estates metrics
- Summarise the estate vision and principles
- Set out the strategic context, policy drivers and commissioning intentions, including Healthier Together and Stockport Together
- Describe a potential site development plan to address current issues and make the Trust's estate fit for the future
- Assess the impact of that site development plan and how implementation will drive improved performance and facilitate strategic change
- Define the Trust's approach to risk management and mitigation in the context of the estate
- Describe the Trust's approach to procurement and identify potential sources of project finance to support delivery
- Set out the Trust's environmental action plan

At this stage of its development, this draft Estate Strategy sets out a possible scenario, which is intended to stimulate debate. The parameters of that debate go well beyond 'the estate' itself and the physical environment and are closely aligned with the Trust's vision and aspirations and those of its partners.

Although based on sound evidence and a clear rationale, the Estate Strategy, as a draft, does not purport to set out a definitive 'solution' but it does offer a direction of travel and a framework for debate, prioritisation and decision making. It also represents a statement at a point in time and under a particular set of circumstances and assumptions – it is vital that it remains a living document that continues to evolve as those circumstances change and new challenges emerge.

3 Trust overview and development of the Estate Strategy

3.1 Trust overview and overall service profile

The Trust provides the full range of district general hospital services for children and adults across Stockport and the High Peak, as well as community health services for Stockport. As an associate teaching hospital, we are also proud to help train doctors and nurses for the future.

Our main hospital is Stepping Hill, south of the town centre, which receives around 500,000 patients every year, with additional community services delivered through 24 health centres and people's homes.

We also run specialist units including the Devonshire Centre for neuro-rehabilitation, Meadows palliative care centre and Swanbourne Gardens respite facility for children and young people with severe disabilities.

We are the second largest employer in Stockport, with approximately 5000 highly-skilled, committed and award-winning employees. Our annual budget is circa £300 million.

As a Foundation Trust we have a Board of Governors who are the voice of the local community, the majority of whom are elected from our public membership.

We are now one of four specialist centres, as part of the Healthier Together decision, for emergency and high risk general surgery in Greater Manchester. As part of the Stockport Together partnership, we are at one of the most exciting and transformative points in our history. The partnership brings Stockport's providers of primary and secondary health and social care services together, as part of a formal alliance, to deliver integrated services closer to people's homes.

The Trust also sits within the sustainability and transformation plan footprint of Greater Manchester and will be part of the future development of an Integrated Care System.

3.2 Trust values, vision and priorities

Our values are at the heart of everything we do as an organisation and come from our '*Your Health. Our Priority*' promise. This means putting people at the centre of everything we do. These values drive the behaviour and actions of every person in our organisation and have been developed through talking to our patients and staff about the behaviours necessary to consistently deliver safe, effective and compassionate care. The values are about:

- Quality and safety - we deliver safe, high quality, compassionate care and a clean and safe environment for better care
- Communication - we treat our patients, their families and our staff with dignity and respect and communicate with everyone in a clear and open way
- Service - we provide effective, efficient, innovative care and work in partnership with others, to deliver improved care, in the right place at the right time

Our vision is to achieve excellent patient care each and every time.

Our mission, or purpose, as a Trust is to provide safe, high quality, integrated care to people through a range of excellent, accessible health and social care services.

Our strategic priorities and associated aims are:

- Quality improvement – to keep our patients safe at all times
- Financial resilience – to be a well-led and governed Trust with sound finances
- Partnership working - develop effective partnerships that support better patient care

- Operational performance - provide excellent patient experience and deliver expected outcomes
- Leadership development - create a culture of clinical excellence through highly developed and resilient leaders

3.3 Drivers for change

The draft strategy seeks to identify the key drivers for change across the Trust and its partners, where, how and when change will occur, for example in areas such as:

- Activity and growth, in total and across all services/specialties
- Changes in priorities and models of care
- Collaboration and partnership – now and in future and implications of change
- Technological advances and their impacts
- Patient experience and satisfaction, effectiveness and outcomes - what drives improvements in these areas?
- Staff recruitment, retention and satisfaction

It then seeks to set out how the estate respond, what impact these changes will have and how the estate can support and facilitate continued success over short/medium and longer term?

3.4 Developing the Estate Strategy

This Estates Strategy which will set out the processes and routes to enabling the Trust to fulfil its plans and improve the condition of its buildings and overall site coherence.

The first stage of developing the Estate Strategy includes a comprehensive appraisal of the condition and performance of the existing estate and covering:

- Physical condition
- Compliance with fire, health & safety and other statutory standards
- Environmental Management
- Functional suitability
- Space utilisation
- Quality
- Adaptability

The Trust will consider how to address the current poor condition and performance of the estate and move toward the provision of safe, secure, appropriately positioned and high-quality buildings that are used efficiently and effectively for the delivery of modern healthcare services. However, the Estate Strategy and any future investment must be service and user led with patients at the centre of any proposed changes.

Whilst the estate is highlighted above as a key enabler, the use and quality of the Trust estate runs through each of the above strands in one form or another, as defined by this strategy. The Trust needs to develop innovative and forward-looking solutions that will achieve a productive estate and aims to:

- Improve accessibility to healthcare for patients who need our services
- Improve the condition and performance of the estate
- Refurbish/redevelop the Trust's clinical estate, aligned with the capital plan
- Promote and facilitate new ways of working
- Integrate services with the wider health community and improve utilisation by collaborating with the whole health community and public sector more widely
- Provide staff accommodation to support recruitment and retention

- Provide modern facilities such as restaurants and retail outlets to support 7-day working
- Disinvest in assets with high operating costs, back log maintenance requirements and investing to reduce backlog maintenance
- Improve asset performance on all key performance indicators
- Dispose of any property and land surplus to future clinical requirements, where there is a clear strategic benefit in doing so
- Release capital from underutilised assets

The Estates Strategy cannot be developed in isolation. The strategy is closely aligned with the emerging strategic view and clinical services plan enabling robust service planning as the Trust and wider community move forward.

Our Estate Strategy will provide the following benefits:

- Estates development clearly linked with the Trust's strategic direction and objectives
- Board level commitment to sustainable development and carbon reduction initiatives
- An opportunity to dispose or develop any surplus land
- An opportunity to reduce underutilised areas of the estate
- A means of targeting investments to minimise risks associated with the estate
- An opportunity to recruit and retain staff by offering a good standard of staff accommodation

As a part of the Trust's Estate Strategy, the Trust's vision is to consolidate the estate and achieve a significant reduction in floor area by 2019, with no unoccupied or underutilised floor area. Estate consolidation is possible through a variety of methods including working with our partners, improved space utilisation and agile working.

The agile working initiatives now being implemented by the Trust will begin to reduce reliance on dedicated, permanent desks for certain groups of staff and improve efficiency and effectiveness. Hot desking facilities, supported by appropriate technologies, will be among the solutions adopted. In addition, the development of new agile working practices will directly support other Trust initiatives including the Estate Strategy plans and the Trust's commitment to sustainability by reducing unnecessary travel and production of paper documentation.

This document sets out the Trust's Estate Strategy and supporting vision for up to the next 20 years. It aligns with and supports the delivery of the Trust's core strategies. Specifically, it addresses the development of the estate, the evolution of a coherent long term masterplan and the capital investment required to deliver it, which will have a positive impact on the hospital in the long term.

The strategy makes a clear statement at a point in time but will not be a fixed document; it will evolve and adapt to the changing requirements of the Trust and its stakeholders and will be updated regularly to maintain its relevance. Future directions in healthcare, as well as changes within the Trust itself and the environment in which it operates, cannot all be known or predicted with any degree of certainty. A long term estate strategy such as this must therefore remain responsive to change so that it continues to meet the Trust's needs.

4 The Trust's current estate

4.1 Introduction and overview - where are we now?

This Estate Strategy exists to facilitate delivery of the current and future healthcare needs of our population. We start that process by identifying the current condition of our healthcare estate.

4.1.1 Main estate age profile

The Table below and Figure 10 show the age profile of the buildings that occupy the main site at Stepping Hill Hospital. The core of newer facilities are wrapped in and around the 1980's nucleus development that currently accommodates emergency care services along with some radiology and diagnostics services as well as higher acuity and surgical care services.

	Area	
Profile by Build Date	m^2	%
Age profile - 2015 to 2024	6108.00	7.22
Age profile - 2005 to 2014	7895.00	9.33
Age profile - 1995 to 2004	19533.00	23.08
Age profile - 1985 to 1994	2817.00	3.33
Age profile - 1975 to 1984	12908.00	15.25
Age profile - 1965 to 1974	18826.00	22.25
Age profile - 1955 to 1964	7542.00	8.91
Age profile - 1948 to 1954	1864.00	2.20
Age profile - pre 1948	7122.00	8.42

Figure 10. Age profile of building at Stepping Hill Hospital

4.2 Description of the existing estate

4.2.1 Stepping Hill Hospital

The Stepping Hill estate has some 37 buildings predominately single storey on 14.2 hectares of land. A large part of the Stepping Hill estate and services are more than 60 years old, with some over 100 years old, meaning that many of the buildings and services are past their useful life. A combination of old buildings and ageing plant presents operational challenges that in some cases prevent the hospital from working at maximum efficiency. A lack of investment in backlog maintenance over the years has exacerbated this situation to a point where only a very few buildings remain serviceable and suitable for modern healthcare.

The Trust has a new flagship building focused on the delivery of surgical services, delivering significant benefits for our patients, but our ability to update the rest of the site to this standard is restricted by our financial position. This has a negative effect on patient and public perception of the Trust, with some elective patients choosing to go elsewhere for treatment. Aspirations to form strategic business relationships in order to deliver retail services onsite and increase income may also be hampered and we are reviewing this.

We are not unique in these set of challenges. Over the last few years public sector organisations within Stockport have been working successfully to remodel and achieve efficiencies from their estates. However, it is recognised that a more collaborative and innovative approach is now required to be able to break down historic barriers and to pool resources more effectively for the wider system benefit. This approach aligns fully with the Greater Manchester One Public Estate Initiative that was recently launched.

Stockport public sector partners are committed to delivering improved public services for everybody in the area by directly delivering or commissioning the highest quality services available. We want to provide these high-quality services as close to our resident's communities and homes as we can, in a joined-up way, giving them the best possible value for money and improved accessibility at a time and location convenient with them).

Figure 11. A summarised graphic of the current Stepping Hill Hospital site with key hospital functions overlaid

4.2.2 The Devonshire

The Devonshire Neuro-rehabilitation Centre which opened in July 2000 is located at the junction of Dialstone Lane and Cherry Tree Lane, 2½ miles S.E. of Stockport town centre and ¾ mile from Stepping Hill Hospital.

The Devonshire Centre is a 19 bedded Centre and provides neurological rehabilitation care for patients with an acquired brain injury or who suffer from neurological illnesses living in the Stockport and the surrounding areas. The Centre is specifically designed for patients requiring neuro-rehabilitation and includes a purpose built therapy and pool room. Care is delivered by consultants in rehabilitation medicine, medical staff, nursing staff, physiotherapists, occupational therapists, speech and language therapists and a psychologist experienced in the field of neuro-rehabilitation.

4.2.3 The Meadows

The Meadows provides a wide range of mental health and specialist care services for older people, including a dementia day care service and community outreach services. The mental health liaison service won a Principles of Care Award for providing outstanding support.

The Meadows was opened in 1999. It provides 80 in-patient beds, some of which operate as respite beds. The range of care services includes intensive intervention for those in crisis, assessment of patients with a functional mental illness, diagnosed or undiagnosed, step down services for Stepping Hill Hospital and on-going services for those with enduring mental health problems as well as those receiving acute physical health care.

The Meadows was procured under a Private Finance Initiative and is currently operated in partnership with Walker Healthcare and Stockport NHS Foundation Trust. However the concession for provision of estates and facilities services rests with walker Healthcare and these are provided via a third party agreement with MITIE.

4.2.4 Swanbourne Gardens

Swanbourne Gardens is a purpose built house located in Edgeley in Stockport providing respite and short breaks to children aged 5 to 18 with learning disabilities and complex heath needs. The building has capacity for four children to stay overnight. Staff are employed by Stockport NHS Foundation Trust and the building is leased from a housing association.

The facilities include two wheelchair adapted vehicles so that children can experience as many events as they may wish, promoting social inclusion. There are four bright bedrooms, a lounge, dining room, activity room, kitchen and bright conservatory and garden.

4.2.5 Other properties

The Trust also provides services to a much larger area, delivering NHS community health services from 27 locations across the Stockport Borough. These properties are generally leased via NHS Property Services and as such come with estates and facilities services as part of the lease.

The Trust is working closely with both the Community Business Group and NHS Property Services in reducing the footprint of property to drive down cost. More recently we have been successful in releasing space in 2 buildings within Stockport as well as re-negotiating leases to bring about savings.

4.3 Evaluation of the existing estate: The 6-facet survey

The 6 Facet Survey forms the ‘core’ estates information required by HBN 00-08 (NHS EstateCODE). Historically this has always been regarded as the ‘minimum data set’ of information necessary on which to base intelligent decisions about the future of an estate. It provides good baseline information for an Estates Strategy and can assist property transfer and is consistent with the updated NHS Premises Assurance Model (PAM) and the updated ERIC Returns and the Carter and Naylor Reviews.

Thorough six-facet surveys have been undertaken to enable appraisal with regard to fitness for purpose for health care buildings in terms of use, condition and compliance. The six facets which are assessed and ranked are:

- Physical condition
- Functional suitability
- Space utilisation
- Quality
- Fire, health and safety requirements
- Environmental management

Each facet is broken down into building systems and fabric elements as well as highlighted written information about the property for example any defining issues are raised to give context to the backlog findings. Following reviews score A to DX are provided for all major property facets. This can then be used to drive Estates Strategy updates (and or property rationalisations and investment plants) as described by Estatecode Section 4: “Land and Property Appraisal” and as referred to in the Department of Health’s ‘Developing an Estate Strategy’. The report summarises these findings and provides indicative investment costs.

All the backlog condition surveys (the 'Physical condition' facet) are based on the approach to such information assessment as described in the Department of Health's risk based approach to assessing backlog maintenance.

4.4 Estate physical condition

4.4.1 Stepping Hill Hospital estate

4.4.1.1 Introduction and context

At this stage, this draft document focuses very much on a strategic direction for the estate to respond to the overall strategy for the Trust. The concept of lifecycle and maintenance might therefore be considered more of an operational issue but it becomes a strategic issue when lack of continued investment in the life-cycle and maintenance of buildings impacts on the strategic aspirations of the Trust. The physical estate is in many areas suffering from a lack of investment in its upkeep, which negatively impacts on its functionality and creates a sense of malaise across the hospital site.

This strategy recognises this issue as one of the most fundamental concerns that impacts on the attractiveness of the hospital site and needs significantly more resources to remedy current defects in some buildings. This requires a costed programme of investment across the Trust's central estate either to improve the grades of current buildings through refurbishment programmes or replace unfit buildings through a planned programme of further investment.

Such issues of comparatively poor overall estate impact on the attractiveness of the environment, working conditions and a sense of wellbeing but also have a material impact on a range of important estate metrics. Ageing and poorly maintained estate has a negative effect on satisfaction, ties up energy and resources in merely trying to maintain the estate in working order results in poorer than average statistics for energy use and environmental sustainability and will prevent the Trust from reaching its corporate goals. This Strategy sets out a vision and indicative programme for how the estate may be improved over the short to long term to support its vision for the future.

4.4.1.2 Summary of the physical condition of the estate

Figure 12 notes the overall grade of the estate based on an assessment of the value of the building compared to the cost of improving or repairing that building to condition B or above. The greater the cost of repair and improvement compared to the value of the building, the lower the current assessment of the building's grade. This summary is based on the most recent six facet survey and analysis of building condition.

As previously noted, there is a core of newer buildings in generally better condition, which can act as the functional heart of the hospital as it is redeveloped. These analyses of suitability, condition and backlog maintenance costs reinforce this concept and also highlight very clearly the buildings, and zones of the hospital estate, in the worst condition and presenting the most obvious opportunities for site clearance and greater efficiency.

Whilst the condition of the buildings does not represent the primary driver for the estate strategy, the condition of the buildings will be considered in any assessment of funds utilisation to bring such buildings back towards a Category A condition. A number of buildings are functionally poor and are not considered capable of supporting modern healthcare services and it is therefore uneconomic to continue to support these buildings in terms of backlog maintenance.

As a long term strategy which identifies the phasing and timing of demolition of such buildings is further developed, such buildings should be maintained to the minimum to

provide adequate care and services in anticipation of the strategic redevelopment of those services.

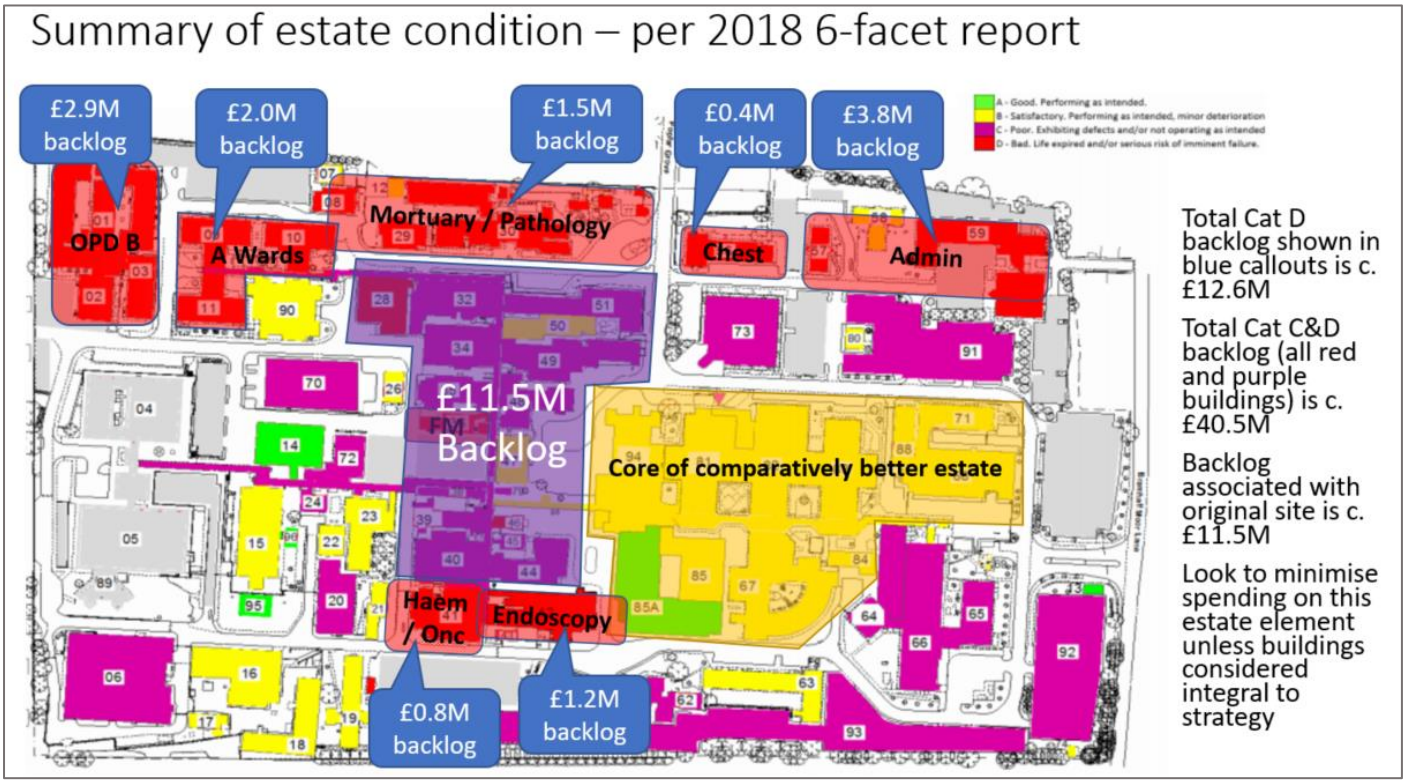


Figure 12. Summary of Stepping Hill site backlog maintenance issues

4.5 Backlog maintenance analysis

The definition of "Backlog" is the amount of repair and maintenance work needed to bring a property up to a certain standard of physical condition. The Trusts Backlog consists of items, services and plant that fall into a condition that is less than a class B category. In addition to this all items on the Trusts Backlog register have been risk assessed in order of four priorities:-

- High Risk – requiring investment urgently to reduce such risk
- Significant risk - should be planned to be dealt with as a priority
- Moderate risk – should be dealt with as soon as all greater risks have been removed
- Low risk – should be monitored and addressed when funding is available

The total backlog maintenance, based on the latest 6-facet survey undertaken in April/May 2018 is circa. £61.1M summarised below in Figure 13.

Condition Category	Backlog Maintenance Cost
B	£18,536,250.00
C	£18,471,600.00
D	£24,189,610.00
Total	**£61,197,460.00**

Figure 13. Backlog maintenance costs by condition category

The total backlog maintenance costs by grade and by summary works description are shown overleaf in Figure 14.

	CONDITION CATEGORY			
Summary of Works Required	**B**	**C**	**D**	**GRAND TOTAL**
A - Building - Physical Structure	£0	£180,500	£2,000	£182,500
B1 - Building - External Fabric	£227,750	£979,300	£24,300	£1,231,350
B2 - Building - External Fabric	£902,750	£3,399,150	£130,500	£4,432,400
C - Building - Internal Fabric	£4,465,250	£5,863,650	£558,350	£10,887,250
D - Building - Roof - Flat	£234,750	£2,796,400	£128,750	£3,159,900
D - Building - Roof - Pitched	£139,800	£431,200	£100,500	£671,500
F - Building - External Works	£2,500	£1,310,100	£9,000	£1,321,600
I - Engineering - Heating Systems	£816,050	£223,000	£0	£1,039,050
J - Engineering - Steam Systems	£199,000	£0	£0	£199,000
K - Engineering - Vent & Cooling	£5,411,500	£154,000	£0	£5,565,500
L - Engineering - Medical Gases	£107,000	£419,750	£0	£526,750
M - Engineering - Hot/Cold Water	£667,250	£233,700	£0	£900,950
N - Engineering - Lifts	£975,000	£36,000	£0	£1,011,000
O - Engineering - Medical Systems	£778,500	£105,000	£0	£883,500
P - Engineering - Lightning Protection	£0	£3,000	£0	£3,000
R - Engineering - Electrical	£3,600,750	£2,333,900	£22,000	£5,956,650
Statutory Compliance	£0	£0	£23,214,210	£23,214,210
V - Engineering - Fire Systems	£6,000	£2,950	£0	£8,950
X - Engineering - Fuel Storage	£2,400	£0	£0	£2,400
Grand Total	**£18,536,250**	**£18,471,600**	**£24,189,610**	**£61,197,460**

Figure 14. Summary of backlog maintenance by works type

Of the £55.2M backlog maintenance requirement, £21.9M (circa 40%) relates to statutory compliance issues. All buildings which have statutory compliance issues are Condition D and relate to asbestos (£19M) and fire compartmentalisation (£2.8M) issues.

The risk associated with the backlog maintenance requirement is superimposed on the total cost of backlog maintenance below in Figure 15.

Risk Assessment of Backlog Maintenance	B	C	D	Grand Total
Low	£3,075,450	£1,141,350	£48,000	**£4,264,800**
Moderate	£11,450,700	£2,325,000	£20,575,850	**£34,351,550**
Sigificant	£3,786,900	£13,713,000	£3,478,760	**£20,978,660**
High	£223,200	£1,292,250	£87,000	**£1,602,450**
Grand Total	**£18,536,250**	**£18,471,600**	**£24,189,610**	**£61,197,460**

Figure 15. Total backlog maintenance requirement by risk and condition category

A full analysis of backlog maintenance can be found at Appendix A.

4.6 Backlog Projects Undertaken 2015 – 2018

The previous 3 years backlog maintenance works undertaken are listed below. Expenditure has been significantly below anticipated levels to actively reduce backlog levels, particularly in 2015 and 2016. Capital expenditure rose in 2017 working towards effectively reducing the associated backlog risks.

Backlog Maintenance 2015/16	
Scheme Title	**Value**

Pest Control	£10,000
Roof Repairs	£30,000
Heating Systems Upgrade	£25,000
Ventilation Duct Cleaning	£15,000
Pre-paint Prep	£30,000
Painting programme	£30,000
Pest Control	£10,000
Fire Precautions	£130,000
Legionella Prevention	£15,000
Asbestos Removal	£15,000
Equality Act	£30,000
Slips, Trips and Falls	£15,000
Electricity at Work	£30,000
Ward Kitchen EHO Compliance	£10,000
Fire Precautions	£130,000
Total	**£385,000**

Backlog Maintenance 2016/17	
Scheme Title	**Value**
Poplar Grove Corridor Roof Repair	£15,000
Pathology Lab Roof Repairs	£10,000
Restaurant Corridor Roof light Replacement	£10,000
Eye Centre Boiler Replacement	£20,000
Ward A14 Window Replacements	£20,000
Holly House Window Replacements	£5,000
Ward E3 Window Replacements	£10,000
Cedar House Window Replacement	£25,000
Oak House Window Replacement	£10,000
Fire Safety Report Infrastructure Reinforcement	£20,000
External Waste Storage Compounds	£40,000
Internal Waste Disposal Rooms	£20,000
Electrical Remedial Works	£40,000
Accessible Shower Room in Ward A1	£30,000
EHO Maternity Kitchen Upgrades	£15,000
Total	**£290,000**

Backlog Maintenance 2017/18	
Scheme Title	**Value**

Nurse call replacement (E3, E1, B5 and B6)	£50,000
Main corridor pipework alterations (Phase 1)	£100,000
Main corridor flooring replacement	£50,000
Lift Control Panels (Lift 11 - Woodlands)	£23,000
E3 Window Installation	£20,000
Maternity water storage tank replacement (4no.)	£80,000
Holly House window replacement	£5,000
Willow House window replacement	£20,000
Cedar House window replacement	£30,000
Nurse call replacement (E3, E1, B5 and B6)	£50,000
Main corridor pipework alterations (Phase 1)	£100,000
Main corridor flooring replacement	£42,000
Lift Control Panels (Lift 11 - Woodlands)	£23,000
Maternity water storage tank replacement (4no.)	£80,000
Holly House window replacement	£5,000
Willow House window replacement	£20,000
Cedar House window replacement	£30,000
Road resurfacing / line marking	£20,000
Nurse call replacement (E3, E1, B5 and B6)	£50,000
Main corridor pipework alterations (Phase 1)	£100,000
Main corridor flooring replacement	£42,000
Lift Control Panels (Lift 11 - Woodlands)	£23,000
Maternity water storage tank replacement (4no.)	£80,000
Holly House window replacement	£5,000
Treehouse Smoke Damper Installation	£5,000
Structural Fire Protection	£30,000
Waste Storage Compounds	£20,000
Equality Act Works	£15,000
EHO Compliance	£10,000
Asbestos Management	£7,500
Legionella Compliance	£7,500
Total	**£1,124m**

4.7 Functional suitability

The functional suitability analysis describes how effectively a site, building or part of a building supports the delivery of a specified service. The criteria used in such assessments include:

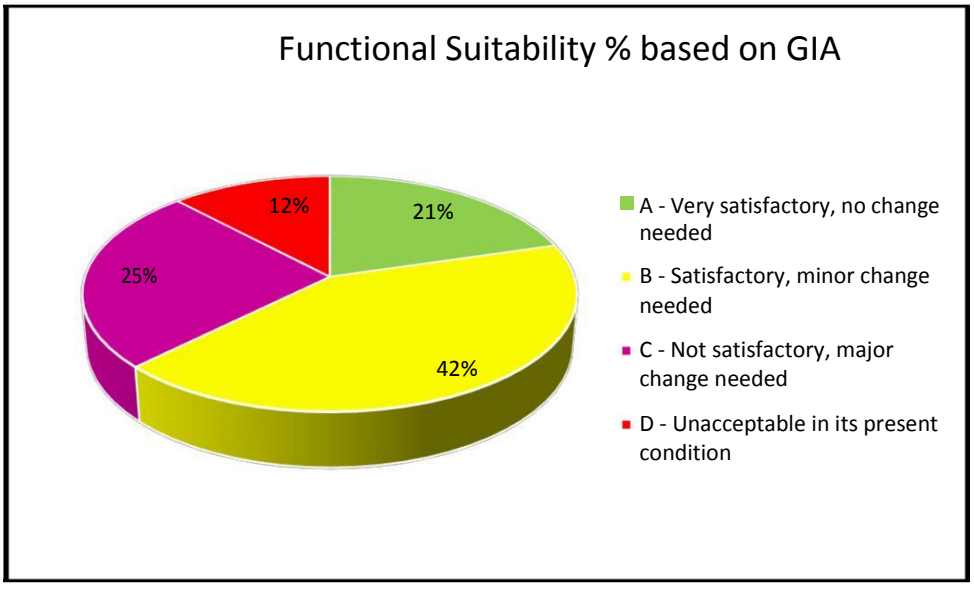
- Space relationships
- Services
- Amenity
- Location
- Environmental conditions
- Overall effectiveness

Assessments were undertaken with service managers for each particular area of the main NDDH hospital site and community hospitals by in house facilities staff. Areas assessed included clinical and non-clinical areas.

The Estatecode categories for functional suitability are:

- A: High degree of satisfaction (no change)
- B: Acceptable/reasonable (minor change necessary)
- C: Below acceptable standard (major change)
- D: Unacceptable in its present condition
- X: Supplementary rating added to Estatecode category D to indicate that the facility is below standard that nothing but a total rebuild will suffice

A pie chart illustrating the results of the functional suitability assessment by floor area for all properties is provided below:



4.8 Space utilisation

As part of this Estate Strategy, an assessment of the levels of non-clinical departmental and building utilisation has been undertaken.

The assessments were based on NHS guidance documentation, Hospital Technical Memorandums and Health Building Notes. Interviews were then carried out with service managers.

The space utilisation analysis identifies under or over-utilised floor space. Under-use of space is serious since it represents a waste in terms of property overhead costs, for example energy, maintenance, cleaning, capital charges and rates. Unused spaces may be difficult to re-use or release because of their physical features, scattered locations, and physical barriers to their rationalisation. Over-utilised space may impede the effective delivery of healthcare. The Estatecode categories are:

- Empty
- Underused
- Fully used
- Overcrowded

Whilst it is accepted that these definitions are both open to interpretation and are subjective. They do, however, provide a useful snapshot of the space currently available. In addition in accordance with the 2016 Carter Report and the need to manage the non-clinical occupied space this information is included in this section.

The following charts represent a summary of the space utilisation assessment undertaken across the whole of the Trust's estate and are based on assessments originally done in October 2017 as part of the Stockport Together Estates Enabling work.

Non Clinical Desk Utilisation

Non-Clinical Desk Utilisation

BLOCK	FLOOR	GIA m2	NIA m2	DESKS	SQM DESKS	UTILISATION %
Block 2 - Medical Records	Ground	365	274	13	21.1	54
Block 3 - EPR	Ground	377	324	74	4.4	27
Block 6 - Medical Records / Facilities	Ground	1977	260	69	3.8	54
Block 18 - Estates	Ground	590	237	28	8.5	54
Block 18 - Estates	First	229	194	19	10.2	40
Block 19 - Beech House	Ground	434	295	34	8.7	43
Block 21 - Birch House	Ground	184	257	12	13.1	49
Block 22 - EBME	Ground	170	73	4	18.3	35
Block 24 - Switch	Ground	93	55	9	6.1	50
Block 24 - Switch	First	93	74	8	9.3	50
Block 57 - Ash House	Ground	161	128	17	7.5	78
Block 57 - Ash House	First	164	127	26	4.9	65
Block 59 - Aspen House (Old)	Ground	812	444	62	7.2	40
Block 59 - Aspen House (Old)	First	640	501	66	7.6	53
Block 59A - Aspen House (New)	Ground	491	231	29	8	52
Block 59A - Aspen House (New)	First	484	407	43	9.5	56
Block 62 -Willow House	Ground	386	255	49	5.2	40
Block 63 - Cedar House	Ground	611	484	52	9.3	46
Block 63 - Cedar House	First	611	470	77	6.1	46
Block 63 - Cedar House	Second	611	524	101	5.2	42
Block 67 - Treehouse	Second	729	584	76	7.7	50
Block 73 - Pinewood House	Ground	1109	254	20	12.7	56
Block 73 - Pinewood House	First	1032	505	45	11.2	25
Block 90 - DMOP	Third	849	580	57	10.2	38
TOTAL		**13,202**	**7,537**	**990**		

Clinical Desk Utilisation

Clinical Desk Utilisation						
BLOCK	FLOOR	GIA m2	NIA m2	DESKS	SQM DESKS	UTILISATION %
Block 1 - Outpatients B	Ground	1613	1281	14	8.9	50
Block 7 - Cardian research Centre	Ground	118	108	5	7.6	80
Block 8 - Occupational Health	Ground	268	240	8	13.6	38
Block 28 - EEG, ECG, Lilac Suite	Ground	535	456	19	9.6	63
Block 32 - Eye Centre	Ground	721	382	9	16.9	83
Block 34 - Physiotherapy	Ground	320	220	5	5	50
Block 38 - Rowan Suite	Ground	197	170	8	5	53
Block 39 - Magnolia Suite	Ground	314	274	12	7.8	24
Block 40 - Radiology B	First	217	162	17	9.5	54
Block 42 - Endoscopy	Ground	689	408	9	14.2	72
Block 44 - Bobby Moore	Ground	519	405	6	12.5	66
Block 48 - Poplar Grove Entrance	Ground	465	282	35	6.9	57
Block 56 - Chest Clinic	Ground	426	336	21	12.2	68
Block 61 - Cardiac Rehabilitation	Ground	224	178	8	9.1	50
Block 66 - Maternity	Sixth	928	740	74	10	46
Block 72 - Urology	Ground	414	266	11	13	48
Block 82 -Radiology A	Ground	1501	704	27	12.1	43
Block 83 - Outpatients A	Ground	1050	505	10	9.5	35
TOTAL		10519	7117	298		

The average workstation utilisation for Stepping Hill hospital throughout the week was measured at 48%, waiting areas seats 19% and meeting rooms at 36%. These figures are for all clinical and non-clinical space (back office) and do not include wards. These figures indicate an oversupply of meeting room space and waiting area seats.

There are 298 workstations within the clinical blocks which were measured at 50% workstation utilisation. By definition many staff who have workstations within the clinical areas will spend time away from their desks performing their duties/functions, this would indicate that the space is well utilised and that there is little scope to free up space within these areas.

The non-clinical functions i.e. back office, total 990 workstations with an average utilisation rate of 47% offer up opportunities to free up workstations and space. The current functions could operate from 560 workstations which is the average utilisation plus a 20% buffer. This could free up 430 workstations or equivalent space for other uses.

The Trust should consider adopting the following strategies to ascertain costs and potential square meter savings, in effect a cost benefit analysis of potential space savings.

- Design a moves strategy to condense departments into fewer buildings without carrying out any major refurbishment
- Investigate how a workstation ratio would affect the functionality of departments, under this scenario for every 10 Whole Times Equivalent staff (WTE) there would be an allocation of between 6 & 8 workstations
- By either accident or design the workplace strategy at Stepping Hill has resulted in high numbers of staff being located in small cellular space. Of the circa 1260 workstations, 50% are situated in 1 - 4 person offices, which includes 112 single person offices across the site. This is both spatially inefficient and a barrier to collaboration. A policy of refurbishing blocks to enable open plan working would further increase capacity
- New build office block to accommodate all non-clinical functions, freeing up space on the site

4.9 Energy and sustainable development

This Estate Strategy recognises the need to ensure that all aspects of 'sustainability', in different ways and at different levels, become mainstream and are considered part of short term planning and longer term strategy. In making sustainability integral to these processes the objective is not to constrain or delay the developments required but to ensure that the consequences of investment decisions in terms of sustainability, for example impacts on the Trust's energy/carbon reduction targets, are fully understood.

The sustainability agenda can support flexibility and adaptability for the future and, when redeveloping the Trust's estate or individual buildings, sustainability should be considered in terms of:

- Biodiversity and habitat
- Energy and carbon and potential offsetting
- Health and wellbeing
- Waste management
- Environment in a holistic sense
- Innovation and research
- Aesthetics and living environments
- Energy Consumption Categories
- Energy Consumption
- Energy Costs
- An Energy Strategy – the First Steps
- The European Union Emissions Trading Scheme
- Carbon Management Implementation Plan

4.10 Ongoing capital development

The Trust is continuing to invest in its estate, recognising the need to continue to maintain its existing building and engineering infrastructure as well as investing in new innovative technologies that provide potential revenue incentives.

In 2018/19, the estates capital investment programme is circa £3m and made up of the following key projects:

- ED Patient Streaming – The £1.2 million building programme will enable the hospital to improve patient waiting area and reception and create additional consulting and treatment rooms. The scheme is designed to make it easier for patients go straight to the area most suitable for their needs and assist staff to provide immediate care for minor illnesses and injuries where required.
- HSDU New Build Extension – The £770k project new provides a centralised decontamination facility that supports sterilisation services to Urology, Endoscopy and Theatres.
- Backlog Maintenance - £1.2m of funding has been allocated against several schemes aimed at reducing this liability.

With limited capacity to generate further capital internally, the organisation has sought additional investment by applying for national STP capital funding via GM (currently Wave 4) to support the site transformation plans. Two bids were submitted in June 2018 which consisted of the following:

- Emergency Campus – The £31m proposal delivers a new 3-storey purpose built multi-disciplinary facility opposite the existing Emergency Department (ED) with an integrated link to provide:
    - A new 'Emergency Campus' setting at the heart of Stepping Hill hospital; and

    - A number of building extensions and internal remodelling/refurbishments around the 'Emergency Campus' footprint that collectively will provide a sustainable integrated clinical service model.
- Essential Services Laboratory (ESL) - The £5.6m proposed development would provide a new single storey ESL would replace an aging laboratory and deliver the future needs of the Trust, commissioning CCGs and coincide with pathology consolidation across Greater Manchester (GM).

The outcome of these bids is expected to be received in the autumn of 2018.

4.11 Allocation and appropriate use of capital resources

Any successful bids for external capital are generally accompanied with conditions to ensure that any allocated capital is only spent within the designated department or area that met the original criteria was awarded against. This can then benchmarked against any original submission benefits.

An example of this was the £1m recently awarded to the Trust to initiate ED Patient Streaming which forms the majority of the £1.2m construction project.

5 Estate vision and principles

5.1 Introduction

The Trust's vision is to be an outstanding healthcare provider, committed to improving quality, and caring with compassion. A safe, reliable estate supporting delivery of effective, efficient services and facilitating transformation is a key enabler in realising this vision.

The Trust will need to address the current poor condition and performance of the estate and move toward the provision of safe, secure, appropriately positioned and high-quality healthcare buildings that are used efficiently and effectively for the delivery of modern healthcare services. However, the Estate Strategy and any future investment must be 'service and user led' with patients at the centre of any proposed changes.

Changes are taking place both within the local health economy and nationally to ensure that the NHS is fit for the future. The NHS recently published its Five Year Forward View highlighting the challenges faced.

Whilst the estate is highlighted above as a key enabler, the use and quality of the Trust estate runs through each of the above strands in one form or another, as defined by this strategy.

The Estates Strategy cannot be developed in isolation. The strategy is closely aligned to the strategic direction, enabling robust service planning as the Trust and wider community move forward.

5.2 Aims and objectives

The Trust will develop innovative and forward-looking solutions that will achieve a productive estate and aim to:

- Support and facilitate delivery of the Trust's organisational and clinical strategies
- Improve accessibility to healthcare for patients, providing sufficient capacity in appropriate locations, with flexibility to respond to changes in demand and new ways of working in the future
- Integrate services with the wider health community
- Promote and facilitate new ways of working
- Improve utilisation by collaborating with the whole health community and public sector
- Improve estates asset performance on all key performance indicators
- Disinvest in assets with high operating costs, back log maintenance requirements
- Ensure that estates risks are managed and that non-compliance with statutory and non-statutory standards is minimised
- Release capital for reinvestment from underutilised assets where retention is no longer consistent with the Trust's clinical strategy
- Provide staff accommodation to support recruitment and retention
- Provide modern facilities such as restaurants and retail outlets that will support 7-day working
- Set out a baseline of information and gaps to guide decisions on priority setting and next steps and work to close those gaps to increase the robustness of investment decisions
- Enable improvements to be delivered rapidly but cost-effectively recognising the urgent need for investment as well as the constraints of capital and revenue funding

5.3 General principles

General principles in delivering the estate strategy are that:

- Treasury provided capital funding is very unlikely to be available to improve facilities
- Estate investment will be guided by the shared aspirations of partners in the local and regional health and social care community to achieve transformation
- The plans emerging from this estate strategy framework will support sustainability by conserving resources
- Business technology will be a key enabler in service transformation, empowering service users by improving communications and driving efficiencies through remote and agile work
- The Trust should invest in careful planning and preparation before commencing with physical works to ensure that, wherever possible, works can be delivered quickly but also on a value for money basis, benefiting from innovative solutions and best practice
- The Trust recognises that in order to see a step change in the quality and reliability of the estate, the Trust must plan decisively, with determination and prepare to deliver several projects in parallel. Available capital must be invested as soon as possible in order to achieve results at the earliest opportunity

5.4 Estate strategy benefits

Our Estate Strategy will provide the following benefits:

- Estates development closely linked with the Trust's Clinical Strategy
- Board level commitment to sustainable development and carbon reduction initiatives
- An opportunity to dispose or develop any surplus land
- An opportunity to reduce underutilised areas of the estate
- A means of targeting investments to minimise the risk associated with the Estate
- An opportunity to recruit and retain staff by offering high standards of staff accommodation

5.5 Critical success Factors

Critical success factors in investment decisions have been defines as:

- Reducing the scale of the estate to match service needs
- Reconfiguring the community estate to enable transformed services to be delivered from appropriately located, cost effective sites
- Reconfiguring inpatient beds to improve quality through co-location of services
- Reducing non-compliance
- Reducing backlog maintenance
- Embedding sustainable resource use through a whole life cycle approach to planning and capital development
- Improving space utilisation through service consolidation, functional patient and staff flows and agile working to increase efficiency and value for money
- Disposing of the least appropriate estate to realise proceeds for investment in improving quality
- Disposing of properties with above average running costs and backlog maintenance where alternative buildings and sites meet clinical objectives more effectively

5.6 Agile Working

As a part of the Estate Strategy, the Trust's vision is to consolidate the estate and achieve a significant reduction in floor area by 2019, with no unoccupied or underutilised floor area. Estate consolidation is possible through a variety of methods including improved space utilisation and agile working.

Steps are already underway to improve the utilisation of Aspen House, which houses Finance and Procurement Teams. Space Utilisation is at the core of the agile working plan to ensure that the Trust uses its estate efficiently and productively by making the best use of the space available. Aspen House will have standardised desk space, which will create open plan work areas with hot desk facilities. Teams from other directorates will vacate older buildings and move to a new way of working. This will allow the Trust to make better use of its estate, and in some cases lead to the disposal of buildings that are no longer required.

Agile working will remove the need for the Agile Worker to be reliant on a dedicated and permanent desk. Utilisation of hot desking facilities will be available as a solution. In addition, the development of new agile working practices will directly support other Trust initiatives including the Estates Strategy plans and supporting the Trust's commitment to sustainability through a reduction in unnecessary mileage and production of paper documentation.

6 Strategic context, policy drivers and commissioning intentions

6.1 Introduction

Over the past 10 years, the health sector has seen unprecedented requirements to improve both quality and efficiency; improving patient outcomes whilst facing increasing demand; an ageing demographic with increasingly complex service needs. Nationally, if the health service continues to deliver services in the current manner, by 2030 we will need an additional 40 acute hospitals at a cost of £20bn just to meet demand. We have a population expanding by 8 million people by 2032; almost 3 million people living with 3 or more long-term conditions by 2018; the number of people living with dementia will double over the next 30 years; the rate of diabetes will increase by 30% by 2025, affecting some 4 million people.

The NHS Five Year Forward View reported that unless determined action was taken, the gap between need and NHS resources would be £32bn in 2021/22. It sets local leaders the task of achieving the "triple aim" of improved health and wellbeing, transformed quality of care delivery, and sustainable finances. Approaches relevant to healthcare estates planning are:

- Patient needs are changing and new treatment options are emerging
- Challenges in mental health, cancer and support for the frail elderly
- New partnerships with local communities, LAs and employers
- The need for rapid upgrade in prevention and public health
- The need for patients to gain more control of their care
- Removal of barriers - Care provided by family doctors, hospitals, physical and mental health and health and social care
- More services delivered locally but others in specialist centres
- More support for patients with multiple health conditions
- Radically different care delivery options including integrated hospital and primary care providers

6.2 National Policy Changes

There have been a number of national policy changes over the past couple of years, the main ones being:

- Primary Care Five Year Forward View 2016
- Encouraging Trusts to work together (not in competition) to reduce costs, resolve issues of sustainability of some services
- Development of new models of services/care, for example Multi-specialty Community Providers (MCPs), Primary and Acute Care Services (PACS) or Accountable Care Organisations (ACOs)
- An extremely challenging financial settlement for both the NHS and local authorities
- Development of Sustainability and Transformation Plans (STPs)
- Emergence of formal devolved Integrated Care Systems and Integrated System working
- NHS Five Year Forward View Delivery Plan 2017
- Refreshing NHS plans for 2018/19
- The principles of the One Public Estate initiative

In response to these drivers of changes listed above a new Estate Strategy was required.

Our Estate in the Context of Policy Drivers and Commissioning Intentions

- Greater Manchester Devolution
- Healthier Together implementation

- Stockport Together implementation – Beds and Outpatients

6.3 Local and regional factors

There have been a number of local and regional factors that have been significant enough to affect the strategic direction of the Trust. These have been identified as:

- The Healthier Together (HT) decision in 2016;
- East Cheshire talks that began in 2017: East Cheshire are being formally reviewed by Cheshire and Merseyside STP. The outcome of this is unknown but it is likely to have a significant impact on the Trust in relation to services currently provided on the Macclesfield site
- Greater Manchester Combined Authority Theme 3 work streams gathered pace in 2017: Standardising acute hospital care across majority of services, especially surgical but also paediatrics, obstetrics, respiratory and cardiology. To note that the Orthopaedics, Paediatric and Benign Urology transformational management leads are from the Trust. In addition, Pathology (clinical element) and Radiology (clinical element) are underway;
- Greater Manchester Combined Authority Theme 4 work streams progressed in 2017: These are corporate functions creating an NHS-led multi-agency solution in areas such as finance, HR, procurement and IM&T in the first phase
- Shared services: in addition to the GM work across back office functions the Trust has undertaken an options appraisal with SMBC under the Stockport Together plans. The Trust will then assess working with the council and areas of the GM work streams.

6.4 Stockport Integrated Service Solution (Stockport Together)

The Board of Directors is committed to working in partnership to deliver the Stockport Integrated Service Solution (ISS), formally known as Stockport Together.

The Stockport ISS vision is: to provide a joined up, high quality, sustainable, modern and accessible health and care system. This aligns to our corporate Trust vision, mission and priorities.

The new model of care addresses the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport. To this end, there are a range of approaches to support the health and wellbeing of the 85% of the local population without chronic health needs, and intensive, highly integrated approaches for the 15% of the population with chronic health needs who are most at risk of a hospital intervention or long term care. In other words, we are segmenting the care needs of the population and differentiating interventions.

The four key underpinning concepts within the Stockport Together business cases are to:

- Invest £19.7m recurrently over the next four years largely in those ‘out of hospital’ areas that benchmark as either low or very low; primary care, community, social and mental health care
- Implement a new fully integrated 24/7 neighbourhood based model of health and social care built from and led by General Practice which is based on the best available evidence and with an emphasis on validated prevention activities that will create the capacity and capability (in both primary and community care alternatives) to deliver the right care/support in or close to people’s homes rather than in hospital
- Train and develop a well-resourced, motivated, empowered and flexible workforce integrated across health and social care with the right skills, experience and attitude to deliver this new joined up model of care

- Realise, with partners, financial savings based on cost reduction of £22.4m by 2020/21, as a by-product of delivering the right care and support to people

In 2017/18, by agreement with our partners, a formal alliance agreement was put in place and an Alliance Provider Board was established. This agreement enables us to provide an MCP service within a vehicle we have called Stockport Neighbourhood Care - our model of integration designed to provide services as a national MCP vanguard site.

The fundamental core of the MCP is that it is based on the GP registered population and is primary care led. Providers and commissioners in Stockport have agreed that an Accountable Care Trust is the preferred organisational form through which this will be provided. In 2018/19 to 2019/20 we will develop the necessary governance requirements to move forward with this transaction in collaboration with partners.

As described earlier in this document, we have reconfigured our business groups in preparation to become an Accountable Care Trust that incorporates two major service components – specialist hospital services and integrated health and social care.

One of the four business groups is Integrated Care, which has brought together community services and emergency and acute medicine. This is part of the structure of Stockport Neighbourhood Care.

The focus in 2018/19 is on implementation of the operational service models as part of Stockport Together business cases approved by the Board of Directors in June 2017. The emphasis will be to deliver the benefits articulated by the whole system working of the Stockport ISS, Specifically these programmes/business cases are:

- Active recovery
- Crisis response
- Enhanced case management
- Neighbourhood models and GP home visiting
- Outpatients

6.5 Healthier Together implementation

The Board of Directors is committed to the implementation of Healthier Together.

In the South East Sector, where Stockport sits, the hub site was confirmed as Stepping Hill and Stockport partnered with Tameside Integrated Care Trust as a non-hub site.

Across Greater Manchester's four sectors, detailed planning continues for the implementation phase arising from the Healthier Together model.

The scope of Healthier Together includes a range of services including, directly: Medicine, Diagnostics, Anaesthetics and Critical Care, Emergency Medicine and, indirectly, a series of other services that are co-dependent with these. The principal focus of the changes, however, is the reorganisation of General Surgical services such that each sector has one identified 'hub' site which will be the centre for high risk elective and non-elective surgery, linked to one or more non-hub sites, providing a wide range of lower risk, planned services and having a critical role in the reception, assessment and, where necessary, the transfer of unplanned patients. The underpinning principle is that sector general surgical services should be provided by combined teams of clinicians in 'single services'.

Preparation for the implementation of Healthier Together (now under formal Theme 3 governance) is anticipated to progress early 2018/19 subject to access to national capital funding and agreement of revenue costs at a sector level. Locally we will continue to progress implementation. The transfer of high acuity surgical activity from Tameside is now anticipated to be in 2019/20.

6.6 Greater Manchester STP and Emerging Integrated Care System

The Board of Directors is committed to aligning our activities with that of the Greater Manchester STP and the emerging Integrated Care System where possible.

The key change since the 2015 strategy is that the environment has changed regarding our ability to be able to carry out clinical service reconfiguration. We are now part of the formal GM STP and every proposed change must be considered in a collaboration context. The business focus going forward is cohesion and cooperation, no longer competition and commerce.

In 2018/19, all STPs nationally, will be taking an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs are expected to:

- Ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners
- Work with local clinical leaders to implement service improvements that require a system-wide effort for example: implementing primary care networks or increasing system-wide resilience ahead of next winter
- Identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions
- Undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate
- Take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners

The Trust will be required to respond to this system wide approach.

Perhaps the biggest challenge for us going forward is how we contribute to single system planning that encompasses CCGs and NHS providers. The system plan is expected to align key assumptions on income, expenditure, activity and workforce between commissioners and providers.

The Trust recognises that it is important that our current Stockport locality plans reflect GM developments in Themes 1 and 2 which focus on: communities, health and well-being and social care. We will proceed on this basis until such a time that a single system operating plan comes into force.

As it stands, the development of future acute service provision under the scope of Theme 3 and Theme 4 will fundamentally impact the Trust and services delivered from the Stepping Hill site over the next 2-3 years.

7 Site development plan

7.1 Introduction

Development of a coherent masterplan, based on sound evidence drawn from a number of sources and balancing short/medium term imperatives with longer term requirements and aspirations is a core output of this draft Estate Strategy. The masterplan is an expression of the analyses undertaken, of the Trust's wider strategic objectives and of the views of stakeholders, bringing them together as a single, longer term vision for the estate.

Though based on a clear rationale and evidence base, the masterplan represents one possible scenario and does not purport to offer a definitive solution. However, it does offer a direction of travel and a framework for debate, prioritisation and decision making. Each element of the masterplan will be challenged and developed at the programme phase of the strategy to follow, with option identification, development and decision being made at the project business case phase that follows the programme phase. The phases involved in developing and realising the strategy are summarised below in Figure 16.

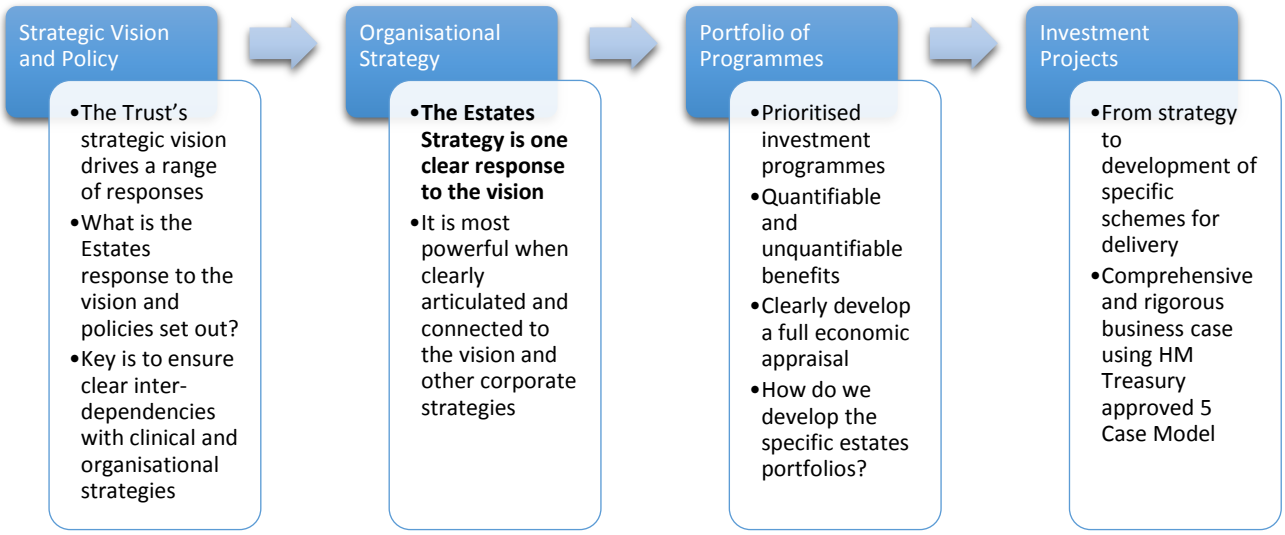


Figure 16. Phases in the development from strategic vision to specific capital projects

7.2 Masterplanning

The Estate Masterplan identifies the potential capacity of the estate and provides a guide to how we might develop our estate over the long-term. Its purpose is to provide a clear spatial framework for the delivery of the Estate Strategy and site development. It sets out a scenario for possible future land use, distribution of activities, flexibility of building use and movement patterns within which individual projects may be taken forward in the future.

In the context of Greater Manchester (GM), a Master Plan is a long term plan for a hospital site (and the surrounding community) that takes into account the existing estate, cost pressures and future service needs.

The vision for Stockport is for the delivery of integrated care across health and social care, with primary care at the centre of a remodelled service.

The estate would need to be responsive to change, taking account of demographic trends, increasing specialisation, provision of care closer to home, technological advances and new ways of working.

In parallel the estate has an important role to play in enabling change, delivering savings, reducing running costs and ensuring that all investment is properly targeted.

We have also spent the past 12 months working with Stockport Borough Council to ensure that the Masterplan is consistent with the emerging Borough Plan and technically capable of delivery.

The delivery of the Masterplan will take place over at least the next 10 – 15 years and the Trust's Board has yet to make a detailed assessment of all the options presented.

7.3 Backlog Maintenance (2018/19)

Investment is needed in order to reduce backlog maintenance and to maintain the condition of many building, which are rapidly reaching the end of their useful life. The Trust is currently planning for a £761k capital backlog investment which is below the minimum required to maintain the current estate, however with the estate reductions planned within this strategy this will reduce the current backlog level and with careful risk assessment of remaining backlog items it should be possible to maintain the current backlog levels.

Key backlog project areas currently planned are shown in the table below.

Estates (Backlog)	Budget
Main corridor heating pipework replacement	80,000
Main corridor flooring replacement	10,000
Cedar House window replacement	40,000
Maternity heating header tank replacement	8,000
Ogden pump replacement (HSDU/Endoscopy/Pharmacy/DCU)	40,000
Woodlands lower condensate receiver and pumps	25,000
Main corridor pipework replacement DHW	80,000
Lift L8 refurbishment	20,000
Lift L12 refurbishment	20,000
Lift 2 refurbishment	10,000
Neo natal UPS replacement	60,000
Deck car park surfacing and repairs	80,000
Nurse call replacement Treehouse first floor	84,000
Nurse Call Replacement Maternity 1 and 3	40,000
Road resurfacing / line marking	20,000
Endoscopy AHU replacement	80,000
Maternity AHU upgrade (fan and inverters)	15,000
Woodlands AHU attenuators/frost coil/rebalance	25,000
Medical Air Dryer replacement	24,000
	761,000

7.4 Rationalisation of the Trust's Estate

The Trust completed the new D Block Surgical & Medical Centre in 2016. This three storey building provided accommodation for a 59 bed Acute Medical Unit, 6 bed Primary Care Referral Unit, 4 operating theatres, 12 recovery beds, 19 space trolley bays, 2 single room Surgical Assessment Unit, 18 bed Short Stay Surgical Unit and a 12 trolley bay extension to an existing Day Case Unit.

The planning permission granted had conditions attached which included the removal of the same number of beds that had been included as part of the new build. The Trust could not add any further beds to the hospitals footprint. A demolition plan was drawn up and this included demolition of the Bobby Moore Unit, Wards B6 and C6, Maple Suite and Wards B4 and C4, and Wards A12, A14 and A15.

As part of the Stockport Together programme Ward A14 was seen as the most viable building to be refurbished to accommodate the Integrated Transfer Team, this required a £386k of capital investment.

Ward A15 was commissioned as a community ward for a trial period which has now finished, and the Ward is currently not in use. Ward A12 is currently being used as part of the escalation and winter pressures planning. However, once emptied the plan is to close and demolish these 2 wards.

Power, Heat and Water to Ward A14 will need to be diverted and enabling works are required to utilise the adjacent DMOP building plant room. As part of the 2018/19 Capital Plan, a number of enabling schemes have been included in support of the above demolition strategy.

The minor projects are shown in the table below.

Minor Projects	Budget
HT Offices and records storage on GF Maternity (Block 66)	100,000
HT Maternity management offices to Tree House	40,000
Ripley Avenue property disposals	5,000
Demolition programme enabling works - A14 service diversions	47,000
Aspen Business Finance office refurbishment	20,000
Demolition or refurbishment of A12, A15, OPDB	200,000
Generator controls and sync panels 9A, 9B, 9C	12,000
Generator controls and sync panels 1A, 1B	10,000
Site signage and wayfinding	20,000
Accessible shower rooms in HDU	20,000
R&I move to C2 (£20K external funding)	20,000
	494,000

7.5 Transport, access and parking

The main hospital estate suffers from overcrowded car parks, particularly at peak times of activity. This situation is exacerbated by a current layout that complicates the ability of patients and visitors to locate free spaces as spaces are currently dispersed across the site due to historic development of car parking in a more opportunistic manner.

The strategic vision for car parking is to reduce the number of parking locations and remove scattered parking from many areas of the estate to allow greater use of the public realm by pedestrians, creating greener spaces that can be used without concern for traffic. A further key principle that drives parking solutions is to minimise the ingress of cars by developing car parks on the estate periphery, avoiding cars having to travel through the estate in what is often a protracted search for an available space.

A significant number of parking locations will be removed but the overall number of spaces will be increased and investment in constructing multi-storey car parks at key access nodes will be included in the capital programme. The vision includes peripheral car parking hubs which are closely associated with the services they support and will be broadly split into parking hu8bs for visitors, emergency activity, planned and ambulatory activity and staff parking.

The parking and access strategy will closely support the developing clinical strategy and associated estate response, this will include reviewing and responding to key estate issues including simplifying and easing access to departments on site through prioritising access for principle users of the site and restricting use of the site for those who may use it as a means of cutting through in vehicles.

7.5.1 Public transport

The overarching main site strategy regarding transport is to enable the most efficient and effective public transport access to the estate, including making provision for as yet unknown developments to public transport routes that may affect the estate. Such future developments may involve additional bus or other services from the town centre to the hospital

7.6 Improving the public realm

One of the key benefits in determining a strategic estates programme for the Trust is the development of the public realm on the hospital site. This key development will confer a number of benefits to the Trust as follows:

- Development of space that will be of benefit to staff, patients and visitors as an outdoor place and amenity to give pleasure and enhance physical and mental wellbeing.
- Creating a green heart to the estate to act a space which will enhance the environmental and sustainable credentials of the hospital site.
- Developing the public realm so that is may also act as key expansion or building replacement space in the future (notwithstanding the ability of different public realm space to be further developed as part of a much longer term development and demolition strategy on the site).

7.7 Space management

The management of space across the estate is a key consideration both in terms of under and surplus capacity issues. This Estate Strategy identifies a number of key principles and processes to be adopted to ensure that space is effectively managed.

Where pressures on space currently exist, these can be for a variety of reasons including increased patient and staff numbers, increased requirements for space for equipment and changes in the type of space required, reflecting new models of care.

Each project within a capital programme will be developed with a clear brief to ensure that future space responds to the clear statement of need. Such a statement will include detail on how space requirements have changed and will change and therefore projects will not simply replicate current space with optional increases in size, but actively ensure that space no longer needed is rationalised to maximise usable space.

Innovative space solutions will be explored, for example, innovative storage solutions, to free up more valuable space for core activities. All future developments will also ensure that space can be as adaptable as possible over the longer term to allow for organic and emergent changes in use without significant capital expenditure.

Each project will include a space audit to identify underutilisation and scope for efficiencies.

7.8 Developing a vision of the future

There is a core of newer buildings, in better condition generally, that consolidates key services to an extent and maps onto the functional core of the acute hospital. This is therefore a good starting point for a site development and investment strategy.

The estate strategy needs to reflect and focus on these core services - what Stepping Hill needs to deliver as an acute hospital - and also consider alternatives for 'non-core' services.

In terms of developing the site and improving utilisation, it is also known that certain buildings will be vacated in the future, for example the Pennine Care mental health services relocation planned for 2021, which will also create opportunities.

Adopting the core/non-core principle has advantages in that it:

- Makes a virtue of identifying how care can be delivered closer to home, avoiding unnecessary visits to or stays in hospital.
- Delivers quantifiable benefits from vacating elements of the site and allows a coherent development strategy to emerge.

7.8.1 Clinical priorities and estate response

The estate strategy will need to respond to the Trust's clinical priorities, including:

- **Emergency care** - the ED is undersized and poorly configured. The STP Wave 4 Emergency Campus bid will begin to address, as will the Healthier Together commercial case for ED reconfiguration, but the Trust will also need to plan for longer term expansion of all its emergency care services, including vital clinical support services such as diagnostic imaging.
- **Beds** – the number, types, location and mix of the Trust's current acute bed stock is inappropriate and suffers from poor adjacencies and access. The quality and functionality of the bed stock is poor, particularly in medicine. There is a clear need to consolidate and improve short term and relocate/reconfigure longer term as part of a coherent site plan, reflecting key adjacencies and models of care. The HT commercial case will act as one enabler.
- **Outpatients** – currently out-patient services are delivered in diffuse, outdated, inefficient and poor-quality accommodation. Services are desperately in need of consolidation, considering the implications of Stockport Together.

Estate planning and strategy will need to reflect the overall direction of travel and new models of care consistent with collaborative working - many existing buildings are simply not fit for purpose. Necessary improvements in these areas, including the short term, need to be mindful of the longer term estate strategy to avoid problems of the past, for example, ensuring adequate expansion space for the future, avoiding isolating particular service provision when co-locating services would be more efficient and effective and ensuring that each development at the very least does no harm to future strategic developments and at best enables future developments to deliver optimal value for money through development synergies.

7.8.2 Core activities

In line with the Estate Strategy objectives, the strategic drivers and agreed clinical priorities, an analysis of the Trust's 'core' and 'non-core' activities, appropriate to its role, and what this analysis means for the estate is one of the building blocks of a coherent site development plan. For example:

- What is 'core' to the role of Stepping Hill as an acute hospital – clinical services and clinical support, for example ED, diagnostic imaging, acute beds, surgery, some outpatients, etc?

- Conversely, what constitutes 'non-core' clinical, clinical support or non-clinical support?
- Can non-core services be relocated away from the hospital site or to areas of the site not required for core services now or in the future?
- How will more efficient, technology-enabled patient care and working practices, including agile working, impact on this analysis over time and act as an enabler?

This graphic, peeling away the layers of a 'strategic onion' to reveal the core, illustrates the point and offers a starting point for debate.

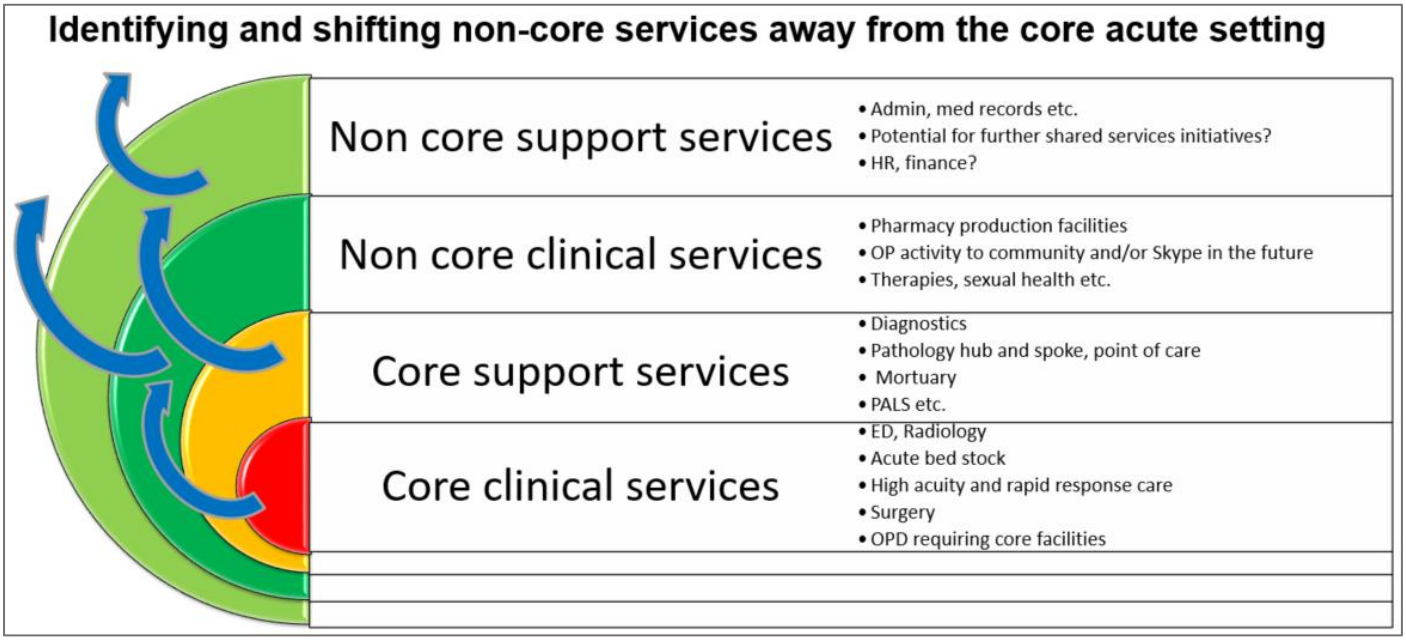


Figure 17. Conceptual shifting of care away from the core acute setting

7.9 Site development scenarios

Bringing all of these elements together, including current planning for projects like the Wave 4 bid and the Healthier Together Commercial Case, enables us to develop a number of potential scenarios that offer a vision of a much more coherent, effective and efficient Stepping Hill site that will be fit for the future.

These scenarios are based on the analysis to date, views on clinical priorities and fixed points identified, and are therefore underpinned by evidence and a clear rationale, but they are conceptual. These concepts are intended to stimulate debate about the way forward rather than present definitive solutions at this time. It is proposed that the conceptual plans shown here are developed in detail through a comprehensive engagement exercise with all relevant internal and external stakeholders to the Trust. The next iteration of this Estate Strategy will therefore develop a preferred direction of travel for the long-term redevelopment of the Stepping Hill site in conjunction with its other facilities and responding to the Trust's developing clinical strategy.

Some key clinical issues associated with the current site as well as a high-level analysis of site activities are summarised in Figure 6 below.

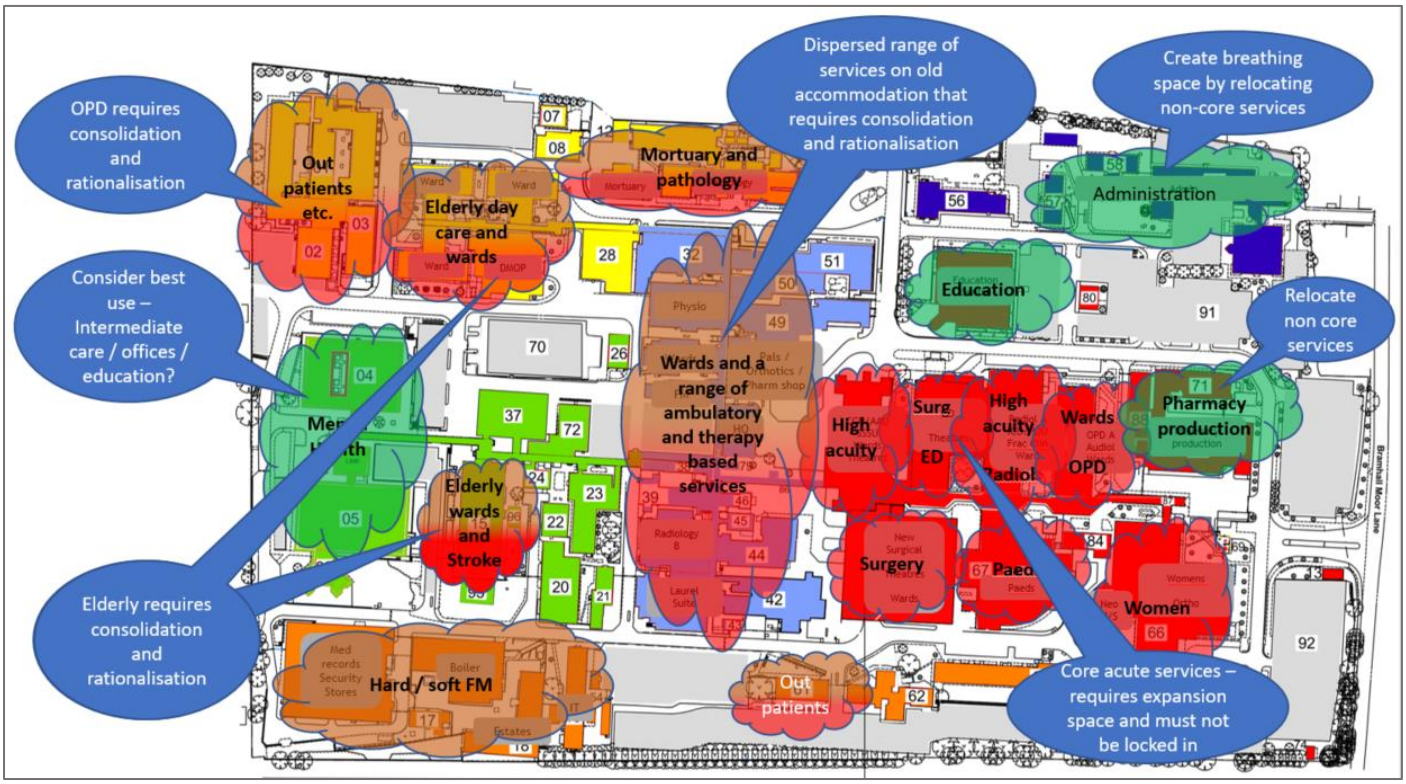


Figure 18. Key clinical issues and high-level analysis of activities at Stepping Hill Hospital

The current Wave 4 bid to develop and support emergency care at the hospital, develops an Urgent Treatment Centre close to the current Emergency Department (ED) whilst also developing needed retail facilities and additional car parking requirements. Additionally, a range of other facilities are planned in the short term to support clinical activities including a 4th CT scanner, enlargements to the Clinical Decision Unit (CDU) and further urgent treatment facilities and developing options for an Essential services Laboratory (ESL) to support point of care and rapid turnaround pathology support to emergency care.

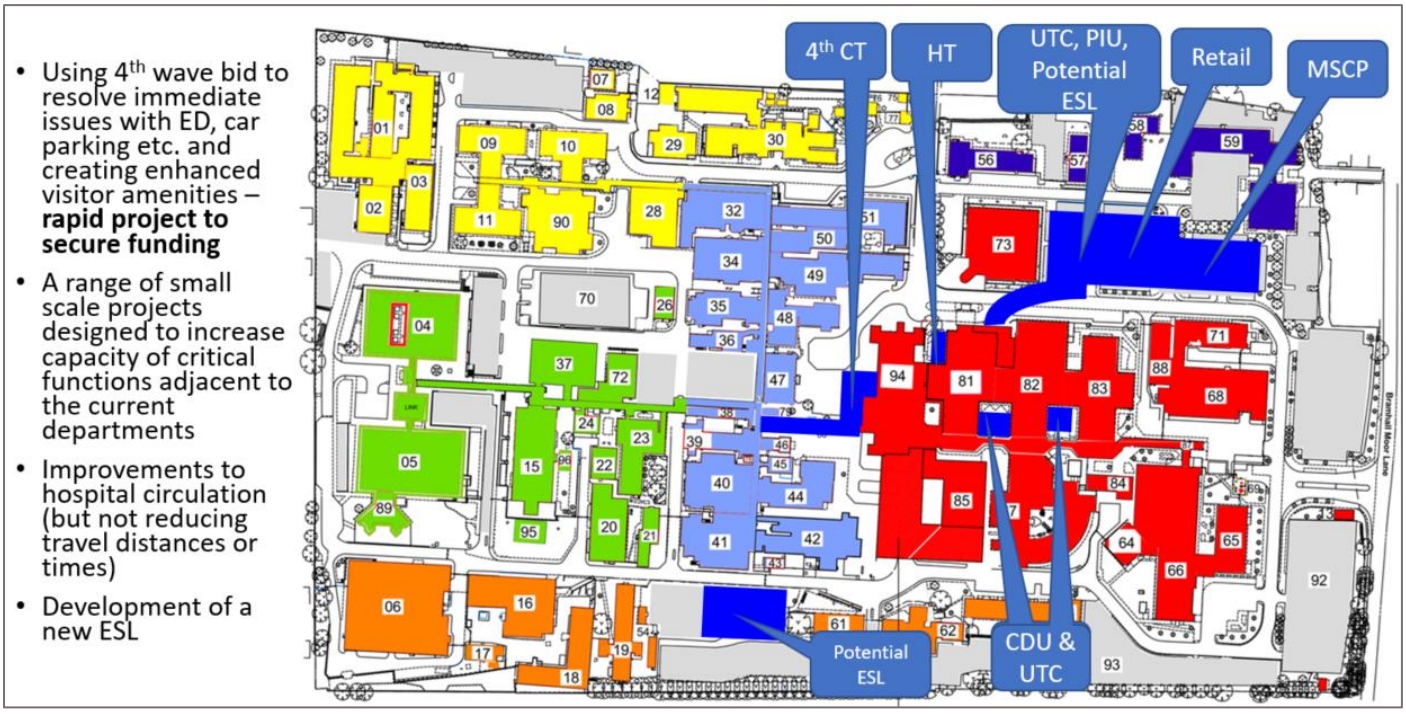


Figure 19. Summary of short-term projects associated with the current Wave 4 funding bid

7.10 Coherence and adjacencies

Figure 21 below summarises the approach to the development of future zones across the main Trust site. It builds on the current zones but also identifies a number of important changes that will need to occur over the life of the strategic estates programme, particularly where capital investment has been identified in order to relocate some buildings and departments into a new zonal layout. A balance has been struck whereby any such investment has only been identified for buildings considered to require replacement in their own right.

The planned developments associated with the Wave 4 bid above will be considered alongside the developing long-term estate vision, a key principle being to ensure that there are clear alignments and synergies between Wave 4 and future long-term developments. Some adjustments to ensure those synergies are expected and a conceptual scenario for the development of the whole site is shown in Figure 8.

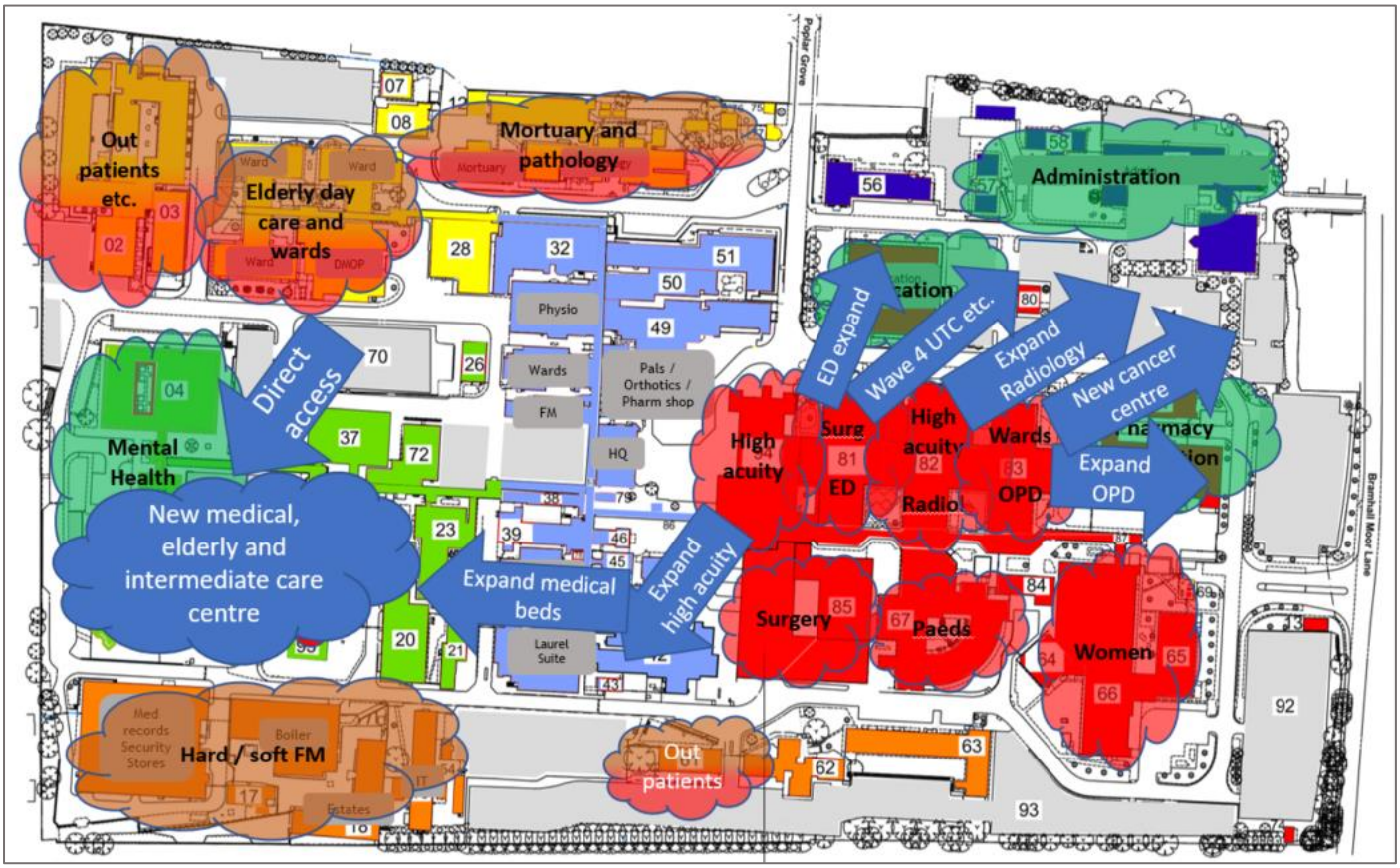


Figure 20. Conceptual development of the Stepping Hill site

The draft conceptual vision for Stepping Hill Hospital will include building on the core acute services provision facilities by

- Establishing future requirements for Emergency Care and associated diagnostics and support, ensuring synergies between those and the developed UTC
- Consolidating out-patient and other ambulatory services on site to be supported by enhanced diagnostics and laboratory facilities
- Developing radiology and diagnostics as both a supporting and patient facing service
- Developing a new Cancer centre which will consolidate current cancer services which are delivered in aging and functionally poor facilities across the site

- Developing a new Endoscopy service with close associations to the current surgical facilities, utilising common support facilities and developing synergies wherever possible
- Creating additional high acuity accommodation adjacent to the current similar accommodation
- Developing and replacing the current medical bed stock where functionally poor and physically remote from other supporting services. Creating a graduated medical care facility which places patients in medically appropriate accommodation from high acuity care through to general care requiring acute facilities and establishing the potential for the site to effectively and economically support additional step up / down facilities on site, as appropriate, as part of this graduated or intermediate care model

7.11 Site masterplan

The following plan builds on the zonal planning assumptions and identifies how the hospital site might look on completion of the proposed programme.

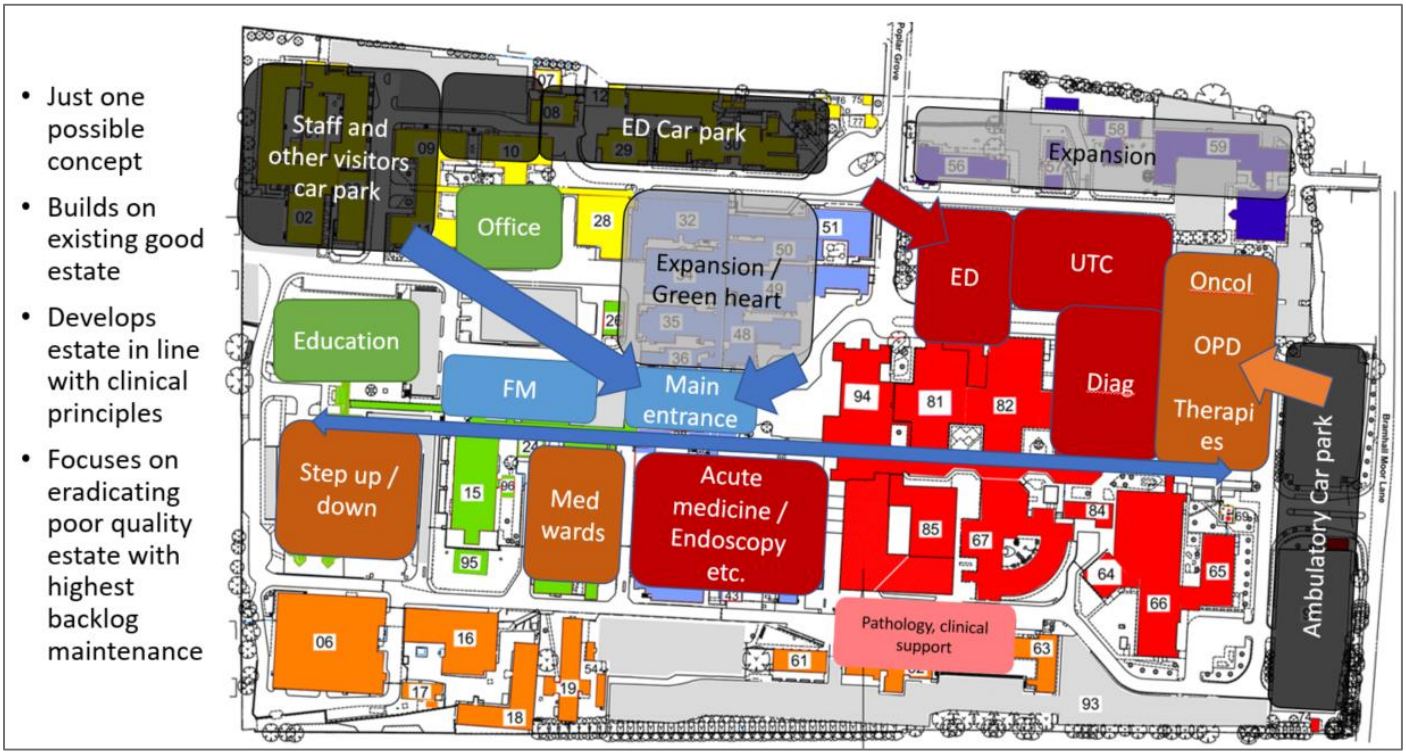


Figure 21. Conceptual high-level vision for Stepping Hill Hospital

The conceptual vision comprises:

- Creation of a clear car park strategy which locates parking to the periphery of the site and clearly designates between parking for emergency, ambulatory, staff and visitor parking, located to optimise flows around the site and to allow ease of access to associated care facilities
- Developing and clearing outdated, inefficient and functionally inadequate buildings as part of the clinical strategy for future care provision on the site, creating space which can be an asset in terms of enhanced public realm and also creating future expansion space for service provision beyond the timescale set for this current long-term strategic estate vision

- Developing an enhanced entrance strategy which will incorporate a new main entrance but also create clear separate entrances to key clinical service groups such as Cancer care, OPD and other ambulatory care, visitor access and emergency access

7.12 Ensuring current and future fitness for purpose

This draft strategy has focused strongly on a service led approach to understanding future requirements. The resultant Estate Strategy is based on developing an estate that is functionally sound and fit for purpose, this approach differs markedly from an approach that places the current buildings at the centre of the strategy and focuses on ensuring that the current and future buildings are sound and in good repair without understanding how those building are to be utilised in the future and whether they are capable of supporting changes in capacity requirements and the manner in which the Trust is to develop in line with its overarching strategy.

8 Impact of the Trust development plan

8.1 Introduction

Section 7 details a potential end state 'vision' for the hospital estate. The phasing and prioritisation in order to achieve that end state is a product of a number of different and often competing approaches and issues. The eventual phasing and prioritisation will be agreed through the detailed estate capital programming phase which will follow the agreement and initiation of this estate strategy. It is understood that an organisation comprising a wide range of staff who are committed to the development and success of their own sphere of interest will inevitably be competing for capital funding and prioritisation of their own particular areas of interest.

Key criteria developed and used to phase the draft capital programme are as follows:

- Understanding and legislating for growth in high demand areas, responding to pressure on space for patients and staff
- Assessing functionality and fitness for purpose of the current estate and how that will change in the future
- Prioritisation is based on identifying where the estate can improve outcomes and adopts a broad principle of targeting to ensure maximum impact
- Establishing projects that are required in order to create zonal coherence – delivering an increased sense of collaboration, identity and place, promoting staff and patient satisfaction
- Identifying building and organisational risk, focusing on statutory or safety compliance issues, reducing building inefficiency, reducing backlog maintenance issues by demolition or targeted investments in refurbishment in addition to creating a backlog maintenance fund
- Investing to create improved performance on key estate metrics
- Noting where masterplan issues affect the phasing of individual projects, identifying where constraints may affect programming issues or where there are practical considerations that affect the overall delivery of the master plan
- The assumption of pragmatism and timing, interdependencies or lack of them, which can create early wins where a rapid response is available despite a particular project not being considered a priority over another
- External funding and opportunism – understanding that the prospect of external funding streams may place a different emphasis on the timing of key projects but also realising that any such changes in prioritisation should only be considered in the knowledge of how the overall future programme will be affected and that the Trust legislates for that change and the overall programme is not compromised

There is inevitably a tension between these criteria, there is no magic formula and nor is there a single answer when developing a strategic programme. The balance will depend on specific proposals and circumstances and views on priorities as the programme develops over time.

8.2 Operational, tactical and strategic timescales

There is an inevitable tension between immediate, short term needs, longer term aspirations that are ambitious but realistic and the tactical decisions on how to get there. These are the proposed timescales for considering site development:

- **Operational** - within next 2 years (some things much sooner)
- **Tactical** – within 5 years

- **Strategic** - over next 15-20 years, but 20+ years is not a particularly long timescale for large scale strategic investment

There is uncertainty about future funding, and this is obviously a concern, but this should not constrain the strategic vision for the estate, reflecting the Trust's ambitions.

We need to be realistic about what can be achieved right away, some things will take time, but short-term planning needs to take account of the longer term vision.

A clear strategy will act as a blueprint that allows the Trust to develop and prioritise off the shelf solutions consistent with the strategic direction, acting as 'oven ready' projects that can exploit funding opportunities that may well arise and plug in without compromising the longer-term site development plan.

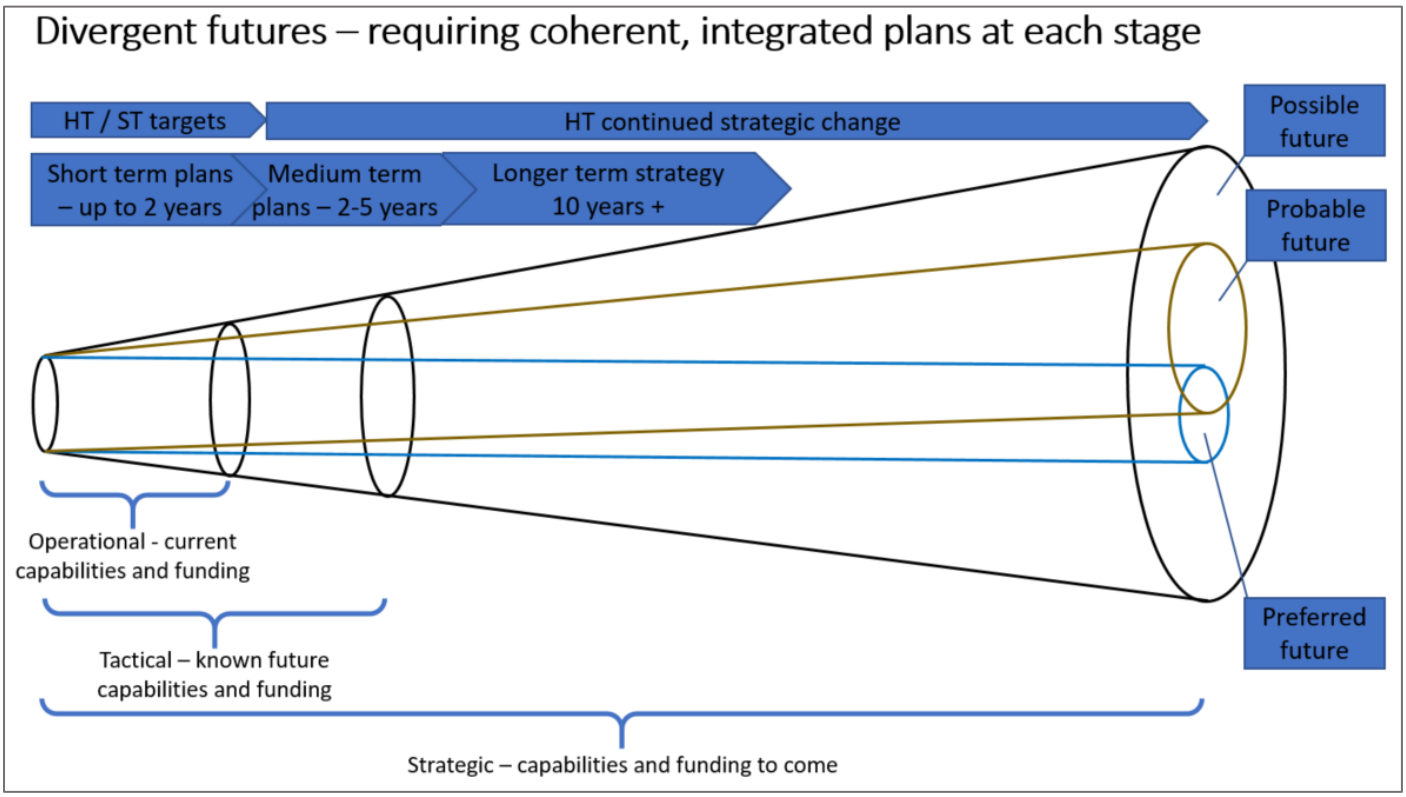


Figure 22. Strategic vision in the context of future possible technologies and funding streams

8.3 Practical implications

The estate will change rapidly as a result of short term changes which are currently planned, medium changes which are the subject of current funding requests and longer term changes which, whilst not yet funded, will be planned and enacted as and when a potential range of funding streams are identified and enabled.

8.3.1 Short term implications

Closure and subsequent demolition of A Block wards – relocation of beds currently used within A Block wards to alternative locations within the hospital including the Woodlands Unit. As part of the Trust's clinical strategy, beds located in the Transfer Ward will be relocated to community based settings as part of the longer term intermediate care strategy, contained within the developing clinical strategy.

Ward rationalisation will continue in the short term and will be driven by clinical strategy (a common approach between acute and community provision) alongside the identification of

ward bed stock which is functionally unsuitable and where there is no strategic value in further investment in that estate in terms of backlog maintenance, repurposing or redevelopment.

Wherever possible, estate that is identified as redundant with no viable alternative use, will be demolished. Use of the land made available will be assessed as to the most economically advantageous including

- Potential short term additional car parking provision pending development and enactment of the medium to long term car parking strategy
- Landscaping as part of the public realm development strategy
- Identification of site locations for other permanent or temporary development as part of the overarching estate strategy

8.3.2 Medium term implications

The medium term implications for the site will focus in particular on the planned Wave 4 development which is currently the subject of funding approval. Should such a bid for capital funds be successful, then the development of facilities to support emergency care on the site will form a key medium term development.

It is anticipated that the Wave 4 development will be refined and reviewed in terms of ensuring it offers optimal value for money and is also strategically aligned to longer term development plans for the site. Such plans will take account of future car parking strategies, visitor, staff and patient amenities and the longer-term requirement for additional emergency care facilities and supporting functions on the site.

8.3.3 Longer term implications

The detailed phasing and development of the estate will be the subject of future iterations of this Estate Strategy. They will however consist of planned development of services with a focus on rationalisation and consolidation of those services which are spread around the site and are in functionally poor accommodation. The agreed clinical strategy will determine the scale and nature of those services on the site and which may strategically be delivered in improved non-acute surroundings.

Key clinical services that will be included within this longer-term programme are broadly identified in 7.10 and 7.11 and include (in terms of broad phasing):

- Repurposing of the buildings currently used by mental health services on their vacation with potential prioritisation of use by medical/intermediate care facilities and as future education facilities, this allows the freeing up of the site currently occupied by the Education centre for future alternative use.
- Vacation of the site currently occupied by the Pharmacy production facility as this activity is not core to the site and could be re-provided elsewhere, allowing that part of the site to be redeveloped to support the core services located in that part of the site. Specific development opportunities will be based around rationalisation and consolidation of out-patient and other ambulatory services and the development of a cancer care centre on the site of the Pharmacy production facility.
- Development of core supporting services centred around radiology and diagnostics to support the developed ambulatory and out-patient hub and cancer care centre, as well as supporting the emergency department and urgent treatment centre.
- Development of the emergency care hub to include further accommodation for emergency care and higher acuity requirements.
- Development of higher acuity care provision as further day care facilities which will include endoscopy as part of the development of a spine of care which graduates from

high acuity care through acute medical care bed development through to lower acuity medical care provision which may well include intermediate care facilities for step up/down care.

8.4 Overview of indicative programme

The emerging estate development programme that will support the estate strategy will require application of a rigorous business case structure and process to identify and develop the solutions that fulfil the requirements, offer the best value for money, are affordable and deliverable.

The main issue that will affect the duration of the programme will be the level of capital funding that the Trust can support over the life of the programme. This capital funding will potentially be sourced from non-traditional sources, including collaborative capital funding, leverage of value contained within the existing estate and ensuring that the Trust is optimally placed to take advantage of opportunistic tranches of capital funding that will continue to become available to NHS organisations which can demonstrate the ability to achieve strong value for money for smaller projects by clearly referencing such bids for capital to its longer term strategic vision. Figure 23 below gives details of the indicative programme.

Short Term (2018/19)		
Area	Timescale	Outcome
Ward 12 - Block 010	March 2019	Demolishment of Ward 12 Block 010 **(Reduces £1.25m Backlog Maintenance)**
Ward 15 - Block 09	March 2019	Demolishment of Ward 15 Block 09 **(Reduces £1.25m Backlog Maintenance)**
Medium Term (2020/23)		
Outpatients B	2020	Demolishment of Blocks 01, 02 & 03 **(Reduces £3.5m Backlog Maintenance)**
Emergency Campus - STP Wave 4	2023	Creates new Emergency Campus on site integrating an Urgent treatment Centre, Planned Investigation Unit and replacement car parking provisions within a multi-disciplinary building.
Pathology Laboratory - Block 30	2023	Demolishment of Block 30 **(Reduces £1.5m Backlog Maintenance)**
Pennine Care Facilities - Blocks 04 & 05	2023	Refurbishment of building to provide acute inpatient services
Aspen House - Block 59	2024	Demolishment of Block 59 **(Reduces £2.7m Backlog Maintenance)**
Cedar House - Block 63	2024	Demolishment of Block 63 **(Reduces £1.8m Backlog Maintenance)**
Long Term (2025 onwards)		
A, B & C Wards - Blocks 31 - 51.	2028	Replacement of Blocks 32 to 51 With new Central Reception and Drop Off, Outpatients and Medical Ward facilities. **(Reduces £20.3m Backlog Maintenance)**

Figure 23. Indicative programme and timescales

Considering the short, medium and long term goals a full schedule of site proposals and a timeline can be found at Appendix B.

8.5 Indicative cost profile

The future drafts of this estate strategy will develop an indicative cost profile as and when the detailed strategy takes shape to support the developing clinical strategy.

8.6 Improving the condition of the estate

The above capital programme sets out a clear development strategy for the estate, one that witnesses significant improvement to the quality of the buildings through either refurbishment or demolition following a number of significant new build developments. The consequential impact on the overall condition of the estate is clearly one of significant improvement, which if adequately maintained in terms of lifecycle and maintenance following construction should sustain an overall high building grade rating in the years to come.

Detailed programme planning will allow the grade of the estate to be clearly planned over the programme timeframe and the estate will improve significantly in terms of the overall quality and grade of buildings which remain long-term on the site.

9 Risk management

9.1 Introduction

The Estates team will continue to maintain an accessible and up to date Risk Register for all estates and facilities management issues. When high risks are identified, a standardised risk mitigation plan will be linked to the register detailing plans and actions. This will link to the wider corporate risk register which is reported monthly to the Trust Board.

Over time the profile of the estate will change as action is taken to:

- Demolish or dispose of poorly performing properties
- Terminate leases, where feasible, on poorly performing properties
- Invest in renewal and refurbishment to improve the quality of accommodation
- Realise capital receipts from land and buildings that may be surplus to requirements, but subject to a rigorous strategic assessment of requirements

As a result, risks associated with statutory and non-statutory compliance will reduce as modern, fit for purpose, high quality estate replaces outdated, inappropriate and poorly performing buildings.

9.2 Backlog maintenance

On an ongoing basis, the risk adjusted backlog maintenance profile reflects the degree of risk posed to the Trust by poor quality estate. Backlog maintenance is managed to the outcome of condition appraisals and compliance reports. Annually the estate management teams meet to discuss estate compliance in relation to plant and equipment and to assess priorities in respect of works to be included within a "Backlog Maintenance" programme. The works are risk rated and consideration is given to the future known Trust business needs and plans.

The annual backlog maintenance proposal is prioritised to available capital funding allocation and presented to the trust Capital Programme Development Group (CPDG) for their approval. The approved programme is managed by a dedicated project manager every financial year.

Backlog maintenance is also considered as part of a process within each service developmental project to capture M&E and engineering infrastructure and compliance to support project needs and influence longevity of the building or environment.

9.3 Risk Management

The specific risks and financial implications of delivering the key Estate Programmes will need to be mitigated.

Overall risk will be mitigated by the inherent incremental and flexible approach of the Estate Strategy. This is strengthened by the focus on remodelling the existing estate whenever possible, which is not only less expensive in capital terms, but also contributes to the reduction of the Backlog Maintenance.

New build is mainly limited to continuing to infill by building on top of existing buildings to achieve excellent clinical adjacencies. This avoids the ground take and car parking losses, and reduces infrastructure duplication.

The proposed Urgent Treatment Centre will be constructed as a shell so that individual floors can be fitted out as financial, workforce and capacity factors optimise.

The above approach will ensure that, where appropriate, schemes can be modified or halted as the need changes or if the anticipated capital, revenue or workforce does not become

available. In addition, it will be possible for wards, theatres and OPDs to be used for different specialties if Trust or Commissioner Priorities change.

Whilst the initial prioritisation of schemes has been based on capacity requirements, and then adjusted to reflect physical estate factors, the Capital Investment Plan is driven by the availability of capital. The incremental factors noted above will enable development to follow the available funding. If it reduces, the Plan slows down, and maybe also adjusts priorities: if funding improves, the Plan can speed up, since the range of independent schemes can be progressed in parallel.

All schemes will be the subject of individual business cases. New build is minimised and refurbishment remodelling maximised to make best use of existing space and to minimise capital costs and additional revenue capital charges and rates. Wherever possible, charitable funds will be raised for specific projects where the upgrading of the existing ward will be the objective.

Where quality improvements could lead to reduced space efficiency, other compensating productivity gains will be maximised (through, for example, the optimisation of the size of the ward units).

The establishment of the Capital Programme to control annual capital expenditure against sources of income, together with the monitoring and prioritisation roles of the Capital Programme Development Group (CPDG) will ensure financial risks are mitigated.

The above approach is therefore sustainable development, with least risk.

9.4 Post Project Evaluation

All major projects will be evaluated as part of the overall Trust process for learning from experience. In accordance with current guidance and good practice, the Project will be evaluated in 3 stages:

- Monitor progress and evaluate the project outputs on completion of the new facilities. This will take place at each stage as new facilities are completed
- Initial post-project evaluation of the service outcomes six to 12 months after all the relevant facilities have been commissioned
- Follow-up post-project evaluation to assess longer-term service outcomes two years after the facilities have been commissioned

The evaluation process will be overseen by the relevant Project Board. At each stage of the evaluation, a formal report will be issued.

At each stage, the project evaluation on completion will determine what went well during the procurement of the new facilities, what went less well and what lessons may be learnt from the process. This will be addressed through the following specific issues:

- To what extent relevant project objectives have been achieved
- To what extent the project went as planned
- Where the plan was not followed, why this happened
- What learning may be transferred to other projects, internally or externally

10 Procurement and project finance

10.1 Introduction

The Trust is committed to providing the most cost effective delivery of estate and facilities services, which in some cases requires us to be supported by external suppliers. In securing this support we acknowledge that lowest cost does not necessarily represent the best value and also that traditional procurement methods often do not deliver the most efficient and effective solution. This has been continually evidenced by Government and industry guidance. Lessons can be learnt from the relatively poor results driven by the adversarial approach and the conflicting motivations of the organisations involved in construction related transactions.

To address this, the Trust wishes to keep abreast of national developments in procurement and to maximise the value it receives from its supply chain.

Following a review of all planned, reactive and minor works jobs that are required of the estates department, a full review was recently undertaken, which looked at the following aspects:

- Workload volume
- Workload complexity and specialism
- Current resource
- Skill mix
- Current contract and market rates
- Internal charge out rates

The outcome of this study identified that shifting a large majority of workload to in house provision and open market tendering of the remainder would offer a number of advantages:

- Cost reduction and value for money
- Increased management and control
- Increased quality and less re-work
- Familiarisation with the Trust's requirements
- Consistency
- Relationships with units
- Reflects our customer's wishes and requirements
- Succession planning for the Estates team and apprentices
- Potential to grow and market our services to achieve further income streams

For works that cannot be completed in house, i.e. specialist works, a tender is currently in the process of being written, which will be issued by way of an OJEU notice. This tender will test the market and enable the Trust to demonstrate value for money in terms of market rates.

10.2 Affordability and funding

Affordability of capital projects will be challenging, with investment in new facilities having to overcome:

- Increases in estates and FM costs as new clinical buildings enjoy more generous space standards than the ones they replace, which brings benefits to patients and staff but is inevitably more expensive
- Large increases in capital charges as low value accommodation is replaced by larger, new buildings

- The pressure for inpatient ward sizes of around 15 beds, thus reducing the income over which overheads can be spread

Large scale capital expenditure may therefore be easier to support with new services forming part of the developments. With these constraints, not all proposed investment makes sense purely on financial grounds but the Trust will need to decide, on the merits of each project, whether the qualitative improvements will support its vision to provide so are worth the investment.

Capital funding is limited to internally generated capital, available reserves and proceeds of sales. The Trust will also wish to retain a cash buffer, yet to be determined, reducing potential available funds.

10.3 Procurement objectives

The Trust is seeking appropriate procurement solutions together with some degree of external project finance across the range of likely projects from minor refurbishments up to £20m+ new buildings that:

- Support rapid implementation timescales to meet emerging commercial requirements.
- Support flexibility in terms of future changes to the built environment.
- Provide value for money in all cases.

Projects will be delivered conventionally, within the following range of procurement routes considered to be appropriate and in accordance with local SFI's and OJEU thresholds:

Competitive Tendering: suitable for any project or size using traditional contacts such as JCT, NEC or NHS supply contracts

- ProCure 22: Suitable for major projects over £2m.
- Measured Term Contract: where none of the above is suitable for minor works of a small and repetitive nature, where previously agreed rates can be applied.
- Negotiated Contracts: if any of the above are not appropriate due to timescales or unforeseen circumstances.

10.4 Solutions

This section compares the suitability of internal and external project financing solutions.

Funding Option	Description	Pros	Cons	Recommendations
Capital Resource Limit (CRL)	Funding of the Trust's annual capital programme is based on the estimated depreciation charge for the year. This can be supplemented by either reinvesting revenue surpluses generated in previous years, re-investing receipts	Guaranteed	Limited amount meant for backlog and minor projects. Unlikely to cover larger new developments	Use on priority projects

	from the sale of surplus assets (see below) or through the funds from the DH for centrally funded schemes (see below)			
Capital reserves	The Trust uses its reserves of capital to fund the investment	Readily available Cheap funding	Depends on whether there is any money available in the reserve NHS Improvement will need to agree with risk impact	Use on priority projects
Public Dividend Capital (PDC)	Capital funds supplied by the DH for expenditure on capital projects. Subject to capital charges and depreciation	Cheapest form of funding relative to other externally sourced options	Currently in very short supply. Projects should not assume it is available	First option for external finance but engage NHSI early about realistic prospects of obtaining it
Loan Funded	Trust borrows against its Prudential Borrowing Limit (PBL). It then pays back the loan with interest over say 15 years	Access to external funding at reasonable rates circa (2.65%)	Needs NHS Improvement approval for impact on risk profile Impacts upon revenue budgets	Consider
Land Sale	The organisation disposes of an asset and uses the net disposal proceeds to fund redevelopment	Can support enhanced asset utilisation rates. Can provide a receipt and reduce annual estates and facilities running costs	Timing – the money only becomes available once the asset is vacated and disposed of so bridging loan may be needed. Planning consent for change of use may be required Reduces asset base and therefore CRL Reduces space for future redevelopment Potential impairment Possibility of restrictions on use of proceeds	Only pursue if property is not required, is in a poor location and alternative income generation opportunities from the asset are not attractive
Private Finance	Private sector	No capital outlay	Lengthy	This route is unlikely

Initiative (now PF2)	consortia design, build, finance and operate (FM) new facility. Capital, interest and FM and Lifecycle costs paid monthly through Unitary Payment. PF2 is a reincarnated version of PFI that differs as follows and is now the norm: • Govt equity investment • Transparency requirements • Centralised procurement • Streamlined process/new docs • Extra HMT checks on OBC • Excludes soft FM • Different risk allocation on change in law and insurance	required Lifecycle expenditure "ensured" with building handed back at condition B in c30 years. PF2 supposedly quicker to deliver than PFI Payment mechanism drives performance	procurement Long term commitment to unitary payment UP increasing at higher rate than NHS funding PFI is behind the financial instability of a number of Trusts/areas (e.g. Bart's) Expensive and unwieldy to vary Expensive to buy out No longer off balance sheet Requires robust contract management	to be attractive for the small to medium scale developments under consideration
LIFT **Local Improvement Finance Trust**	LIFTCos work in partnership with local stakeholders and have exclusivity on delivering projects in their areas, 2 stage process with affordability envelope set early on to be met.	Fixed process for project development and contractual arrangements in-place Access to private sector funding	Perception of high cost (but cost of capital should now be lower than at inception and servicing cost should be marginal). Signatories may limit who can use it	Explore possibility, particularly in relation to services provided in partnership in hub settings
Joint Venture (JV) **with private sector** **on site by site basis**	Development or redevelopment in partnership with individual private sector parties best suited to location and use of site	Enables roll-out at pace determined by Trust Maximum flexibility Trust control of solutions	High administrative burden to procure Slow realisation of benefits	Consider if this is appropriate on a case by case basis
Arrangement with clinical / or non-clinical specialist partners on site.	Single or multiple partnerships for redevelopment of a site (e.g. healthcare with elective care	Trust retains freeholds Ground rent revenue Private parties	Reaction to private sector involvement on main site	Consider if this is appropriate on a case by case basis

Funded by partner or 3rd party e.g. Aviva, L&G, M&G	providers or health charities/hospices + staff residences with student accom providers + key worker accom with RSLs + private residential with property developers	provide funding Various successful precedents		
Non-Profit Community Interest Company (CIC)	Transfer property and selected services to Community Interest Company on leasehold basis. Opportunity to combine with services such as libraries, employment, social services etc with other bodies such as local authority, charities, other trusts etc	Trust retains freeholds Ground rent revenue CIC access to private funding Potential capital receipts to reinvest Ease of set-up	Loss of control of some services	Consider if this is appropriate on a case by case basis
SEP Strategic Estates Partnership	Trust enters into 10 to 15 year arrangement with a partner to identify and implement property based solutions using Trust property assets and private sector funding Works a bit like the LIFT model	Flexible structure adapted to precise Trust needs Access to private funding and property expertise Trust retains involvement in estate High level contractual arrangement, reasonably quick to procure	Exact form will be unique to Trust but reasonable number of generic precedents Non FTs not able to enter into LLP – but arrangement can be made contractually No central governance Would require NHSI sign-off	Suitable if a pipeline of property related opportunities are evident

10.5 Procurement - Construction Options Evaluation

Potential procurement routes for projects financed from Treasury funding, capital receipts, reserves, or in some cases developed by a JV or 3rd Party, are compared below against industry standard criterion for assessing the most appropriate strategy.

Construction Procurement Option	Speed of Delivery	Flexible	Value for Money	Deliverability	Risk Transferred	Control	Quality	Innovation	Market Appetite
Bill of Quantities	Low	Low	Medium	Medium	Low	Medium	Medium	Low	High
Design and Build	Medium	Low	Medium	Medium	Medium	Low	Low	Low	High
Management Contracting	High	Medium	Medium	Medium	Low	Medium	Medium	Low	High
Measured Term	Medium	Medium	Medium	Medium	Low	Low	Low	Low	High
Procure 22	High	Medium	Medium	High	High	High	High	Low	High

For the majority of projects, particularly those with a value of over £1m or part of a number of simultaneous projects on one site, ProCure 22 may provide the best solution for the Trust. This solution will potentially gain the best results where a PSCP is engaged to deliver a defined programme of works and where SNHSFHT is able to support the projects through clearly expressing its required outcomes and cost targets and where it has sufficient internal and external expertise to meet its responsibilities and obligations under the contract. For smaller contracts, with a value of less than £1m, which for SNHSFT would typically include conversions or refurbishments, it is recommended that the Trust continue to use the range of other contractual arrangements it currently employs, matching the project needs to the most appropriate procurement route.

Consideration should be given to establishing a framework for these minor projects, but only if the benefits outweigh the costs. Both these solutions are compatible with a Joint Venture or Strategic Estates Partnership approach if the Trust wishes to make them a pre-condition.

11 Environmental action plan

11.1 Introduction

The Trust is committed to taking a proactive approach to sustainability and will continue to explore opportunities for improvement. As the Trust's Estate contributes substantially to its carbon footprint, the Estates team will be required to proactively demonstrate how this will be reduced. Actions will be prioritised according to the impact that can be achieved.

The Estate Team will produce a thorough review of the options to deliver a significant reduction in the environmental impact of the estate and will make recommendations for capital investment approval.

11.2 Objectives

The Trust's objectives are to:

- Improve patient health and wellbeing, safety, experience and clinical effectiveness through a more sustainable and efficient estate
- Maintain high quality of care as sustainability improvements are made throughout the estate
- Improve efficiency measures aligning with HTM 00-00 - HTM 00-08 guidance
- Develop a more responsive service based on improved engagement with patients and staff
- Improve staff and users understanding of how buildings operate to avoid excessive energy use
- Improve continuity between hospital and community sites including consistent documentation and sustainability targets
- Improve governance between projects with effective sharing of best practice, and lessons learnt from previous capital projects across the estate
- Increase recycling to 50% in next 5 years by improving segregation, re-using waste and building in performance KPI's within the waste contract

11.3 Care without Carbon (Sustainability)

The Trust will increase sustainability, consistent with delivery of safe high quality healthcare by striving to conserve resource use in:

- **Energy** - The Trust is continually looking at ways to reduce its impact through energy usage to become a 'greener' business, reducing energy costs thereby mitigate the effect of future increases in energy costs
- **Water** - A profile of Trust's water usage has been mapped and consumption trends established. Monitoring and targeting plays a key part to ensure improvements are made in reducing the amount of water used and wasted. Using minimum quantities necessary and complying with or exceeding statutory requirements concerning the quality of discharges. Reducing leakages and introducing water saving devices including sensor taps in clinical areas and press taps elsewhere, based on best practice experience from newer capital developments
- **Procurement** - Identifying goods and services doing least harm to the environment in production, delivery, packaging, use, re-use, recycling and disposal; reducing carbon miles in transport, and minimising waste through responsible management of perishable items
- **Transport** - Promoting sustainable transportation for business travel and operate Trust controlled vehicles to minimise environmental impact. In addition we are looking at

ways to work in partnership with local transport groups and staff, also supporting the walk to work, cycle and lift share schemes in order to reduce the impact of site parking and transport

- **Waste** - The identification and the management of the different waste streams produced by the Trust has been the key driver in enabling segregation and recycling targets to be met. This success has only been achieved through an in-depth study of the waste created and the alternatives for waste management. We will continue in minimising waste generation, promoting re-use and recycling, and applying best practice in disposal
- **Carbon reduction** - implementing and periodically reviewing a carbon reduction strategy aiming to reduce the carbon footprint by 3% per annum by 2020 from the 2015-2016 baseline, consistent with the NHSE Carbon Reduction Strategy

12 Conclusion and next steps

This paper summarises the key elements of the Trust's emerging draft Estate Strategy and its supporting analyses, setting out a potential vision, or blueprint, for the future of its estate and the opportunities that it presents.

It takes a long-term view of how the estate could evolve, but also acknowledges the issues and challenges that we face in the short term and seeks to identify practical steps that will help us to manage operational pressures while we plan for the future.

At this stage the draft strategy focuses primarily on the Stepping Hill Hospital site, its challenges and opportunities, but it does so in a wider strategic context that includes the Trust's specialist and community centres and the need for much closer partnership working in Stockport and across Greater Manchester.

The potential site development scenarios are underpinned by evidence and a clear rationale but are intended to stimulate debate rather than present definitive solutions.

The case for change is a compelling one. The scale and extent of the significant estate issues in terms of coherence, efficiency, risk, compliance, backlog maintenance, obsolescence and fitness for purpose seriously impact on the Trust's commitment to deliver high quality services now and in the future. The opportunities, however, to strategically develop the site into a modern, flexible and future-proofed site are significant and present valuable opportunities to the Trust at this time.

The Board is asked to consider the key messages and proposed approach outlined in this paper and to approve further development of the draft Estate Strategy to establish a clear strategic direction for the Trust's estate, a coherent long-term plan and a consistent framework for decisions that will help us to maximise the benefits from investment.

Appendix A. Backlog maintenance analysis

Appendix B. Schedule of site proposals and timeline

Stockport NHS
NHS Foundation Trust

Appendix C. Estates Strategy Proposed Schedule Gantt Chart

Block/Element	Cost Summary
000 - Site/External Grounds	£3,096,000.00
001 - Outpatients Department B	£2,885,360.00
002 - Outpatients B Retail Area	£397,530.00
003 - EPR Offices	£305,780.00
006 - Med Record/Facilities	£2,291,270.00
007 - Cardiac Research Centre	£26,850.00
008 - Occupational Health	£154,460.00
009 - Ward A15	£953,420.00
010 - Ward A12	£678,060.00
011 - Transfer Hub	£448,800.00
013 - Sub-Station Bramhall Moor Lane	£0.00
014 - Kitchen	£49,590.00
015 - Woodlands Wards	£1,626,180.00
016 - Boiler House	£954,360.00
017 - Estates Conference Centre	£101,050.00
018 - Estates Workshops/Admin	£378,070.00
019 - Beech House	£244,250.00
020 - HSDU	£854,990.00
021 - Birch House	£185,250.00
022 - Medical Electronics (EBME)	£73,000.00
023 - Staff Restaurant	£448,070.00
024 - Telephone Exchange/Admin	£97,600.00
026 - Main Plant Room	£270,050.00
028 - Outpatients	£598,350.00
029 - Mortuary	£193,870.00
030 - Pathology	£1,454,260.00
031 - Pathology Stores	£26,550.00
032 - Stockport Eye Centre/Wards B2, C2	£1,290,240.00
034 - Physiotherapy	£445,340.00
035 - Theatre 12/Wards B4, C4	£2,077,770.00
036 - Facilities HUB	£162,330.00
038 - Risk Management	£144,200.00
039 - Ward A5 SSU, B5 & C5	£1,088,200.00
040 - Radiology B	£1,323,230.00
041 - Day Case	£922,010.00
042 - Theatres 1, 2 & Endoscopy	£1,231,880.00
043 - Medical Gas Store	£15,150.00
044 - Bobby Moore Unit/Wards B6, C6	£1,316,680.00
045 - Chapel	£120,270.00
046 - Post Room/Admin	£120,600.00
047 - Oak House	£426,120.00
048 - Admin/Pharmacy Shop/M.A.U/C.C.U/Wards B3, C3	£414,890.00
049 - M.A.U.	£1,447,750.00
050 - Hydrotherapy Pool/Occupational Therapy	£167,570.00
051 - Rheumatology Unit	£754,070.00
052 - Path Store	£21,250.00
053 - Main Corridors	£1,844,600.00
054 - Voluntary Services (Support Internship)	£82,600.00
056 - Chest Clinic	£402,250.00
057 - Ash House	£270,200.00
058 - Holly House	£820,180.00
059 - Old/New Aspen House	£2,746,010.00
061 - Cardiac Rehab	£149,760.00
062 - Willow House	£777,890.00
063 - Cedar House	£1,760,270.00
064 - Ultra-sound/Theatre & Recovery	£614,010.00
065 - Ante-natal	£750,070.00
066 - Womens Unit/Orthopeadics	£5,464,430.00
067 - Treehouse (Childrens Services)	£698,750.00
068 - Production Pharmacy	£851,880.00
069 - VIE	£373,800.00
070 - Car Park - Rowan	£161,900.00
071 - Quality Control NW	£464,550.00
072 - Urology	£128,680.00
073 - IEC Pinewood Education	£411,870.00
074 - Gas Meter House B M L	£14,700.00
075 - Gas Meter House Pop Gr	£8,100.00
076 - Elec Substation Pop Gr	£14,100.00
077 - Security Lodge	£12,100.00
078 - Theatre Lift - 5 Block	£4,900.00
079 - Lift Block Oak House	£36,000.00
080 - Water Storage Tanks	£74,000.00
081 - Emergency Department/Theatres 3, 4, 5, 6 & 7	£2,937,630.00
082 - Radiology 'A'/Fracture Clinic/ICU/HDU/Ward D3	£694,510.00
083 - Outpatients A/Audiology/Wards D2, D1	£593,420.00
084 - Power House	£42,400.00
085 - Southern Sector - Phase 1	£234,860.00
085A - D Block	£272,100.00
086 - Link Corridor	£49,500.00
087 - Maternity Link Corridor	£41,730.00
088 - Pharmacy Aseptic Suite	£176,580.00
090 - DMOP	£710,960.00
091 - Car Deck Pinewood	£232,280.00
092 - Car Deck Women's Unit	£235,040.00
093 - Car Deck Cedar / Elm	£531,670.00
094 - CSU - Outpatients	£2,460,390.00
095 - Switch Room	£415,000.00
096 - Woodlands Extension	£2,600.00
151 - Devonshire Rehabilitation Unit	£346,620.00
Grand Total	**£61,197,460.00**

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APPENDIX B

Estates Strategy 2018 – Schedule of Site Proposals

Short Term (2018-2019)				
Area	**Current Status**	**Proposed Action**	**Timescale**	**Outcome**
Ward 12 – Block 010	Currently occupied with medical patients (Bed No 26).	Decant ward into one of the following options; • unoccupied ward C3 (requires enabling works), or • E2, (requires migration of E2 into B5 & C5 as individual single sex wards, and migration of C5 outpatients into Research Unit pre-fab building). Combined net increase 2 beds, or • Migrate into existing DMOP wards as part of clinical strategy towards bed reduction. • Undertake asbestos demolition survey to determine extent of abatement required and remove as required.	March 2019	Demolishment of Ward 12 – Block 010 **(Reduces £1.25m Backlog Maintenance**)
Ward 15 – Block 09	Ward currently vacant. Existing services such as medical gases isolated. Asbestos demolition survey completed.	Undertake asbestos abatement programme, currently for September 2018 in preparation in readiness for joint demolition with Ward 12 (note unable to demolish in silo due to service connections with Ward 12).	March 2019	Demolishment of Ward 15 – Block 09 **(Reduces £1.25m Backlog Maintenance)**
Medium Term (2020-2023)				
Outpatients B	Outpatient facility currently occupied along with EPR offices & Medical Records Library.	Outpatient facility moved either into a central location on site or migrated into a community setting in accordance with Stockport Together. Medical Records to be incorporated within existing Laundry Building.	2020	Demolishment of Blocks 01, 02 & 03 **(Reduces £3.5m Backlog Maintenance)**
Emergency Campus – STP Wave 4	Current application for STP Capital funding has been submitted and is awaiting formal decision in the autumn of 2018.	Full design team to be established to commence working full design proposals, consultation with the local Planning Authority and approved inspector to obtain necessary permissions and establish restrictions. Alternative site reservoir to be established as part on enabling works and consideration for temporary car park provisions	2023	Creates new Emergency Campus on site integrating an Urgent treatment Centre, Planned Investigation Unit and replacement car parking provisions within a multi-

APPENDIX B

		duration		disciplinary building.
Pathology Laboratory - Block 30	Current application for STP Capital funding has been submitted and is awaiting formal decision in the autumn of 2018 as either integrated model within Emergency Campus (above) or stand-alone Essential Services Laboratory (ESL).	Full design team to be established to commence working full design proposals, consultation with the local Planning Authority and approved inspector to undertaken to obtain necessary permissions and establish restrictions.	2023	Demolishment of Block 30 **(Reduces £1.5m Backlog Maintenance)**
Pennine Care Facilities – Blocks 04 & 05	Currently occupied by Pennine Care under a SLA agreement and are responsible for maintaining the building. Currently anticipated that Pennine Care will relocate their services from the estate handing the building over the Trust.	Buildings are left in-situ in a reasonable condition to allow for change of use into suitable acute inpatient facilities.	2023	Refurbishment of building to provide acute inpatient services
Aspen House - Block 59	Currently occupied by Finance, Procurement and various other clinical and support services. The older part of the building has a timber frame structure which had failed, in part, in 2018.	Potential for demolition, particularly the older part of the building due to age, condition and ability to adapt to modern standards and regulations. The released footprint could be used to pre-provide other key clinical and/or support services.	2024	Demolishment of Block 59 **(Reduces £2.7m Backlog Maintenance)**
Cedar House – Block 63	Currently occupied by various other clinical and support services.	Potential for demolition, particularly the older part of the building due to age, condition and ability to adapt to modern standards and regulations. The released footprint could be used to pre-provide other key clinical, support services or multi storey parking provisions that would unlikely be prohibited due to adjacent railway lines.	2024	Demolishment of Block 63 **(Reduces £1.8m Backlog Maintenance)**
Long Term (2025 Onwards)				
A,B,& C Wards - Blocks 31 – 51.	Current outpatient facilities are scattered across the hospital estate. The existing medical wards are largely provided in aging nightingale wards that are not conductive to modern, mixed sex inpatient facilities. The existing unofficial main entrance, Oak House is extremely space limited and does not offer modern entrance provisions such as self-check-in facilities etc.	Demolish, in phases, the central spine of the hospital made of blocks 32 – 51 to provide modern, fit for purpose healthcare inpatient and outpatient facilities centrally within the hospital estate. Formation of new accessible main entrance to create central and suitable location for patients and visitors.	2028	Replacement of Blocks 32 up to 51 with new Central Reception and Drop Off, Outpatients and Medical Ward facilities. **(Reduces £20.3m Backlog Maintenance)**

APPENDIX B

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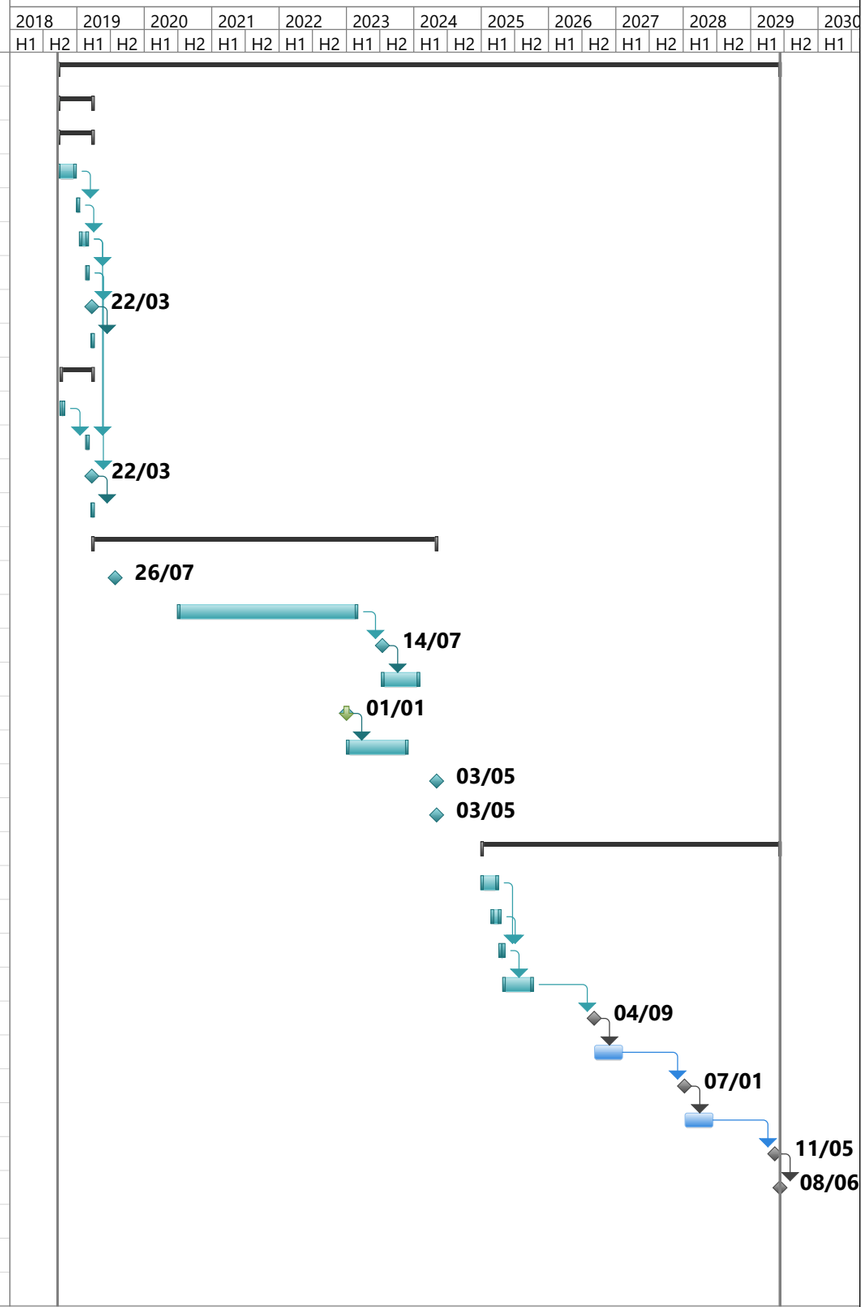
ID	Task Mode	Task Name	Duration	Start	Finish	Predece	Resource Names
1		**Estates Strategy 2018 - Proposed Schedule**	**2795 days?**	**Mon 24/09/18**	**Fri 08/06/29**		
2		**Short Term Goals**	**135 days?**	**Mon 24/09/18**	**Fri 29/03/19**		
3		**Ward 12 Demolition**	**135 days?**	**Mon 24/09/18**	**Fri 29/03/19**		
4		Relocate Ward to Agreed Location	65 days	Mon 24/09/18	Fri 21/12/18		
5		Undertake R&D Survey	2 days?	Mon 07/01/19	Tue 08/01/19	4	
6		Planned Removal of Asbestos (A12)	25 days?	Tue 22/01/19	Mon 25/02/19	5	
7		Decommission Existing Services	5 days?	Mon 25/02/19	Fri 01/03/19	6	
8		Demolition of Building (A12)	15 days?	Mon 04/03/19	Fri 22/03/19	7	
9		Maintain Area as Safe Brownfield Site	5 days?	Mon 25/03/19	Fri 29/03/19	8	
10		**Ward 15 Demolition**	**125 days?**	**Mon 08/10/18**	**Fri 29/03/19**		
11		Planned Removal of Asbestos (A15)	10 days?	Mon 08/10/18	Fri 19/10/18		
12		Decommission Existing Services	5 days?	Mon 25/02/19	Fri 01/03/19	6,11	
13		Demolition of Building (A15)	15 days?	Mon 04/03/19	Fri 22/03/19	7	
14		Maintain Area as Safe Brownfield Site	5 days?	Mon 25/03/19	Fri 29/03/19	13	
15		**Medium Term Goals**	**1331 days?**	**Fri 29/03/19**	**Fri 03/05/24**		
16		Outpatients B Demolition	86 days?	Fri 29/03/19	Fri 26/07/19		
17		Construction of Emergency Campus (STP Wave 4)	690 days	Mon 06/07/20	Fri 24/02/23		
18		Pathology Demolition	100 days?	Mon 27/02/23	Fri 14/07/23	17	
19		Construction of New Surface Car Park Provisions	140 days?	Mon 17/07/23	Fri 26/01/24	18	
20		Pennine Care Depart from Site	0 days?	Sun 01/01/23	Sun 01/01/23		
21		Undertake Refubishment to Blocks 4 & 5	230 days?	Mon 09/01/23	Fri 24/11/23	20	
22		Demolition of Old Aspen House, or	85 days?	Mon 08/01/24	Fri 03/05/24		
23		Demolition of Cedar House	85 days?	Mon 08/01/24	Fri 03/05/24		
24		**Long Term Goals**	**1155 days?**	**Mon 06/01/25**	**Fri 08/06/29**		
25		Decant Compliment of Medical Wards to Blocks 4 & 5	60 days	Mon 06/01/25	Fri 28/03/25		
26		Suitable on Site Temporary Accomdation is established	30 days?	Mon 03/03/25	Fri 11/04/25		
27		Decant Compliment of Medical Wards, outpatients etc.	15 days?	Mon 14/04/25	Fri 02/05/25	25,26	
28		Demolition Phase 1	110 days?	Mon 05/05/25	Fri 03/10/25	27	
29		Construction of New Facilties Phase 1	240 days?	Mon 06/10/25	Fri 04/09/26	28	
30		Demolition Phase 2	110 days?	Mon 07/09/26	Fri 05/02/27	29	
31		Construction of New Facilties Phase 2	240 days?	Mon 08/02/27	Fri 07/01/28	30	
32		Demolition Phase 3	110 days?	Mon 10/01/28	Fri 09/06/28	31	
33		Construction of New Facilties Phase 3	240 days?	Mon 12/06/28	Fri 11/05/29	32	
34		Formal Handover & Commissioning	20 days?	Mon 14/05/29	Fri 08/06/29	33	
35							
36							
37							



Project: Estates Strategy 18.09.2
Date: Wed 19/09/18

Task	Project Summary	Manual Task	Start-only	Deadline
Split	Inactive Task	Duration-only	Finish-only	Progress
Milestone	Inactive Milestone	Manual Summary Rollup	External Tasks	Manual Progress
Summary	Inactive Summary	Manual Summary	External Milestone	

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NHS
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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	People Strategy		
Report of:	Interim Director of Workforce & OD	**Prepared by:**	Deputy Director of Workforce & OD

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this paper is to present the People Strategy for consideration and approval of the Board. This strategy has been developed through a wide engagement and consultation process, involving key staff groups, staff representative groups and external advisors to the Trust. It has been developed taking account of the Trusts current ambitions and challenges, and of the changing system in which it operates. It aligns with the developing Trust strategy, and will support the successful achievement of the Trust's priorities and Strategic objectives. The Board is requested to approve the attached strategy.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	Annex A – People Strategy

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

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1. INTRODUCTION

1.1 The purpose of this paper is to present the People Strategy for approval. This strategy has been developed through a wide engagement and consultation process.

2. BACKGROUND

2.1 The People Strategy describes how the Trust will create the workforce needed to deliver its vision of how it provides safe, high quality hospital and community services.

It sets out our strategic workforce priorities and the approach we will take to deliver them. The strategy builds on our culture of innovation and continuous improvement, of openness and transparency, and of collaborative compassionate leadership, grounded in our values.

Our workforce and the needs of our patients are changing and so is the way we deliver care. Shortages of clinical staff nationally, an older workforce, and changes to education pathways means our workforce profile is evolving. Pressures in secondary and social care and the emergence of new ways of working as part of our commitment to excellent patient care each and every time require our staff to have new skills.

As a Trust we value our people and recognise they are our greatest asset. Our overall aim is to develop our staff, give them clear career pathways, provide them with the leadership, skills and knowledge they need to deliver the care our patients need now and in the future, to support their wellbeing and to recognise and value their diversity.

The strategy builds on our strong foundations as a model employer and our values, and is key to the delivery of our Strategy.

This strategy is supported by a robust operation plan, which will allow us to plan how we will deliver this strategy, and track our progress against those plans.

3. CURRENT SITUATION

3.1 The Trust has a number of documents and actions plans all of which describe the activities taking place to deliver the workforce priorities of the Trust. The People Strategy draws all the work being undertaken together and provides an over-arching strategy.

4. RISK & ASSURANCE

4.1 The People Strategy delivery will be managed and monitored by the People Performance Committee; which will receive regular progress updates.

A detailed operational implementation plan has been developed which allows for oversight of the progress against the strategic objectives.

5. RECOMMENDATION

5.1 The Board is requested to approve the attached strategy for approval and implementation.

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Stockport
NHS Foundation Trust

People Strategy

2018 – 2023

‘Your Health. Our Priority’ putting people at the centre of everything we do

Contents

Introduction

Our people strategy describes how we will create the workforce we need to deliver our vision of how we *provide safe, high quality hospital and community services*. Supported by the development of a Neighbourhood led approach for Stockport; holding contracts for our health & care services thereby creating, in collaboration with our partners, a single health and care system for Stockport

It sets out our strategic workforce priorities and the approach we will take to deliver them. Our strategy builds on our culture of innovation and continuous improvement, of openness and transparency, and of collaborative compassionate leadership, grounded in our values.

Our workforce and the needs of our patients are changing and so is the way we deliver care. Shortages of clinical staff nationally, an older workforce, and changes to education pathways means our workforce profile is evolving. Pressures in secondary and social care and the emergence of new ways of working as part of our commitment to excellent patient care each and every time require our staff to have new skills. There are opportunities to make best use of emerging technology and to support new models of working.

As a Trust we value our people and recognise they are our greatest asset. Our overall aim is to develop our staff, give them clear career pathways, provide them with the leadership, skills and knowledge they need to deliver the care our patients need now and in the future, to support their wellbeing and to recognise and value their diversity.

The strategy builds on our strong foundations as a model employer and our values, and is key to the delivery of our Clinical Strategy.

Vision, values & goals

The Trust's vision is of a health and care system that has excellent care at the heart of the community. To realise our vision we will remain true to our core values of Quality & Safety, Communication, and Safety. To achieve our vision, the Board has set three strategic goals.

Vision

- Excellent patient care each and every time.

Mission

- To provide safe, high quality, integrated care to people through a range of excellent accessible health & social care

Values

- **Quality & Safety**
  - We are proud to deliver safe, high quality & compassionate care.
  - We take care to provide a clean & safe environment for better care.
- **Communication**
  - We want our patients, their families and our staff to feel that they are being treated with dignity & respect.
  - We will take time to communicate with everyone in a clear & open way.
- **Service**
  - We will continuously challenge ourselves and each other to provide effective, efficient & innovative care.
  - We will work in partnership with others, to deliver improved care, in the right place at the right time.

People Strategy Overview

Our people strategy is developed based on the Trust's five strategic priorities. Realising those priorities will ensure we achieve consistently well-led, fully staffed teams, where individuals' wellbeing and identity is nurtured, enhancing our excellent care to patients.

Education & Practice Development	• *To invest in a well-educated workforce, developing skills and competences to support continuous improvement and to enable our staff to reach their full potential.*
Culture & Engagement	• *To offer a compassionate and inclusive work environment where our people are engaged, motivated, and have shared purpose.*
Leadership Development	• *To offer support and development to our leaders and managers to lead well, so that they can create a workplace where our people flourish, and our patients are receiving the best possible care.*
Resourcing	• *To create a workplace that attracts and retains people with the right skills, and commitment to providing high quality, safe care.*
High Performing	• *To provide the right systems, processes and environment to enable our workforce to be as efficient and effective as they can be.*

'Your Health. Our Priority'

Education & Practice Development

- **Objective:** ***To invest in a well-educated workforce, developing skills and competences to support continuous improvement.***

Links to:

- **Quality Improvement:** Keeping our patients safe at all times.
- **KLOE-** Safe **WELL LED-** capacity and capability

Key Measures:

- **HEE & national Standards achieved**
- **Apprentice Levy utilisation.**

Where are we now?	Where do we want to be?	How to get there…
1.1 All staff receive an induction that is streamlined to GM standards.	1.1 All staff will receive an excellent experience of corporate, clinical and local induction.	1.1 Incorporation of clinical competences in clinical and local induction programmes.
1.2 Students and Trainees are offered high quality placements Trust wide in partnership with all local Universities & HEE.	1.2 Trust is a placement of choice, more students/trainees are attracted to join/return based on our reputation for high quality placements.	1.2 Enhance student/trainee support by increasing the number of placements.
1.3 Education and training programmes are delivered as part of a competency led framework.	1.3 Our education and training programmes underpin the delivery of excellent patient care and align with existing and emerging career frameworks.	1.3 In partnership with clinical services develop a competency framework for all clinical and professional roles.
1.4 Year 1 of the Training Needs Analysis (TNA) met 98% of all training and development requests Trust wide.	1.4 Training & development requests approved, supporting innovation in education.	1.4 Review and enhance the Training Needs Analysis (TNA) process to support career progression and mapped to individual personal development plans & our strategic priorities.
1.5 Statutory and Mandatory Training is currently above compliance rate and staff are committed to the process.	1.5 Our staff have ease of access routes to Statutory and Mandatory training.	1.5 Offer a blended approach to learning through face to face, e-learning clinics. Review and refresh e-learning packages.
1.6 Commitment to creating innovative apprenticeship opportunities across the organisation for staff at all levels.	1.6 We achieve our apprenticeship target and full utilisation of the levy.	1.6 Continue with the current Apprenticeship plan and further engage with the workforce to design and develop new apprenticeships.

Culture & Engagement

- **Objective:** ***To offer a compassionate and inclusive work environment where our people are engaged motivated, and have shared purpose.***

Links to:

- **Operational Performance:** Provide excellent patient experience & deliver expected outcomes.
- **Well Led:** Culture **KLOE:** Well led

Key Measures:

- **Staff Survey and Staff Friends & Family Test**
- **Appraisal**
- **Sickness Absence**

Where are we now?	
2.1	Staff survey completion rate of 43%.
2.2	Commitment to staff health and wellbeing through well managed interventions.
2.3	Developed staff networks for BAME & LGBT.
2.4	Culture & Engagement plan monitored by the Culture & Engagement Group.
2.5	40 Cultural Ambassadors established with a growing network.
2.6	Coaching network in place
2.7	Celebrating Stockport & good practice events, thank you cards & team member of the month established.
2.8	Values based training, development and recruitment.

Where do we want to be?	
2.1	On a trajectory to 70% with a 7% annual increase.
2.2	Staff are healthy and report that the Trust is proactive with its health & wellbeing agenda.
2.3	Open communication where diverse views are listened to and respected.
2.4	We retain staff who are happy and working resiliently to their optimum in challenging times. They feel valued across all services regardless of role and responsibility. Cultural Ambassador in every service.
2.5	A wider network of diverse coaches and a
2.6	Trust wide coaching culture. Celebration of skills and talents is
2.7	embedded within all services. Recognition for our staff. Values integrated into all documentation
2.8	and processes.

How to get there…	
2.1	To engage with all staff areas and promote ambassadors.
2.2	Health and wellbeing included in all Trust wide objectives and business plans.
2.3	To map well led capability against required standards and hold leaders to account.
2.4	Equality Advocate role established Trust wide.
2.5	Fulfil all aspects of the Culture and Engagement plan including a Trust wide cultural assessment.
2.6	Current coaches to promote the role and train annual cohort.
2.7	To continue with themed events that align to the Culture and Engagement plan.
2.8	Review of values and behaviour framework.

Leadership & Development

- **Objective:** ***To offer support and development to our leaders and managers to lead well, so that they can create a workplace where our people flourish and our patients are receiving the best possible care.***

Links to:

- **Corporate Objective**: Leadership Development
- **Well Led:** Leadership capacity and capability

Key Measures:

- **Staff Survey**
- **Leadership evaluation (Kirkpatrick)**

Where are we now?	
3.1	Talent Management (TM) included in leadership development activity.
3.2	Developing consistent leadership capability for all leaders through our leadership programme.
3.3	Commenced Board development.
3.4	Compassionate Leadership launched with senior leaders.
3.5	Senior leadership programme launched for Clinical Directors, Nursing and Allied Health Professionals.
3.6	Quality Improvement (QI) OD plan developed to support leadership capability.
3.7	WRES data published.
3.8	Focus on 'Holding to account' (masterclass delivered to 500 managers.

Where do we want to be?	
3.1	A TM strategy that is measured, and fully represents the workforce we employ at all levels.
3.2	To fill future leadership pipelines with the right numbers of diverse, appropriately developed people.
3.3	Continuing to increase the effectiveness of the Board through our Board development programme.
3.4	Leaders demonstrate inclusion and compassion in all their interactions. They develop their own and their staff's skills and capacity to improve health services.
3.5	All clinical and support service leaders to complete the Leadership development programme.
3.6	QI methodology and principles embedded in all interventions.
3.7	Culture of holding to account Trust wide.

How to get there…	
3.1	Developing the talent management process and ensure it is systematic across the organisation and aligns to national strategy.
3.2	Robustly manage the leadership programme and align to national and regional TM plan.
3.3	Board development plan reviewed to include cultural assessment.
3.4	Continue with phase 2 of the Compassionate and Collective leadership programme.
3.5	Evaluate the current leadership offering to ensure there is positive service impact on patient experience.
3.6	Work in partnership with AQuA to further develop QI offering.
3.7	Targeted work to implement required actions via EDS2 & WRES/ WDES.
3.8	Key component of all leadership development.

Resourcing

- **Objective:** ***To create a workplace that attracts and retains people with the right skills, and commitment to providing high quality, safe care.***

Links to:

- **Financial Resilience:** Being a well-led & governed Trust with sound finances.
- **Well Led:** information

Key Measures:

- **Retention & Stability performance**
- **Staff Friends & Family Test**
- **Vacancy, turnover & temporary staffing metrics**

Where are we now?	
4.1	Workforce KPI metrics are sound and well used.
4.2	Workforce plan is incremental & based on the financial plan.
4.3	Robust governance of recruitment & use of temporary staffing.
4.4	New and flexible roles developed and embedded.
4.5	Lack of brand identity.

Where do we want to be?	
4.1	Workforce metrics as an integral part of the business planning approach.
4.2	A well-developed workforce plan reflecting demand, commissioning & design/supply factors.
4.3	Continued reduction of agency spend.
4.4	Ability to recruit to specialty posts.
4.5	Employer of choice with well-developed brand/identity.
4.6	Innovative and flexible work models are integrated into every service.

How to get there…	
4.1	Improved metrics for translating themes/trends into clear workforce data.
4.2	Granular work with business groups to develop plans.
4.3	Implementing 24/7 services where appropriate.
4.4	Developing 'new' roles, through improved partnership working.
4.5	Development of employer brand within the overall development of the Trust identity/brand.

High Performing

- **Objective:** ***To provide the right systems and environment to enable our workforce to be as efficient and effective as they can be.***

Links to:

- **Well Led:** continuous improvement and innovation
- **Use of resources**

Key Measures:

- **Retention & Stability performance**
- **Staff Friends & Family Test**
- **Vacancy, turnover & temporary staffing metrics**

Where are we now?	Where do we want to be?	How to get there…
5.1 Well established policy development group.	5.1 'Just Culture' embedded.	5.1 Implementation of 'Just Culture' and new ways of working.
5.2 Time to hire of 10 weeks.	5.2 Time to hire of 8 weeks.	5.2 Implementation of Trac System.
5.3 Limited use of Model hospital data.	5.3 Model hospital used to inform decision making.	5.3 Improved metrics for performance.
5.4 ESR SS roll out complete.	5.4 ESR MSS full roll out.	5.4 Ensure benefits realisation for systems by rolling out all aspects of ESR.
5.5 eRostering basic in deployment and functioning	5.5 Full eRostering roll out and use of all functions.	5.5 Ensure benefits realisation for systems by rolling out all aspects of Allocate.
5.6 Limited mediation capabilities.	5.6 Early interventions prevent issues escalating.	5.6 Launch mediation service.
5.7 Limited service performance data / approach.	5.7 An HR team with a reputation of getting it right first time (shared service).	5.7 GIRFT HR accreditation process in place.
5.8 'Traditional' flexible working.	5.8 Fully flexible/agile workforce.	5.8 Implement mobile & agile working.
5.9 Appraisal compliance of 94.7%	5.9 Appraisal process is fully embedded and valued as an effective performance and development tool.	5.9 Robust Appraisal policy and process that is values led.

Delivering this strategy

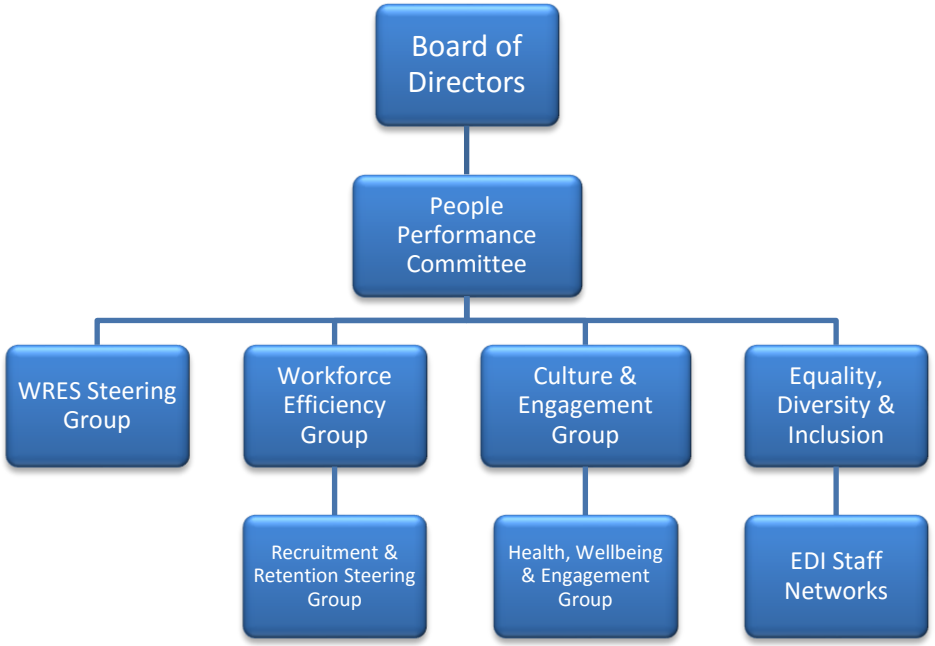
The six strategic priorities will be delivered through four delivery groups:

- The **Recruitment & Retention Steering group** will deliver the recruitment and retention and the temporary workforce priorities.
- The **Workforce Efficiency group** will deliver the workforce transformation priorities.
- The **Health, Wellbeing and Engagement group** will deliver the wellbeing priority.
- The culture priority will be led by the **Culture & Engagement Group,** which will also deliver our developing talent & leadership priorities.
- The **Equality, Diversity & Inclusion Group** will provide strategic direction for promoting and maintaining EDI across the Trust in both workforce and service delivery, supported by the **WRES Steering Group**.

Each group has clear Terms of Reference and an action plan and are chaired by the Deputy Director of Workforce & OD / Head of OD & Learning.

Performance against plans will be managed by the People Performance Committee which reports to the Board of Directors.

Assurance on workforce priorities and progress against the plans will be presented to the People Performance Committee. Key Performance Indicators are reported through the Integrated Performance Report (IPR) to the Board of Directors.



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Risks to delivering this strategy

The delivery of the Workforce Strategy is dependent on the appropriate planning of future workforce needs and supply.

The greatest risks in delivering the strategy therefore are:

- We do not attract and retain sufficient numbers of staff to deliver services
- We do not develop and train our workforce to deliver the new models of care
- We do not make sufficient use of the apprenticeship opportunities to replace reduced funding for clinical development
- We do not develop our leaders and create a culture of coaching for improvement
- We do not invest sufficiently to ensure recruitment, retention, training and development can take place systematically and consistently
- We rely too much on temporary staff to provide our services

The risks will be continually reviewed and mitigations put in place to ensure that this strategy can be delivered.

Associated documents & strategies

- Clinical Care Strategy
- Patient Experience Strategy
- Developing People – Improving Care
- 5 year strategic plan
- Stockport Neighbourhood Care (Locality Plan)
- Quality Improvement Plan
- Informatics Strategy
- Estates Strategy
- Recruitment and Retention Strategy
- Facing Facts, Shaping the Future: A Health & Care Strategy for England to 2027
- Leadership Development Strategy & Plan

People Strategy Map

6 months	Year 2	Year 3	Year 4 - 5
Design and commence the NHSI Culture Programme	Equality advocate role developed to support EDS2/WRES/WDES, and used to develop proactive EDI approach	Full development of a culture and engagement map means that we listen and respond to our colleagues	Trust culture that promotes innovation and continuous improvement through challenge and trust
Skills and competencies are developed to ensure the highest levels of patient care	Fully developed coaching framework that offers skilful coaching support to individuals and teams.	Comprehensive Talent Management process aligns to future needs of the Trust and the aspirations of colleagues	Trust is a placement of choice for trainees and other placements based on effective and supportive placements
Develop enhanced retention plans	Appraisal process includes strengthened career planning and progression for colleagues.	Recruitment strategies are informed by robust workforce plans and attract a diverse workforce	Employer brand and reputation that attracts and retains a flexible and agile workforce
Scoping of sharing services/collaboration opportunities.	Continued development of new roles/working models to meet changing system priorities	Develop Trust-wide workforce plans that include enhanced career pathways	Leadership and development programmes include innovation and system planning
Develop workforce planning processes to support the implementation of the strategy	Full e-Rostering roll-out and consistent use of all functions	Self-service workforce metrics support leaders to maximise individual and team performance.	Systems support integrated workforce planning, development and performance management
.Implementation of the TRAC recruitment system	Implementation of the 'Just Culture' approach to restorative practice, learning and support	Workforce wellbeing programme embedded to support colleagues to be at their mental and physical best	Mobile and agile working supported by fit for purpose systems
2018/19	**2019/20**	**2020/21**	**2021/23**
Getting it Right First Time			

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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Medium Term Financial Strategy (MTFS)		
Report of:	Director of Finance	**Prepared by:**	Director of Finance

REPORT FOR APPROVAL

Corporate objective ref:	C12, C13	**Summary of Report** One of the key urgent actions resulting from NHSI's Review of Undertakings at Stockport NHSFT in 2017 was the development of a Medium Term financial Strategy (MTFS). The MTFS sets out the actions required as a Five-Point Improvement Strategy to address the deterioration in the financial performance of the Trust. Since the Draft MTFS was presented to the Board of Directors in July, a task and finish group was arranged and the final version reflects the discussions and agreements. Following review by the Finance and Performance Committee in September, This report seeks approval of the MTFS from the Board of Directors.
Board Assurance Framework ref:	S05	
CQC Registration Standards ref:		
Equality Impact Assessment:	☐ Completed ☒ Not required	

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

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1. INTRODUCTION

1.1 In 2017/18, the Trust had a Review of Undertakings by NHSI as it was failing to deliver the Emergency Department performance, it had been given a rating of "requires improvement" by the CQC and there were concerns on the Trust's ability to deliver the financial plan in 2017/18. One of the urgent actions from the review was that the Trust needed to develop an MTFS to show how the Trust would return to a break-even position over the next five years.

1.2 Developing a medium-term financial strategy (MTFS) will help bring together all known factors affecting an organisation's financial position and its financial sustainability into one place. It allows the Board of Directors to balance the organisation's objectives against constraints in resources.

2. THE DEVELOPMENT OF THE MTFS

2.1 The development of the MTFS was predicated on three options but following discussion with Board Members, four options were considered;

a) To only deliver 2% implicit improvement per year over the planning timeframe in line with national experience;
b) To develop improvement objectives to offset the inflationary challenges over the next four years;
c) To develop improvement objectives to half the overall deficit over the planning timeframe; or
d) To develop improvement objectives that delivered a financial break-even in the next five years.

2.2 The MTFS is intended to be reviewed in tandem with the overall Trust Strategy and other enabling strategies such as the Workforce Strategy and Estates Strategy. As internal and external factors change, the Trust needs to be able to respond appropriately to changes in its operating environment.

3. DEVELOPMENT SINCE JULY

3.1 Further to the Board of Directors meeting, there have been a series of meetings to determine the best possible outcome from the MTFS. The Trust has now also developed a Trust that shapes the future of services at the Trust.

3.2 In order to meet the £70.4m sustainability challenge over the next five years, further analysis is being undertaken of the Trust's strategy by the Finance Team, namely:

a) For patient services that the Trust will maintain as part of its strategy, what is the overall level of efficiency opportunity;
b) For patient services that the Trust wants to expand to sector wide provision, what is the overall level of efficiency opportunity AND market share opportunity; and
c) For patient services that the Trust aims to collaborate, what is the level of loss / profitability that the Trust can gain?

3.2 Further opportunities will need to driven from:

d) Extensive back office reductions through shared services and automation; and
e) A 20% reduction in management posts across the Trust.

3. CONCLUSION

3.1 Financial forecasts show that that starting with a pre-CIP deficit of £49m and the Trust incurring inflationary pressures of a further £44m in the next four years (average £11m per annum), the Trust would need to deliver a cost improvement of £93m, equating to £18.6m per year (c6.7%) to achieve the breakeven. Annual savings of this magnitude would impact upon the quality and safety of services.

3.2 The financial strategy therefore, focussed upon the Trust delivering improvement objectives to half the financial deficit over the planning period. The level of financial improvement to deliver this option is £70.4m, which is still considered to be challenging. This document describes the strategy to be employed to achieve this objective.

4 RECOMMENDATION

4.1 The Board of Directors are asked to:

- approve the Trust's Medium term Financial Strategy; and
- agree to share with regulators and stakeholders.

Stockport
NHS Foundation Trust

MEDIUM TERM FINANCIAL STRATEGY

2018 – 2023

1. BACKGROUND

1.1 The Chartered Institute of Public Finance and Accountancy (CIPFA) has published an Insight Briefing entitled "Looking Forward"[1], which articulates the importance of Medium Term Financial Planning. The CIPFA document summarises a number of factors that required Public Sector Organisations to plan ahead.

1.2 Financial planning sits at the heart of good public financial management. Alongside budget preparation, performance management and stakeholder reporting, the ability to look strategically beyond the current budget period is a crucial process to support an organisation's resilience and long-term financial sustainability.

1.3 Given the current level of global economic uncertainty, fluctuating currency values, and the widespread pressures on public spending, it is more important than ever that public sector organisations have a thorough understanding of their financial outlook and are planning effectively for the future.

1.4 Despite, or perhaps because of, our current political, economic and resourcing challenges, taking a longer and more strategic approach to planning will provide a catalyst for more sustainable changes to services and provide a framework against which an organisation's budget should be produced.

1.5 Developing a medium-term financial strategy (MTFS) will help bring together all known factors affecting an organisation's financial position and its financial sustainability into one place. It allows the Board of Directors to balance the organisation's objectives against constraints in resources.

2. INTRODUCTION

2.1 In 2017/18, the Trust had a Review of Undertakings by NHSI as it was failing to deliver the Emergency Department performance, it had been given a rating of "requires improvement" by the CQC and there were concerns on the Trust's ability to deliver the financial plan in 2017/18. One of the urgent actions from the review was that the Trust needed to develop an MTFS to show how the Trust would return to a break-even position over the next five years.

2.2 In the development of the MTFS, the financial strategy was predicated on four options;

a) To only deliver 2% implicit improvement per year over the planning timeframe in line with national experience;
b) To develop improvement objectives to offset the inflationary challenges over the next four years;
c) To develop improvement objectives to half the overall deficit over the planning timeframe; or
d) To develop improvement objectives that delivered a financial break-even in the next five years.

2.3 Early analysis showed that starting with a pre-CIP deficit of £49m and the Trust incurring inflationary pressures of a further £44m in the next four years (average £11m per annum),

[1] Looking Forward, Medium Term Financial Planning in the Public Sector (10th November 2016)

the Trust's sustainability challenge would be £93m, equating to £18.6m per year (c6.7%) to achieve the breakeven which would impact upon the quality and safety of services.

2.4 The financial strategy therefore, focussed upon the Trust delivering improvement objectives to half the financial deficit over the planning period. The level of financial improvement to deliver this option is £70.4m, which is still considered to be challenging. This document describes the strategy to be employed to achieve this objective.

2.5 This MTFS includes:

- The Trust's recent financial performance including why is the Trust delivering a deficit (Section 3 and 4);
- The Initial Financial Forecast (Do Nothing Scenario) (Section 5);
- The Five Point Financial Improvement Plan to significantly strengthen the financial sustainability of the Trust (Section 6);
- The Financial Impact of the Improvement Strategy (Section 7)
- The delivery resources and mechanism (Section 8)
- Key Influencing Factors of Risk and Opportunity to the Strategy (Section 9).

2.6 The MTFS is intended to be reviewed in tandem with the overall Trust Strategy and other enabling strategies such as the Workforce Strategy and Estate Strategy. As internal and external factors change, the Trust needs to be able to respond appropriately to changes in its operating environment.

3. THE TRUST'S RECENT FINANCIAL PERFORMANCE

3.1 In order to appreciate the direction of travel for financial resilience and sustainability, it is important to understand the Trust's historic financial performance. Table 1 overleaf summarises the key financial metrics for the Trust

Financial Position	2013/14 (£'m)	2014/15 (£'m)	2015/16 (£'m)	2016/17 (£'m)	2017/18 (£'m)
Financial Plan (Surplus / (Deficit)	(4.0)	(4.9)	(13.1)	(6.0)	(27.4)
Reported Performance (Surplus / (Deficit)	1.0	3.7	(12.9)	(6.3)	(22.0)
Normalised Performance (Surplus / (Deficit)	1.0	(0.1)	(15.5)	(14.5)	(27.2)

CIP	2013/14 (£'m)	2014/15 (£'m)	2015/16 (£'m)	2016/17 (£'m)	2017/18 (£'m)
Target	8.4	13.3	11.8	25.7	15.0
Recurrent Delivery	7.1	6.6	9.1	8.1	6.3
Non-Recurrent Delivery	2.2	6.9	2.7	14.6	12.0
Achievement (Under / Over)	(0.9)	(0.2)	0.0	3.0	(3.3)
Recurrent Shortfall	1.3	6.7	2.7	17.6	8.7
Cumulative	*1.3*	*8.0*	*10.7*	*28.3*	*37.0*

Agency Costs	2013/14 (£'m)	2014/15 (£'m)	2015/16 (£'m)	2016/17 (£'m)	2017/18 (£'m)
Agency Spend (All Staff)	8.6	12.0	18.2	13.5	12.0
% of total pay costs	*4%*	*6%*	*8%*	*7%*	*6%*

Cash	2013/14 (£'m)	2014/15 (£'m)	2015/16 (£'m)	2016/17 (£'m)	2017/18 (£'m)
Yearend Cash Balance	46.6	44.6	31.4	23.7	15.5

Capital Programme	2013/14 (£'m)	2014/15 (£'m)	2015/16 (£'m)	2016/17 (£'m)	2017/18 (£'m)
Capital costs	9.4	9.9	16.4	8.8	6.6

Table 1 – Historical Key Financial Metrics

3.2 In 2016/17, the Government announced a £1.8bn Sustainability and Transformation Fund (STF), which was linked to the delivery of a financial control set by NHSI and the delivery of an agreed ED target (determined locally). The Trust's received £11.4m in 2016/17 from the STF including incentive and bonus payment.

3.3 The Trust historically delivered financial surpluses but as the external climate changed, largely as a result of the economic downturn and a squeeze on the public sector, the Trust has not adapted quickly enough to mitigate the impact of these changes. This includes developing and sustaining an environment of continuous improvement using an improvement methodology. As a result there has been an over reliance on one-off measures which in reality has inhibited the ability to change the Trust culture. By 2015/16, the underlying deficit had reached £15.5m partly explained by:

a) an unplanned increase in additional capacity required to deal with the urgent care demand, which has continued in the past two years;
b) the increase of agency costs from £12.0m in 2014/15 to £18.2m in 2015/16 representing 8% of total pay costs, resulting in the Trust having one of the highest medical agency spend in the country ; and
c) the cumulative effect of not delivering recurrent improvements in previous years. The recurrent cumulative shortfall reached £10.7m in 2015/16 and has continued to increase to £37.0m in 2017/18.

3.4 It was also during 2016/17, that the Trust was chosen of as one of twenty Trusts nationally to partake in Wave 1 of the Financial Improvement Programme (FIP). The Trust was supported by KPMG to help deliver the financial performance in 2016/17 however, the delivery of the performance was through extremely challenging one-off projects and failed to deliver significant clinical transformation change.

4. WHY IS THE TRUST DELIVERING A DEFICIT?

4.1 The Trust needs to understand why it is in the current financial position. NHSI use a provider controllability model review a Trust's financial position. The model illustrated in the diagram below assesses how much control an organisation has over its financial position to understand where the opportunity and accountability can be influenced.

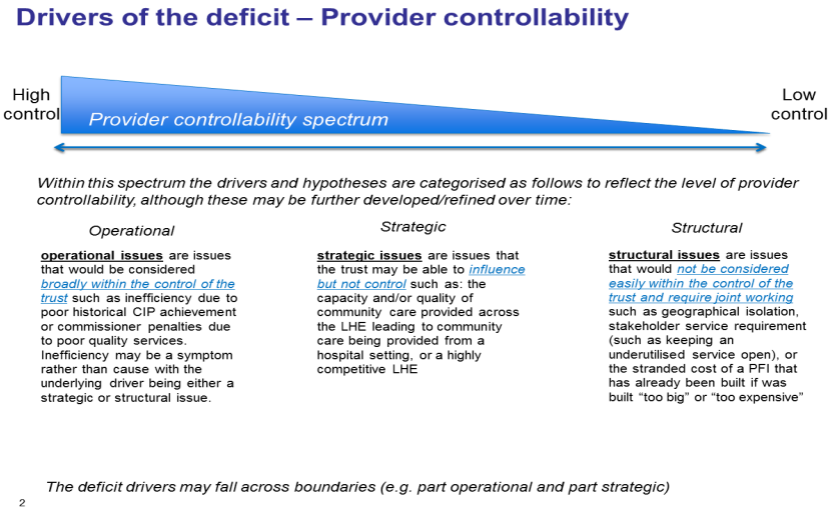

Diagram 1 – Provider Control of the Deficit

4.2 Using this approach we can break down the underlying issues that are causing the current deficit. Table 2 presents the main drivers of the deficit from a £1m surplus in 2013/14 to the planned £34m deficit in 2018/19. Operational issues are described as cost pressures, strategic issues are described as service investments and structural issues as contract changes.

Cost Pressures	£m
Agency medical staff based on out-turn	4.5
Delivering elective capacity with minimal contribution from outsourcing	2.1
Delivering diagnostic capacity at premium rates including endsocopy	1.3
Nurse and medical recruitment support	1.0
Nurse specialling in Medicine	0.8
Community consumable contracts	0.2
Nursing acuity	0.5
CIP non recurrent delivery - where balance sheet or other non recurrent means has met the shortfall	7.9
Reverse of CIP on car parking charges linked to salary sacrifice	0.3
Total	**18.6**

Service Investments	£m
Investment in nursing for safe staffing following Berwick & Francis reports	1.2
Additional investment in ED - medical	1.3
Additional CQC investment in nursing	1.4
Electronic Patient Record	3.0
D Block	1.0
Urology robot	0.3
Transformation Team / Exec Team / Management structure	1.5
GI bleed rota / Gastroenterology permanent posts	0.5
Stockport Together risk share	2.4
Total	**12.6**

Contract changes	£m
Transfer of Community Services to Tameside after incorporating into Stokcport Community and therefore loss of contribution	2.4
Loss of contracts for Sexual Health for Stockport (contribution)	0.3
Loss of contract for wheelchairs for Tameside (contribution)	0.4
Diagnostic angiography transfer to UHSM (loss of contribution	0.1
SMBC deflation on Health Visiting contract	0.6
Total	**3.8**

Grand total	**35**

Table 2 – Stockport FTs Spectrum of Deficit Controllability

4.3 The issues described above could be re-presented by individual specialty profitability. The Trust has invested in a patient level costing system (PLICs), to support operational and clinical leadership teams to understand the contribution to overheads that specialties make to the Trust financial position.

4.4 A summary of the specialty financial performance for 2017/18 is shown in Table 3. The table shows the overall contribution to the overheads as well as the overall surplus / deficit by specialty.

Service line description	Contribution to overheads £m	Overheads £m	Surplus / (deficit) £m	Overall Surplus/(Deficit) as percentage of Income
Emergency Department	(3.1)	(0.9)	(4.0)	-29%
Acute Medicine	5.2	(1.6)	3.6	23%
General Medicine	(1.4)	(5.2)	(6.7)	-22%
Other Medical specialties (inc. diabetes/rheu/chest)	3.7	(1.6)	2.1	13%
Care of the Elderly	(2.7)	(2.8)	(5.5)	-43%
General Surgery	(0.6)	(3.5)	(4.1)	-21%
Ophthalmology	0.3	(1.5)	(1.2)	-19%
Trauma & Orthopaedics	0.8	(4.5)	(3.8)	-14%
Urology	2.2	(2.2)	(0.1)	0%
Other surgery (inc breast, ent)	1.4	(3.1)	(1.7)	-12%
Adult Critical Care	0.4	(0.6)	(0.2)	-3%
Gynaecology	1.3	(1.1)	0.2	3%
Obstetrics	0.3	(2.4)	(2.1)	-14%
Paediatrics	2.8	(2.0)	0.9	7%
Community	2.0	(4.9)	(2.9)	-9%
Support Services (inc. pathology/ radiology/ pharmacy)	5.2	(0.6)	4.6	34%
Total	17.6	(38.5)	(20.8)	

Table 3 – Key Specialty Profitability in 2017/18

4.5 A different way of analysing the data would be to show this by "point of delivery" which refers to how a patient is treated e.g. outpatients, elective inpatient or day case or emergency admission. Point of delivery is analysed for each specialty and the following table shows a high level analysis of this for the Trust.

Point of delivery	Overall Surplus/(Deficit) £m
Elective admissions	(1.5)
Day cases	2.8
Non-elective admissions	(12.5)
Out patients	(6.6)
A&E attendances	(4.0)
All other	0.9
Total	**(20.8)**

Table 4 – PLICs 2017/18 by point of delivery

4.6 Table 4 shows that 60% of the Trust's deficit is related to non-elective admissions and 19% due to A&E admissions. This financial challenge was one of the key factors in the Trust's support for the Stockport Together Programme.

5. THE INITIAL FINANCIAL FORECAST (THE DO NOTHING SCENARIO)

5.1 In line with the NHSI Operational Planning Guidance of 2017/18, the Trust developed a two year Financial Plan, which was refreshed following the publication of the 2018/19 Planning Guidance. The main financial movement between the 2017/18 outturn and the 2018/19 Final Financial Plan is illustrated in the diagram below.

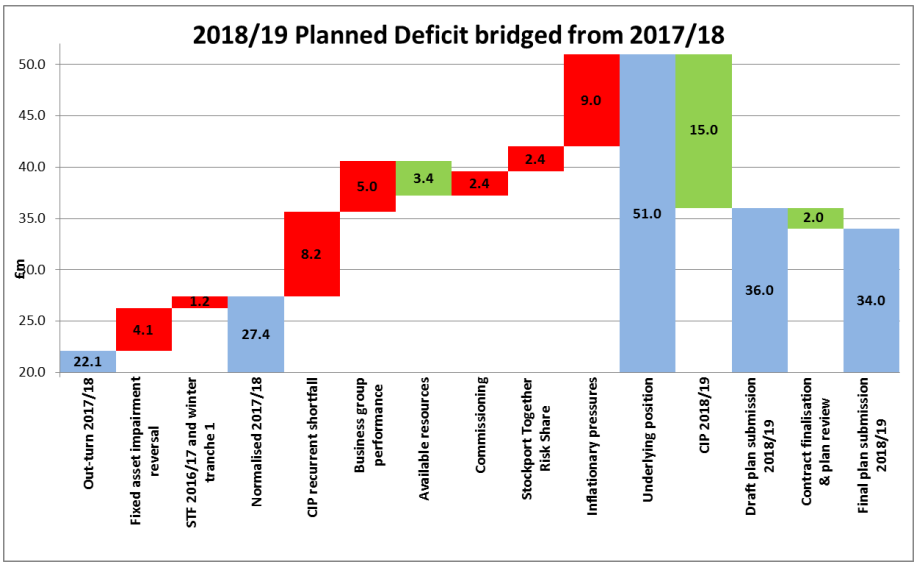

Diagram 2 – Key movements between 2017/18 and 2018/19

5.2 In developing the 2018/19 financial plan, the Board of Directors rejected the offer of £10.7m Provider Sustainability Fund (PSF) to deliver a surplus of £2.0m. The Trust would have needed to deliver a CIP of £40.3m (c14%) to achieve the required control total. The Board felt that this level of saving could not have been enacted without deterioration in quality and safety

5.3 Using the 2018/19 Final Operational Financial Plan as a foundation, the Trust has created a five year model which aligns to the reporting required for Greater Manchester Health and Social Partnership (GMH&SCP), where a "roll-up" of the ten localities is requested that incorporates Providers, Clinical Commissioning Groups (CCGs) and Local Authorities (LAs). This is to compare the latest financial forecast versus the original £2bn gap analysis undertaken previously as part of the GM devolution strategic financial case.

5.4 The Trust has used the NHSI national mandated planning assumptions in the development of the "do nothing" scenario. The underlying assumptions that have been used to develop the model are presented in Table 5 below.

Expenditure inflators	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical supplies & services	3.10%	3.10%	3.10%	3.10%	3.10%
Drugs	4.10%	4.10%	4.10%	4.10%	4.10%
Other non pay costs	1.90%	1.90%	1.90%	1.90%	1.90%
Pay inflation and incremental drift (pre pay award 18/19 finalisation)	1.60%	2.90%	2.90%	2.90%	2.90%
Indicative hospital activity model (IHAM) growth	Published	Published	*Estimated*	*Estimated*	*Estimated*
A&E attendances	2.02%	2.11%	*2.07%*	*2.07%*	*2.07%*
Non elective	1.80%	2.00%	*1.90%*	*1.90%*	*1.90%*
Elective	1.70%	1.60%	*1.65%*	*1.65%*	*1.65%*
Out patients	3.50%	3.50%	*3.50%*	*3.50%*	*3.50%*

Table 5 – Inflation and growth assumptions

5.5 The headline financial forecast for the “do-nothing” scenario is summarised in Table 6 below.

Category	2018/19 (£'m)	2019/20 (£'m)	2020/21 (£'m)	2021/22 (£'m)	2022/23 (£'m)
Income	281.0	284.3	293.3	299.2	303.3
Expenditure	(330.0)	(328.1)	(341.2)	(352.3)	(361.6)
Underlying Deficit	(49.0)	(43.8)	(47.9)	(53.1)	(58.3)
Agreed Improvement	15.0				
Assumed 2% Improvement		6.2	6.7	6.8	6.9
Forecast "Do Nothing" Deficit	**(34.0)**	**(37.6)**	**(41.2)**	**(46.3)**	**(51.4)**

Table 6 – Do nothing base model

5.6 In developing the scenario, there are three assumptions that are subjective, all other assumptions such as the impact of Stockport Together have been agreed:

a) The latest NHS Pay Deal has been fully assessed and analysed. The Trust is incurring a £0.5m financial pressure in 2018/19 and is continuing discussions with NHSI. The assumption for planning purposes is that the increase in 2018/19 and beyond is fully funded and therefore assumed as being cost neutral in this model (this may change when final funding details emerge).

b) Any activity growth costs the Trust approximately 14% more than the income based on our current rate of overall loss; and

c) The 2% CIP in 2018/19 and beyond is assumed to be delivered on a recurrent basis based on historical trends and outcomes of national reviews.

5.7 As can be seen in Table 6, if the Trust only delivers 2% recurrent CIP (in line with all available historical national learning) the Trust financial deficit increases every year leading to a £51.5m deficit by 2022/23. This level of financial performance is not sustainable and the Trust needs to enact strategies to mitigate the scale of the forecast losses.

5.8 It is highly unlikely, given the experience of other Trusts in a similar position in recent years (once in a deficit position it can be stabilised but becomes persistent), that the Trust will be able to break even in the next 5 years unless there is a significant change in the economic operating context of the NHS for example enabling the Provider Sustainability Funding to be distributed on a more realistic basis. Using NHSIs 2017/18 Quarter 4 Performance Report 65% of acute providers ended the financial year in a deficit position.

6. THE FIVE POINT FINANCIAL IMPROVEMENT STRATEGY

The Five-Point Financial Improvement Strategy utilises all available information and knowledge to significantly reduce the forecast losses. The proposed improvements stem from the drivers of the deficit described at in section 4.2.

6.1 Objective 1 - Significantly reduce workforce costs and reliance upon non-substantive staff (Lead Director – Interim Director of Workforce & OD).

6.1.1 As with most other Trusts in the country, the Trust has struggled to recruit to key clinical posts across the Organisations.

6.1.2 The Trust has seen particular consultant gaps in areas such as Microbiology, Neuro Radiology, Cardiology, Respiratory and Histopathology where there are national shortages and the agency costs is significantly higher and in excess of the hourly rate set by NHSI.

6.1.3 The Trust is experiencing significant shortfalls in Doctor training grade rotas across the Board and therefore needs to utilise costly agency staff, coupled with approximately 170 nursing and midwifery vacancies that are predominantly filled by bank staff.

6.1.4 In order to address the issue, the Trust will have to undertake the following actions:

i. **Increase Retention** – The Trust is currently experiencing staff retention rates of approximately 10%-12%, which is average nationally however the Trust is struggling to recruit to these vacancies. The strategy involves:
   a. Increasing staff health and well-being, making staff much more resilient and reduce the overall numbers of staff leaving taking up posts in less stressful roles;
   b. Develop better progression prospects for staff either joining the hospital or have worked in the Trust for a considerable period. The Trust retention rate is symptomatic of staff not being able to progress into more senior roles;
   c. To develop job enhancement and allow staff to experience and develop into other roles across the Trust.

ii. **Increase Recruitment** – The Trust has struggled to recruit to individual posts and therefore may need to consider different approaches such as:
   a. Redevelop historically acute based services such as respiratory, cardiology and care for the elderly into more community focussed roles;
   b. Develop job share roles with tertiary centres and allow new recruits to spend some time in other Trusts;
   c. To give an overall focussed recruitment campaign recruiting significant number of posts to allow for a more flexible working pattern.

iii. **Redesign Traditional Job Roles** – The Trust, like many other Providers, still have the historic medical and nursing model. The Trust must focus upon the development of other staff groups to provide healthcare such as:
   a. develop more ANPs and Physician Associates for traditional Junior Doctor roles;
   b. better use of therapy staff to provide more generic nursing care;

c. develop Trust based development programmes that take HCAs into more experienced care workers.

6.1.5 The elements above must help solve the 7 day working programme and be an enabler to more safe and efficient care.

6.1.6 If the Trust was to reduce the agency spend as percentage of total pay costs in line with another GM DGH (Bolton NHSFT) then the estimated savings could be £5.4m per year[2] fully realisable in 2020/21.

6.2 Objective 2 – Drive all available opportunities in Model Hospital, CHKS and Reference Costs (Lead Director – Chief Operating Officer)

6.2.1 The key way in which the Trust assesses its financial opportunities is by using benchmarking information from services which the Trust subscribes to such as the Comparative Health Knowledge System (CHKS).

6.2.2 The national way forward with benchmarking is to use the Department of Health's Model Hospital which uses data from a variety of sources including Trust reference costs, annual accounts and the employee service records (ESR) to create a weighted activity unit (WAU) in order to compare every Trust in the country. The data also looks at findings from the Getting it Right First Time reviews (GIRFT) of clinical specialities in order to identify areas of unwarranted clinical variation.

6.2.3 It is planned to embed the model hospital principles throughout the Trust in order to challenge specialties to move from their current position by percentage points to a different quartile or to average or to upper quartile; each specialties circumstances will be different.

6.2.4 The Trust still shows a Potential Productivity Opportunity (PPO) of £21.8m opportunity in the presentation by NHSI North's Operational and Productivity Team. The main focus is regarding the pay costs per Weighted Activity Unit and the actions focussed in the Workforce Strategy should reduce this PPO to £16.4m. The software produces an overall productivity improvement chart which shows the potential within specialities from benchmarking nationally. The results currently available show the following for the Trust:

[2] Stockport FTs 2016/17 agency performance was 7% compared to Bolton NHSFT who experienced 4% in the same period.

Compartment Area	Spend	Indicative Potential Productivity Opportunity (PPO) in £	Potential Productivity Opportunity (%)
General Medicine	£39.7m	£3.5m	8.7%
Geriatric Medicine	£26.9m	£2.6m	9.6%
Orthopaedic & Spinal Surgery	£32.8m	£2.2m	6.7%
Obstetrics & Gynaecology	£22.4m	£1.2m	5.5%
Pathology	£10.7m	£1.1m	31.2%
General Surgery	£27.5m	£898k	3.3%
Ophthalmology	£7.1m	£766k	10.8%
Urology	£13.1m	£657k	5.0%
Cardiology	£6.5m	£546k	8.4%
Ear, Nose & Throat	£4.6m	£154k	3.3%
Breast Surgery	£2.7m	£92k	3.4%
Paediatrics	£9.7m	£66k	0.7%
Diabetes & Endocrinology	£1.8m	£56k	3.0%
Oral & Maxillofacial	£1.9m	£55k	3.0%
Cancer Services	£802k	£2k	0.2%

Table 7 – Model hospital opportunities June 2018 extract – 2016/17 reference costs

6.2.5 Sustainable change will come from clinical engagement and leadership. The Trust is developing a culture of improved quality of care through the leadership of the Chief Nurse and Director of Quality Governance. Improvement in the use of resources and the reduction in unwarranted clinical variation in the Trust will need to formulated and delivered through focussed Clinical Service Reviews that have commenced in 2017-18.

6.2.6 Whilst the model hospital will not be updated for 2017/18 reference costs until November 2018, the indicative productivity opportunities broadly match the specialties which have the greatest deficit.

6.2.7 When looking at the opportunities in the Model Hospital, the Trust has the opportunity to compare itself against all acute Trusts in the country or a specific peer group. Based on Acute Trusts with a similar turnover and delivering similar District General Hospital (DGH) services, the Trust has agreed a peer group summarised in Appendix A.

6.2.8 The Trust has established a specialty review programme which will in turn review each of the specialties within the Trust in order to identify all the opportunities available, challenge the data available and agree an action plan including a financial opportunity. It is planned to have a rolling programme of specialty reviews that ensures that there is a continuous improvement cycle.

6.2.9 The results of the first set of service reviews have highlighted a number of opportunities which are being pursued as actions through the current CIP themes. A summary can be shown in the following table:

		Cardiology	DMOP	General Surgery	Obstetrics	Rheumatology
Oversight & Delivery	FIG - Improving Patient Flow	6 beds	27 beds			
	FIG - Workforce	50% locum costs	50% locum costs			
	FIG - Theatres & Endoscopy			13% point improvement in Utilisation		
	FIG - Procurement & Clinical Standardisation			Potential £50k saving	Potential £35k saving	
	FIG - Clinical Support				Increased activity	
	FIG - Corporate & Estates & Facilities				Retail Opportunities	
	FIG - Medicines Management					Potential £129k saving
	Business Group to lead	Service options post-Cath Lab	Service model to improve profitability	Review of Non-Elective Pathway	Market share and birth rate analysis	Future model for service provision
		Coding review	Outpatient efficiency	Outpatient efficiency	Quality and Efficiency metrics	One-stop shop development
		Upskill Primary Care	Model for Day Hospital	Market share analysis	Departmental configuration	Outpatient efficiency

Table 7 – Matrix of opportunities through service reviews

6.2.10 Whilst the majority of focus is on front line clinical services, the Model Hospital also directs users towards opportunities in clinical support services and corporate services. The Trust is currently developing opportunities in:

a) Shared corporate services with either the local authority or other NHS Organisations in Greater Manchester dependent upon fit; and
b) Federated Pathology services to create resilience and sustainability.

6.2.11 Through these means, the Trust must develop plans to develop approximately 4% cost improvement over the planning period which should deliver approximately an extra £6m per year.

6.3 Objective 3 - Deliver the Stockport Together Benefits (Lead Director – Deputy Chief Executive)

6.3.1 In June 2017, the Board of Directors considered the Stockport Together Outline Business Cases and endorsed the development and implementation of new models of care. This decision was made on the basis the new models of care will deliver significant financial savings to the Health and Social Care Economy.

6.3.2 Since that date, the Health and Social Care Partners of Stockport Together (Partners) have been recruiting, mobilising and delivering parts of the new models of care. In July 2018, the Partners have reassessed the Stockport Together Benefits following challenge from the Greater Manchester Health and Social Care Partnership Team (GMH&SCP) and the CQC. One of the factors in the financial modelling is the impact of activity growth especially in

urgent care pathways. Stockport is an outlier in GM and nationally and the cost of delivering the urgent care pathways is negatively impacting the Trust by £16.5m as presented in table 4 above. The diagram below shows Stockport CCG's comparative position.

Diagram 3 – Stockport CCG Comparative Emergency Admissions

6.3.3 The Trust will receive investment of £7.9m recurrently to deliver increased service provision in ambulatory care and neighbourhood services.

6.3.4 The Stockport Together programme has a two-fold benefit to the Trust. It negates activity growth which reduces the need for increased capacity at costs above tariff but it also begins to reduce the requirement for loss making services contributing a net saving £0.5m per year.

6.3.5 The financial impact of achieving the refreshed benefits will require the Trust to contribute £2.4m and £2.3m in 2018/19 and 2019/20 respectively into the risk and gain share before receiving £2.0m and £3.6m in 2021/22 and 2022/23 respectively.

6.4 Objective 4 – Increase income opportunities through repatriation of planned daycase and elective activities, increase births and contract discussion (Lead Director – Director of Finance)

6.4.1 A recent review of Stockport CCG activity (2017-18) showed that a significant level of activity is being delivered at either an Independent Sector organisation or other Trust as per the table below:

	IS Provider	NHS Provider
Daycases	6,324	11,112
Elective Cases	570	2,481
Grand Total	**6,894**	**13,593**

Table 9 – Analysis of Stockport CCG Activity

6.4.2 Most of the activity undertaken at the Independent Sector Provider (IS Provider) will be low risk, low cost and high contribution activity. A closer review shows that the majority of activities are in Ophthalmology (Cataracts), Orthopaedics (Minor Procedures) and General surgery (Hernia Operations) or Scoping Procedures. Each activity is potentially cash cows in other Trusts.

6.4.3 Activity at other NHS Providers is significantly more complex predominantly due to the specialist activity such as cancer treatment, heart surgery etc. However the Trust needs to review referral patterns for non-specialist activity to undertake them at the Trust and aid the relative profitability.

6.4.4 A recent review found that the Trust waiting times was not updated and accurate at the time that patients were making decisions under the patient choice option and therefore were choosing to be treated at the Independent Sector provider.

6.4.5 If the Trust assumed that 50% of the work undertaken at the Independent Sector could be repatriated with an average tariff of £500 then the Trust could benefit from an injection of £1.7m per year however a fuller assessment is required to ascertain variable costs.

6.4.6 With regards to Maternity Services, the Trust has the consultant and estate capacity to undertaken 4,000 births however at present the Trust is only delivering 3,300 as many would be mothers choose to have their children elsewhere. If the Trust was able to attract 700 births that had a financial contribution of 70% than the Trust would benefit by £1m per year.

6.4.7 In both of these aspects, the Trust would benefit from expert marketing specialists as we are not intending to negatively impact CCGs but rather transfer available resources towards Stockport FT.

6.4.8 The Trust continues to be penalised for readmission penalties and non-elective threshold adjustments as per the national contract to the value of approximately £4m each year. Local health and social care economies have decided to phase out these adjustments in return for assured contracts (block). The Trust will aim to phase these adjustments out over the period.

6.5 Objective 5 – Exploit opportunities arising from Greater Manchester development and / or neighbouring Trusts (Lead Director – Deputy Chief Executive)

6.5.1 There are a number of services across the Trust that are seen as well led and are able to provider services over a larger geographical footprint. Whilst the GMH&SCP Theme 3 work may influence the overall strategy of where services develop, the Trust already has a number of highly regarded services that provides (will provide) services across a larger footprint such as services such as:

a) General Surgery – preferred provider of emergency complex care for the population of the South East Sector and the High Peaks (currently a number of years behind plan) ;
b) Urology Services – currently provide Consultant led care across the South East Sector;
c) Orthopaedic Services – currently the second largest provider in Greater Manchester.

6.5.2 The Trust continues to engage with neighbouring Trusts to review all available opportunities to consolidate services to create resilience from a workforce and financial basis.

7. FINANCIAL IMPACT OF THE IMPROVEMENT STRATEGIES

7.1 As described in Section 2.4 above, the Trust has a sustainability challenge of £93m over the next five years. The overall Five Point Improvement Plan will partially address the challenge and even with the assumption that the £10.7m Provider Sustainability Fund (PSF) becomes recurrent in 2020/21, the Trust will still have a residual gap as per Table 10 below

Category	Total (£'m)
2018/19 Underlying Deficit	(49.0)
Inflationary Pressures	(44.0)
2018/19 CIP	15.0
Benchmark Improvement	38.0
Income Improvement	6.7
Provider Sustainability Fund (PSF)	10.7
Residual Shortfall	**(22.6)**

Table 10 – Impact of Sustainability Challenge

7.2 For modelling purposes, it has been forecasted that improvements will passed equally over the next four years. The following table summarises the forecasted impact of the improvements along with the impact on the underlying deficit.

Category	2018/19 (£'m)	2019/20 (£'m)	2020/21 (£'m)	2021/22 (£'m)	2022/23 (£'m)
Deficit before CIP	(49.0)	(43.9)	(43.4)	(32.9)	(31.5)
Agreed Improvement	15.0				
Assumed 2% Improvement		6.2	6.7	6.8	6.9
Forecast "Do Nothing" Deficit	(34.0)	(37.7)	(36.7)	(26.1)	(24.6)

Category	2018/19 (£'m)	2019/20 (£'m)	2020/21 (£'m)	2021/22 (£'m)	2022/23 (£'m)
Improvement 1 - Workforce		1.4	1.4	1.4	1.4
Improvement 2 - Service Reviews		1.5	1.5	1.5	1.5
Improvement 3 - Stockport Together			0.5	2.0	1.6
Improvement 4 - Income Opportunities		1.7	1.7	1.7	1.7
Improvement 5 - Federation					
Provider Sustainability Fund (PSF)			**10.7**		
Total Improvement	**0.0**	**4.5**	**15.7**	**6.5**	**6.1**
Total Sustainability Plan	**15.0**	**10.7**	**22.4**	**13.3**	**13.0**
Revised Surplus / (Deficit)	(34.0)	(33.2)	(21.0)	(19.5)	(18.5)

Table 11 – Net Impact of Improvement Strategy

7.3 It is important to note that there will be duplicating factors involved in trying to deliver the current improvements under the "Do Nothing" Scenario and the values attributed to the Improvement Plan. The original assumption and the overall improvement strategy deliver approximately £70.4m (including the PSF) over the planning period and would approximately half the financial deficit.

7.4 The Prime Minister has also announced 3.6% real growth which may have a positive impact on the underlying deficit. At present, the Trust has to find savings to meet inflationary pressures

of £10m per year. The Trust could benefit of additional real growth in the autumn statement however it would be difficult to plan on this basis for the strategy.

8. DELIVERY RESOURCES AND MECHANISM

8.1 In order to support the development of transformation change, the Trust has made significant investment in the supporting infrastructure at the Trust. This cost has added significant pressure into the underlying deficit and therefore it is important that these assets are utilised to deliver the strategy. The investments in the supporting structure are:

- Medical Leadership
- Transformation Team
- Investment in Finance, HR and Corporate Nursing
- PMO
- Strategy and Planning
- Information Resource

8.2 In order to deliver sustainable change, the Trust has introduced two groups:

i. Operational Performance Group (OPG) chaired by the Chief Operating Officer (COO) reviewing all aspects of the Operational Performance including the delivery of key efficiency metrics such as length of stay and N:FUP Ratios. The COO will be supported by the Delivery Director and the Director of Transformation and Performance; and

ii. Strategy and Planning Group (SPG) chaired by the Deputy Chief Executive (DCEO) reviewing all aspects of Strategic change at Specialty level as depicted in the Trust's Strategy. The DCEO will be supported by the Strategy and Planning Team.

8.3 Over and above the resources described above, the Trust has additional senior operational capacity to develop sustainable clinical change in the system. Using the AQUA's PDSA methodology the Trust needs to develop the clinical improvement journey to deliver at least 5% efficiency recurrently in the next two to three years.

9. KEY INFLUENCING FACTORS OF RISK AND OPPORTUNITY TO THE STRATEGY

9.1 There are a number of key internal influencing factors of risk and opportunity that need to be considered:

a) **Operational Performance** – The single biggest issue facing the Trust is that Stockport FT has not delivered the 95% Emergency Department target since 2013, and is the main focus of regulatory action from NHSI at the moment. More recently the Trust is failing RTT and cancer and these issues are diverting much needed attention from quality of care or the financial challenge;

b) **Care Quality Commission – Requires Improvement Rating** – Linked to the above, the Trust has a Requires Improvement Rating following unannounced visits in 2016 and 2017. The Trust is currently being assessed against the Well-Led Domian and has had the latest CQC unannounced visit in September as well as the Use of Resources assessment.

c) **Workforce -** The greatest challenge to the Trust is to have sufficient workforce in order to be able to deliver its priorities. As demonstrated in Table 4 the Trust incurred £12m in agency costs, 6% in 2017/18 but also incurred a further £12.2m in bank costs. The Trust therefore has costs equivalent to 12% of pay costs. This does not include the substantial level of activity undertaken using waiting list initiatives. If included, the Trust reliance on non-substantive workforce costs would rise to 26%. The Government has asked businesses to plan for the impact of exiting the European Union however this is risk that had yet to be assessed.

d) **Changes in leadership** – Since the retirement of the Chief Executive in December 2017, the Trust has yet to secure a permanent replacement and with other interim Executives in place.

e) **Capacity and Capability –** The Trust has recently restructured the clinical departments into revised Business Groups in preparation for the development of Integrated Care Organisation. Medical Leaders have been appointed in the form of Associate Medical Directors (AMDs) and Clinical Directors (CDs). The challenge for the leadership team is how to make the Triumvirate (Operational Manager, AMD and Associate Nurse Director (ANDs) work together to deliver across quality, workforce, operational and financial objectives.

f) **Condition of the Trust's Estate and IM&T Infrastructure -** The current condition of the Trust's estate and IM&T Infrastructure is not conducive to the delivery of efficient care and therefore the development of the these supporting strategies will need to focus upon a reduction the overall footprint, reduce utility usage and support efficient working practices is crucial. The Trust is continuing to develop the acute and community Electronic Patient Record (EPR) as an enabler to delivery safe and efficient care. Furthermore, the Trust has submitted bids to the Department of Health for Urgent Care monies however due to restricted investment funds, the safest option to raise funds is to request investment from the Independent Trust Financing Facility (ITFF) on the premise that land can be freed up to develop social low cost or key worker housing.

g) Commissioning Landscape - There is continual change in the commissioning landscape with Clinical Commissioning Groups and Local Authorities creating Joint Strategic Commissioning Boards and devolving "tactical" commissioning to Providers. The Trust should see this development as an opportunity and influence the patient pathways for the future.

APPENDIX A – AGREED PEER GROUP TO BENCHAMRK SERVICES

- St Helen's & Knowsley Hospital Services NHS Trust (RBN)
- North Lincolnshire & Goole NHS Foundation Trust (RJL)
- University Hospital of South Manchester NHS Foundation Trust (RM2)[3]
- Bolton NHS Foundation Trust (RMC)
- University Hospitals of Morecambe Bay NHS Foundation Trust (RTX)
- Medway NHS Foundation Trust (RPA)
- North Cumbria University Hospitals (RNL)
- Countess of Chester Hospital NHS Foundation Trust (RJR)
- Mid-Cheshire Hospitals NHS Foundation Trust (RBT)
- Burton Hospitals NHS Foundation Trust (RJF)
- Kingston Hospital NHS Foundation Trust (RAX)

[3] To be reviewed when new dataset is released as now part of the Manchester University Foundation Trust however, could be replaced with Aintree Hospitals NHS.

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Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Proposed Amendments to Constitution		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref: N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to seek approval of proposed amendments to the Trust's Constitution. The proposed amendments relate to: ▪ Meeting Attendance Requirements ▪ Nominations Committee Membership The report also seeks a view from the Board of Directors on the subject of Tenure of Governors.
Board Assurance Framework ref: N/A	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed X Not required	

Attachments: Appendix 1 – Extract from Annex 5, Trust Constitution

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

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1. INTRODUCTION

1.1 The purpose of this report is to seek approval of proposed amendments to the Trust's Constitution.

2. BACKGROUND

2.1 Potential amendments to the Constitution, relating to Meeting Attendance Requirements for Governors were considered at a meeting of the Governors' Governance & Membership Committee held on 3 September 2018. In addition, the Committee considered an amendment relating to membership of the Nominations Committee following policy guidance received from NHS Improvement. The Committee made appropriate recommendations to the Council of Governors.

2.2 Amendments to the Constitution require initial approval from the Board of Directors and final approval by the Council of Governors. The intention is to present a report for final approval at the next meeting of the Council of Governors in October 2018.

3. CURRENT SITUATION

3.1 <u>Meeting Attendance Requirements</u>

The current meeting attendance requirements are set out at s8.2, Annex 5 of the Trust's Constitution. A copy of the relevant section is included for reference at Appendix 1 to this report. Removal of a Governor can currently be effected as a result of an individual failing to attend two formal meetings of the Council of Governors in any Governor Year unless the other Governors are satisfied that the absences were due to reasonable causes and that he/she will be able to start attending meetings within such a period as they consider reasonable.

3.2 The current requirements could result in the removal of a Governor if an individual failed to attend meetings over a relatively limited 3-month period. While the Governance & Membership Committee agreed a process which would be followed in such cases, to ensure that any extenuating circumstances are taken into account, it was agreed that an approach based on absence from two meetings was overly draconian.

3.3 A review of the Constitutions' of a number of local NHS Foundation Trusts suggest that the attendance requirement is commonly based on either failure to attend three meetings in a Governor Year or three consecutive Council of Governors meetings. Consequently, the Committee agreed to propose an amendment to the Constitution to reflect failure to attend three consecutive Council of Governors meetings. The Board of Directors is recommended to approve this proposal.

3.4 Nominations Committee Membership

The Trust recently received correspondence from NHS Improvement on the subject of Nominations Committee membership as reflected in the Trust's Constitution. This was part of a national review of NHS Foundation Trust Constitution documents carried out by NHS Improvement.

3.5 The correspondence required the Trust to comply with the NHS Improvement policy position on membership of the Nominations Committee. Specifically, the policy position requires that a Chief Executive should not have formal membership of a Nominations Committee but may advise and/or offer views to the Committee. Annex 6, Section 4 of the Trust's Constitution currently states:

The Nominations Committee will comprise the Chairman (or, when a Chair is being appointed, the Deputy Chair unless they are standing for appointment, in which case another Non-Executive Director), Deputy Chairman, five Governors and the Chief Executive. The Chairman of another Foundation Trust will be invited to act as an independent assessor to the Nominations Committee.

3.6 It is proposed that this section of the Constitution be amended as follows:

The Nominations Committee will comprise the Chairman (or, when a Chairman is being appointed, the Deputy Chairman unless they are standing for appointment, in which case another Non-Executive Director), Deputy Chairman and five Governors. The Chairman of another Foundation Trust will be invited to act as an independent assessor to the Nominations Committee. The Nominations Committee will consult the Chief Executive.

3.7 Board members should note that, in stating its policy position, NHS Improvement referred to the NHS Foundation Trust Code of Governance and Director-Governor Interaction in NHS Foundation Trusts. The guidance is not clear in either instance and the Director of Corporate Affairs has suggested to NHS Improvement that greater clarity be provided in any subsequent revisions of the publications. That said, the rationale for ensuring that an individual has no decision-making powers in relation to appointment of their immediate superior is sound, and the Board is recommended to approve the proposed amendment. A subsequent amendment to the Nominations Committee Terms of Reference would also be required.

3.8 Both of the proposed amendments were considered by the Executive Management Group on 18 September 2018 and recommendations were made for approval of both amendments.

4. OTHER MATTERS

4.1 Council of Governors - Tenure

Section 14 of the Constitution states that an elected governor may hold office for a period not exceeding three years and shall be eligible for re-election at the end of his/her term. There is currently no upper limit on the overall tenure of Governors raising the possibility that individuals could serve ad infinitum.

4.2 This position is unusual, as the overwhelming majority of NHS Foundation Trust's will have an upper limit for the tenure of Governors. The rationale for such a limit is similar to that applied to Non-Executive Directors, whom are subject to a maximum term of office, in that it is reasonable to expect that an individual's degree of independence and objectivity will deteriorate over an extended period of time. There is also the benefit which results from periodic refresh of composition to balance alongside arguments relating to continuity of experience.

4.3 The Governance & Membership Committee was requested to consider the inclusion of the following at s14 of the Constitution:

A Governor may not hold office for more than nine consecutive years, and shall not be eligible for re-election if they have already held office for more than six consecutive years.

4.4 The discussion at the Committee meeting was inconclusive, with differing views expressed as to whether a maximum term of office should be adopted. The argument against this approach was based on the assertion that extended tenure resulted in experienced Governors and that suitability for re-election was a matter for the membership to determine through the election process. The outcome of the Committee's deliberation was that the matter should be referred to the Council of Governors for consideration.

4.5 It is suggested that consideration of this matter by the Council of Governors should be informed by a view from the Board of Directors on the proposed amendment. This subject was also considered at the EMG meeting held on 18 September 2018 and the proposal at s4.3 of the report was endorsed on the basis that the approach reflects good governance practice.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the proposed amendments set out at s3.3. and s3.6 of the report.
- Provide a view on the subject of Tenure of Governors for consideration by the Council of Governors.

Extract from Annex 5, Trust Constitution

Termination of office and removal of Governors

8 A person holding office as a Governor shall immediately cease to do so if:

8.1. He/she resigns by notice to the Trust Secretary;

8.2. He/she fails to attend two formal meetings of the Council of Governors in any Governor Year unless the other Governors are satisfied that:

8.2.1. The absences were due to reasonable causes; and

8.2.2. He/she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

For the purposes of this paragraph, a "Governor Year" runs from one Annual Members' Meeting until the next.

8.3. He/she has failed without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

8.4. He/she has failed to sign and deliver a statement to the Trust Secretary in a form required by the Trust confirming acceptance and agreement to abide by the Trust's statement of roles and responsibilities in relation to the Council of Governors, the Trust's Code of Conduct for Governors and the Trust's Stewardship Standards for Governors;

8.5. He/she is removed from the Council of Governors under the following provisions.

9 A Governor may be removed from the Council of Governors by a resolution approved by two thirds of the remaining Governors present and voting at a General Meeting on the grounds that:

9.1. He/she committed a serious breach of the code of conduct; or

9.2. He/she has acted in a manner deemed to be detrimental to the interests of the Trust,

and the Council of Governors considers that it is not in the best interests of the Foundation Trust for them to continue as a Governor.

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Report to:	Board of Directors	**Date:**	27 September 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:	2a,3a,3b	**Summary of Report** **The data for this report was collated on 6 September 2018.** This paper provides an overview of the current Trust Risk Register. This report includes all current risks of 15 and above for the members to review. There are currently 331 live risks recorded on the Risk Register systems. There are 33 risks rated 15 or above on the Trust Risk Register with corporate approval. The same as last month. Across the 33 risks rated 15 or higher that have been corporately approved; • 9 risks are associated with staffing issues (231, 505, 125, 50, 67, 75, 78, 408, 587) • 8 risks are associated with capacity issues or increase in demand (130, 183, 429, 506, 96, 576, 286, 407,) • 7 risks are associated with financial issues (101, 127, 458, 461, 466, 469, 476) • 7 risks associated with statutory or regulatory activity (134, 135, 162, 167, 513, 499, 586 , 638) • 2 risks are associated with equipment (46,167,) Members are asked to note the risks and the identified actions to mitigate those risks
	SO2, SO3, SO5, SO6	
CQC Registration Standards ref:	17	
Equality Impact Assessment:	☐ Completed ☑ Not required	

Attachments:

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

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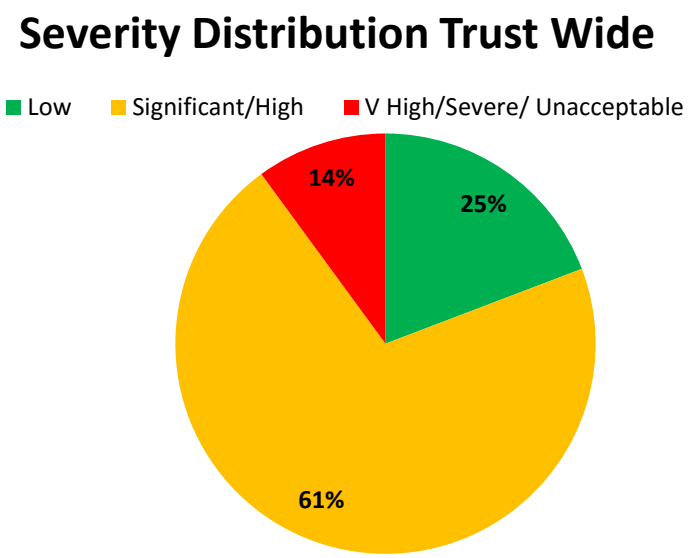
1.0 Trust Wide Risk & Severity Distribution

1.1 There are currently 331 live risks recorded on the risk register system. This is an increase of 25 since last month. In addition there are 9 risks waiting for corporate approval and 44 risks waiting for business group approval

1.2 Trust wide distribution of risk is shown below:-

	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
New System	1	3	12	47	2	44	41	55	12	78	12	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	1	6	0	11
Integrated Care	0	2	1	0	3
Medicine and Clinical Support	4	4	0	0	8
Surgery, GI and Critical Care	1	4	0	0	5
Women's and Children's	1	4	1	0	6

1.6 Risk movement of risks of 15 and above in month

The table below shows the movement of risks that are on the trust risk register and those that have been taken off 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	20	20	20	↔						
130	20	20	20	20	20	20	20	↔						
134	20	20	20	20	20	20	20	↔						
135	20	20	20	20	20	20	20	↔						
101	20	20	20	20	20	20	20	↔						
231	20	20	20	20	20	20	20	↔						
469				20	20	20	20	↔						
429			20	20	20	16	16	↔						
458				16	16	16	16	↔						
461			16	16	16	16	16	↔						
466				16	16	16	16	↔						
505							16	↔						
506						16	16	↔						
125	16	16	16	16	16	16	16	↔						
127	16	16	16	16	16	16	16	↔						
167	16	16	16	16	16	16	16	↔						
183	16	16	16	16	16	16	16	↔						
50						16	16	↔						
67				16	16	16	16	↔						
75	16	16	16	16	16	16	16	↔						
78	20	20	20	20	16	16	16	↔						
96	16	16	16	16	16	16	16	↔						
286		15	15	15	15	15	15	↔						
407						15	15	↔						
408			15	15	15	15	15	↔						
162	15	15	15	15	15	15	15	↔						
513						15	15	↔						
576						15	15	↔						
499				15	15	15	15	↔						
586							20	N						
638							15	N						
476							15	N						
261	16	16	16	16	16	16	C	↔						
108	16	16	16	16	16	16	8	↓						

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

1.7 Risk movement in previous months

The table below shows when risks have been removed from the trust risk register.

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												
76	16	16	16	16	4									
74	25	10												
87	16													
91	15													
109	16	16	1											
126	16	16	16	16	12									
137	16	16												
145	16													
159	20	20	16	12										
160	15	15	8											
177	15	12												
282	15	15	12											
288	15	15	9											
296	15	15												
318	15	6												
319	15													
355	15	15	12											
362	15	15	15	9										
399		15	15	15	c									
305				15	15	10								
354	16	16	16	16	16	**C**								

2.0 New Risks Identified

2.1 The Safety and Risk Group approved 3 new risks this month (586, 638, 476)

3.0 Existing Risks

3.1 There are 33 risks rated 15 or above on the trust risk register with corporate approval. This is an increase of 1 since last month.

3.2 Movement this month;

- 3 risks have been added to the register this month
- 1 risk has been reduced to below a risk of 14
- 1 risk has been closed

4.0 Trends

4.1 The risk register is presented in order of current rating

4.2 Across the 30 risks rated 15 or higher that have been corporately approved;

- 9 risks are associated with staffing issues (231, 505, 125, 50, 67, 75, 78, 408, 587)
- 8 risks are associated with capacity issues or increase in demand (130, 183, 429, 506, 96, 576, 286, 407)
- 7 risks are associated with financial issues (101, 127, 458, 461, 466, 469, 476)
- 7 risks associated with statutory or regulatory activity (134, 135, 162, 167, 513, 499, 586, 638)
- 2 risks are associated with equipment (46,167,)

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

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	46	Smethurst, Mr Richard	Women Children and Diagnostics Business Group	There is a risk that the Telepath Server will Fail	16	Telepath has 24/7 365 day support (hardware 11 years old). This system also has a failover server (also 11 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.	5	4	20	Replacement Telepath Server	16/01/2019	5
Corporate Risk	130	Plummer, Susan	Integrated Care	There is a risk that the ED 4 Hour Target will not be met	20	Existing internal escalation processes	4	5	20	High Impact Priority Action Plans	01/11/2018	10
Strategic Risk	134	Kershaw, Helen	Corporate Nursing	There is a risk that the statutory requirements and billing will not be met due to lack of capacity in the medico-legal team	20	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	4	5	20	Continue Weekly updates from Team	30/09/2018	8
										Continue weekly monitoring of situation for a month	30/09/2018	
										Use volunteers and bank staff to increase throughput	30/09/2018	
Strategic Risk	135	Lehnert, Mrs Jean	Information and IT	There is a risk that Subject Access Provisionis not adequate to meet GDPR requirements	20	Medico Legal Team adhere closely to guidance (see earlier risk re pressures) There is a clear process (doesn't include all areas) Health Records follow process	4	5	20	Determination of requirements to meet legislation post review	31/10/2018	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Strategic Risk	101	Rigby, Susan	Finance	Failure to have sufficient cash reserves to operate	20	"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.	5	4	20	Stress testing of the 13 week cash flow by the Cash Action Group on a monthly basis	29/03/2019	5
										As part of Finance and Performance meetings highlight the Trust cash position and the inter-dependencies on a monthly basis	29/03/2019	
										Implementaton of No PO No Pay Procedure	28/09/2018	
										Submission of 13 week cash flow	29/03/2019	
Corporate Risk	231	Glynn, Marie	Corporate Nursing	lack of medical and nursing staff resulting in mandatory work only being undertaken resulting in an inefficient IP service.	20	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	4	5	20	present compliance data against the H&SC act	28/09/2018	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	469	Wiss, Kay	Finance	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	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.	5	4	20	Ensure that the Business Groups are held to account on the delivery of their respective operational plans	29/03/2019	10
										Develop a demand and capacity model	28/09/2018	
										Preparation of a workforce plan	28/09/2018	
										Principles for the Stockport Together risk share	28/09/2018	
										To regularly report the key issues facing the Trust as part of the Stockport Together Programme	29/03/2019	
										CIP Recovery Plan	28/09/2018	
Corporate Risk	429	Curtis, Mrs Kelly	Women Children and Diagnostics Business Group	Inadequate capacity to meet demand in Paediatric ADHD Services	20	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	4	4	16	Paper to SMT to agree resource requirement for increase demand on service	30/09/2018	8
										Advertise additional consultant PA's to provide ADHD Service	31/10/2018	
										Additional Consultant PA's in post to provide ADHD service	31/10/2018	
										Review pathway for ADHD service	30/09/2018	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
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	16	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.	4	4	16	Monitoring of weekly activity v plan	31/03/2019	8
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	16	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment eg, physician associates, ANP's etc Validation of all activity with a view to alternativer	4	4	16	All actions completed		12
Business Group Risk	466	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the BG will fail to deliver the CIP Target	16		4	4	16	Programme Management for CIP	19/09/2018	8
Risk Assessment	505	May, David	Women Children and Diagnostics	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	16	Locum pathologist employed on part time basis. Forwarding work to Source Bioscience for reporting	4	4	16	Recruit to vacant histopathologist posts	31/10/2018	4
										Appoint additional Locum	28/09/2018	
										Recruit Cancer Tracker in laboratory	28/09/2018	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Business Group Risk	506	Tunnicliffe, Mr Andrew	Surgery GI and Critical Care	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	weekly monitoring and tracking of elective activity weekly meeting with waiting list teams to ensure optimal theatre utilisation fortnightly tracking of elective activity in business group finance meeting Ring fence protocol agreed for elective orthopaedic unit. Support from executive team to continue elective inpatient orthopaedic operating throughout the winter to maintain activity and as part of financial recovery plan	4	4	16	Refresh EOU ring fencing policy	01/11/2018	8
Business Group Risk	125	MR1	Integrated Care Business Group	Reduced Emergency Department Medical Staffing	20	Dependant on internal cover and locum bookings	4	4	16	Plan for increase to midnight finish and Healthier Together implementation	28/09/2018	8
Business Group Risk	127	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the M&CS BG overspends due to agency costs	16	Monthly reporting of finance and performance; 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.	4	4	16	Introduction of medical e-rostering Management of nurse e roster	25/10/2018 14/09/2018	12
Business Group Risk	167	Connaughton, Michelle	Surgery GI and Critical Care	There is a risk of breach of confidentiality through lack of secure storage of Patient Records on wards	16	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.	4	4	16	Install new kit on arrival	28/09/2018	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Strategic Risk	183	KEH	Executive teams	Failure to meet the 62 day Cancer target standards	12	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	4	4	16	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	30/09/2018	8
										Action plan being created with input from Business Groups to ensure sustained performance	30/09/2018	
										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)	30/09/2018	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	50	Cotton, Mrs Janet	Women Children and Diagnostics Business Group	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	- Monthly review and dashboard monitoring of midwife/birth ratio based on Birth Rate Plus workforce tool. - Required staffing establishment calculated using a nationally recognised workforce tool in June 2017 ie Birth Rate Plus - Compliance with the intrapartum acuity using Birth rate Plus Acuity tool undertaken every 4hrs, and reviewed in light of any reported staffing related incidents/diverts. - Midwifery staffing provision aligned to appropriate areas - Effective skill mix within in all areas, forward plan on a weekly basis, review daily or as required. - NHS Professionals / staff working extra hours used to supplement staffing levels to maintain safe staffing levels. - Detailed workforce safe staffing review undertaken twice yearly by the Chief Nurse/HOM. - Additional staff recruited to address any funded staffing deficits	4	4	16	Outline business case to be collated and presented.	10/09/2018	8
Business Group Risk	67	Drury, Mrs Margaret	Women Children and Diagnostics Business Group	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	20	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.	4	4	16	Continuity for locum cover	30/09/2018	8

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	75	Waterman, David	Integrated Care Business Group	There is a risk that there could be management of palliative atients due to lack of Specialist Palliative Care Medical Cover	20	During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. Clinical Nurse Specialists attend some cancer MDT's if they have capacity Current Consultant is available for telephone advise in own personal time	4	4	16	There is a risk that Macmillan will not fund ongoing costs of new recruitment in palliative care	30/09/2018	9
Corporate Risk	78	Ingleby, Mrs Sarah	Medicine and Clinical Support	There is a risk to patient safety and BG finances due to the excessive registered nursing staffing deficit within Medicine & CS	20	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons 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	4	4	16	Reference to the Minimum safe staffing escalation policy	08/02/2019	8
										Local recruitment	08/02/2019	
										Supporting the retention of staff	08/02/2019	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Business Group Risk	96	Edwards, Joanne	Medicine and Clinical Support	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	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 cases and short term follow ups are being prioritised Glaucoma and DRS patients are given top priority for capacity	4	4	16	Review spend on WLI and convert to substantive	13/09/2018	8
										Create an OP SOP in line with RC Ophth guidance	13/09/2018	
										Implement new EPR to ensure appropriate coding of patients	26/10/2018	
Strategic Risk	162	Kershaw, Helen	Corporate Nursing	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, q	20	NHSI improvement Board Patient Quality Summit weekly Safe, High Quality care action plan Quality Governance Framework Regular contact with the CQC	5	3	15	Deliever safe, High Quality Care Action plan	31/10/2018	5
Business Group Risk	286	Wheelton, Mrs Fiona	Surgery GI and Critical Care	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	15	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.	3	5	15	All actions completed		3
Business Group Risk	407	Cartner, Janine	Medicine and Clinical Support	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	12	- Urgent OWL codes used to identify patients who need to be prioritised for urgent Follow Up. - Consultants doing some validation of longest waiting patients to see if may be better managed in Primary Care. - monitoring of OWL in Trust performance meetings. - Capacity and Demand work underway. - Admin and clerical navigator role to be piloted to arrange surveillance chest x-rays for patients on surveillance for lung nodules.	3	5	15	Recruit to Navigator post (pilot)	14/09/2018	6
										Locum (Resp Medicine) LAKHANPAL to perform WLI	15/10/2018	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
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	15	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	3	5	15	Bank pharmacist	14/09/2018	3
Risk Assessment	513	Whitehead, Mr Stephen	Estates and Facilities	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards.	15	Survey Specification	3	5	15	EHO Advice/Guidance	15/10/2018	9
										Review cleaning programme for Ward Kitchens	15/10/2018	
										Programme of Food Safety Training for Ward Based Staff	31/10/2018	
Business Group Risk	576	Cartner, Janine	Medicine and Clinical Support	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	- ring-fenced capacity for 2ww and Cancer upgrade patients - clinical triage of all referrals - patients booked into clinic by clinical urgency / longest wait - monitoring of wait times in Trust performance meetings. - Capacity and Demand work completed. - Consultants offering WLI's where able but often focused on seeing the 2WW or cancer upgrade patient. - Business case in the process of being written to highlight the risk and request permission to expand the Respiratory Team.	3	5	15	Business Case for expansion to be developed	17/09/2018	6
										Service Review	19/11/2018	
										Clinic Utilisation	15/10/2018	
										Additional Clinics	10/09/2018	
										Capacity and Demand Modelling	10/09/2018	
										Review of Lung function provision	10/09/2018	

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	587	Fox, Mrs Paddy	Information and IT	There is a risk to the operation of the Trust electronic syst/ntwrk due to the need to recruit Senior IT Technical Support	15	1. Deputy Systems Manager is being trained up but can not yet do the majority of security updates and patching. 2.Asst Director IT (Infrastructure) has signed a document to say he accepts he needs to work more than 45 hours per week - some additional payment. 3. Re-advertising both posts following JD and advert reviews 4. ECP agreed could recruit agency in interim	5	3	15	Recruit to 2 senior IT posts	25/09/2018	10
Corporate Risk	499	Buckley, Lisa	Corporate Nursing	There is a risk that complaints responses are not being completed within Trust timescales	15	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	3	5	15	weekly monitoring of complaints that are overdue	31/10/2018	4

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Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Corporate Risk	586	Statham, Mr David	Estates and Facilities	There is a risk due to the significant Estate Backlog Maintenance Increase	20	The significant increase is a fair reflection of the estate at the present time. The implications of the report have highlighted a large number of high and significant risks which the directorate are prioritising. The current available capital expenditure is insufficient therefore posing a risk to the Trust. The updated survey provides individual risk assessments for each element to understand where the risks are associated to. Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised. Planned Preventative Maintenance (PPM) schedule of works. Regular walkrounds/visual checks undertaken by Estates Staff. Estates Helpdesk: Facility to report jobs. On-going review & monitoring of DATIX Incidents & appropriate	4	5	20	Prioritise Identified High Risks	01/01/2019	8
Risk Assessment	638	Hatch, Mrs Catherine	Women Children and Diagnostics Business Group	There is a risk to non compliant with HSE guidleines due to CL3 room access and sealing	15	Access is restricted by a digital lock system Room is risk assessed yearly by the external company who would perform the emergency fumigation in the event that a spillage occurs, findings of the report are sent to the estates department for repair by Trust staff	3	5	15	Awaiting a quote for the new CL3 swipe card access	21/09/2018	9
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 antibx consumption CQUIN 18/19	15	Guidelines on reviewing antibiotics exist and should be embedded in practice already. Antibiotic stewardship ward rounds and education sessions are carried out when staffing allows – currently less than 10% of planned activity.	3	5	15	Consider additional antibiotic pharmacist post	14/09/2018	6

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 September 2018
Subject:	Board Assurance Framework		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR ASSURANCE

Corporate objective ref:	2a, 2b	**Summary of Report** This report details the summary of the Quarter 1 2018/189 position against of the Board Assurance Framework. The Board of Directors are asked to note the assurance provided relating to each of the Trust's 7 Strategic Objectives.
Board Assurance Framework ref:	SO2	
CQC Registration Standards ref:	17	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:

This subject has previously been reported to:

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

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1.	**INTRODUCTION**
1.1	This report details the summary of the Quarter 1 2018/19 position against of the Board Assurance Framework.
2.	**BACKGROUND**
2.1	The Board Assurance Framework (BAF) identifies the principal risks to achieving each of the 7 Trust objectives. It provides detailed information of the controls in place, gaps in control and assurance that relate to each objective. As agreed through the Risk Management Framework and Strategy, the BAF is cross-referenced to significant risks recorded on the Trust Risk Register (TRR).
2.2	The Trust Risk Register (TRR) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. The Executive Team are responsible for the escalation and de-escalation of risk from, and to the TRR.
3.	**STRATEGIC OBJECTIVES**
3.1	The Trust Strategic Objectives are: • To achieve full implementation of the Trust's refreshed strategy • To deliver outstanding clinical quality and patient experience • To strive to achieve financial sustainability • To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Together / Stockport neighbourhood Care / Integrated Service Solution • To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements • To develop and maintain an engaged workforce with the right skills, motivation and leadership • To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality
4.	**RISK & ASSURANCE**
4.1	The Quarter 1 Board Assurance Framework provides assurance that there are sufficient controls in place to manage the principal risk to each strategic objective. Some of the controls that are in place are newly developed and therefore may represent a gap; their continued development through application of agreed strategies and frameworks will further strengthen the controls. The next steps are to identify and map the gaps in control to provide further assurance.
5.	**RECOMMENDATIONS**
5.1	Members are asked note the contents of the report and the assurance it provides at end Q1.

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Strategic Objective 1:
To achieve full implementation of the Trusts refreshed strategy

Principal risk	**Risk of failure to implement the strategy will result:** - in missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience - inability to modernise services - delays in delivering integration - failure to engage effectively and lead developments with key partners - adverse partner perceptions of working with Stockport NHS Foundation Trust

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
11 June 2018	July 2018	October 2018	Well Led NHSI – Use of Resources	Director of Support Services	Board of Directors	Finance and Performace

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Target Date**
4	5	20	4	5	20	4	1	4	March 19

Executive commentary for the Current Risk Score

The mitigated risk score is 20 which relates to early improved engagement internally and externally. Strengthening is required of the plans to refresh the strategy. ATTAIN have been commissioned to help the Trust complete the refresh of the strategy.

Corporate objectives

1a. To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy
1b. To lead the annual operational planning cycle in line with NHSI guidance.

Links to other Strategic Objectives: SO2, SO3, SO4, SO5, SO6, SO7

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	Risks not yet on place – HM waiting for response from ATTAIN following presentation						

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	2018- 20 Strategy in place	• Timescales for delivery of refreshed Strategy	• 1:1s • Team meetings • Stakeholder events	• Executive Management Group • Board of Directors • EMG minutes • Board minutes	• NHSI Oversight	• Monitoring of Strategy and annual review	• Strategy review in progress • Communication Plan in place
Adequacy of Assurance (Level of Confidence)							
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:		Strategy has not been finalised and embedded. Trust has sought external support from ATTAIN to assist with final product					
Quarter 2 Commentary:							
Quarter 3 Commentary:							
Quarter 4 Commentary:							

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 2:
To deliver outstanding clinical quality and patient experience

Principal risk	There is a risk that the Trust will fail to achieve the 2018/19 developments set out in the Quality Improvement Plan resulting in not consistently providing the safest, highest quality care to patients, their families and carers.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
13 April 2018	n/a as 1st assessment	October 2018	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Chief Nurse & Director of Quality Governance Medical Director	Quality Governance Group Patient Experience Group Safeguarding Group Medicines Management Group Infection Prevention and Control Group	Quality Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	2	10	March 2019

Executive commentary for the Current Risk Score

The mitigated risk score is 20 which relates to early improved engagement internally and externally. Strengthening is required of the current action plans, the risk management strategy and framework, and the quality governance framework in order to provide sustained demonstrable improvements and associated assurances at ward, department and business group levels

Corporate objectives

2a. To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy

2b. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.

Links to other Strategic Objectives:	SO3, SO4, SO5, SO7

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
46	There is a risk that the telepath server will fail	20	06/04/2018				
130	Failure to deliver the 4 hour target	20	01/09/2017				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

231	Lack of consultant microbiologists and nursing team in IP service	20	02/10/2017				
183	Failure to meet the 62 day Cancer target standards	20	20/04/2010				
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	14/02/2018				
506	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	11/06/2018				
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017				
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
75	Lack of consultant in palliative care team	16	02/11/2016				
78	Registered Nurse Vacancies	16	21/11/2016	↓ from 20			
96	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	23/03/2017				
286	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	15	22/11/2017				
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
576	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	01/06/2018				
499	There is a risk that complaints responses are not being completed within Trust timescales	15	07/06/2018				
126	Surges in demand in the Emergency Department	16	11/05/2016	↓ to 12			
137	Pressure ulcers	16	01/09/2016	↓ to 9			
160	Policies and procedures	15	17/11/2011	↓ to 8			
288	Central Venous Access Device Service	15	27/11/2017	↓ to 9			
362	Ketone Testing	15	04/02/2018	↓ to 9			
296	Blood Pressure monitors	15	06/12/2017	Closed			
358	Location of the AI unit	15	26/01/2018	↓ to 9			
346	Use of escalation beds	15	09/01/2018	Closed			

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Quality Governance Framework in place 2018/2020	• Revised monthly governance reports • Well-Led / Use of Resources initial review required (NHSI Framework).	• 1:1 Meetings • Team Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings • Patient Quality Summit	• Quality Governance Group • QG and sub-groups key issues reports (KIR) • Quality Committee • QC KIR • Integrated Performance Report • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Review	• Quality Account • CQC rating RI in October 2017 • NHSI Improvement Board • Annual Governance Statement- April 2018 • Quarterly Review Meetings with NHSI • MIAA Review of Committees Report: Partial Assurance • CQC insights report	• Mock CQC inspection June 2018 • Externally facilitated Developmental Review NHSI Well Led Framework required in 2018	• Reports to Quality Committee from December 2017 with quarterly monitoring • Well-Led / Use of Resources Initial Review April 2018
2	Risk Management Strategy & Framework	• Revised quarterly risk register reports at business group/corporate level in	• 1:1 Meetings • Team Meetings	• Quality • Committee • QC KIR	• Internal Audit Programme • Annual	• Externally facilitated Developmental	• Reports to Quality Committee from April 2018 and Audit Committee from May 2019	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	2018/2020 in place with 6 key priorities	development. • Well-Led / Use of Resources initial review required (NHSI Framework).	• Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Audit Committee • AC KIR • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	Governance Statement- April 2018 • MIAA Risk Management & Corporate Governance Report: Partial Assurance • Planned approval of new strategy May 2018 • Quarterly Review Meetings with NHSI • NHSI Improvement Board	Review NHSI Well Led Framework required in 2018	with quarterly monitoring • Well-Led / Use of Resources Initial Review April 2018
3	Infection Prevention & Control (IPC) Team and supporting strategies & policies	• MRSA Bacteraemia x 2 • Business case relating to IPC Service	• 1:1 / Team Meetings • Harm Free Care Panels • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Infection Prevention and Control Group • IPCG KIR • Quality Committee • QC KIR • Board of Directors • Integrated Performance Report • Monthly MESS data return • Account-April 2018	• CQC RI rating- October 2017 • CCG Contract meetings monthly • CCG Quality Visits • NHSE/NHSI Feedback • Single Oversight Framework Segmentation • Quality Account-April 2019		• Business Case being progressed

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

4	Maternity Dashboard	tbc					
5	Quality Improvement Strategy 2018/2019 implementation	• Data access & collective intelligence • Quarterly CQUIN reports	• 1:1 Meetings • Monthly Business Group Quality Boards • Monthly CQUIN report • Quarterly Performance Meetings	• Professional Advisory Group • Quality Safety and Improvement Strategy Group • Quality Governance Group • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • NHSI Improvement Board • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019		• Quarterly review to commence June 2018 • Development of reports / data collection in progress including Model Hospital data.
6	Patient & Public Involvement Strategy implementation	PPI Strategy Patient Experience Strategy Carers Strategy Equality and Diversity Strategy	1:1 / Team Meetings	• Patient Experience Action Group • Patient Experience Group • Quality	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits	• There is no current PPI, Patient Experience or Carers Strategy • An E&D strategy is in place	• Strategies to be developed and in place by Q4 2018/19

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				Governance Group • Quality • Committee • QC KIR • People and Performance Committee • PPC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019		
7	Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence • Quarterly Performance Quality Reviews	• 1:1 / Team Meetings • Safety Collaboratives • Monthly CQUIN meetings	• Quality Governance Group • Quality • Committee • QC KIR • People and Performance Committee • PPC KIR • Board of Directors • Integrated Performance	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Report exceptions: Internal Audit Programme • Quality Account-April 2019		• Development of reports / data collection in progress Q1

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				• Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews			
8	Safety Team established with objectives and associated policies & procedures	Data access & collective intelligence. Dashboards by CQC Domains Accreditation for Continued Excellence (ACE) Quarterly Quality Reviews Business Case to support Quality improvements completed	• 1:1 Meetings • Patient Safety Summit • Monthly Business Group Quality Boards • Monthly CQUIN report • Quarterly Performance Meetings	• Quality Governance Group • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Report exceptions: Internal Audit Programme • Quality Account-April 2019		• Progress Business Case
9	Governance Teams in place	• Review of Governance Team	• 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business	• Quality Governance Group • Quality • Committee • QC KIR • Board of	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits	• Improving triangulation of data and oversight in reports.	• Complete and progress Governance Team review

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Group Quality Boards • Quarterly Performance Meetings	Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Quality Account-April 2019		
10	Systems in place to address external clinical alerts		• 1:1 Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Quality Governance Group • QGG KIR • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • Quality Account-April 2019		
11	Quality Impact Assessment (QIA) Process	• QIA process in place – requires overarching document from May 2018.	• Programme/Project Team in place	• Medical Director & Chief Nurse reviews	• Single Oversight Framework Segmentation	• Strengthen reporting and monitoring of QIA process	• Revised QIA Procedure to be implemented •

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				• Finance Improvement Group • FIG KIR • Finance and Performance Committee • F&P KIR • Board of Directors Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• NHSI Improvement Board • CQC Good rating-January 2015 • CQC RI rating-October 2017 • Quality Account-April 2019 • Quarterly Review Meetings with NHSI		
12	Adult & Child Safeguarding Team & policies & procedures.		• 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Safeguarding Group • SG KIR • Quality Committee • QC KIR • Board of Directors • Annual Safeguarding Report (July 2018) • Alliance	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews			
13	Nursing, Midwifery and Allied Health Professionals Strategy	Annual Strategic Staffing Reviews	• 1:1 Meetings	• Nurse Leadership walkarounds • Professional Advisory Group • Quality Governance Group • QGG KIR • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating-January 2015 • CQC RI rating-October 2017 • Quality Account-April 2019 • Quarterly Review Meetings with NHSI		
14	Learning from Deaths Policy & Mortality Review Process	Report to Quality Committee	• Mortality and Morbidity Reviews	• Trust Mortality Reduction Group	• CQC RI rating-October 2017 • NHS	• Mortality data / reporting systems	• Triangulated learning from deaths report • Mortality review structured

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			• Learning from Deaths Process • 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• CHKS and BIU data & reports • Quality Governance Group • QGG KIR • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews • Quarterly Learning from Deaths Report from December 2017 • Quality Account-April 2019	Improvement data • CCG Contract meetings monthly • CCG Quality Visits • CQC Outlier Alert process • Nationally benchmarked mortality data • Advancing Quality Quarterly Safety Reports • Internal Audit Programme:	• Lack of triangulation	assessment process • Deteriorating Patient Safety Collaborative April 2018
15	7 Day Clinical Services	Clinical Directors Forum	1:1 / Team meetings • Business Group Quality Boards	Quality Governance Group			

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			• Quarterly Performance Meetings				
Adequacy of Assurance (Level of Confidence)			Significant				
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:	Clinical Services review was completed on the second of July to asses our position and improvement journey. Positive assurance for delivery of care. Areas of concern identified included safeguarding, polices and documentation. Safety and Quality Leadership meetings have commenced. Walk rounds by senior teams and governors have given positive assurance about patient experience.						
Quarter 2 Commentary:							
Quarter 3 Commentary:							
Quarter 4 Commentary:							

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 3:
To strive to achieve financial sustainability

Principal risk	Risk of failure to maintain financial stability which may impact on the Trust's compliance with the NHS Improvement Provider Licence

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led NHSI -Finance and use of resources	Director of Finance	Executive Management Group Financial Improvement Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	4	16	4	1	4	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score relates to urgent actions that the Trust must enact in order to deliver the financial plan. These actions are documented in the financial recovery paper to be considered by the Board of Directors in July.
If the action come within the planned parameters then the risk will reduce to a likelihood of 1

Corporate objectives

3a. To ensure full compliance with the NHSI Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services
3b. To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services
3c. To review and monitor a revised performance management framework

Links to other Strategic Objectives:	SO1

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
101	There is a risk that the Trust will not have sufficient cash reserves to operate	20	05/07/2017				
469	There is a risk that the Trust will not deliver its 2018/19 financial performance		30/04/2018				
458	There is a risk of not achieving the Theatre & Endoscopy CIP Programme	16	19/04/2018				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	2018-19						
461	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19	16	23/04/2018				
466	There is a risk that the BG will fail to deliver the CIP Target	16	28/04/2018				
127	There is a risk that the BG overspends due to agency costs	16	22/06/2017				
305	There is a risk that the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements	15	14/11/2017				
469	There is a risk that the Trust will not deliver its 2018/19 financial performance	20		↓10			

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Long term health economy with clear governance structure	• COO & DOF bi-weekly meetings with SRO's • 1:1 / Team Meetings • Business Group Accountants 1:1s • Bi-weekly Exec-BG finance meetings • FIG • *FIG minutes/KIR* • EMG	• Bi-monthly Performance Meetings • Finance & Performance Committee • Internal Audit Reports to Audit Committee • Board of Directors • Board of Directors minutes • F&P Minutes/KIR • Annual budget/planning	• NHS Improvement Segment 3 (July 2017) (Segment 3= Providers identified as 'Challenged' status). • NHS Improvement-submitted annual plans & feedback provided • Internal Audit Programme • NHSI enhanced financial	• Use of Resources metric assessment • Routine use of Model Hospital • Wider understanding of the Trust's financial challenge	• Transformation projects • Cost Improvement Plan • Quality Impact Assessments • CCG contract in place.
2	Identified CIP schemes	• Well-Led / Use of Resources initial review required (NHSI Framework).					
3	Monthly finance & activity review meetings	• Review of financial /activity delivery					
4	Performance management reporting systems	• Review of delivery and identification of improvement plan					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

5	Job descriptions contain financial responsibilities	• Clear accountability	Recruitment process	• Monthly Integrated Performance Report Contracting and activity finance group Quality Governance Committee	oversight meetings monthly • External interim CIP support • Executive contract Group with CCG		
6	CCG Contract	Review performance and agree improvement trajectories	Monthly CCG meetings				
7	CQUIN Schemes & process to deliver	Monthly meetings to ensure compliance	Monthly CCG meetings				
8	Monthly Performance Report	Identify any variance to plan or changes to forecast	• 1:1 / Team Meetings • Business Group Accountants 1:1s • Weekly CIP development meetings chaired by COO • Operational performance group to hold Business Group directors to account				
Adequacy of Assurance (Level of Confidence)							
Overall Assessment of Assurance			Partial				

Quarter 1 Commentary:	The trust has achieved its Q1 financial performance and is slightly behind on the CIP performance in the period. The trust faces considerable financial risk described above and needs to continue with close monitoring
Quarter 2 Commentary:	
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 4:
To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Together / Stockport Neighbourhood Care / Integrated Service Solution

Principal risk	**Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial sustainability and viability due to:** - **Lack of full engagement – being a key partner** - **Failure to engage effectively and lead the development of the local health economy** - **Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change** - **Partners perceptions of working relationships with Stockport NHS Foundation Trust**

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Safe, effective, responsive and well led NHSI – Quality of care, operational performance, strategic change	Director of Support Services / Deputy Chief Executive	Executive Management Group	Alliance Provider Board

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Target Date**
4	5	20	4	5	20	4	4	16	31/03/2019

Executive commentary for the Current Risk Score

Trust partners' governance arrangements are being reviewed and a revised Alliance Provider Board is being put into place. There is a 3 month delay in realising the benefits

Corporate objectives

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	No risk on Trust risk register						

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Engagement in Stockport Provider Alliance Board	• Trust Strategy	• 1:1's • Team meetings	• Executive Management Group • Board of Directors	Greater Manchester Combined Authority	• Scale & pace of change • Relationship building with key partners • Governance Arrangements		
Adequacy of Assurance (Level of Confidence)								
Overall Assessment of Assurance			Partial					
Quarter 1 Commentary:		Revised arrangements are in place, however timescales within this are ambitious and may lead to further delay in expected outcomes						
Quarter 2 Commentary:								
Quarter 3 Commentary:								
Quarter 4 Commentary:								

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 5:
To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements

Principal risk	Risk of not delivering the NHS Improvement Single Oversight Framework Operational Performance Metrics impacting on the quality of care we provide, patient and staff experience and the Trust's provider licence.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led, safe NHSI Leaderhip and improvement capability	Chief Operating Officer	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	3	15	5	2	10	31/10/2018

Executive commentary for the Current Risk Score

Concerns around emergency Department performance, cancer waits and RTT. Plans are in place to enable recovery by end of Quarter 2

Corporate objectives

5a. The Trust will complete an independently assessed Well Led Review by 30 September 2018
5b. The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improves access to care by 30 September 2018
5c. The Trust will comply with its trajectory for improvement against the 4 hour A&E target, with actions identified in the Stockport System Urgent Care Plan
5d. The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
130	Non delivery of ED 4 hour performance	20	01/09/2017				
183	Failure to meet the 62 day cancer target standards	20	20/04/2010				
506	There is a risk that winter pressure son ED, patient flow and capacity will affect the delivery of the 2018 – 19 elective plan in ortho	16	11/06/2018				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

96	There is a risk of lack of capacity for timely outpatient reviews in the ophthalmology department		23/03/2017				
286	There is a risk to patient experience due to Endoscopy capacity and demand		22/11/2017				
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
162	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, quality experience and Trust reputation	15	06/07/2017				

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Bi- Monthly Performance Reports	External influences on medically fit for discharge patients Insufficient community capacity Failure to deliver sustainable Stockport Together programme	1:1/ 2:1 meetings Team Meetings Monthly Senior Management Team Meetings Monthly BG Boards Bi-Monthly Performance Management Group Meetings Operational Performance Group	Finance & Performance Committee F&P minutes and KIR Board of Directors Executive Management Group	CQC rating overall NHSI Quarterly Review Meetings Cancer Peer Review Monthly CCG Contract Meetings Urgent and Emergency Care Delivery Board		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			OPG minutes and KIR		Internal Audit Programme:		
	Improving patient flow programme	Staff engagement Transformation support Finance support Winning hearts and Minds Changing culture Embedded new practice	1:1/ 2:1 meetings Team Meetings Monthly Senior Management Team Meetings Monthly BG Boards Bi-Monthly Performance Management Group Meetings Finance improvement Group Operational Performance Group OPG minutes and KIR	Finance & Performance Committee F&P minutes and KIR Board of Directors Executive Management Group	CQC rating overall NHSI Quarterly Review Meetings Cancer Peer Review Monthly CCG Contract Meetings Urgent and Emergency Care Delivery Board Internal Audit Programme:		
	Quality Impact Assessment Process	Development of overarching document Completing the Quality Impact Assessments	1:1/ 2:1 meetings Team Meetings Monthly Senior Management Team Meetings Monthly BG	Medical Director and Chief Nurse & Director of Quality Governance approval of QIAs	CQC rating Monthly CCG meetings NHSI Oversight	Strengthen reporting and monitoring of QIA process	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Boards Bi-Monthly Performance Management Group Meetings Financial Improvement Group (FIG)	F&P Committee Board of Directors			
	Emergency Planning (EP) & Business Continuity		1:1 meetings Desktop exercises	Emergency Planning Group Board of Directors *NHSE Emergency Preparedness, Resilience and Response Self-Assessment Substantial Assurance Return-October 2017 – did that go in*	Emergency Preparedness, Resilience and Response NHS England submitted-when did we submit?		
	Non elective performance	Capacity and demand oversight Analysis reports Data and KPI Performance monitoring	Urgent care operational group Programme development group	Urgent care delivery Board Executive management Group Finance and performance committee	CQC NHSI GMCA		
	Elective performance	Business Group PTL's Trust wide PTL's	Operational performance group	Executive management Group	CQC NHSI		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

		RTT and Cancer Monitoring OWL Clinical pathways Staff training	Cancer Board	Finance and performance committee	GMCA		
Adequacy of Assurance (Level of Confidence)			Significant				
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:	Emergency department performance met improvement trajectory. RTT diagnostics and Cancer did not meet target. Quarter 2 trajectories have been realigned for improved performance. Significant assurance for diagnostics and cancer for quarter 2						
Quarter 2 Commentary:							
Quarter 3 Commentary:							
Quarter 4 Commentary:							

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 6:
To develop and maintain an engaged workforce with the right skills, motivation and leadership

Principal risk	There is a risk that the trust fails to recruit, develop and retain suitably skilled and motivated workforce

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July	n/a as 1st assessment	October 2018	Safe, effective responsive caring NHSI – use of resources	Director of Workforce & Organisational Development	Workforce efficiency Group Culture and Engagement Group	People and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	3	15	5	2	10	31/03/2019

Executive commentary for the Current Risk Score

Current mitigation includes recruitment and retention strategy, developing people strategy. Comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work

Corporate objectives

6a. To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum

6b.To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement

6d. To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage

Links to other Strategic Objectives:	SO2, SO3

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
231	Lack of consultant microbiologists and nursing team in IP service	20	02/10/2017				
108	Failure to provide a robust imaging service due to reduced radiographer	16	01/08/2016				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	staffing						
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
75	Lack of consultant in palliative care team	16	02/11/2016				
78	Registered Nurse Vacancies	16	21/11/2016				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Recruitment and retention strategy	GM theme 3 – employer banding and streamlining	WEG CEG Staff survey Workforce reports Staff friends and family Workforce KPI's Temporary staff meetings JLMC JNC Training needs analysis Schwartz rounds	People and performance Committee Executive management board Trust Board	Greater Manchester Combined authority NHSI CQC	Employment market – key skills shortage Building leadership skills to support change and improvement	Workforce remodelling Proactive workforce plan Just culture programme
2	Culture plan	Embedding the plan					
3	People strategy	Signed off strategy Embedded processes					
4	Operational plan	Delivery of plan					
Adequacy of Assurance (Level of Confidence)			Partial				
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:		Good performance against workforce KPI's and significant progress in the development of the people strategy with active engagement from workforce groups					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

Quarter 2 Commentary:	
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (June 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 7:
To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

Principal risk	Risk in not delivering the trust capital programme in a planned and efficient manner

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	Not applicable	October 2018	Well led NHSI finance and use of resources	Director of Support Services / Deputy Chief Executive	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	3	12	4	4	16	4	3	12	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score is 16 which relates to a reduced planed spend, agreed capital programme against risk assessed concerns. Benefits of EPR have not yet been realised and there is a delay in go live.

Corporate objectives

7a. To implement an Acute EPR in line with the programme timescales to improve efficiency osf systems and technology
7b. To refresh the Estates Strategy based on the six facet survey and master planning information
7c. To manage investment relating to the Trust's capital programme to:

I. Medical equipment
II. IT
III. Estates

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
46	There is a risk that the telepath server will fail	20	06/04/2018				
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will	16	27/10/2017				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	fail our Cancer Targets						
167	Due to Lack of secure storage facilities on wards / units causing insecure patient records leading to failure of CQC / ICO standards in relation to confidentiality of patient information	16	29/09/2017				
261	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.	16	27/10/2017				
399	There is a risk to patient care due to the potential Failure of PACs Infrastructure	15	27/02/2018	Closed			
354	The risk of abduction or paediatric patient absconding.	16	18/01/2018				

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Risk assessment for each area	Further review on all risks	CPDG	Executive management Group Finance and performance committee	Greater Manchester CA			
2	Signed off capital programme for 18/19 operational plan	Review when changed information	CPDG	Executive management Group Finance and performance committee	Greater Manchester CA			
Adequacy of Assurance (Level of Confidence)			Significant					
Overall Assessment of Assurance			Significant					
Quarter 1 Commentary:								
Quarter 2 Commentary:								
Quarter 3 Commentary:								
Quarter 4 Commentary:								

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

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