Public Board meeting

Thu 03 October 2024, 09:30 - 12:30

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for Absence

09:30 - 09:30
0 min

2. Declaration of Interests (Verbal)

09:30 - 09:35
5 min

3. Patient Story (Verbal)

Information *Nicola Firth*

09:35 - 09:35
0 min

4. Minutes of Previous Meeting - held on 1 August 2024 (Paper)

Decision *Marisa Logan-Ward*

04 - Public Board Minutes - 1 August 2024.pdf (13 pages)

09:35 - 09:40
5 min

5. Action Log (Paper)

Information *Marisa Logan-Ward*

05 - Public Board Action Log - October 2024.pdf (1 pages)

09:40 - 09:50
10 min

6. Chair's Report (Paper)

Discussion *Marisa Logan-Ward*

06 - Chair's Report - October 2024.pdf (5 pages)

09:50 - 10:00
10 min

7. Chief Executive's Report (Paper)

Discussion *John Graham*

07 - Chief Executive's Report - October 2024.pdf (5 pages)

PERFORMANCE

10:00 - 10:25
25 min

8. Integrated Performance Report (Paper)

Discussion *John Graham / Executive Directors*

- Quality

- Operational Performance
- Workforce
- Finance

08a - IPR Front Sheet 2024-09.pdf (2 pages)
08b - Trust Board IPR - Aug24 Final.pdf (24 pages)

10:25 - 10:35
10 min

9. Financial Performance

9.1. Financial Position at Month 5 (Paper)

Discussion *John Graham*

09.1a - Financial Position Report Month 5 2024 front sheet.pdf (3 pages)
09.1b - Financial position 2024-25 M05 Board.pdf (16 pages)

9.2. Revenue Support Application (Paper)

Decision *John Graham*

09.2 - Revenue Support Application Quarter 3 Board Paper.pdf (8 pages)

10:35 - 10:50
15 min

10. Stepping Hill Hospital Estate: Update Report (Paper)

Discussion *Paul Featherstone*

10a - Estates Update Oct 2024 Front Cover.pdf (4 pages)
10b - Estates Update Oct 2024 Report v2.docx.pdf (11 pages)

10:50 - 11:00
10 min

COMFORT BREAK

PEOPLE

11:00 - 11:10
10 min

11. Freedom to Speak Up Report (Paper)

Discussion *Nadia Walsh*

11 - Freedom to Speak Up Report - October 2024.pdf (14 pages)

11:10 - 11:20
10 min

12. Safer Care (Staffing) Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

12b - Safer Care (Staffing) Report.pdf (25 pages)
12a - Safer Care (Staffing) Report Front Sheet - October 2024.pdf (3 pages)

11:20 - 11:30
10 min

13. Medical Appraisal and Revalidation Report (Paper)

Decision *Andrew Loughney*

13a - Medical Appraisal and Revalidation - Front Sheet.pdf (3 pages)
13b - Medical Appraisal and Revalidation - Annual Submission to NHSE NW.pdf (32 pages)

QUALITY

11:30 - 11:40
10 min

14. Infection Prevention Control Annual Report (Paper)

Discussion *Nicola Firth*

- 14a - IPC Annual Report.pdf (36 pages)
- 14b - 2023-24 IPC Annual Report Presentation.pdf (8 pages)

11:40 - 11:55
15 min

15. Health Inequalities: Board Self-Assessment (Paper)

Decision *Andrew Loughney / Annie Lowe (Public Health Registrar)*

- 15a - Health Inequalities - Board Self Assessment - Front Sheet.pdf (3 pages)
- 15b - Health Inequalities - Board Self Assessment.pdf (10 pages)

11:55 - 12:05
10 min

16. PLACE - Locality Provider Partnership (Paper)

Discussion *Paul Buckley*

- 16 - PLACE - Locality Provider Partnership.pdf (10 pages)

GOVERNANCE

12:05 - 12:15
10 min

17. Board Assurance Framework 2024/25 and Significant Risk Register (Paper)

Decision *John Graham*

- 17a - Board Assurance Framework Q2 2024-25 - Front Sheet.pdf (4 pages)
- 17b - Appendix 1 - Board Assurance Framework 2024-2025.pdf (21 pages)
- 17c - Appendix 2 - Significant Risk Register - September 2024.pdf (2 pages)

STANDING COMMITTEE REPORTS

12:15 - 12:30
15 min

18. Board Committees - Key Issues Reports:

- 18 - Board Standing Committees Key Issues Reports - Front Sheet.pdf (2 pages)

18.1. People Performance Committee (Paper)

Information *David Hopewell*

- 18a - People Performance Committee Key Issues Report - September 2024.pdf (3 pages)

18.2. Finance & Performance Committee (Paper)

Information *Anthony Bell*

- 18b - Finance & Performance Committee Key Issues Report - September 2024.pdf (4 pages)

18.3. Quality Committee (Paper)

Information *Mary Moore*

- 18c - Quality Committee Key Issues Report - September 2024.pdf (6 pages)

18.4. Audit Committee (Paper)

Information *David Hopewell*

CLOSING MATTERS

12:30 - 12:30
0 min

19. Any Other Business (Verbal)

12:30 - 12:30
0 min

20. Board Work Plan and Attendance - For Information (Paper)

Information

- 20a - 2024-25 Board of Directors Annual Workplan.pdf (4 pages)
- 20b - Board of Directors 2024-25 Attendance.pdf (1 pages)

DATE, TIME & VENUE OF NEXT MEETING

12:30 - 12:30
0 min

21. Thursday, 5 December 2024, 9.30am, Pinewood House Education Centre

12:30 - 12:30
0 min

22. Resolution:

"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 1 August 2024, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Dr Marisa Logan-Ward	Interim Chair
Dr Samira Anane	Non-Executive Director
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & Organisational Development
Mr Paul Buckley	Director of Strategy & Partnerships*
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mr David Hopewell	Non-Executive Director
Mrs Jackie McShane	Director of Operations
Mrs Mary Moore	Non-Executive Director
Dr Louise Sell	Non-Executive Director

Quoracy:
To be quorate the meeting requires:
At least six voting Directors including not less than two Executive Directors (one of whom must be the Chief Executive, or another Executive Director nominated by the Chief Executive), and not less than two Non-Executive Directors (one of whom must be the Chair or the Deputy Chair of the Board of Directors)

Quorate: Yes

In attendance:

Mrs Rebecca McCarthy	Trust Secretary
Dr Peter Nuttall	Director of Informatics *(Item 89/24)*
Ms Margaret Deakin	Head of Safeguarding *(Item 90/24)*
Mr Lee Woolfe	Named Professional Safeguarding Lead *(Item 90/24)*
Ms Wiesia Woodyatt	Research & Innovation Manager *(Item 91/24)*

Apologies:

Dr Andrew Loughney	Medical Director
Mrs Karen James	Chief Executive

** indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
78/24	**Apologies for Absence** The Interim Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
79/24	**Declarations of Interest** There were no declarations of interest.	
80/24	**Patient Story** The Board of Directors watched a video regarding care of the dying person. In response to a question from the Interim Chair querying the extent to which the mortuary team was involved in the 'Dying Matters' week, the Chief Nurse confirmed that the mortuary team were fully engaged. She highlighted the exceptional care provided by mortuary, as recognised by families, and noted	

	that mortuary was also included in the programme of Board walkabouts. **The Board of Directors received and noted the Patient Story.**	
81/24	**Minutes of Previous Meeting** The minutes of the previous meeting held on 6 June 2024 were agreed as a true and accurate record.	
82/24	**Action Log** The action log was reviewed, and it was noted that there were no open actions.	
83/24	**Chair's Report** The Interim Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Board of Directors received an update on the following: - Operational and financial pressures - External partnerships - Trust activities - Governors - Strengthening Board oversight - Other activities. The Interim Chair reflected on the shocking recent events in Southport and on behalf of the Board of Directors, expressed condolences to the families of those who had been affected and lost their lives. The Interim Chair highlighted her attendance at the Stockport Social Value Roundtable, a multi-agency networking event bringing together senior officers from across the borough to explore opportunities to increase social value. Mrs Beatrice Fraenkel, Non-Executive Director, stressed the importance of close working between the Trust and partners with respect to social value, health promotion and illness prevention. **The Board of Directors received and noted the Chair's Report.**	
84/24	**Chief Executive's Report** The Deputy Chief Executive presented a report providing an update on local and national strategic and operational developments, including: - Outcome of General Election - Shaping Better Services for Children and Young People - Cyber Security - Covid-19 Inquiry - Greater Manchester System - Trust Operational Pressures - Industrial Action by Junior Doctors - Estates Issues - Success & Celebrations The Deputy Chief Executive also informed the Board of Directors of the sad news of the recent suicide of a staff member. He confirmed the Trust had followed the required process for suicide of a staff member in service and that support was being provided to colleagues and family members.	

	The Deputy Chief Executive also reported the sad news that Mrs Margaret Malkin, Director for Integrated Care, had passed away following a short illness. The Board of Directors heard that Margaret had worked at the Trust for some ten years and was respected by all she worked with. The Deputy Chief Executive stated that the Trust was supporting colleagues and Margaret's family through this difficult time. In response to a question from Mr Tony Bell, Non-Executive Director, querying the timescale for the forthcoming Lord Darzi Review into NHS performance in England, the Deputy Chief Executive stated that the timings were still awaited, however the Government had highlighted the importance concluding the review and publishing findings quickly. In response to a question from Mr Tony Bell, Non-Executive Director, regarding the high number of daily Emergency Department (ED) attendees versus planned attendance, the Director of Operations confirmed the Trust was experiencing approximately 30-40 more daily attendees than commissioned/planned. She noted the adverse impact of higher than planned attendances, and space constraints, along with increased acuity, on performance against operational standards for emergency care. **The Board of Directors received and noted the Chief Executive's Report.**	
85/24	**Operational Plan 2024/25** The Director of Strategy & Partnerships presented a report providing an overview of the Trust's final Operational Plan 2024/25, submitted by the Trust to Greater Manchester (GM) Integrated Care Board (ICB) in June 2024. He briefed the Board on the content of the report, highlighting the performance standards set by the national planning guidance and risks to the delivery of the plan. It was noted that performance against the plan would be reported to the Board through the Integrated Performance Report. In response to a question from Mr Tony Bell, Non-Executive Director, regarding the capital plan, the Chief Finance Officer confirmed that the figure stated in the plan included public dividend capital (PDC), which was over and above the capital departmental expenditure limit (CDEL). In response to a question from the Interim Chair regarding the 92% bed occupancy target, the Director of Operations highlighted challenges in achieving this target due to the level of no criteria to reside (NCTR), with concern raised at locality level. **The Board of Directors received and noted the final Trust Operational Plans for 2024/25 submitted to Greater Manchester Integrated Care Board.**	
86/24	**Opening Budgets** The Chief Finance Officer presented a report detailing the opening budgets for 2024/25, which reflected the current submitted financial plan. He briefed the Board on the content of the report, noting that, as in previous years, it was likely that the capital plan and allocation would change in year. Furthermore, he provided contextual information regarding ongoing discussions regarding cash and how this would be transacted.	

	The Interim Chair queried if there was an understanding of the scale of the financial risk across GM and how this was being managed. The Chief Finance Officer stated that GM was aware of areas of risk. He noted that GM was under national scrutiny and stressed the importance of transparency across the system to comprehensively understand the financial risk and develop system level mitigation plans. Mrs Beatrice Fraenkel, Non-Executive Director, supported this view, highlighting the importance of understanding the Trust's position within the system, to understand how the Trust can work collaboratively to deliver effective and safe healthcare to the system population. The Chief Finance Officer highlighted the Trust's input through the Trust Provider Collaborative (TPC) and other director groups, noting openness and transparency, peer challenge and support. He briefed the Board on the GM Future Funding Flows work, a programme reviewing the allocation of funding versus activity delivered, in addition to a piece of work to understand the drivers of the deficit for Stockport NHS Foundation Trust (SFT). In response to a question from Dr Samira Anane, Non-Executive Director, querying whether the pay award would be fully funded, the Chief Finance Officer advised that Trusts had been informed the pay award would be fully funded, albeit cautioning that the amount of funding received had not always covered the costs in previous years. Mr Tony Bell, Non-Executive Director, commented on the lateness of the opening budget sign off, due to approval of the financial plans and queried if GM was an outlier in this. The Chief Finance Officer confirmed that GM was not an outlier. He advised that the Trust had budgets in place based on draft submissions that divisions have been working to. Mr Tony Bell, Non-Executive Director, commented on the significant process the Trust had to complete each time it was required to access cash in line with the financial plan. The Chief Finance Officer noted that this was a national process and had to be completed monthly at present. He highlighted the additional pressure the process had on the Finance Team and other colleagues. **The Board of Directors approved the Opening Budgets for 2024/25.**	
87/24	**Integrated Performance Report** The Deputy Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Quality** The Chief Nurse presented the quality section of the IPR and highlighted challenges and mitigating actions regarding sepsis, infection prevention & control (IPC), pressure ulcers, complaints, incidents and maternity due to under-achievement in month. The Board heard that timely administration of antibiotics within the necessary timescales continued to be challenging, with this matter discussed in detail at Quality Committee. The Chief Nurse advised that reported infection rates for Clostridium Difficile (CDiff) continued to be higher than projected and all root cause analyses had	

	been communicated via community and primary care to ensure shared learning. It was noted that E.coli rates were showing strong improvement in trends. The Chief Nurse reported an increase in pressure ulcers and highlighted a deep dive in this area. In response to a question from the Interim Chair on how different skin tones were considered in the grading of pressure ulcers, the Chief Nurse advised that national guidelines had been changed recently and further guidance was awaited, noting that the Trust would review and adapt policies accordingly. **Operations** The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, No Criteria to Reside (NCTR), diagnostics, outpatient efficiency, and theatre efficiency metrics due to under-achievement in month. The Board heard that performance against ED 4-hour and 12-hour metrics showed some signs of improvement, albeit performance was still outside the target thresholds. The Director of Operations advised that action plans were in development to support the new national ED 4-hour ambition of 78% by March 2025. The Director of Operations advised that the diagnostic position continued to be challenged due to backlogs in MR, Echo and Audiology, highlighting Audiology a particular area of concern. The Director of Operations reported positive performance against cancer metrics in month, particularly around 62-day and 28-day faster diagnosis performance. The Board heard that significant improvements had been made to the Trust's RTT position in 52, 65, and 78-week waits. It was noted that the Trust was performing well against trajectory plan to have zero 65+ week waits by September 2024. The Director of Operations advised that outpatient efficiencies in relation to Did Not Attend (DNA) and clinic utilisation had shown deterioration in performance and noted ongoing process reviews in this area. The Board commended all teams for their response to the recent estates incidents in ensuring that the safety of patients and staff had been maintained. The Board heard that while the Trust continued to be one of the best performing trusts in GM for theatre touch-time utilisation, new transformation workstreams had commenced, focusing on key areas known to be adversely impacting performance. Dr Louise Sell, Non-Executive Director, welcomed the use of Get It Right First Time (GIRFT) and queried if consideration had been given to utilising the High Intensity Use approach to address waiting lists. The Director of	

	Operations confirmed that this had been considered in some specialties and continued to be explored as part of the theatre improvement programme. Dr Louise Sell, Non-Executive Director, highlighted the importance of including staff feedback. Mr Tony Bell, Non-Executive Director, acknowledged the operational challenges, alongside improvements. In response to a question from Mr Tony Bell, Non-Executive Director, regarding NCTR challenges in Stockport, the Director of Operations noted that the improvements in NCTR were dependent on a locality wide approach. She advised that GM had implemented Provider Oversight Meetings (for Trusts) with plans in place for Locality Oversight Meetings, which would provide opportunity to hold the locality to account. **People** The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted challenges and mitigating actions regarding sickness absence and appraisal rates due to under-achievement in month. She briefed the Board on mitigating actions, including the launch of a new toolkit to support appraisals. **Finance** The Chief Finance Officer presented the finance section of the IPR, noting that more detailed financial information was provided within the Finance Report. **The Board of Directors received and noted the Integrated Performance Report.**	
88/24	**Finance Report** The Chief Finance Officer presented a report providing an update on the financial performance for Month 3 2024/25. The Board heard that the Trust had a deficit of £13.4m at Month 3 2024/25, which was an adverse variance of £0.1m against plan, primarily driven by unfunded industrial action costs. The Chief Finance Officer advised that the Trust had delivered savings of £3.3m at Month 3, which was £0.3m ahead of plan. It was noted that the savings plan was weighted towards the second half of the financial year and focus remained on delivering recurrent savings. The Board heard that the Trust was forecasting to deliver the financial plan for 2024/25, subject to risks highlighted. It was noted that the Trust's cash position remained on the significant risk register as a score of 25. The Chief Finance Officer reported continued progress with reducing reliance on agency staffing, however noted increased bank costs in month relating to industrial action. The Chief Finance Officer advised that to date, the Trust had spent £4.1m against a Capital Plan of £4.3m, and highlighted expenditure relating to the Emergency & Urgent Care Campus, the MRI scheme and essential network cabinet refresh.	

	The Interim Chair queried the detail of progress against the cost improvement plan (CIP) monitored via the Finance & Performance Committee. The Chief Finance Officer confirmed Finance & Performance Committee had monthly oversight of delivery via the Finance Report, alongside an in-year deep dive, due to be undertaken at its October meeting. Mr David Hopewell, Non-Executive Director, stated that the Audit Committee had confirmed the terms of reference for an internal audit into CIP processes. **The Board of Directors received and noted the Finance Report.**	
89/24	**Digital Strategy Progress Report** The Director of Informatics presented a report providing an update on the delivery of the Trust's Digital Strategy. He briefed the Board on the content of the report and provided a progress update against the seven digital ambitions: • Digitise patient care delivery • Empower our patients • Support our staff • Invest in our infrastructure • Engage clinical leaders to improve quality • Enhance performance and operational service delivery • Collaborate with our partners In response to a question from the Interim Chair regarding the Electronic Patient Record (EPR) programme, the Director of Informatics noted a good level of confidence that the EPR programme would progress to a full business case and procurement. The Chief Finance Officer endorsed this comment, noting that the Trust was engaged in weekly meetings in this area. Furthermore, the Interim Chair queried how the Board would be kept appraised of the EPR project, the Director of the Informatics noted that, once progressed to the next stage, the Board would receive update, and the frequency of Board reporting would be determined. The Interim Chair commented that EPR was a key question raised at consultant interviews. The Director of Informatics acknowledged that the Trust was an outlier in GM, as the only organisation without EPR. He noted, however, that the Trust had some sound digital systems in place that provided similar functions and highlighted the importance of procuring an EPR system capable of integrating with the current systems. The Chief Nurse supported this view, recognised the functionality provided by existing systems, including Patient Trac. Dr Louise Sell, Non-Executive Director, stressed the importance of articulating the message to new consultants that by working at the Trust, they have opportunity to influence the EPR system development. Mrs Beatrice Fraenkel, Non-Executive Director, highlighted the importance of utilising data analytics, innovation and technology in a collaborative manner, shaping healthcare delivery for the future. The Director of Informatics advised that the Digital Strategy set out the Trusts intentions in this regard and advised that the Trust was fully engaged in discussions at GM and with Health Innovation Manchester with regard to new technologies. Furthermore, he stated that while Artificial Intelligence (AI) was being developed out with the hospital, by experts in this industry, the Trust was engaged in developments through the above. The Director of Informatics advised that the Digital Strategy would be refreshed in 2026, which would provide opportunity	

	to explore new and emerging digital developments and opportunities. Dr Louise Sell, Non-Executive Director, queried where assurance was provided against the strategy delivery, including whether projects were delivered to time and within resource. The Director of Informatics confirmed that progress, at this level of detail, was monitored through the Capital Programme Management Group and Digital & Informatics Group, noting this information could be integrated into the Digital Strategy Progress Report. Furthermore, Mr Tony Bell, Non-Executive Director, advised that post-implementation appraisal of business cases was included on the Finance & Performance Committee work plan. In response to a comment from Dr Samira Anane, Non-Executive Director, the Director of Informatics advised that work continued to explore community EMIS and electronic prescribing. **The Board of Directors received and noted the Digital Strategy Progress Report.**	
90/24	**Annual Safeguarding Report 2023/24** The Head of Safeguarding presented the Annual Safeguarding Report 2023/24, providing an overview of the Trust's safeguarding activity in 2023/24, assurance that the Trust was compliant with its safeguarding duties and outlining the key safeguarding priorities for 2024/25. The Head of Safeguarding confirmed that systems were in place to ensure that patients using Trust services are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise. It was noted that the report has been reviewed and supported by the Quality committee. The Interim Chair welcomed the report and the golden thread of safeguarding through the organisation. The Chief Nurse commended the person centred approach to safeguarding and Mrs Mary Moore, Non-Executive Director, and Chair of Quality Committee confirmed the report had been reviewed and supported by Quality Committee, reflecting assurances received throughout the year. **The Board of Directors reviewed and confirmed the Annual Safeguarding Report 2023/24 as supported by the Quality Committee.**	
91/24	**Annual Research, Development & Innovation Report 2023/24** The Research, Development & Innovation (RD&I) Manager presented the annual Research, Development & Innovation Report describing performance for 2023/24 in line with the Joint RD&I Strategy for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust. She highlighted the impact of organisational changes, a financial summary, key performance indicators from the National Institute for Health and Care Research (NIHR) Greater Manchester Clinical Research Network (GM CRN) and internally for research study set-up, recruitment delivery and research participant experience and key risks and mitigations. The Interim Chair welcomed the report and noted the known improved outcomes for research active organisations.	

	In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding collaboration, involvement of private sector and commercial activity, the RD&I Manager advised that commercial activity was a key part of the strategy and briefed the Board on plans to further expand activity in this area. **The Board of Directors received the Annual RD&I Report 2023/24, confirming delivery in alignment with the Joint RD&I Strategy.**	
92/24	**Learning from Deaths Report Q4 2023/24** The Chief Nurse presented the Learning from Deaths report summarising activity that has taken place regarding learning from deaths (LFD), learning gained in the last quarter and high level information about the actions that have been taken in response. He confirmed that a high level of LFD activity continues with around 43% of all in-hospital deaths receiving a review. Furthermore, he highlighted identification of themes with regard to clinical practice. Dr Samira Anane, Non-Executive Director, referred to the focus on stroke related mortality and the merit of benchmarking to similar organisations in this area. Dr Louise Sell, Non-Executive Director, suggested it would be helpful to highlight deaths involving patients suffering from mental health issues in future Learning from Deaths Reports. This suggestion would be shared with the Medical Director **(ACTION).** The Director of Operations referred to potential harm caused by poor patient flow, as stated in the report, and queried how this information could be shared with locality teams to highlight the importance of patient flow. The Chief Nurse proposed sharing the Learning from Deaths Report at the Stockport locality-wide Quality Meeting. **(ACTION).** **The Board of Directors received the Learning from Deaths Report and confirmed the processes that the Trust has in place that allow it to learn from deaths, considered the themes identified from the process and confirmed action being taken was appropriate in response.**	**Medical Director** **Chief Nurse / Medical Director**
93/24	**People & Organisational Development Plan Progress Report** The Director of People & Organisational Development (OD) presented a report providing a progress update against the People & OD Plan. She briefed the Board on the content of the report, highlighting progress made against the priority areas aimed at improving organisational culture and performance, in line with the NHS Long Term Workforce Plan. The Board heard that the Trust continued to deliver the People & OD priorities alongside the Equality, Diversity & Inclusion (EDI) Strategy 2022-25 and Health & Wellbeing Plan. **The Board of Directors received and noted the People & Organisational Development Plan Progress Report.**	

94/24	**Wellbeing Guardian Report** The Board received a verbal update from the Wellbeing Guardian (Non-Executive Director/Interim Chair). She highlighted the continued focus on health and wellbeing across the organisation, with the People Performance Committee receiving updates against the Health & Wellbeing Plan. The Wellbeing Guardian highlighted partnership working, noting that the Trust worked closely with Life Leisure and Stockport County Community Trust. She stressed the importance of the Staff Psychology and Wellbeing Support (SPAWS) service in supporting staff and stated that work was ongoing to identify and secure sustainable funding for the service. **The Board of Directors received the verbal update from the Wellbeing Guardian.**	
95/24	**Safe Care (Staffing) Report** The Chief Nurse presented a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Board acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Board heard that robust staffing had been implemented throughout the industrial action, ensuring that the Trust was safely staffed and able to provide high quality patient care **The Board of Directors received and noted the Safe Care (Staffing) Report.**	
96/24	**Risk Management Strategy and Policy 2024-26** The Chief Nurse presented the Risk Management Strategy & Policy, which had been updated to reflect the Board's risk appetite. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying sharing of risk and how emergent risk was captured, the Chief Nurse advised that emergent risks were considered at the Risk Management Committee and incorporated in the significant risk register if deemed significant. She noted the population health risk on the Board Assurance Framework as an example. The Director of Strategy & Partnerships commented that future risk scenarios and longer term risks may be considered as part of the Board's risk appetite development session at the onset of the year. This suggestion was supported by the Interim Chair. **The Board of Directors approved the updated Risk Management**	

	Strategy and Policy for the Trust.	
97/24	**Board Assurance Framework 2024/25 – Quarter 1** The Deputy Chief Executive presented the opening Board Assurance Framework (BAF) 2024/25 following approval of the Corporate Objectives 2024/25 by the Board in April 2024. Furthermore, a gap analysis between current and target risk score was provided. The Deputy Chief Executive confirmed that following a Board Risk Appetite Workshop where the Trust's risk appetite in relation to key areas of risk was considered, principal risks to achievement of the objectives had been developed, primarily via the relevant Board assurance committees based on review of principal risks 2023/24 year-end position, confirmed risk appetite, key controls and assurances, including any gaps, and required actions. The Board heard that the significant risks related to financial performance, financial sustainability and operational performance. In addition, it was noted that the highest scoring risks related to a fit for purpose estate and quality of care, both of which have increased in score since the previous quarter. Mrs Mary Moore, Non-Executive Director, highlighted the robust discussion that had taken place at Quality Committee to inform the current risk score, triangulating discussion regarding recent estate incidents and potential and/or known adverse impact on quality of care. The Quality Committee noted that increased harm was not evident in the quality metrics to date, however there had been an impact on patient experience. Mrs Mary Moore, Non-Executive Director, confirmed that the quality of care risk score reflected the increased likelihood and potential severity of harm to patients (and staff) due to the ageing estate. Mr Tony Bell, Non-Executive Director, referred to a discussion held at the Finance & Performance Committee, where it had been suggested that some of the strategic risks previously delegated to Committee/s should sit with the Board. The Trust Secretary confirmed that the review of risk allocation had taken place, with a number of risks now allocated to the Board of Directors, due to the cross cutting nature of the risk, and reporting directly to Board of Directors, as highlighted in the Board work plan y. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director on how risks were escalated and shared between Board Committees, Mr David Hopewell, Non-Executive Director, stated that Audit Committee provided the forum for feedback from the respective Chairs of Committees with regards to risk, including triangulation of risk and escalation. Dr Louise Sell, Non-Executive Director, provided an example on triangulation of risk where a discussion held at the Quality Committee had resulted in a change in risk score based on the current finance and estates related risks. **The Board of Directors reviewed and approved the Board Assurance Framework 2024/25, including action proposed to mitigate risks.**	
98/24	**Board Committees – Key Issues Reports** **People Performance Committee** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the key issues report from the People	

	Performance Committee meeting held on 11 July 2024. She briefed the Board on the content of the report and detailed key people related issues considered. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues reports from the Finance & Performance Committee meetings held on 20 June 2024 and 18 July 2024. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Chair of Quality Committee (Mrs Mary Moore, Non-Executive Director) presented the key issues report from the Quality Committee meetings held on 25 June 2024 and 23 July 2024. She briefed the Board on the content of the report and detailed key quality related issues considered. **The Board of Directors reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.** **Audit Committee** The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the key issues report from the Audit Committee meeting held on 16 July 2024. He briefed the Board on the content of the report and detailed key issues considered. Furthermore, he presented the Audit Committee Annual Review, including Terms of Reference and 2024/25 Work Plan, for Board approval. **The Board of Directors:** • **Reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.** • **Approved the Audit Committee Annual Review, including Terms of Reference and 2024/25 Work Plan.**	
99/24	**Any Other Business** The Board heard that General Practitioners had voted for collective action.	
100/24	**Board Work Plan & Attendance** The Board of Directors noted the Board Work Plan and Attendance for 2024/25.	
101/24	**Date and Time of Next Meeting** Thursday, 3 October 2024, 9.30am, Pinewood House Education Centre.	
102/24	**Resolution** *To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and*	

	staff, publicity of which would be premature and/or prejudicial to the public interest".	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
01/24	1 August 2024	92/24	Learning from Deaths Report	Consider inclusion of highlighting any patients suffering from mental health issues in future Learning from Deaths Reports. **Update October 2024:** Action referred to Quality Committee to be taken forward as part of the quarterly Learning from Deaths Report.	Medical Director	Closed
02/24	1 August 2024	92/24	Learning from Deaths Report	The Director of Operations referred to potential harm caused by poor patient flow, as stated in the report, and queried how this information could be shared with locality teams to highlight the importance of patient flow. The Chief Nurse proposed sharing the Learning from Deaths Report at the Stockport locality-wide Quality Meeting.	Chief Nurse / Medical Director	December 2024

On agenda
Not due
Overdue
Closed

Closed actions will be removed from the Action Log once confirmed by the Committee/Group.

NHS Stockport NHS Foundation Trust

				Agenda No.	6
Meeting date	3 October 2024	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chair's Report				
Director Lead	Dr Marisa Logan-Ward, Interim Chair	**Author**	Dr Marisa Logan-Ward, Interim Chair		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note the content of the report.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in

		Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

This report advises the Board of Directors of the Interim Chair's reflections on recent activities within the Trust and wider health and care system.

1. Purpose of the Report

The purpose of this report is to advise the Board of Directors of the Interim Chair's reflections on her recent activities.

2. Operational and Financial Pressures

Next week will mark 100-days under the newly elected Labour government and there have been major developments in health and care. The new Health Secretary, Rt Hon Wes Streeting MP, commissioned Rt Hon Sir Ara Darzi to undertake a rapid investigation into the state of the NHS. This landmark review gave comprehensive analysis of the healthcare system. It concluded that the NHS is in a 'critical condition' and provided the Government with themes to consider for a 10-year plan for transformation. This provides an opportunity to look at the entire health and care system to deliver these shifts. The challenge will be in delivering both short-term recovery and longer-term transformation.

The Trust is making steady progress on recovery despite the persistent operational pressures. The hospital estate is in urgent need of maintenance and modernisations, and this continues to challenge our ability to provide excellent care. As a board we are cognisant of our duty to provide high-quality and safe services for patients and staff. This is a key priority for the board. Together with system partners, GM ICB and healthcare leaders are working through options to address the immediate and long-term future of our Trust estate.

In more positive news we are one step further to completing the £30M Emergency and Urgent Care Campus with the successful completion of Phase 3 of the scheme.

We continue to work with Greater Manchester ICB with respect to addressing the system-wide financial and operational challenges. You will recall from report of the August board that GM ICS is now working more closely with NHS England to deliver a set of formalised agreed actions under one single improvement plan (the 'Enforcements Undertakings').

3. External Partnerships

Engagement with Stockport County Community Trust as part of a wider locality partnership to promote positive health and wellbeing to residents across Stockport. I am delighted to be joining colleagues from our organisation, the local authority and the third sector at the launch the Stockport County Community Trust's Health & Wellbeing Strategy in October.

Through a lens of staff health and wellbeing, Trust colleagues and I had a follow up workshop with executives from Life Leisure CIC. Exploring further opportunities together to collaborate and expand our offer to support staff and the community with physical activity.

4. Trust Activities

I have met Dr Annie Lowe, a recently appointed Registrar in Public Health. This appointment signals further commitment by the Trust and Locality partners in the delivering public health agenda and addressing health inequalities.

I visited our Pathology Department and met with our recently appointed Consultant Histopathologists. It was encouraging to see the laboratory fit out progressing well and hear about the planned implementation of the new Laboratory Information System (LIMS) and blood sciences instrumentation.

Followed up on my previous visit to Outpatients to speak to staff about how the ongoing disruption following the closure of Outpatients B.

I have met with Dr Ugonna Chukwumaife, Consultant Anaesthetist and our newly appointed Guardian of Safe Working. A role independent of our management structure with the aim to represent and resolve issues relating to junior doctors working hours.

4. Governors

Elections for the Council of Governors have been held in the below constituencies:

- Staff (4 seats)
- Tame Valley & Werneth (4 seats)
- High Peak & Dales (3 seats)
- Outer Region (1 seat)

The outcome of the elections is detailed below:

Constituency	Elected Governors	Contested / Uncontested
Staff	• Yogalingam Ganeshwaran • Paula Hancock • David McAllister • Ruth Perez-Merino	Uncontested
Public: Tame Valley & Werneth	• Howard Austin • Alan Gibson • Alexander Wood • *One vacancy remains*	Uncontested
Public: High Peak & Dales	• Michael Chantler • Tony Gosling • *One vacancy remains following withdrawal post-election*	Uncontested
Public: Outer Region	• Callum Kidd	Contested

On behalf of the Council of Governors and the Board of Directors, I would like to thank Staff Governors, Adam Pinder and Karen Southwick, who have decided not to re-stand, and Muhammad Rahman who was unsuccessful in the Outer Region elections, for their contribution to the work of the Council of Governors and wish them the very best for the future.

I look forward to the forthcoming Annual Members Meeting, being held on 25th September 4.00 – 5.30pm. Doors will open at 3.15pm providing an opportunity for members and the public to meet with governors and share feedback. We hope to see as many governors as possible at the meeting.

5. Strengthening Board Oversight

Our board development session in September focussed on refresh of the Trust's Values and Behaviours which have been developed through a series of engagement activities with staff across the organisation. As a board we also took time to reflect on the importance of Civility Saves Lives campaign which promotes the importance of respect, professional courtesy and valuing each other. There are an increasing number of studies which demonstrate how incivility in the workplace can impact on performance, outcomes and, patient safety.

Our Strategy Team facilitated a workshop on the approach to the new Trust strategy. It was an important discussion which explored the approach in the context of a new government, financial challenge and collaboration across the system.

Planned board development sessions include a follow up to the April session with the Public Health team from the local authority on health prevention and a review of the Health Inequalities Self-Assessment Toolkit.

6. Other activities

I have continued to undertake a range of other activities, including: -

With Chief Executive met with recently elected MPs for Hazel Grove and Cheadle.

- Regular discussions with Non-Executive Directors, Executive Directors, Chief Executive, and the Deputy Chief Executive, Chair of Tameside & Glossop NHS FT.
- Meetings with:
    - North West System Leaders Meeting
    - GM Trust Chairs
    - Lead Governor
- Board sub-committee member: Charitable Funds.
- Chair - Council of Governors meeting (formal and informal meetings).

NHS Stockport NHS Foundation Trust

				Agenda No.	7
Meeting date	3 October 2024	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chief Executive Officer's Report				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary Helen O'Brien, Head of Communications		

Paper For:	**Information**	X	**Assurance**		**Decision**		
Recommendation:	The Board of Directors is asked to note the content of the report.						

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in

		Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

This report draws the Board's attention to key matters including:

- Outcome of the Lord Darzi Review
- GM System
- Trust Operational Pressures
- Key Successes & Celebrations

1. Purpose of the Report

The purpose of this report is to inform the Board of Directors of strategic and operational developments, alongside recognition of key successes and celebrations.

2. National

2.1 Outcome of The Lord Darzi Review

The findings of Lord Darzi's investigation of NHS performance in England were published on 12th September. The review was commissioned by Wes Streeting, Secretary of State for Health and Social Care.

The investigation drew evidence from a wide range of stakeholders, with the findings report focused on 'diagnosing' the problems facing the NHS, and an assessment of access to care, quality of care, and the overall performance of the health system. The report builds a picture of a system where long waits are the norm, quality of care is mixed, productivity is low, and the NHS budget is not being spent where it should be. Key drivers of the challenges are recognised as key drivers of these challenges around performance are described as funding austerity and chronic lack of capital investment, the impact of the Covid-19 pandemic, limited patient and staff engagement, and changing NHS structures and systems.

Lord Darzi sets out the major themes to be explored in the upcoming ten-year plan for the NHS, led by the Department of Health and Social Care. These include re-engaging staff and empowering patients, shifting care closer to home, driving productivity, investing in technology, and contribute to economic prosperity through improved access to care.

The Government intends the ten-year plan for the NHS to be released next spring, and in response to Lord Darzi's report have emphasised the need for reform, with a focus on moving from hospital to community care; from analogue to digital; and from treating sickness to preventing it.

2. Greater Manchester

2.1 As previously reported, NHS England (NHSE) have published the Enforcement Undertakings that set out the improvements required by the GM Integrated Care Board (GM ICB), covering four themes; Leadership and Governance; Quality; Financial Sustainability; Performance and Assurance. In response, a Single Improvement Plan has been developed by the GM ICB, setting out planned improvements.

Together with the Single Improvement Plan, GM ICB have developed a Sustainability Plan, which sets out how the system both returns to financial balance, through addressing the underlying deficit, and secures a sustainable future through addressing future demand growth and implementing new models of care year on year. The Sustainability Plan will be considered by GM ICB at its meeting in September 2024.

2.2 Right Care, Right Person (RCRP)

From 30th September 2024, Greater Manchester Police (GMP) will begin implementing RCRP, which will include changes to how mental health incidents are handled. The national approach is designed to ensure that people of all ages who have health and/or social care needs receive the right support, while also introducing thresholds to reduce the number of incidents the police are called to, where they are not the best agency to do so, in particular, those involving mental health crises.

RCRP will see GMP working alongside GM's Mental Health Services to ensure people get the right support and will still attend mental health related incidents where there is a threat to life or a serious risk of harm to adults or a significant risk of harm to a child or young person.

Alert to the growth in demand and increased complexity of mental health presentations to the Emergency Department, the Trust will ensure any impact is understood to support future work with our partner organisations.

3. Trust

3.1 Operational Performance

August saw some improvement in our performance, with lower levels of demand in our emergency department, which had a positive impact on our capacity within the hospital. Albeit we know that levels of demand rise from September as we head into the winter months. In September we held a 'super' multi-agency discharge event involving trusts and partner organisations across the whole of Greater Manchester.

Elective care performance has continued to improve. The number of patients waiting over 52 weeks from referral to treatment reduced to just under 2,000, a 46% reduction since November last year. We remain on track to meet the national ask of having no patients waiting over 65 weeks by the end of September.

From a cancer perspective, we have continued to achieve the 28-day faster diagnosis standard and are ahead of our improvement trajectory by delivering the current 62-day cancer standard in July. A significant improvement in waiting times for diagnostics, particularly in radiology, have supported these improvements.

3.2 National inpatient survey results

The national inpatient survey results for 2023 were released in August, and for Stockport our results were around the same as the previous year, with no obvious outlying position in any area.

3.3 Community Diagnostics Centre

Our new Community Diagnostics Centre (CDC) opened its doors at beginning of August, at the Crown Point Shopping Park in Denton. The centre boasts two scanning rooms with an MRI and CT scanner, consulting rooms to support health screening services, the latest in imaging and health technology, offering MRI, CT, DEXA, Echo health screening. The centre has been developed alongside Tameside & Glossop Integrated Care NHS FT, in partnership with InHealth, the UK's largest specialist provider of diagnostic solutions.

4. Success & Celebrations

4.1 Patients to benefit from new 'e-patch' stroke monitor pilot scheme

Patients at Stepping Hill Hospital who have experienced minor strokes will soon benefit from a new electronic-patch, which will help monitor whether they are at risk of stroke or heart failure. Patients would previously have had to rely on ECG monitoring which has a waiting list of several weeks. The clinical decision to place the patch is made at the outpatients stage, without the need for a further hospital cardiology appointment, which also saves the patient time.

The pilot scheme has been supported by the Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network (GMNISDN), which was successful in its bid with the global pharmaceutical company Daiichi-Sankyo for a pilot on the Technomed E-patches in primary stroke centres including Stepping Hill Hospital.

4.2 School nurses share success with HPV vaccination

Stockport school nurses who have led the way in the successful HPV vaccination of young girls have been sharing their success with colleagues across the country.

School nurse leaders Anne Marie Gallogly and Fran Jackson attended the NHS ConfedExpo in Manchester Central to discuss with colleagues across the country about their contributions to celebrate the North West's progress towards the national `Race to Elimination` campaign to eradicate cervical cancer by 2040 – a disease that, at present, causes the deaths of more than two women in the UK every day.

Stockport was one of two areas to pilot the HPV vaccination for girls back in September 2007. Since then, the school nursing team from Stockport NHS Foundation Trust has been one of the best performing in the country in successfully introducing HPV vaccination.

4.3 Baby Friendly team for World Breastfeeding Week

NHS teams who care for families and babies in Stockport have celebrated receiving an international award recognising the high standards for breastfeeding.

Health visiting, family nurse and Startwell teams received the prestigious Unicef Baby Friendly Award, and announced their achievement as part of the celebrations for World Breastfeeding Week (1st – 8th August.). This award recognises the high standard of care given to families in Stockport and involved examining staff training and interviewing staff and mothers, who gave their feedback about their experience of the care they received.

4.4 Recognition for surgical team at the HSJ Patient Safety Awards

Improvements in the rate of elective surgery at Stepping Hill Hospital have been recognised by the winning of a major national patient safety award. The Stockport NHS Foundation Trust team which organises elective (or 'non- emergency') surgery received the 'Patient Safety in Elective Recovery' award at the Health Service Journal (HSJ) Patient Safety Awards, which recognise projects to improve and improve patient safety across the country.

The surgical theatres team took a rigorous and constructive approach, looking at the causes of delays and inefficiencies, in order to reduce this backlog while still ensuring rigorous safety standards were in place. Elective operations were increased from around 740 per month to nearer 1090 a month, allowing patients to get the procedures they need sooner, which is better for their health outcomes.

NHS Stockport NHS Foundation Trust

				Agenda No.	8
Meeting date	3rd October 2024	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

Paper For:	**Information**	x	**Assurance**	x	**Decision**	x
Recommendation:	The Board is asked to note and discuss performance against the reported metrics. This includes the described issues that are affecting performance and any mitigating actions to improve performance that are described in the exception reports.					

This paper relates to the following Annual Corporate Objectives

x	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
x	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
x	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
x	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

x	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
x	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
x	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/not agreed	Highlight section and Finance exception report
Regulatory and legal compliance	All sections
Sustainability (including environmental impacts)	

Executive Summary

This report provides an overview of the Trust's performance across a range of Quality, Operational, Workforce and Financial metrics. The report includes a scorecard that incorporates metrics from the Single Oversight Framework, as well as other high priority metrics.

The scorecard details the in-month and year- to- date performance for each metric along with an indicative forecast for next month and summary indicator of performance trend.

Exception reports are included for each metric group that is not currently achieving target thresholds and includes metric descriptions, in-month performance and target thresholds, as well SPC charts clearly showing performance trends. Exception reports also include detailed narrative from the relevant services detailing key issues affecting performance, and mitigating actions of note.

Please see introduction page of the report, which includes summary highlights for each section.

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting period

August 2024

Introduction

This report provides the Trust Board with an overview of the Trust's performance across a range of Quality, Operational, Workforce and Financial metrics. The report includes a dashboard that incorporates metrics from the Single Oversight Framework. The dashboard details the in-month, and year- to- date performance for each metric along with an indicative forecast for next month.

Quality Highlight

Exception reports included this month relate to performance against Sepsis, Infection Prevention Control, Pressure Ulcers, Complaints, Incidents, and Maternity.

- SHMI Mortality rates continue to be low, with Stockport reported with the lowest rates across GM.
- The Trust continued to perform well against the Sepsis timely recognition metric, with 96% reported in-month for August, and 98% reported as a rolling 12-month average. Antibiotic administration performance continues to be challenged, with out-of-hours prescribing being a key theme in delays.
- Reported infection rates for C.Diff appear to show an improving trend over the last 4 months. E.Coli rates appear to be stable, with consistent rates reported over the last several months. There have been no significant changes to these over the last 2 months.
- We continue to perform well against all Stroke and Falls metrics.
- Pressure ulcers across most categories and settings show no significant changes to reported numbers, with the exception of Community Category 2 pressure ulcers, which continues to show an overall increase in numbers across the last several months.
- Written complaint rates have shown some improvement since May, reporting below the target in August for the first time this year. Timely response to complaints has been improving in recent months, although latest position for August is below the target of 95%.
- Smoking during pregnancy performance has started to show signs of improvement following target changes introduced in April 2024, with July and August performance both reported below the new targets.

Operations Highlight

Exception reports included this month relate to performance against Emergency Department, Diagnostics, Cancer, RTT, Community, Outpatient Efficiencies, Outpatient Procedures, and Theatres.

- Performance against the ED 4-hour and 12-hour metrics do show some signs of improvement, although still outside the target thresholds. Action plans in development to support the new national ambition of 78% by March 2025.
- No criteria to reside and adult G&A bed occupancy both achieved targets in August.
- The diagnostic position continues to be challenged due to backlogs in MR, Echo, and Audiology. Although improving trends have been seen in the backlog for MR, Echo and Audiology services continue to be a risk due to capacity shortfall.
- In performance against the cancer standards, strong improvements can be seen in the trends for 62-day performance. 28-day FDS continues to perform above local projections but has fallen short of the national target for August 2024.
- Significant improvements seen in our RTT position on the number of 52+, 65+, and 78+ week waits. The Trust is currently above trajectory plan for 65+ waits for August with 216 patients against the trajectory of 141.
- New metrics for virtual ward utilisation and urgent community response have been added this month. Virtual ward utilisation has shown a decrease since May 2024.
- Outpatient efficiencies in DNA and Clinic Utilisation have shown improvements since the previous report in July. PIFU continues to performance well above the projected levels, but work is ongoing to achieve the target of 5%.
- Outpatient procedures levels have been added to the report this month. Rates have shown a steady decrease across the reporting period and currently under planned level.
- Although still showing signs of significant improvement compared to last year, theatre utilisation has been challenged by disruption from the EUCC construction. Business continuity meetings reinstated to improvement communication and pre-empt future disruptions and plan for mitigation.

Introduction
This report provides the Trust Board with an overview of the Trust's performance across a range of Quality, Operational, Workforce and Financial metrics. The report includes a dashboard that incorporates metrics from the Single Oversight Framework. The dashboard details the in-month, and year- to- date performance for each metric along with an indicative forecast for next month.

Workforce Highlight

Exception reports included this month relate to performance against Sickness Absence, Agency Costs, Turnover, Appraisal rates and Mandatory training.

- Monthly sickness absence rates have been rising since March of this year but remain in line with the average reported over the last 12 months.
- Agency costs continue to show an improved position compared with earlier in the year, although July and August PAY costs and are reported above the target threshold.
- Workforce turnover shows a strong improvement in performance trend since August 2023. Although April to June reported below the target threshold, the latest performance has increased and is now reported above.
- Appraisal rates across all staff groups had been showing an improving trend, but June to August have seen rates drop to 89.4%.
- Mandatory training rates have seen strong improvement over the last several months. Although reporting above the 95% target since April 2024, the latest performance for August falls just short of this at 94.7%.

Finance Highlight

The Trust has a plan with an expected deficit of £43.8m for the financial year 2024-25 and the deficit assumes delivery of an efficiency target of £24.6m of which 50% is recurrent.

At month 5 2024-25, the Trust position is adverse to plan by £0.1m – a deficit of £22.4m. The adverse position is due to the cost of industrial action (£0.6m), ERF underachievement (£04m) offset by an overachievement of Cost Improvement (STEP) programme (£0.9m).

The STEP programme is profiled on a stepped basis with an increased requirement in the second half of the year. The STEP target has overachieved to month 5 by £0.9m and to date full year savings of £13.3m have been actioned of which £3.4m is recurrent.

The Trust maintained sufficient cash in August. No revenue support was requested in August but an application of £8.5m has been made for September – the Trust has had confirmation that his has been approved.

The Trusts capital plan for 2024/25 is £29.1m. The submitted plan is now compliant, but we still have challenges with cash as the current forecast expenditure is £50.8m and continues to be discussed with NHSE.

Integrated Performance Report
Scorecard

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: HSMR	Jul-23 to Jun-24	≤ 100		↑	98	●	●
Mortality: SHMI	Jun-23 to May-24	≤ 100		↑	94	●	●
Sepsis: Antibiotic administration	Sep-23 to Aug-24	≥ 90%		→	74.8%	▲	▲
Sepsis: Timely recognition	Sep-23 to Aug-24	≥ 90%		↑	98%	●	●
C.diff infection rate	Sep-23 to Aug-24	≤ 32.75		↗	35.11	▲	▲
Covid-19 infection rate	Sep-23 to Aug-24			→	1.43		
E. coli infection rate	Sep-23 to Aug-24	≤ 31.41		→	34.21	▲	▲
MRSA infection rate	Sep-23 to Aug-24	≤ 0		→	0.45	▲	▲
Stroke: Overall SSNAP Level	Mar-24	≥ C		→	A	●	●
Falls causing moderate+ harm	Aug-24	≤ 22	2	→	0	●	●
Falls due to lapses in care	Aug-24	≤ 425	92	↘	23	●	●
Falls rate	Aug-24	≤ 3.51	2.93	→	2.7	●	●
Pressure Ulcers: Community, Cat 2	Aug-24	≤ 114	56	↘	11	▲	▲
Pressure Ulcers: Community, Cat 3&4	Aug-24	≤ 38	26	→	3	●	▲
Pressure Ulcers: Hospital, Cat 2	Aug-24	≤ 79	27	→	5	●	●
Pressure Ulcers: Hospital, Cat 3&4	Aug-24	≤ 8	10	→	0	●	▲
Complaints: Timely response	Aug-24	≥ 95%	97.1%	↗	93.9%	▲	▲
Complaints: Written Complaints Rate	Aug-24	≤ 7.9	8.76	→	6.27	●	●
Never Event Incidence	Aug-24	≤ 0	1	→	0	●	●
Patient Safety Alerts	Aug-24	≤ 0	12	↗	2	▲	▲
Patient Safety Incident Investigatio..	Aug-24		13	→	2		
Patient Safety Incident Rate	Mar-24 to Aug-24			↓	91.77		
Early Neonatal Deaths	Aug-24	≤ 0	1	→	0	●	●
Maternity Diverts	Aug-24	≤ 0	3	↘	3	▲	▲
Registrable Stillbirth Rate	Aug-24	≤ 0	4.21	→	4.5	▲	▲
Registrable Stillbirths	Aug-24	≤ 0	5	→	1	▲	▲
Smoking In Pregnancy	Aug-24	≤ 4%	4.5%	↗	1.9%	●	●

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
4hr Standard	Aug-24	≥ 78%	63.6%	↗	65.4%	▲	▲
Patients in department over 12 hrs	Aug-24	≤ 2%	9.8%	↗	6%	▲	▲
No criteria to reside (NCTR)	Aug-24	≤ 61	356	↗	61	●	●
Adult G&A Bed Occupancy	Aug-24	≤ 92%	93.8%	↑	91.4%	●	▲
Diagnostics: 6 Week Standard	Aug-24	≤ 5%	20.7%	↘	22.4%	▲	▲
62-day standard	Aug-24	≥ 70%	71.5%	↗	76.1%	●	●
Patients waiting 63 days and over	Aug-24	≤ 49		↗	45	●	●
28-day standard (FDS)	Aug-24	≥ 77%	79.6%	↘	75.6%	▲	▲
14-day standard (2WW)	Aug-24	≥ 93%	97.2%	↘	96.8%	●	●
Incomplete pathways 18-week %	Aug-24	≥ 92%		↘	49.9%	▲	▲
52-week breaches	Aug-24	≤ 3783		↑	1916	●	●
65-week breaches	Aug-24	≤ 0		↑	216	▲	▲
Virtual Ward Utilisation	Aug-24	≥ 80%	58.9%	↘	50.5%	▲	▲
Urgent Community Response	Jul-24	≥ 70%		↘	95.3%	●	●
Outpatient DNA rate	Aug-24	≤ 6.3%	7.8%	↘	7.6%	▲	▲
Outpatient clinic utilisation	Aug-24	≥ 90%	94.3%	↗	94.3%	●	●
Patient initiated follow up (PIFU)	Aug-24	≥ 5%	4.6%	↗	4.5%	▲	▲
OP First Attend and Procedure	Aug-24	≥ 46%	41.6%	↘	40.4%	▲	▲
Capped Touch Time Utilisation	Aug-24	≥ 85%	77.2%	→	74.8%	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Aug-24	≥ 90%	93.2%	→	91.7%	●	●
Sickness Absence: Monthly Rate	Aug-24	≤ 5.5%	5.8%	↘	5.9%	▲	▲
Workforce Turnover	Aug-24	≤ 12.7%	12.6%	→	12.81%	▲	▲
Staff Retention Rate	Aug-24		98.8%	↘	98%		
Appraisal Rate: Overall	Aug-24	≥ 95%	90.7%	↘	89.4%	▲	▲
Mandatory Training	Aug-24	≥ 95%	95.1%	→	94.7%	▲	▲
Agency Costs %	Aug-24	≤ 3.2%	3.3%	→	3.3%	▲	▲
Finance Scorecard							
Capital Expenditure	Aug-24	≤ 10%		↗	-55.2%	●	●
Cash Balance	Aug-24			↘	4.8		
CIP Cumulative Achievement	Aug-24	≥ 0%		↑	20.5%	●	●
Financial Controls: I&E Position	Aug-24	≤ 0%		→	-0.4%	●	●

Legend

1-month Forecast

The 1-month Forecast is an informed prediction of the next month's performance, which may be based on part-month data, operational intelligence, or historical trends.

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

- ↑ strong improvement
- ↗ improvement
- → no significant change
- ↘ deterioration
- ↓ strong deterioration

Quality **Sepsis**

		Target	Actual	6-month trend	Previous Performance						1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	98%								
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	74.8%								

Performance is based on an audit sample of patients, and is based on data from a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.

Timely Recognition

- 96% timely recognition sepsis in August.
- 12 month rolling figure now 98% ahead of 90% trust target.
- 107 records included in audit-103 compliant.
- 4 audit fails: 3 Surgery and 1 Medicine
- All timely recognition fails occurred Out Of Hours and 2222 utilised in 2/4 fails.

Notes

A3/B2/E3 ward moves 8/8/24

Antibiotic Administration

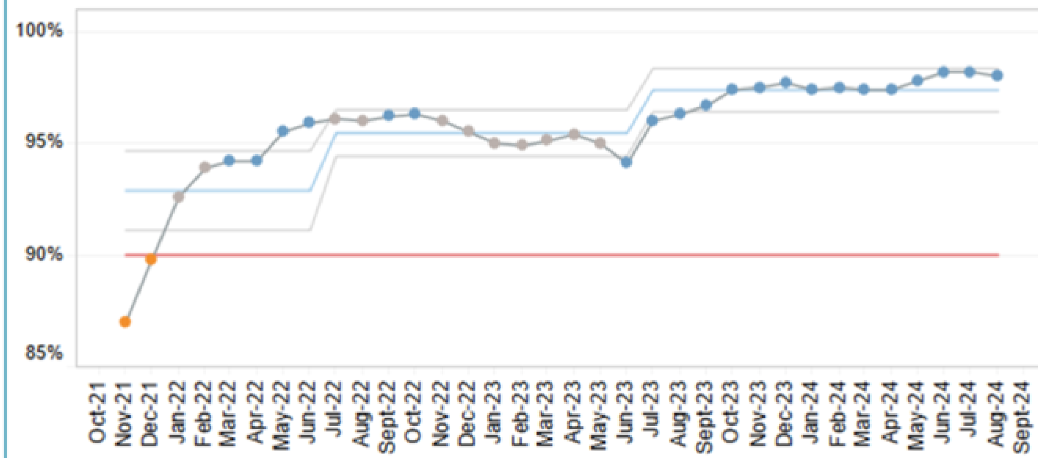
- 75% Timely Antibiotics compliance August.
- 12 month rolling figure now 75%, below trust target of 90%.
- 24/32 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- 7 fails occurred Out of Hours. 2222 utilised in 3 incidents. All incidents were red flag fails.
- 5 fails in Division of Medicine and 3 within Division of Surgery
- Average antibiotic delay was 67mins
- Themes
  - ➢ Delayed prescribing affected 7 incidents
  - ➢ on 3 occasions this was a result of antibiotics being prescribed as a scheduled dose instead of stat dose.
  - ➢ Delayed nurse administration was evident in 2 fails.
- Average time from antibiotic due to time of nurse administration was 23mins
- Sepsis6 completed by clinician in 3 incidents.
- In August Sepsis6 was finalised by clinician in 19% forms. 12 month rolling figure now 21%.

Key Events

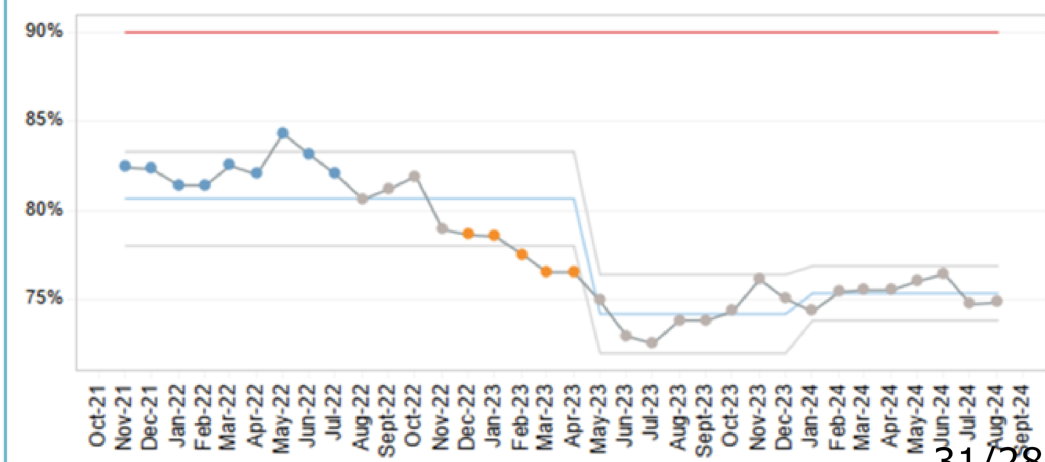
- Sepsis link nurse meeting on 04/09/24
- World Sepsis Day 13/9/24.

Update provided by	Emily Abdy
Executive Lead	Andrew Loughney

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Quality **Infection Prevention & Control**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 32.75	35.11	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	0.45	→	▲ ▲ ▲ ▲ ▲ ▲	▲
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 31.41	34.21	→	▲ ▲ ▲ ▲ ▲ ▲	▲

Performance is based on data from a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.

C.Diff

- There was 1 HOHA case in August, totalling 35 YTD. The Trust is over the projected threshold of 30.4 for the end of August.
- All 35 cases have been presented to the HCAI Panel. The most common themes for learning remain ensuring appropriate antibiotics are prescribed, reviewed and stopped in a timely manner and embedding IPC standard practices across the trust.
- The latest National figures (June 2024) rates Stockport fourth out of the seven GM Trusts which is an improvement from the previous month. Out of the 42 ICB's across the UK, GM is ranked 40th which is the same as the previous month.

E.Coli

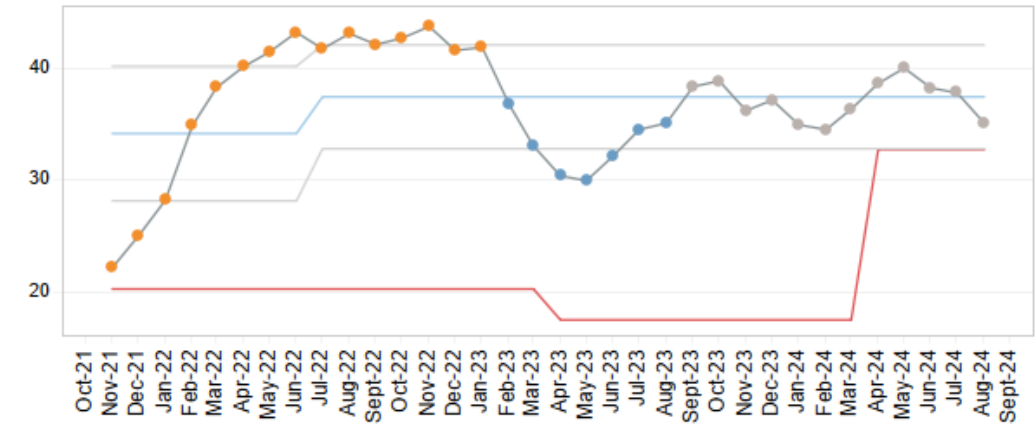
- There were 2 HOHA and 2 COHA cases in August totalling 31 cases YTD. The Trust is over the projected threshold of 29.1 for the end of August.
- The latest National figures (June 2024) rates Stockport third out of the seven GM Trusts which is an improvement on the previous month.
- The task and finish group continues to review and finalise documentation around the care and management of urinary catheters to support practice.

MRSA

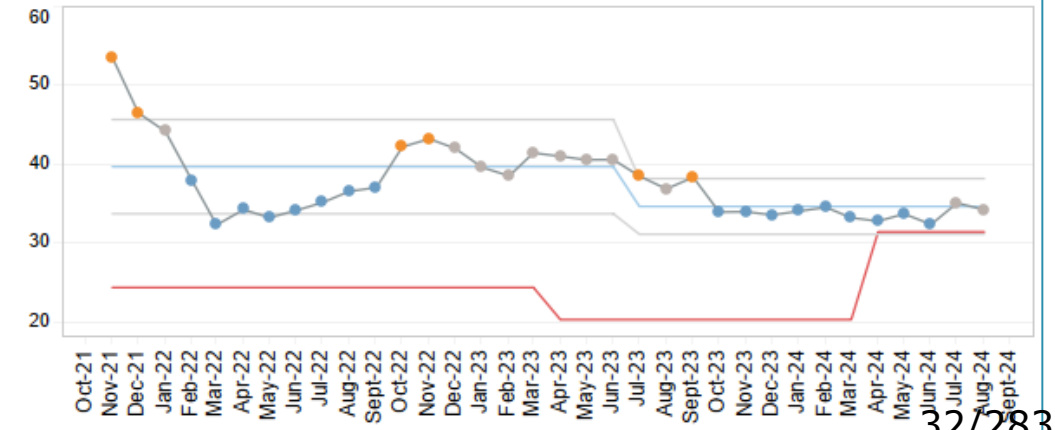
- The Trust had 0 cases of MRSA Bacteraemia in August against a zero-tolerance threshold.
- The latest National figures (June 2024) rates Stockport first out of the seven GM Trusts which is an improvement on the previous month.

McCarthy.Rebecca 03/10/2024 10:39:15

Performance for C.diff infection rate



Performance for E. coli infection rate



Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Quality **Pressure Ulcers**

Measure	Description	Target	Actual	6-month trend	Previous Performance							1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	5	→	▲	●	●	●	▲	●	●	●
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	0	→	▲	▲	▲	▲	▲	▲	●	▲
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	11	↘	▲	●	●	▲	▲	▲	▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	3	→	▲	●	▲	▲	▲	▲	●	▲

Hospital

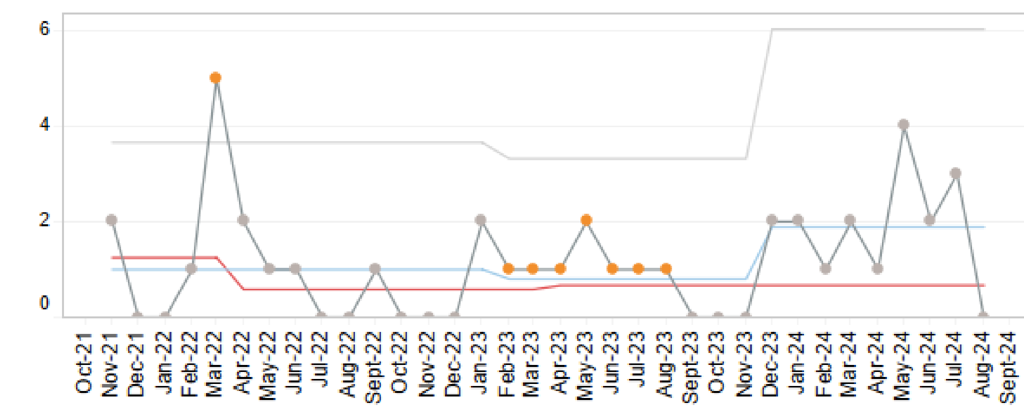
- In August, we have had 5 category 2 pressure ulcers reported: none as a result of a medical device. All pressure ulcer incidents are investigated for any lapses in care where learning and improvement can be identified.
- Of the 5 incidents reported 2 was as a result of a lapse in care (LIC), 1 incident where no lapses in care were found (NLIC) and 2 still require the investigation to be finalised.
- Thematic review of the outcome of incidents will be undertaken both at divisional level and by Tissue Viability Service, across the organisation to highlight areas where support or training is required to improve practice.
- The launch of our risk assessment tool and associated documentation on patient track is now live. The key performance data that can be extrapolated from the system will help to identify good practice and areas for improvement.

Community

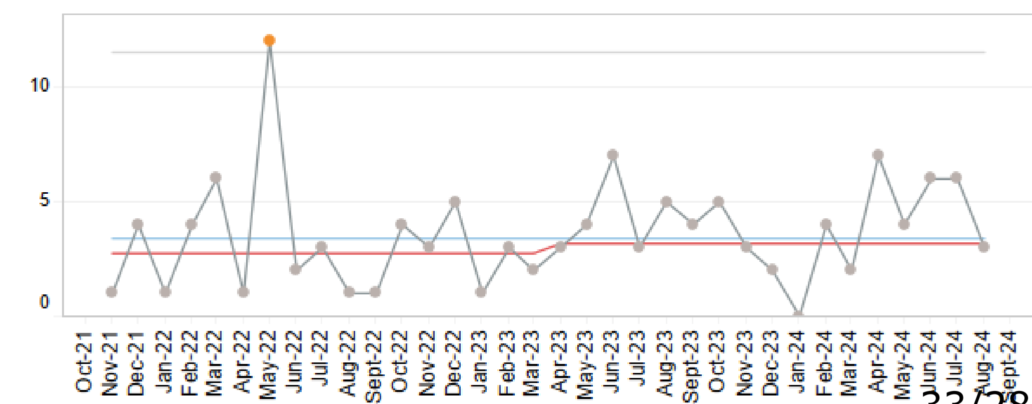
- In August, we have had 11 category 2 pressure ulcers reported. All pressure ulcer incidents are investigated for any areas of lapses in care where learning and improvement can be identified.
- Of the 11 incidents, 4 have had the investigation completed and found no lapses in care. However, there are still 7 incidents awaiting the outcome of the investigation, Improvement is required within the community setting for our investigation time frame target.

- In August, there have been 3 Category 3 & 4 pressure ulcers in the community.
- Each incident of a category 3 or 4 pressure ulcer is investigated and reviewed to identify any learning or lapses in care. All the incidents have been reviewed at PSIRG and found no lapses in care.
- Following a thematic MDT review a number of work streams have been developed with actions to continue to develop and improve our community services in relation to pressure area care.

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Update provided by	Lisa Gough
Executive Lead	Nic Firth

Quality **Complaints**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 7.9	6.25	→	▲ ▲ ▲ ▲ ▲ ●	●
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	93.9%	↗	▲ ● ● ● ● ▲	▲

Written Complaints Rate

34 formal complaints were received in August 2024 - Clinical Support Services = 0, Integrated Care = 3, Medicine & UC = 15, Surgery = 11, Women & Children = 3, Corporate = 1, Estates & Facilities = 1

Top five themes for formal complaints in August 2024 was as follows:

1. Communication
2. Clinical treatment
3. Patient care
4. Staff values & behaviours
5. Admissions & discharges

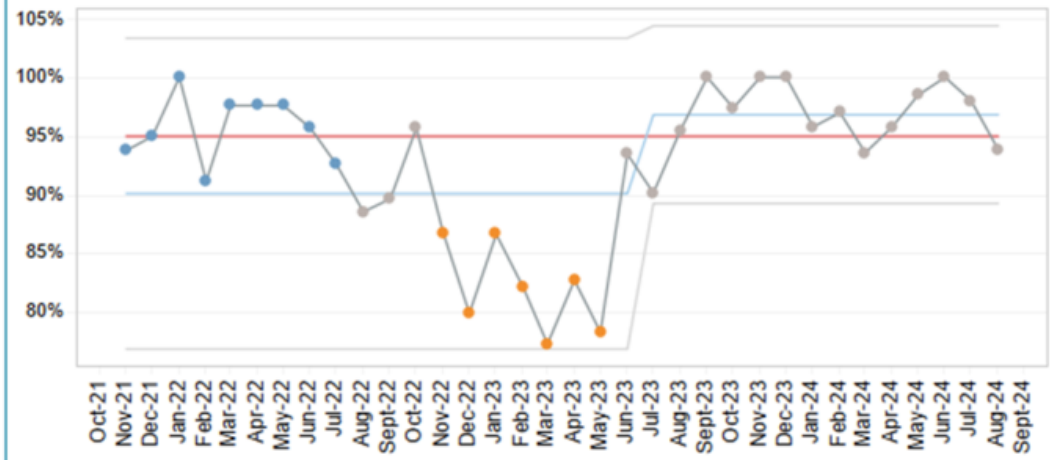
Top five themes for informal concerns in August 2024 was as follows:

1. Appointments
2. Communication
3. Admin procedures & record management
4. Access to treatment or drugs
5. Waiting time

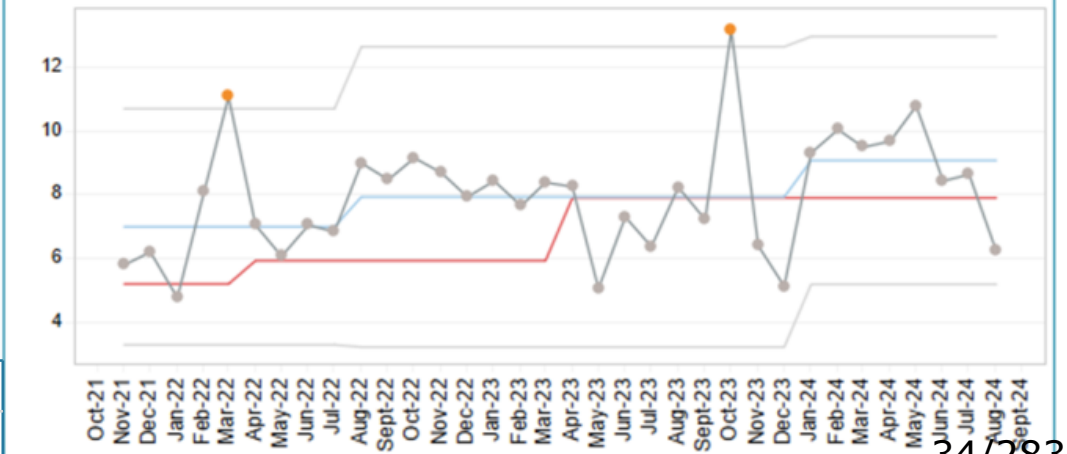
Timely Response

- 49 complaint responses were sent out in August 2024 of which 46 were sent within the agreed timeframe. This resulted in a 93.9% response rate.
- Due to continued pressures at the Trust, for a number of cases the complaints team are not receiving timely or quality statements from staff. This has resulted in delays in completing the responses within the agreed timeframe.
- Where this occurs, the complainant will be contacted to discuss this and if they are in agreement, a revised response date will be agreed.
- Along with this, the complaints team have also undergone a recent restructure and a new way of working.
- This is also having an impact on our ability to respond to some of the cases within time but the complainant is kept informed throughout.

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Update provided by	Rebecca Harrison
Executive Lead	Nic Firth

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Quality **Incidents & Risk**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Patient Safety Incident Rate	The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.		91.77	↓	▲	
Patient Safety Alerts	The number of national patient safety alerts not completed to deadline.	<= 0	2	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient Safety Incident Investigations	A count of the patient safety incident investigations (PSII) that have been declared in month.		2	→		
Never Event Incidence	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur.	<= 0	0	→	● ● ● ▲ ● ●	●

Patient Safety Incident Rate

- There are no issues related to patient incidents to report.
- The Incident Review Group meets on a weekly basis to review incidents with a focus on those where harm has been attributed, as well as other topics of interest.
- Pressure ulcer incidents are reviewed at the Pre-Harm Free Care Panel on a weekly basis.
- Patient falls incidents are reviewed at the Falls Review Panel on a weekly basis.
- Security & Safeguarding Meeting takes place to review Security related incidents.
- There were two National Patient Safety Alerts with completion deadlines in August 2024.

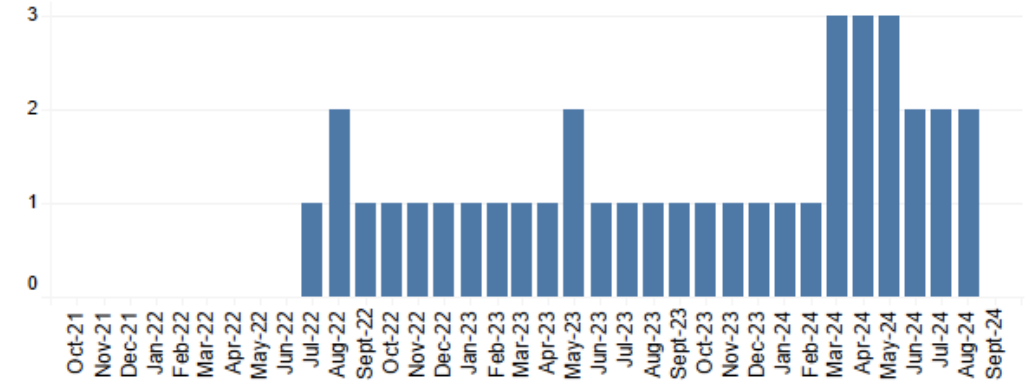
Patient Safety Alerts

- One was completed by its deadline date.
  - NatPSA/2024/008/DHSC - Shortage Of Kay-Cee-L (Potassium Chloride 375mg/5ml) (Potassium Chloride 5mmol/5ml) Syrup
- One was completed after its deadline date.
  - NatPSA/2024/009/DHSC - Shortage Of Human Albumin 4.5% And 5% Dose Vials
- There was also one National Patient Safety Alert with a completion deadline from a previous month where the Trust remained non-compliant at the start of the month but has since been closed as compliant.
  - NatPSA/2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.
- At the end of August there were 0 overdue National Patient Safety Alerts

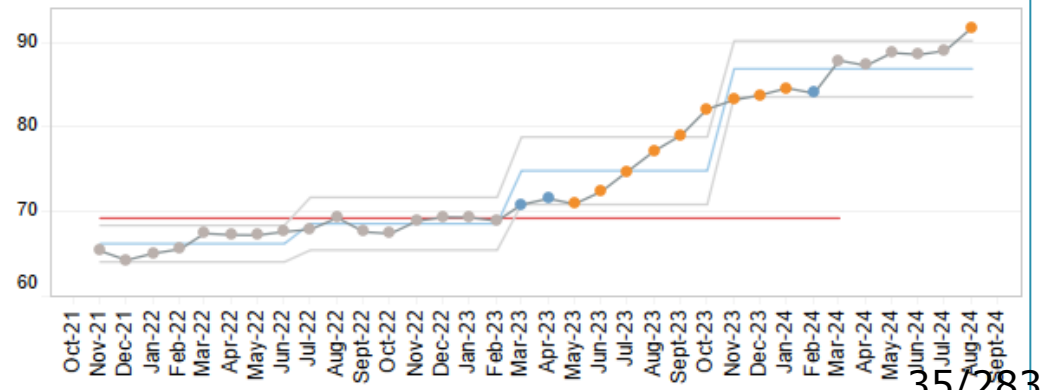
Patient Safety Incident Investigations

- There were 2 Patient Safety Incident Investigations declared in August 2024:
  - One was declared under 'National Priority: Child Deaths'
  - One was declared under 'Trust Priority 2: Pressure Ulcers'

Showing number of Patient Safety Alerts



Performance for Patient Safety Incident Rate



Signed off by	Natalie Davies
Executive Lead	Nic Firth

Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	0	→	● ● ▲ ● ● ●	●
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	1	→	▲ ▲ ● ▲ ▲ ▲	▲
Registrable Stillbirth Rate	Calculated as a rate per 1000 registrable births.	<= 0	4.5	→	▲ ▲ ● ▲ ▲ ▲	▲
Smoking In Pregnancy	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 4%	1.9%	↗	● ▲ ▲ ▲ ● ●	●
Maternity Diverts	The total number of occasions the maternity unit has been unable to admit women during the reporting period.	<= 0	3	↘	▲ ● ● ● ● ▲	▲

Smoking in Pregnancy: This metric excludes women whose smoking status was not known at the time of delivery, and only includes women initially booked with us who then delivered with us. Women known to be smokers at the time of delivery are defined as pregnant women who self-reported that they were smokers. This includes any cigarettes or tobacco at all, but excludes non-combustible nicotine products, such as e-cigarettes or other nicotine containing products. If a woman intends to give up smoking after the delivery, but was a smoker up until the delivery date they are included in this count.

Early Neonatal Deaths
The service has had 0 babies born over 24 weeks that have died within 7 days of birth in August.

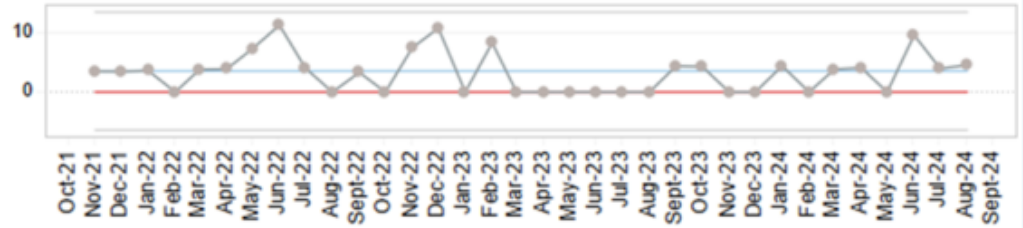
Registerable stillbirths
There was 1 Registerable stillbirth in August. This baby was 24+5 weeks gestation, known poor prognosis. PMRT in progress.

Registerable stillbirth rate
The registerable stillbirth rate for August is 4.5%.

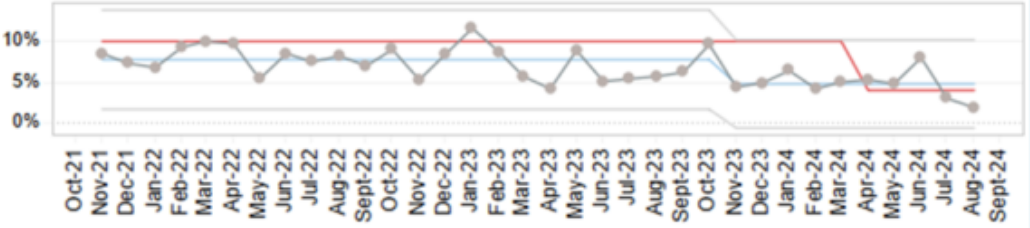
Smoking in pregnancy
The percentage of women who were smoking at time of Delivery in August was 1.9% this demonstrates a further improvement of 2.8% in July and remains below the trust target of 4%.

Maternity Diverts
There were 3 Maternity diverts reported in August. 1 was a planned divert on 7/8/24 due to emergency maintenance work being undertaken in both Maternity theatres, 2 further diverts 13/8 and 16/8 were due to acuity and staffing.

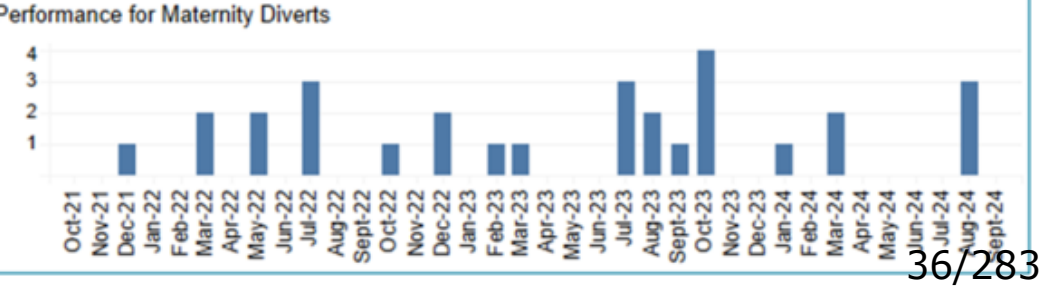
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Updated provided by	Rachel Alexander-Patton
Executive Lead	Nic Firth

Operations **Emergency Department**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 78%	65.4%			
Patients in department over 12 hrs	The number of patients spending 12 hours or more in department, as a percentage of all patients attending the emergency department.	<= 2%	6%			

Performance Summary

- August 2024 performance against the UEC 4hr standard saw an increase from 62% in July to 65.4%
- August 2024 saw a decrease in attendances from 9699 in July 2024 to 8673
- Admissions to hospital from ED remain static at 88 per day, 27% conversion rate
- August saw a significant decrease in 12 hour waits in ED to 520 compared to 1086 in July 2024. Robust processes for managing, reviewing, and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service.

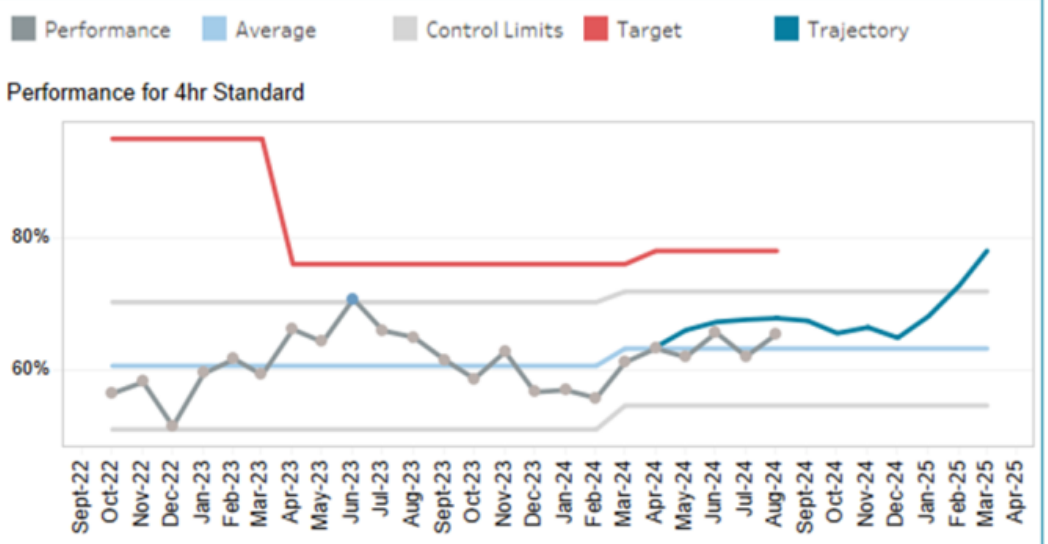
Risk and issues

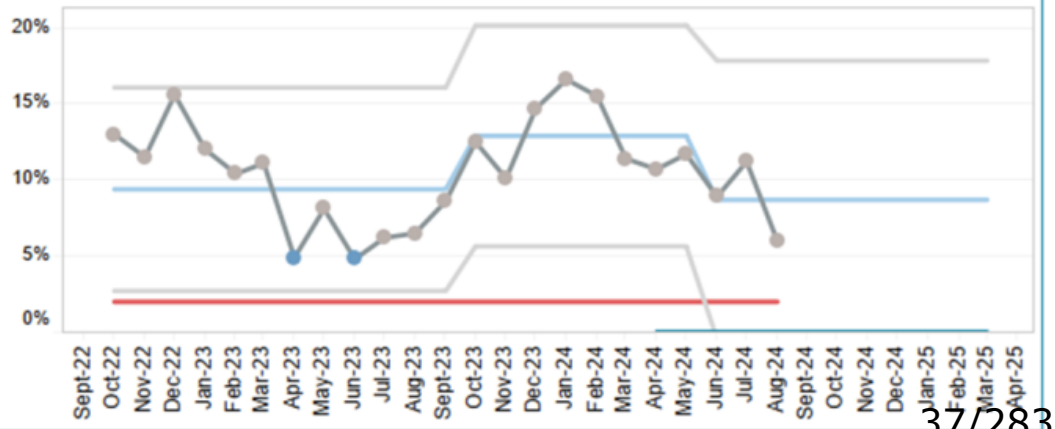
- EUCC estate changes continue to impact on operational flow of the department
- Trainee doctor rotation and induction period impacted on performance

Key Actions

- ED medical workforce recruitment to ensure no rota gaps
- Weekly Trust 4hr clinical standards performance group is in place with full specialty representation with actions to improve position
- Transformation piece of work continues to focus on front door including streaming, triage, bookable NHS 111 slots for UTC & minors and deflection
- New model - Senior Decision Maker at the front door to see & treat and reduce waiting times
- Streamlining diagnostic tests to support early decision making
- ECIST support is now in place with a follow up workshop planned for October
- SDEC escalation process trialled for straight to SDEC patients
- Preparations for internal UTC model to go live

McCarthy,Rebecca
03/10/2024 10:39:15





Signed off by	Suzanne Woolridge
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Diagnostics**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: 6 Week Standard	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	22.4%			

Performance Summary

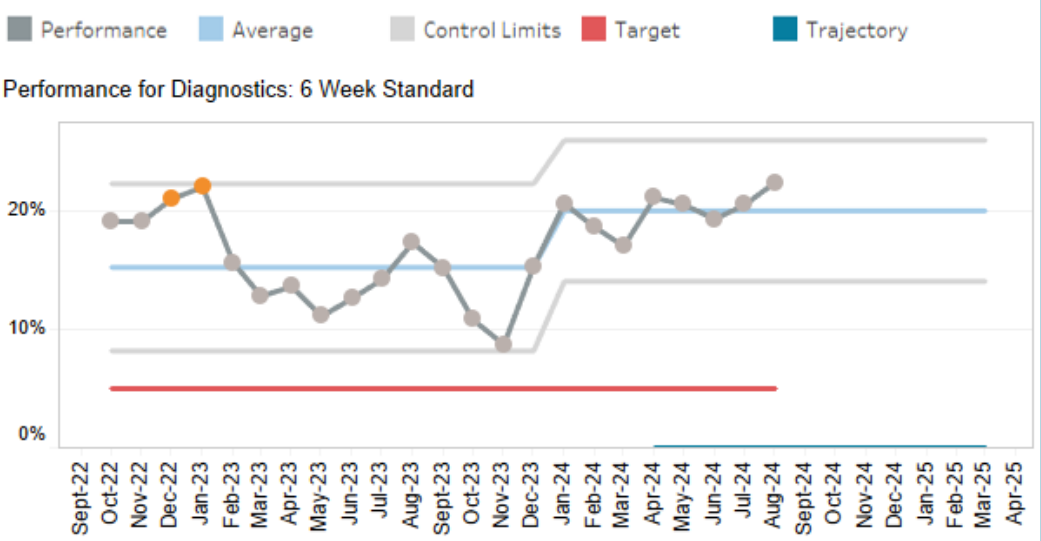
- Echo – The unvalidated August position is 628 breaches, an increase of 86 breaches compared to July.
- Echo – There has been a decrease in the uptake of WLIs from substantive staff due to annual leave and term time working (average 200+, down to 147 for August).
- Echo – Mutual Aid documentation has been completed and submitted, currently waiting outcome
- MR - Backlog has continued to decrease week on week and remains on trajectory for recovery.

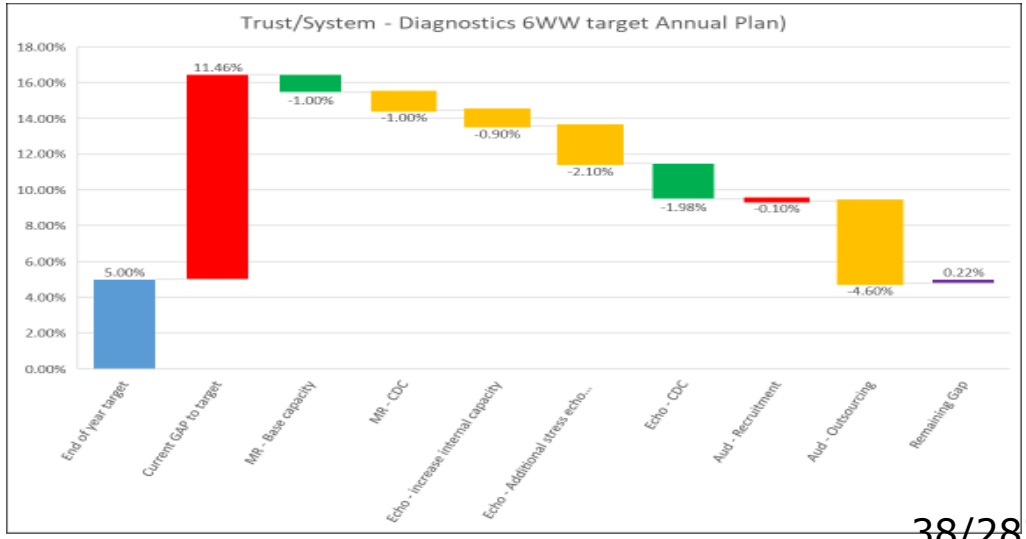
Risks and Issues

- Echo – Loss of Locum weekend working – currently reviewing options for outsourcing
- Echo – Long waiters for Cardiology are being prioritised over other DM01 patients
- Echo – CDC not meeting agreed capacity plans from August, this is impacting on trajectory
- MR – Vacancy for the MR Booking Officer role, to enable more effective booking of CDC capacity
- MR – We are seeing high cancellation and DNA rates for patients booked to attend CDC due to distance/transport

Key Actions

- Echo – Update trajectory with scenarios to secure additional lists via agency (STRESS) and also In-Health Activity figures from September onwards.
- Echo – Job plan review for Cardiology locum is underway, which will provide additional capacity for Echo
- Echo – Cardiology patient pathway review underway to enable cohorted patients to be transferred to CDC - potential to see results from October 2024.
- Echo – Admin support approved and recruitment underway - will support internal processes and recording with the patient pathway reviews
- MR – MR1 is now onsite and will be fully operational 16th September following optimisation of the protocols and staff training.
- MR – We will have 3 scanners onsite and CDC operating 16th-20th September until the relocatable (contingency) scanner is removed from site.
- MR – NHSP 3 day per week temporary CDC booking staff member in post – this should improve MR CDC booking position.
- MR – Recruitment of an MR Booking Officer, will improve utilisation of available CDC capacity





Signed off by	Suzanne Woolridge / Mike Allison
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Cancer**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on any type of cancer pathway that have received their first treatment within 62 days of upgrade or GP referral. Includes two-we..	>= 70%	76.4%	↗	▲ ● ▲ ▲ ● ●	●
Patients waiting 63 days and over	The number of patients on a cancer pathway waiting 63 days and over, split by Two Week Wait, Screening, and Upgrade.	<= 49	45	↗	● ● ● ● ● ●	●
28-day standard (FDS)	The percentage of patients that are notified whether or not they have cancer within 28 days from the date of referral.	>= 77%	75%	↘	● ● ● ● ● ▲	▲
14-day standard (2WW)	The percentage of patients on a cancer pathway that have attended their first outpatient appointment within 14 days of their GP referral.	>= 93%	96.8%	↘	● ● ● ● ● ●	●

Performance summary

- The final 62-day performance for July is 74.3% which is above the trajectory target of 70.64%. The latest performance for August is 76.4% with the final position again forecast to be ahead trajectory.
- The Trust continues to perform well against the 28-day FDS target, achieving 79.5% in July. August performance is slightly lower due to the holiday period and extended turnaround times for Radiology.
- The 63+ backlog increased in month to 45 but remains below the target level of 49.

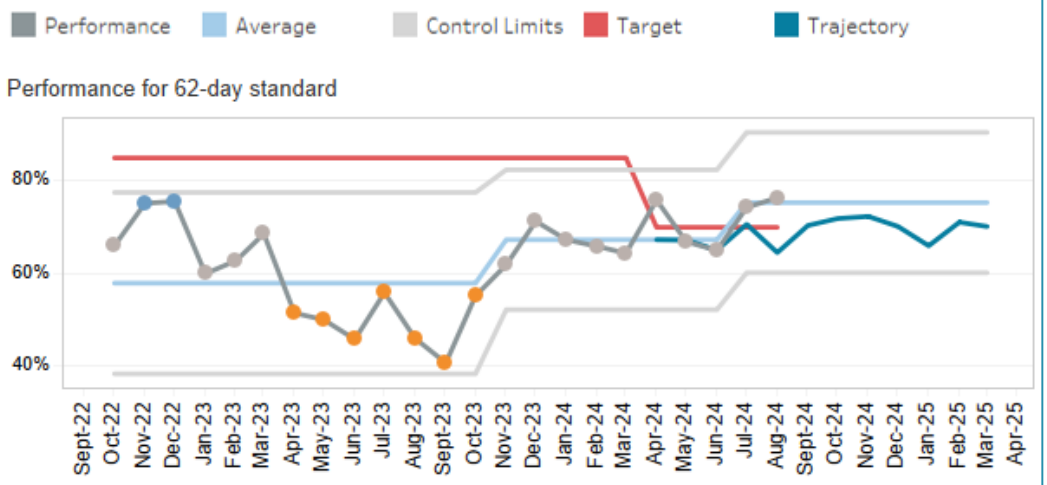
Risks and Issues

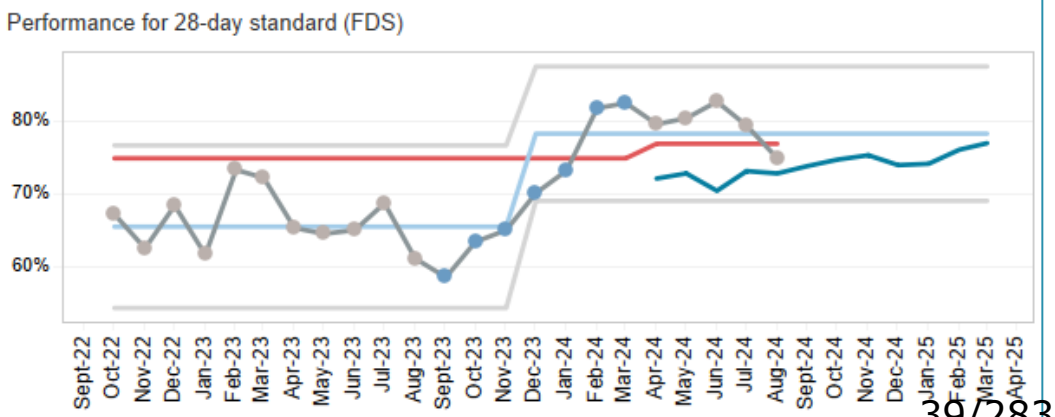
- Extended MR turnaround times have been experienced July and August due to a combination of increased demand (prostate and ENT) and annual leave. This has impacted FDS in August and may also impact 62 day in coming weeks.
- A significant increase in suspected cancer referrals has been seen in ENT (+26%) and UGI (+40%) in the first 5 months of this year.
- The Trust PAS system unavailability will have an impact on performance. Scale of impact currently unknown.
- Risks remain around sustained delivery of performance once temporary funding of key posts supported by GM Alliance come to an end.

Actions and Mitigations

- The replacement Urology Oncologist is now in post and access times have improved for this service.
- The ACP for the UGI team commenced in September. Transformation work will now follow to improve FDS.
- Radiology have successfully piloted a Navigator role for the Lung, pathway, reducing time to request to report for CT down to 3 days.
- Upgrade forms across the tumour groups have been revised and await final sign-off prior to going live.
- A Haematology workshop was held, and improvement opportunities identified.
- Haematology Clinical capacity has improved following the appointment of a locum Consultant.
- Several workshops have been held with the Colorectal team to streamline processes from MDT to treatment including pre-op, waiting list and bookings.

Update provided by	Jo Pemrick
Executive Lead	Jackie McShane





Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Referral to Treatment (RTT)**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	49.9%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
52-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	<= 3783	1916	↑	● ● ● ● ● ●	●
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	216	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

Performance Summary

- The Trust reported a position of 3 patients waiting >78 weeks at the end of Aug-24 due to patient complexity & choice factors. All patients will be treated in September.
- For 65ww, the Trust is above trajectory for end of Aug with 216 patients against a trajectory of 141. This was a reduction on the previous month (350).
- Currently behind forecast due to capacity issues in our at risk specialties (ENT, Haematology & Oral Surgery). Risks have been shared with the GM ICB & NHS England and the trust is working on mitigation plans for September with a current risk of 65 patients against the target of zero.
- For 52ww, we have 1,916 patients at the end of August, which is reduction from last month however the trusts trajectory for the end of August was 1841.
- The trust has made good progress to reduce long waits despite further industrial action at the end of June. Our comparative benchmarked position against other GM trusts is now significantly improved.

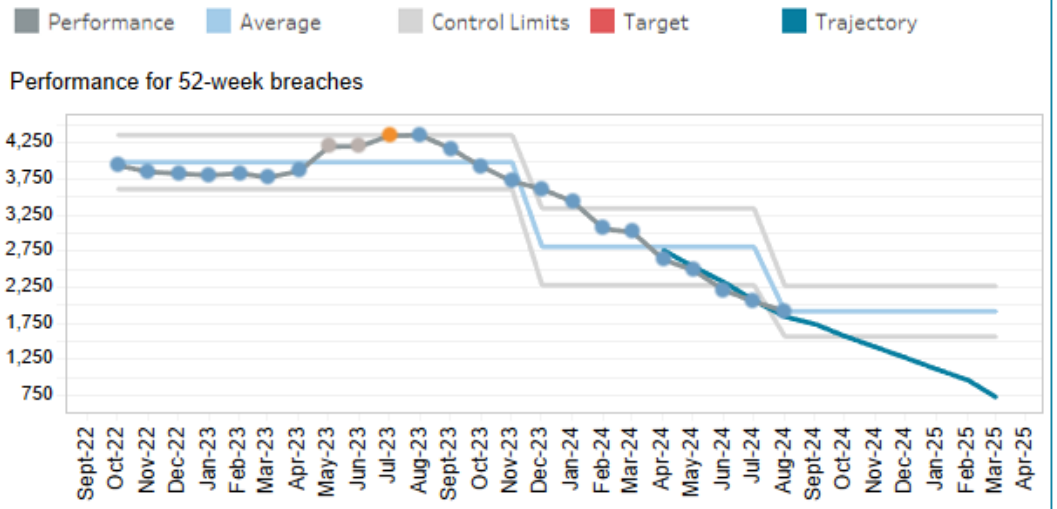
Risks and Issues

- Pathways delays due to complex diagnostic tests done at other trusts (Surgery & Gastroenterology)
- Complex elective patients >65 weeks requiring surgery before the end of September for ENT, Gynaecology & Urology
- Long wait times for 1st appointments remain across several specialties
- Capacity and wait times for diagnostic echo and the impact on cardiology long waits
- Adverse impact of EUCC construction work on theatre activity and cancelled operations
- Returns from the independent sector & data quality issues can lead to unexpected long waiter 'pop ons'
- Slippage on certain schemes to expand elective capacity in year

Actions & Mitigations

- Multiple schemes to expand elective capacity across several specialties following additional funding within the 2024-25 contract. Includes additional locum consultants and use of outsourcing/insourcing
- Additional RTT performance PTLs remain in place to drive performance & aid in expediting pathways.
- The Trust continues to work with the ICB & other GM Trusts to facilitate mutual aid opportunities.
- Ongoing independent sector outsourcing support in ENT & Ophthalmology.
- Additional validation work to cleanse the waiting list and reduce the total waiting list size.
- Initiated escalation processes for diagnostics for long waiters for internal and external (MFT)
- Further insourcing support for Gynaecology, and pursuing further independent sector outsourcing opportunities across other specialties

Update provided by	Andrew Tunnicliffe / Dan Riley
Executive Lead	Jackie McShane



Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Community**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Virtual Ward Utilisation	The number of occupied bed days in the virtual ward service, as a percentage of the available bed days in the virtual ward service.	>= 80%	50.5%			
Urgent Community Response	The total number of Urgent Community Response referrals assessed within 2 hours of referral acceptance, as a percentage of all Urgent Community Response referral..	>= 70%	95.3%			

Performance Summary:

- The Virtual ward average bed occupancy was 50.5% in August 2024, a decrease from 58.7% in July 2024
- 177 admissions and 188 discharges in August 2024 for the Virtual Ward
- The Trust continues to perform well against the Urgent Community Response 2-hour target of 70%, achieving 95.3% in July 2024. Stockport remains one of the highest performing providers within GM which achieved 86.7% in July 2024.

Risks

- Currently not meeting the 80% trajectory
- Lack of substantive Medical cover 7/7 (weekend cover)
- Financial uncertainty

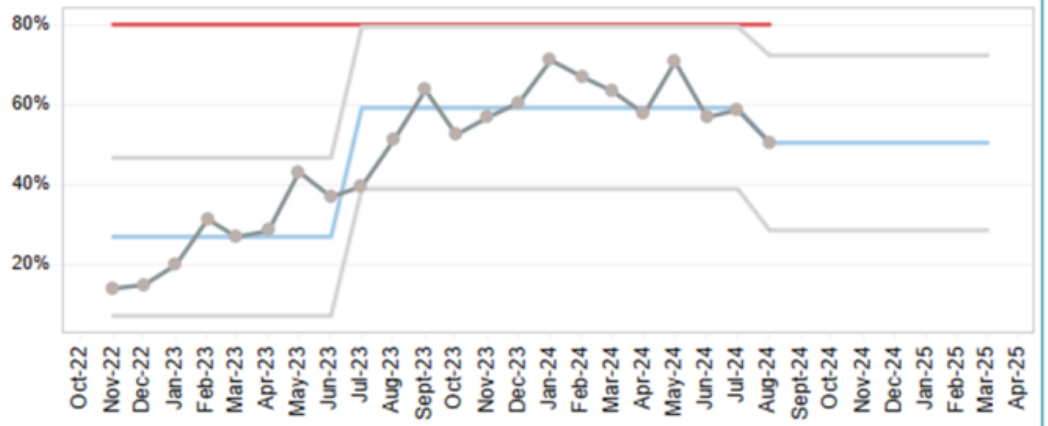
Actions & Mitigations

- Optimised communications to Primary Care with Extensivist attendance at PCN Leadership meetings to promote Step Up pathways
- Optimised communication and in reach to acute wards, MSDEC and ED supporting and promoting Step Down pathways
- Clinical pathway evaluation underway alongside Winter planning identifying opportunities to enhance the Respiratory offer
- To liaise with Blue Wards to encourage early supported discharge into VW within designated pathways

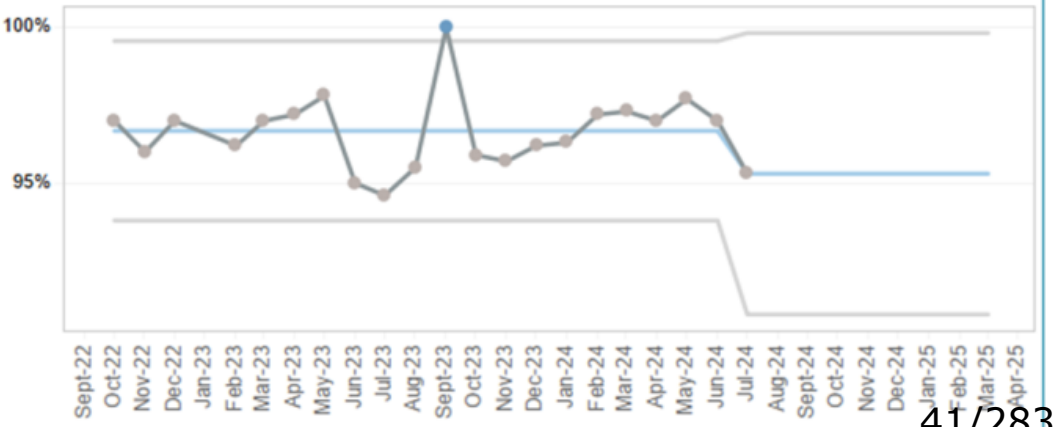
McCarthy,Rebecca 03/10/2024 10:39:15

Update provided by	Liza McIlvenny
Executive Lead	Jackie McShane

Performance for Virtual Ward Utilisation



Performance for Urgent Community Response



Operations **Outpatient Efficiencies**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	7.6%			
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	94.3%			
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 5%	4.5%			

DNA

The DNA rate has reduced in August to 7.64% from 8.35% in June. This is showing an overall improvement in the DNA rate ,with ongoing work needed to achieve the target of 6.3%.

DNA - Deep Dive Key Actions Taken

- Review of reminder service outputs from 2023 for the same months with no differences identified
- Review of invalid contact numbers high in IVR reminders . Data reviewed and system tested by supplier, no issues found
- Data quality audit of undelivered appointment reminders completed
- Ability to monitor DNA's in month. Further drill down to be developed to allow in month remedial actions
- Ability to better identify patients high risk of a DNA patient in place
- Admin SOP 's reviewed with team
- Speciality level reviews completed where DNA rates are higher

Utilisation

Overall utilisation : 94% for August . The Central Booking team at 97% with the Non Central Booking team at 91%

Utilisation Key Actions Taken

- Deep dive into June performance completed and actions taken
- Ability to monitor utilisation in month. Further drill down developed to allow in month remedial actions

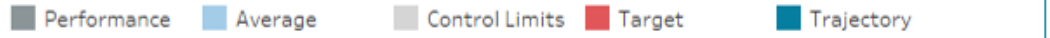
PIFU

August is 4.5%, down from 4.8% in July, with ongoing work needed to achieve the target of 5%.

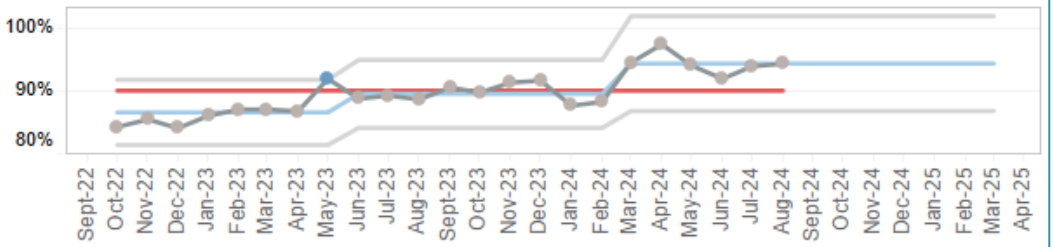
Key Actions Taken

- Specialties continue to engage with the GIRFT Further Faster initiative which is led by the Deputy Medical Director. This is helping teams look at opportunities to increase the use of PIFU. This work is ongoing to support further improvements.

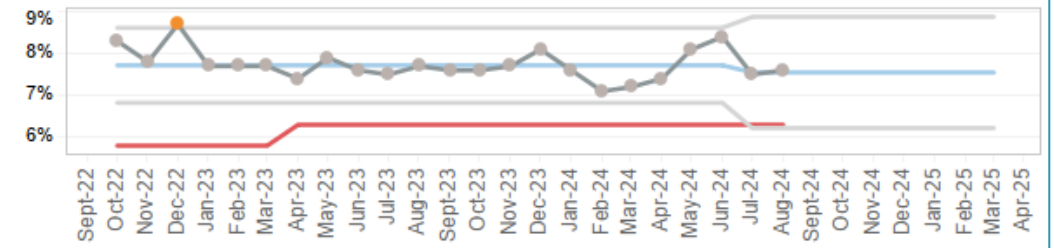
Signed off by	Mike Allison
Executive Lead	Jackie McShane



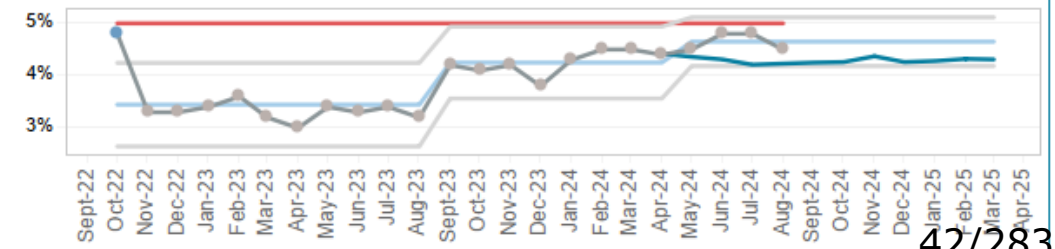
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Outpatient First and Procedures**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
OP First Attend and Procedure	The total number of outpatient attendances that are a first-attendance, or are an outpatient procedure, as a percentage of all outpatient attendances.	>= 46%	40.4%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲

To support the recovery of core services and to continue to shift the balance of outpatient activity towards clock-stopping the NHS Operational Planning Framework for 2024/25 introduced a new metric to measure the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff.

The national ambition is to achieve 46% across 2024/25, the Trust submitted an operational plan to achieve 44%.

Performance Summary

- The current year-to-date position is 42% with a deteriorating trend..
- The month of August is 40.4%.

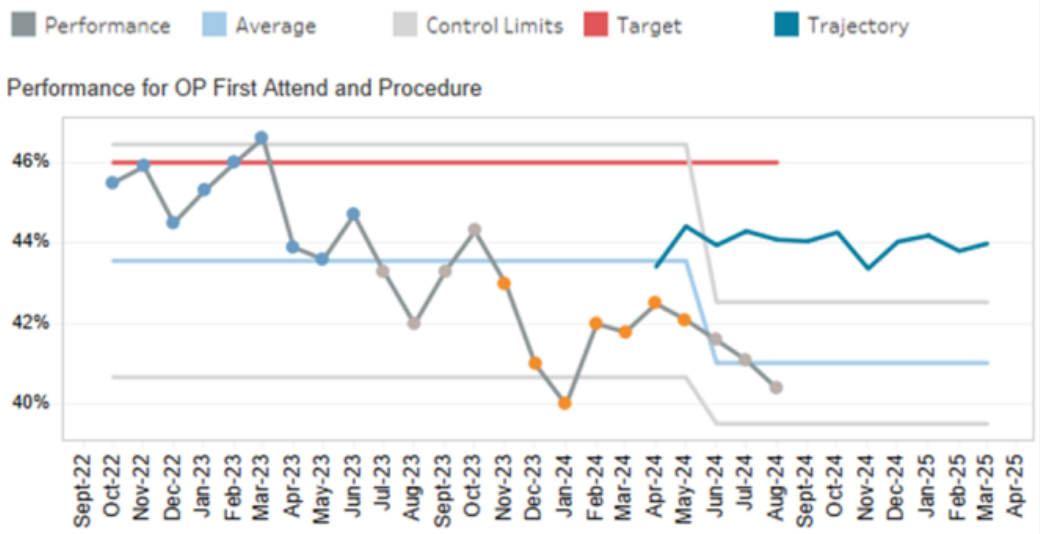
Risk and issues

- Implementation and roll-out of electronic outcome form (CLIO) may be impacting accurate recording of outpatient procedures.

Key Actions

- Deep dive into specialties showing a decline in performance compared to previous year.
- Introduction of extended timeout for CLIO may help with more complete data capture.
- Data quality reports highlighting mismatches in procedure transcribing onto PAS in development developed.

McCarthy,Rebecca
03/10/2024 10:39:15



Updated provided by	Debbie Hope
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Theatres**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded.	>= 85%	74.8%			

Performance Summary

- The latest (11/08/24 refresh) Model Health CTTU Trust performance data is 77.3% - above Peer median of 76.4%.
- Trust CTTU performance is still reporting as 2nd best in GM.
- Urology and Gynae are both achieving CTTU above Peer and National medians.
- Ophthalmology have demonstrated significant improvement in CTTU and is now exceeding Peer and National medians.
- There has increased scrutiny over underlying causes of dip in CTTU performance by specialty, resulting in clear actions for Directorate Managers and Clinical Directors.
- Daily flash reports resurrected
- There has been significant disruption to specialities throughout August due to EUCC construction activities. This has caused delays, disruption, list moves and cancellations, as well as impacting theatre efficiency, theatre performance and the elective activity plan.
- Reliability of locum anaesthetists

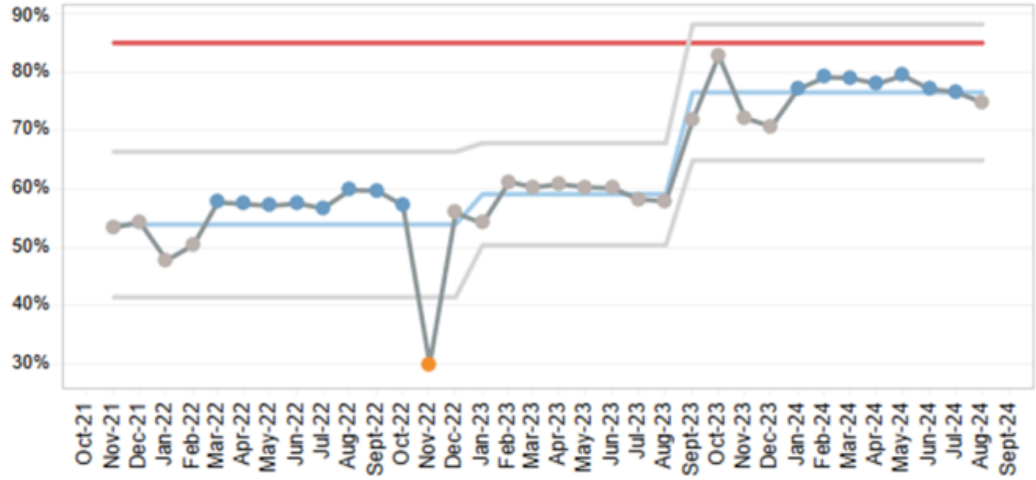
Key Risks/Issues

- Significant disruption to specialities throughout August due to EUCC construction activities. This has caused delays, disruption, list moves and cancellations, as well as impacting theatre efficiency, theatre performance and the elective activity plan.
- Reliability of locum anaesthetists

Key Actions/Priorities

- Average Early Finishes – require significant improvements
- Late Starts – require some improvements
- Intercase Downtime - unusually high; possibly linked to EUCC disruption, requiring a change theatre locations mid-session.
- Business Continuity meetings reinstated to improve communication with the capital estates team, pre-empt disruptive construction activities and plan for mitigation
- Reinstate daily theatre performance meetings to provide support and increase oversight and assurance; focus on poorly performing specialties
- Anaesthetics workforce solutions
- Elective activity recovery planning

Performance for Capped Touch Time Utilisation



Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Workforce **Sickness Absence**

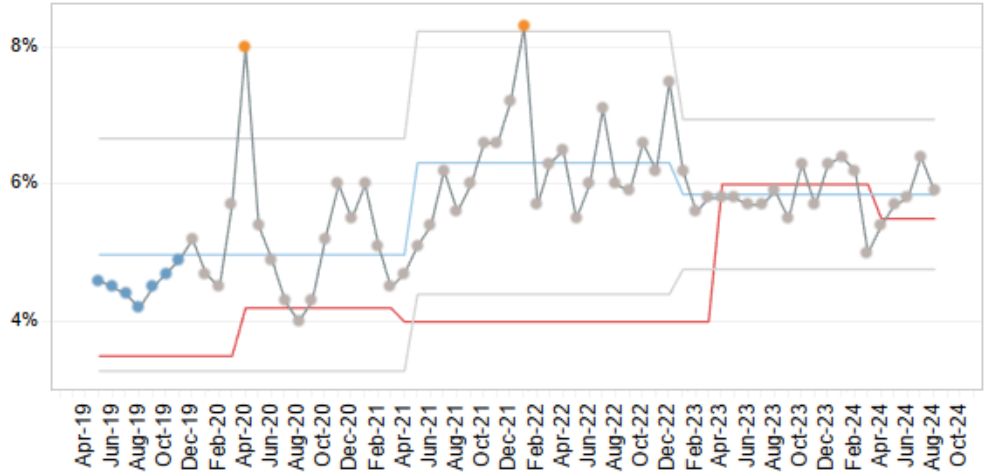
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 5.5%	5.9%			

Absence has reduced in August by 0.5% to 5.89%; following an unseasonable spike in July. Short term sickness rate 2% and Long-term sickness rate 3.87%., both showing a downward trajectory over past 12 months. Oversight by the Deputy Director of People & OD with divisional senior managers & complex case reviews, has demonstrated improvements in the number of those absent the longest & improvement in the numbers absent 1-6 months.

Continue with approach to management of absence, via HR monthly meetings with line managers, ensuring adherence to policy & supporting person-centred approach. Absence reporting and improvement trajectories via, performance management and assurance to People Performance Committee and Board.
Participation in GM sickness absence peer review group.

Continuation of health and wellbeing initiatives, including Occupational Health, Staff MSK Service, Promote Access to Work mental health support, Staff Psychological Wellbeing Service and Staff Menopause service to support staff to remain in work, reduce the length of their absence and return to work as soon as possible, including with reasonable adjustments in place.

Performance for Sickness Absence: Monthly Rate



McCarthy,Rebecca
03/10/2024 10:39:15

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Workforce **Agency Costs %**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Agency Costs % — Total agency costs, as a percentage of total PAY costs.	<= 3.2%	3.3%			

In August 2024, 3.4% of the total pay bill related to agency usage, above the target of 3.2% but an improved position against the previous month; this is the second month we have not achieved the target in 2024/25. The percentage of bank versus agency spend was 74.5% bank, however, the number of bank shifts compared to agency shifts was 85.56%, which is above the GM target of 75%.

The YTD position is 3.3% of the total pay bill related to agency usage which is an unchanged position from the YTD figure in July 24. However, this is an improvement on the to the YTD position in August 2023, of 5.9%.

The Agency Price Cap Compliance has increased from 52.5% in July to 53.4% in August. The average price cap compliance over the last 12 months is 48%, compared to 29.2% over the previous 12 months. The price cap compliance rate recommended by NW NHSE is 60%. The main drivers for the non-compliance with the price cap are the agency rates and the ongoing need for agency staff in difficult to recruit to posts. Compliance with the price cap was an area of focus at August's Workforce Efficiency Group meeting and Divisions have been provided with their breakdown and asked to identify a trajectory of improvement.

Divisional expenditure for agency usage has decreased across all divisions, except for Surgery and Corporate, which have seen slight increases. These increases are mainly due to increased use of Registered Nurses across the Surgical division and continued use of Clinical Coders within Informatics.

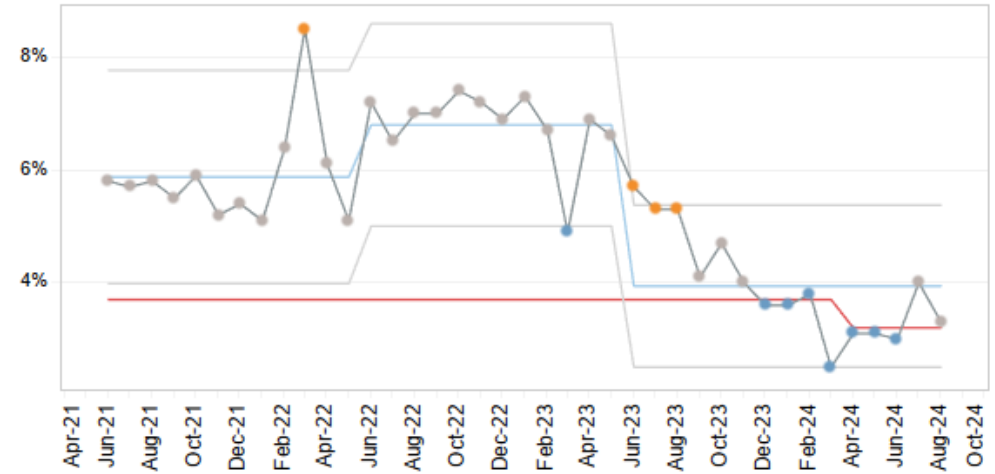
Workforce Efficiency Group (WEG) continues to focus on temporary staffing spend, with a 'deep dive' on price cap non-compliance and the 'enhanced NHSP rate' review scheduled for October.

Engagement with NHSP Gateway Service has commenced, this service aims to deliver IMG Doctors from Foundation equivalent to Consultant, all Gateway Doctors are 'net new' to the NHS. We are exploring the opportunity to appoint doctors to our JCF and SCF gaps, as well as scoping CESR opportunities for hard to recruit to specialties.

We have shifts live with NHS Emeritus for several long-term Consultants, and the Emeritus team are working to identify suitable placements to replace the agency workers, where possible.

We are engaged collaboratively with Tameside Integrated Care NHS Foundation Trust and our direct engagement providers Liaison to undertake an exercise with agencies to reduce rates and agree a standardised approach to commission, which will improve our compliance with the price cap.

Performance for Agency Costs %



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Workforce **Turnover**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.7%	12.81%			

The annualised turnover rate to August 2024 was 12.81% and is an increase of 0.03% compared to July 2024, however, this is a reduction compared to June 2023 (14.56%) Whilst there has been a small upturn in turnover rates over the last quarter, there is an overall improvement trajectory demonstrated throughout the year.

Integrated Care has the highest turnover rate of 15.74%, followed by Medicine & UC (13.87%). CSS has the lowest turnover rate (10.64%). The Additional Clinical Services staff group has the highest turnover rate with 16.73%, however, this has reduced from 17.64% from the last 12 months. Retirements (excluding flexi retirement) accounted for 10.85% of leavers in the last 12 months

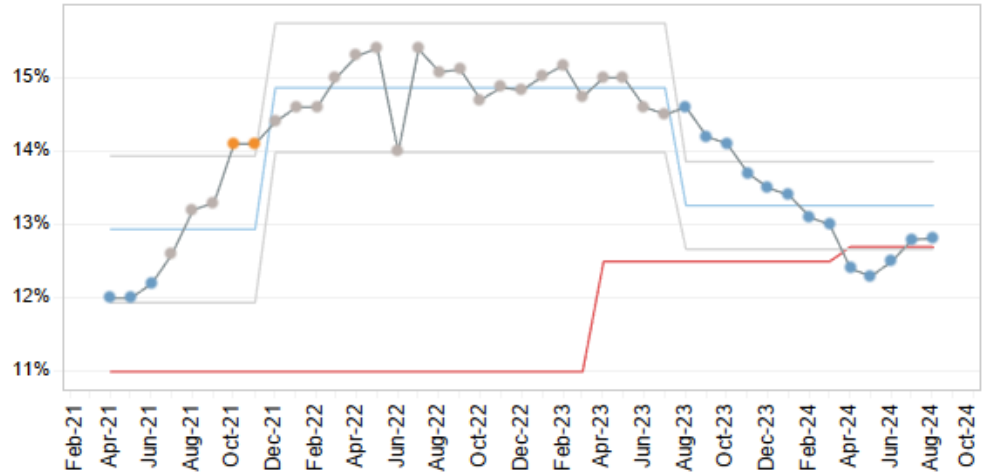
Our top reasons for leaving are Work Life Balance and Relocation, both reasons account for 17% of all leavers, followed by Career Development (including promotions, lack of opportunities and pay and reward related) at 16% and retirements at 12%, of which 57% of retirements are flexible retirements. In the last year, 23 international nurses have emigrated predominantly to Australia for better pay and terms and conditions.

Recently, we have carried out a review of the exit interview process and made improvements to increase the response rate and therefore the value of the data received, which will provide richer data than it is possible to capture through the narrow categories recorded via our Electronic Staff Record (ESR). We have also expanded our data capture to include demographic information to ascertain whether there are any groups which are being disproportionately impacted by their experiences.

Iimproving the retention rates of these staff groups is a priority area, they are the staff groups with many entry level posts and so a higher level of leavers may be anticipated where staff are moving for development opportunities or to undertake training, for example. To understand this in greater detail we will be undertaking a 'deep dive' into these staff groups to identify initiatives which may assist in reducing our attrition rates and presenting our findings to our People, Engagement and Leadership Group.

In line with our OD Plan, we have commenced the facilitation of our 'Curiosity Café's' enabling participation from staff to come and talk about their career journeys, their experience of development opportunities and providing valuable insight unavailable through the staff survey.

Performance for Workforce Turnover



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Workforce **Appraisal Rates**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	89.4%			

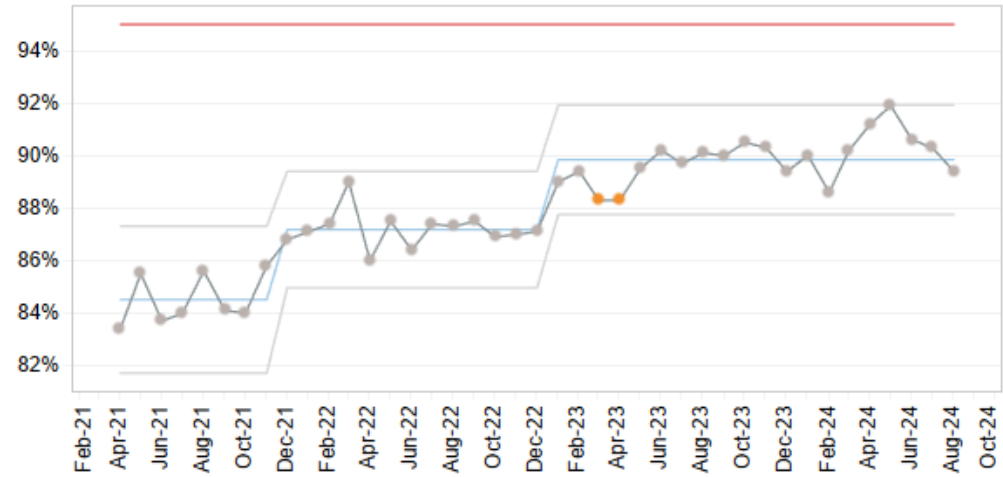
Consolidated appraisal compliance currently stands at 89.4% and performance is on a downward trajectory. Divisions have provided recovery trajectories though August's performance meetings.

We have had new paperwork since 1st June 24, and we are phasing a self-submission process for colleagues to input their own appraisals which may be causing a delay in appraisal reporting.

Performance Appraisal training has been adapted to support colleagues with the self-reporting process. The OD Team is developing a digital 'access any time' training offer.

McCarthy,Rebecca
03/10/2024 10:39:15

Performance for Appraisal Rate: Overall



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

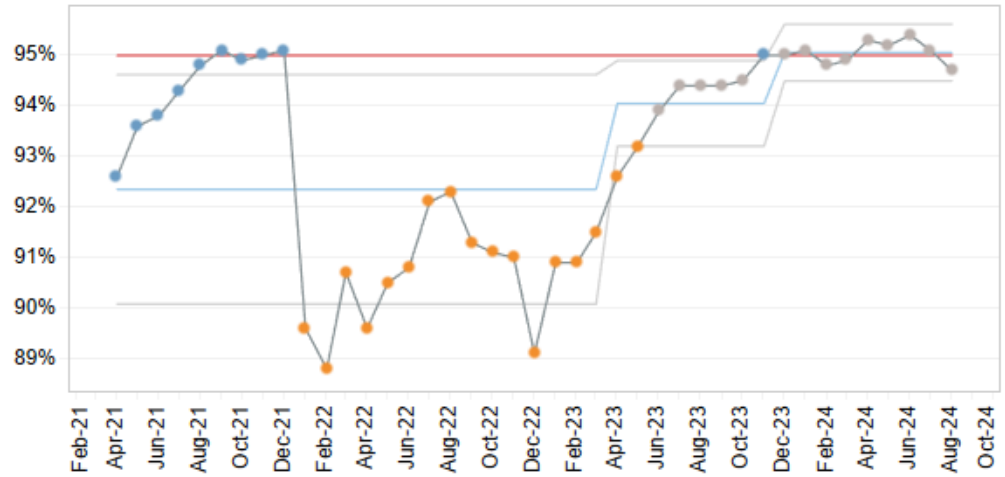
Workforce **Mandatory Training**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Mandatory Training — The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	94.7%			

Our compliance has decreased by 0.3% to 94.7% in month. This has been impacted by the summer period and holidays. Divisions have provided recovery trajectories though August's performance meetings.

After undertaking a deep dive into areas of poor compliance the Learning & Education Team are working with educators in these divisions to improve the current position, including continue to work with managers to book training alongside rosters, providing text reminders and compliance reports.

Performance for Mandatory Training



McCarthy,Rebecca 03/10/2024 10:39:15

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Finance

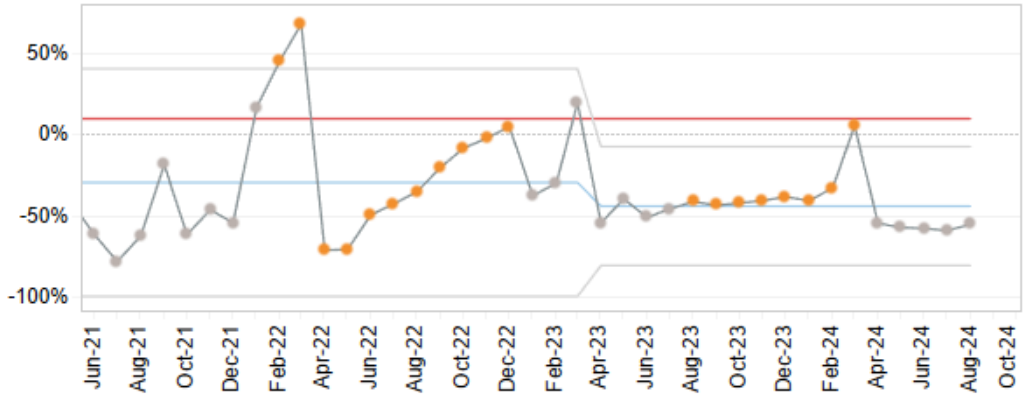
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	-0.4%		▲ ● ● ▲ ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		4.8			
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	20.5%		● ● ● ● ● ●	●
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-55.2%		● ● ● ● ● ●	●

Risks

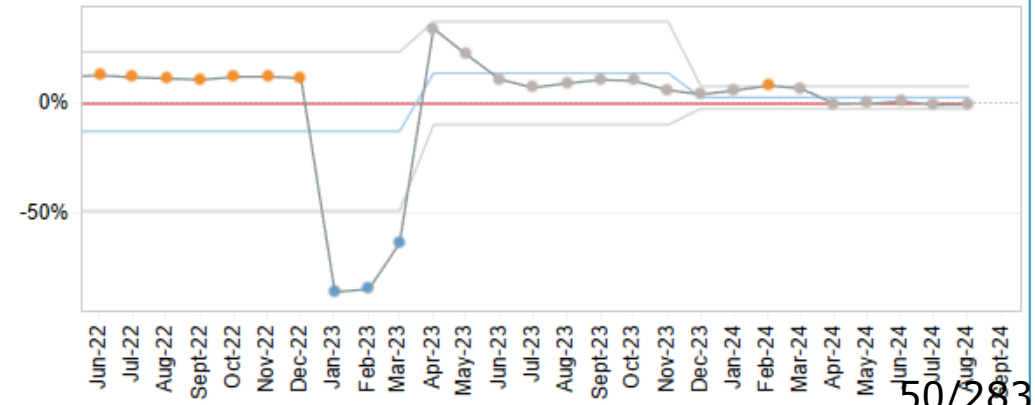
- Cash remains one of the biggest risks for 2024-25. No cash support is required for August; however, support will be required for the remainder of the year via the monthly resubmissions process. The cash forecasts will be updated following confirmation of the pay award values and funding arrangements of the award but are highly likely to drive up the Trust's cash requirement. Cash remains one of the biggest financial risks for 2024-25.
- Capital - Continuing to progress schemes that were part of the original non-compliant plan will now result in a gap of some £21.7m between current available funding and expenditure. This will present further challenges with cash management.
- The pay award has been announced by the government for both medical and agenda for change staff and is considerably higher than the 2.1% set in the annual plan. This will cause a financial challenge if this is not fully funded both from a budgetary and cash position.
- Additional costs and loss of activity due to industrial action has not been included in the planning process. At this point no further industrial action is planned but if this does occur will further impact on activity, expenditure, and cash.
- The STEP target for 2024-25 has been set at 5% (£24.6m), with 50% recurrent. Delivery of this level of savings is challenging for the Trust in year and recurrently; however, all schemes considered continue to be assessed through the Quality and Equality Assessment process.

McCarthy,Rebecca 03/10/2024 10:39:15

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Signed off by	Kay Wiss
Executive Lead	John Graham

NHS
Stockport
NHS Foundation Trust

				Agenda No.	9.1
Meeting date	**3rd October 2024**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Financial Position Month 5 2024/25				
Director Lead	John Graham Chief Finance Officer	**Author**	Kay Wiss Director of Finance		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to receive the Financial Position Report for Month 5 2024/25, to update on the current financial position in support of the Integrated Performance Report.					

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led	X	Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	n/a
Financial impacts if agreed/not agreed	Whole paper
Regulatory and legal compliance	Whole paper
Sustainability (including environmental impacts)	n/a

Executive Summary

The Trust has a deficit of £22.4m at Month 5 (August) 2024/25, which is an adverse variance of £0.1m to plan. A detailed finance paper was presented to the Finance & Performance Committee on the 19th September 2024 and this paper is the summarised key extracts from that paper. The key driver of the variance are unfunded industrial action costs.

The Trust has delivered savings of £5.0m at Month 5 which is £0.9m ahead of plan; the savings plan for the year is weighted towards the second half of the financial year and focus remains on delivering recurrent savings. The total plan for 2024/25 is £24.6m.

The forecast remains to deliver the financial plan for 2024/25 subject to risks highlighted within the paper

The Trust cash position remains at 25 on the significant risk register and whilst cash borrowing was not required in August 2024, further borrowing was drawn in September 2024.

Temporary staffing costs via an agency have remain above the 3.2% target at 3.5% in August but this is improved from the position in July 2024. This remains one of the key focus areas within the financial plan and is overseen by the Workforce Efficiency Group.

The Trust has spent £4.1m against a capital plan of £4.3m to date; costs have been incurred on the Emergency Care Campus, the MRI scheme and the essential network cabinet refresh.

NHS
Stockport
NHS Foundation Trust

Board of Directors

Financial Performance
Month 05 (August)

John Graham
Chief Finance Officer

Contents

Stockport NHS Foundation Trust

1. Overall Financial Position M5 2024-25

Stockport NHS Foundation Trust

Income & expenditure Position	In-Month			Year to date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Total Income	**37.1**	**36.7**	**(0.4)**	**180.4**	**181.2**	**0.8**	**432.2**	**433.9**	**1.7**
Substantive Staff	(24.8)	(24.2)	0.6	(122.6)	(122.6)	0.0	(284.1)	(288.6)	(4.5)
Bank Staff	(3.0)	(3.0)	0.0	(14.6)	(14.2)	0.4	(35.4)	(32.3)	3.0
Agency Staff	(1.3)	(1.0)	0.3	(6.4)	(4.7)	1.7	(14.8)	(9.9)	4.9
Pay Costs	(29.1)	(28.2)	0.9	(143.7)	(141.5)	2.1	(334.2)	(330.8)	3.5
Drugs	(2.3)	(2.0)	0.3	(10.0)	(10.0)	0.0	(23.6)	(23.5)	0.1
Clinical Supplies & Services	(2.3)	(2.6)	(0.3)	(12.9)	(14.1)	(1.2)	(31.6)	(33.5)	(1.9)
Other Non Pay Costs	(5.6)	(6.2)	(0.5)	(24.7)	(26.4)	(1.7)	(58.1)	(61.3)	(3.2)
Below the Line	(2.3)	(2.3)	0.0	(11.5)	(11.5)	0.0	(28.7)	(28.6)	0.1
Total Expenditure	**(41.6)**	**(41.2)**	**0.4**	**(202.8)**	**(203.5)**	**(0.7)**	**(476.2)**	**(477.7)**	**(1.5)**
TRUST SURPLUS / (DEFICIT)	**(4.5)**	**(4.5)**	**(0.0)**	**(22.5)**	**(22.4)**	**0.1**	**(44.0)**	**(43.8)**	**0.3**
Add back Donations of cash for charitable assets	-	-	-	-	(0.3)	(0.3)	-	(0.3)	(0.3)
Remove capital donations/grants/peppercorn lease I&E impact	0.0	0.0	0.0	0.1	0.1	0.0	0.2	0.2	0.0
Remove PFI revenue costs on an IFRS 16 basis	0.1	0.2	0.0	0.7	0.8	0.1	1.7	1.8	0.1
Add back PFI revenue costs on a UK GAAP basis	(0.1)	(0.2)	(0.0)	(0.7)	(0.7)	(0.0)	(1.7)	(1.7)	(0.1)
Adjusted financial performance surplus/(deficit) for the purposes of system	**(4.5)**	**(4.5)**	**(0.0)**	**(22.3)**	**(22.4)**	**(0.1)**	**(43.8)**	**(43.8)**	**0.0**

1. Overall Financial Position

NHS Stockport NHS Foundation Trust

- The Trust has a deficit of £4.5m in month and £22.4m year to date which is adverse to plan by £0.1m. This is due to the cost of industrial action and ERF under performance being offset by CIP delivered ahead of the profiled plan, as shown in the below table:

Variances to plan £m	In Month	YTD
Industrial action	-	(0.6)
CIP ahead of plan	0.4	0.9
ERF under achievement	(0.4)	(0.4)
Total variance to plan	-	(0.1)

- The Trust forecast position at month 5 is in line with the annual plan that has been submitted to GM and nationally – a year end deficit of £43.8m.

- The STEP target at month 5 is £4.1m of which 50% is recurrent. The STEP target has overachieved in month 5 by £0.9m, however at this point most of the savings are non-recurrent. £13.3m (54%) of the full year £24.6m CIP target has been delivered in year, however only £3.4m (28%) of the recurrent target. Delivery of recurrent CIP is the key financial focus for the Divisions.

3. Key Risks within the Financial Position

NHS Stockport NHS Foundation Trust

Financial Plan

- The Trust has submitted a 24/25 deficit plan of £43.8m. It is expected that NHSE will issue a cash backed non-recurrent funding allocation to the system equating to £175m, resulting in a balanced plan overall. The Trust assumes cash will be distributed to providers and is anticipating c.£44m. If this is not achieved, the Trust will not deliver the planned improvements in PDC of £0.9m as a consequence and will require further PDC revenue cash support to fund the deficit plan.
- The STEP target for 2024-25 has been set at 5% (£24.6m). Delivery of this level of savings will be a challenge for the Trust in year; however at this stage full delivery is planned.

Capital

- The capital position is extremely challenging. The Trust has resubmitted the capital plan for 2024-25, and now has a compliant plan totalling £29.1m including £3.5m for IFRS16. Continuing to progress schemes that were part of the original non-compliant plan will now result in a gap of £21.7m between funding and expenditure. This will also present challenges with cash, as the Trust's cash position would not be able to support this additional expenditure without external support.

- A national decision backed by the ability to make payment is urgently required on The Meadows PFI. Payment must be made to Walker Healthcare in September 2024. If £6.0m cash were received to support this purchase the pressure would reduce to £15.7m.

3. Key Risks within the Financial Position

NHS Stockport NHS Foundation Trust

Cash

- Cash remains one of the biggest risks for 2024-25. No cash support was required for August; however, support will be required for the remainder of the year via the monthly resubmissions process. The cash forecasts will be updated following confirmation of the pay award values and funding arrangements of the award but are highly likely to drive up the Trust's cash requirement.

Elective Recovery Fund / Contracts/ Future Funding Flows

- The risk of non-delivery of activity in accordance with ERF is still unclear and whilst an indicative target has been given, the phasing of the plan continues to be discussed. There is also an improvement in activity expected in the second half which could also improve the position. The GM position on transacting ERF performance is also not confirmed at this stage.

- The Trust requires commitment from GM ICB regarding the work of the Future Funding Flows to resolve the significant underpayment against block contract for clinical activity delivered by the Trust. The Trust view is this is substantial and is one of the key drivers to the Trust Deficit in 2024/25. The PWC team assigned to Stockport to lead on this workstream started w/c 12th August.

3. Key Risks within the Financial Position

NHS Stockport NHS Foundation Trust

Other

- Estate risk - The limited availability of capital given the condition of the estate at Stockport presents a higher revenue risk from both and expenditure perspective and a loss of income. There are particular critical infrastructure risks which were known when the plan was submitted but without investment are leading to a further deterioration in the site. This increases the risk to further failures of the estate potentially impacting on service delivery and unplanned expenditure including temporary staffing costs.

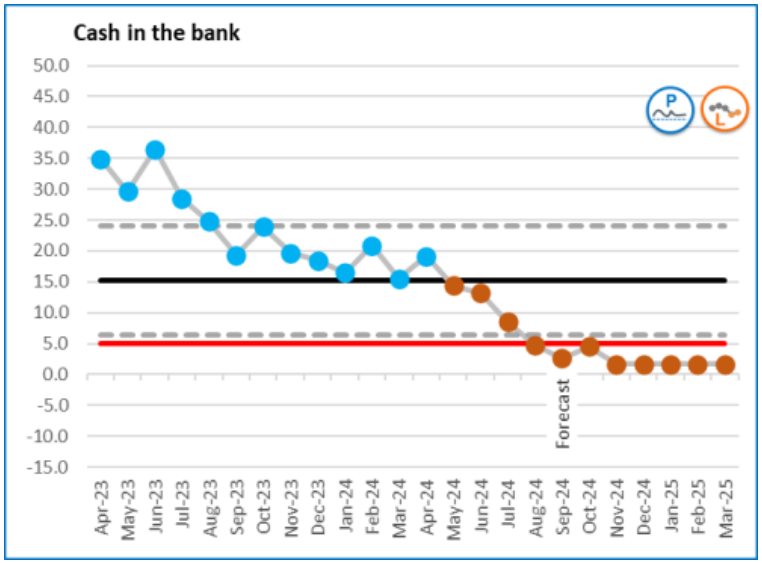
- Industrial action - Additional costs and loss of activity due to industrial action was not included in the planning process. As the junior doctors took industrial action in June and July this has impacted activity, expenditure and cash. It is not clear if funding will be made available nationally to cover any of the costs. Whilst the cost of the action in June and July has been included £0.6m, the forecast does not include any further costs as per NHSE instruction.

Pay award

- Further guidance is awaited on the funding for the Agenda for Change Pay award and Medical Pay awards which are due to be paid in October and November 2024. The pay awards are in excess of the instructed planning assumption and therefore additional costs will be incurred in the range of £12.4m to £14.1m above plan. The Trust will also require cash to support the pay award.

4. Cash

a. Cash Position



Cash at the end of August was £4.8m a reduction from £8.5m in July.

Capital Creditors at the end of August were £4.3m.

No revenue support was requested for August; however, an application for £8.5m of revenue support has been made for September, which will bring the total revenue support year-to-date to £15.6m.

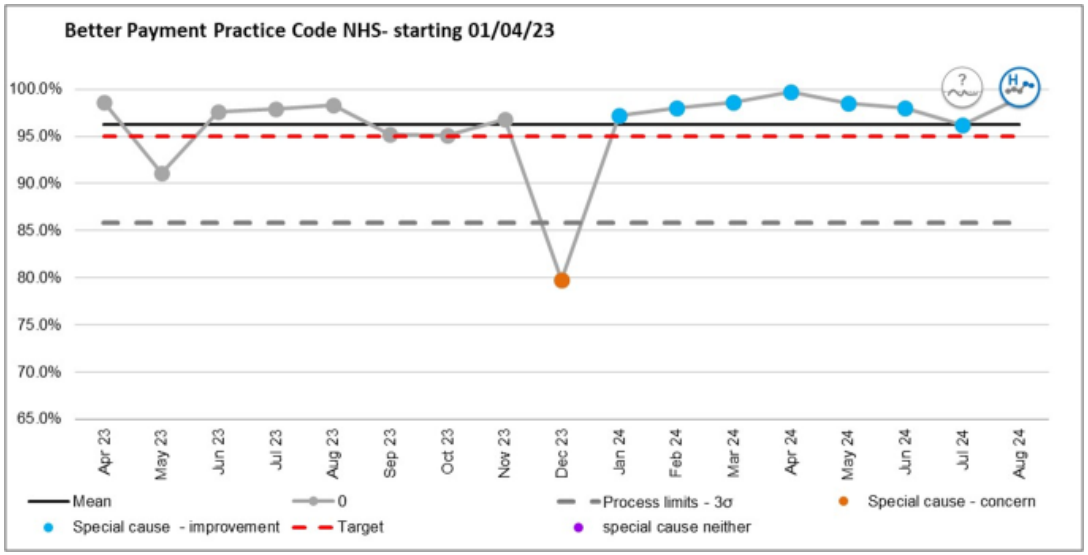
Discussions are underway regarding cash for the purchase of The Meadows, with receipt of £6m capital support assumed in September.

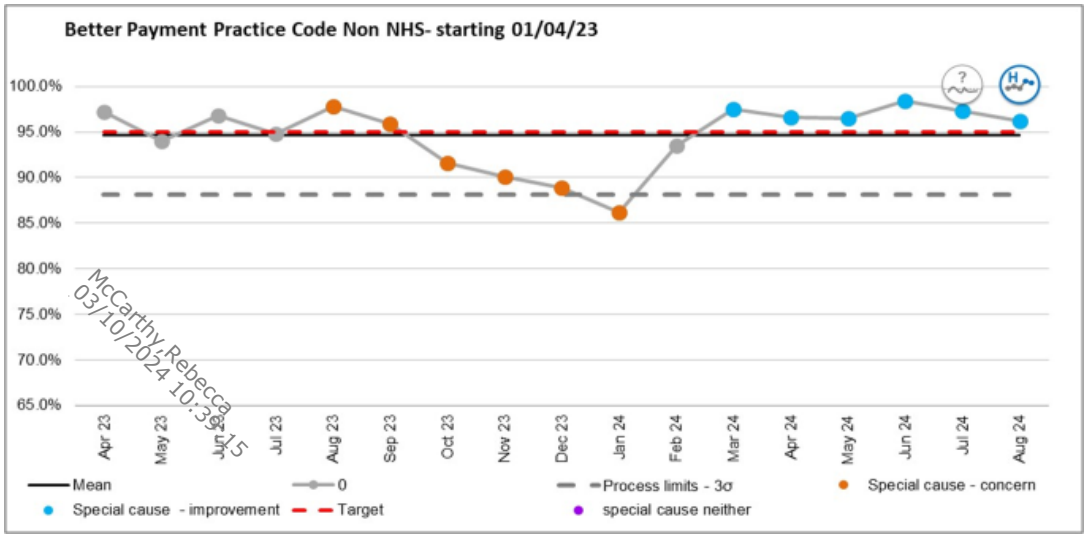
The pay award and arrears are expected to be paid in October and November, with information regarding additional funding for the award yet to be confirmed.

Cash balances for the remainder of the year are expected to be at the minimum cash balance of £1.7m and will be monitored closely by the Cash Monitoring Group. The cash score remains at 25 on the significant risk register

4. Cash

b. Better Payment Practice Code





The Better Payment Practice Codes (BPPC) sets the target for 95% of all valid invoices to be paid within the agreed timeframe.

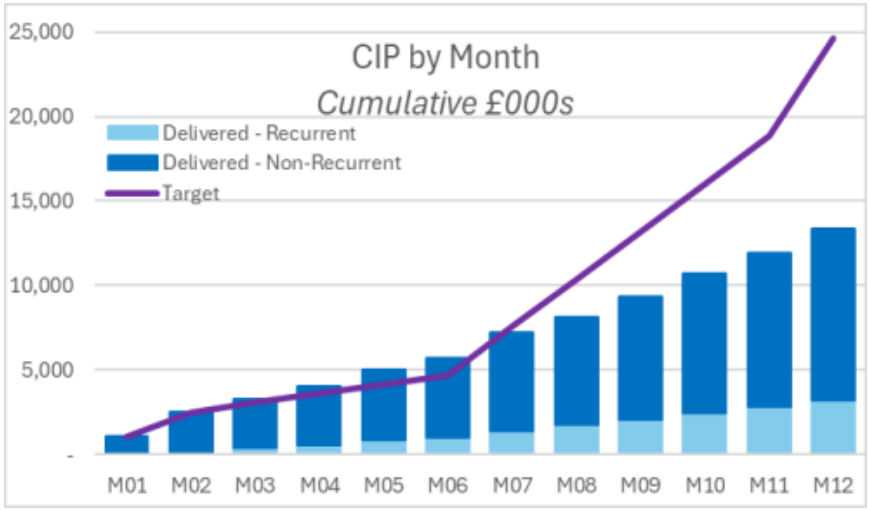
Performance against the standard is reported for both NHS and non-NHS invoices, as shown in the charts.

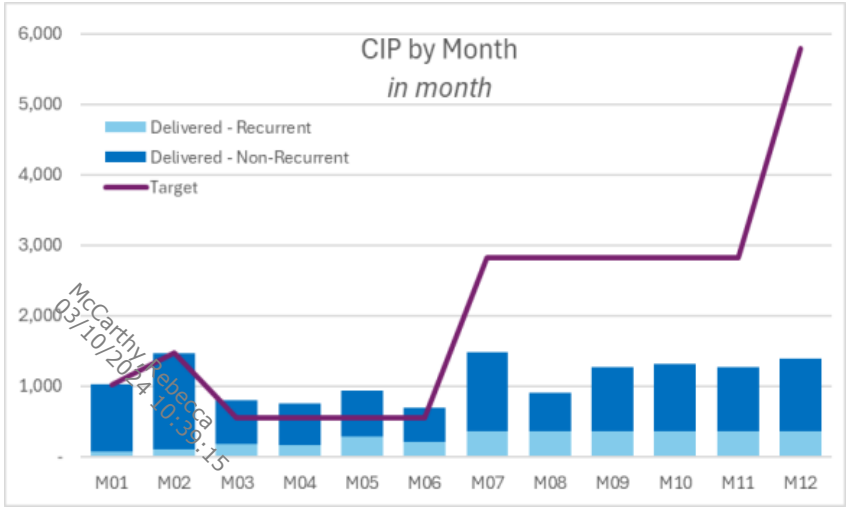
Performance has consistently continued to be above the target in August.

5. Key Drivers of the Financial Position

a. STEP (Stockport Trust Efficiency Programme)

Stockport NHS Foundation Trust





The Trust STEP target for 2024-25 is £24.6m. This is split evenly between recurrent and non-recurrent savings. The target is split £19m across the divisions with £5.6m technical.

The target to month 5 is £4.1m of which 50% is recurrent. Trust has delivered £5.0m to date and so is ahead of the plan by £0.9m; however, only 16% is recurrent.

The total actioned full year is £13.3m (54% of £24.6m target) of which £3.2m (24% of £12.3m target) is recurrent. This is an improvement in full year by £3.2m but only £0.1m recurrent.

Forecast technical CIP has already been included in plans, the shortfall in year delivery remains with the divisions.

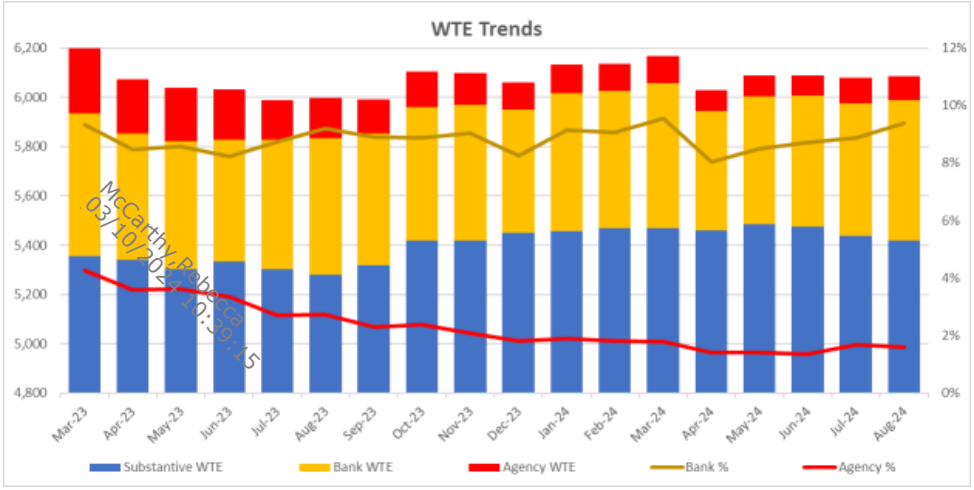
There are series of actions in place to improve the performance position including expediating PIDs and exploring additional options to mitigate the forecast presented as this is worst case scenario.

5. Key Drivers of the Financial Position

b. Staff and WTE reconciliation - WTE

Stockport NHS Foundation Trust

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	*Bank %*	*Agency %*
Aug-24	5,417	572	96	6,085	*9%*	*1.6%*
Jul-24	5,437	539	102	6,078	*9%*	*1.7%*
Jun-24	5,477	531	83	6,090	*9%*	*1.4%*
May-24	5,484	518	85	6,088	*9%*	*1.4%*
Apr-24	5,460	484	85	6,029	*8%*	*1.4%*
Mar-24	5,468	589	110	6,166	*10%*	*1.8%*
Feb-24	5,469	557	111	6,136	*9%*	*1.8%*
Jan-24	5,456	560	115	6,132	*9%*	*1.9%*
Dec-23	5,450	501	110	6,060	*8%*	*1.8%*
Nov-23	5,419	550	128	6,097	*9%*	*2.1%*
Oct-23	5,419	542	145	6,106	*9%*	*2.4%*
Sep-23	5,319	533	139	5,991	*9%*	*2.3%*
Aug-23	5,280	552	164	5,997	*9%*	*2.7%*
Jul-23	5,303	523	161	5,987	*9%*	*2.7%*
Jun-23	5,333	495	202	6,031	*8%*	*3.4%*
May-23	5,303	518	218	6,040	*9%*	*3.6%*
Apr-23	5,339	515	218	6,072	*8%*	*3.6%*
Mar-23	5,356	579	265	6,200	*9%*	*4.3%*



There has been a slight increase in total wte in August compared to July, but both still represent a reduction from March 2024.

In August there has been a further decrease in substantive staffing. This is across all staff groups and all divisions.

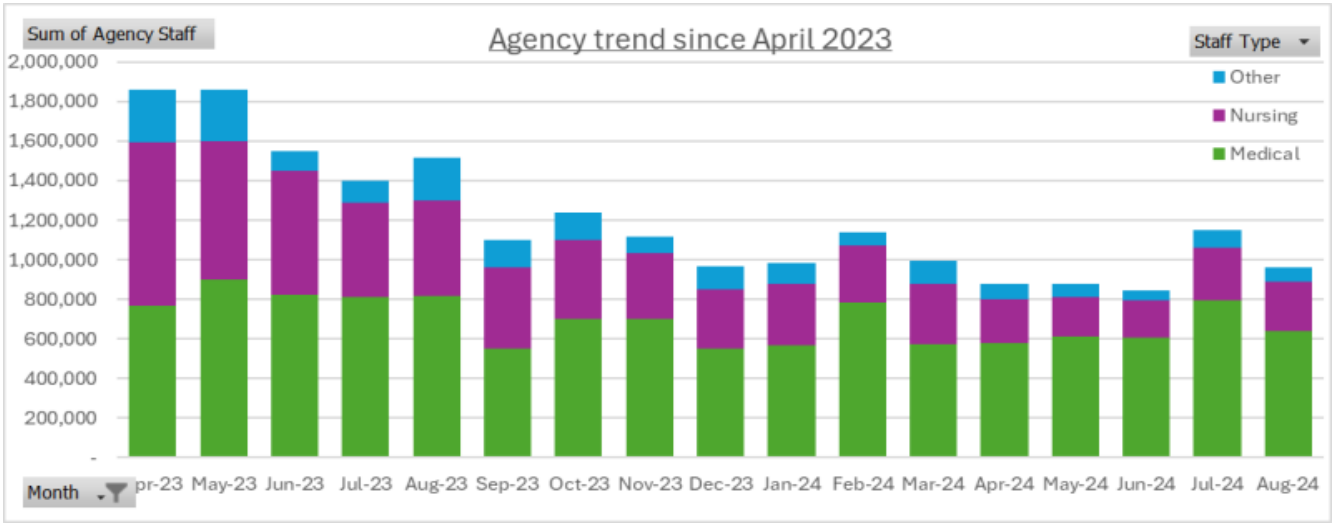
There has been a small decrease in agency in month 5. Following WEG further deep dives are taking place to understand the reasons for this and the forecast for the remainder of the year, with work on a post by post basis underway for long-term agency medical staff.

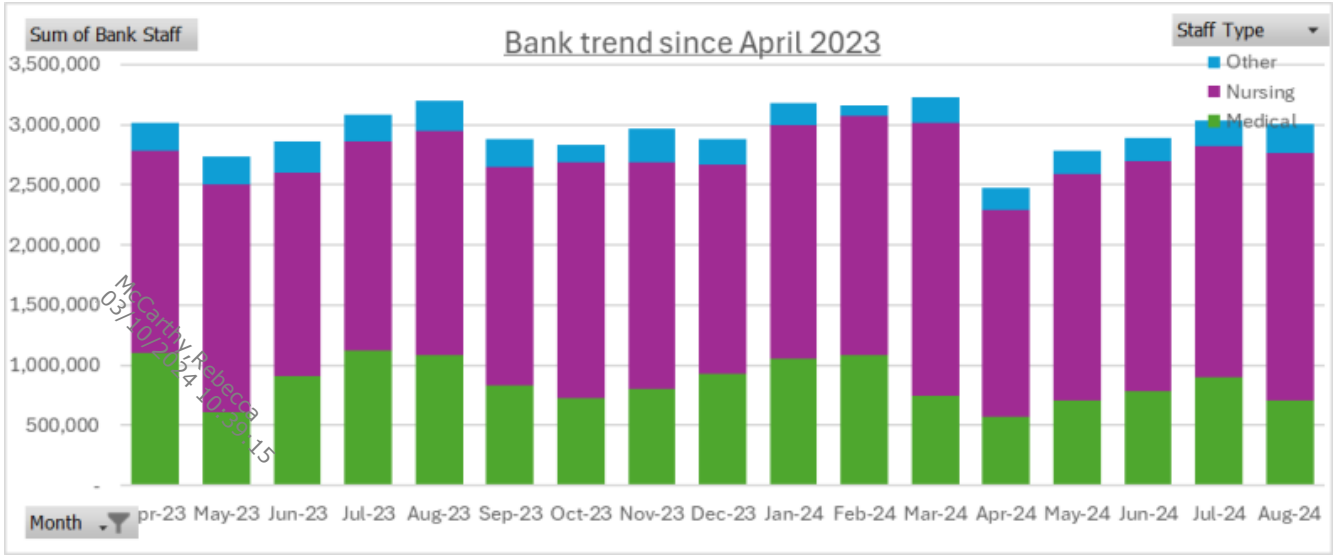
Agency costs are now 3.4% as a percentage of total costs in month which is now above the 3.2% target level. This is the second month the Trust has been above this target.

Bank usage has remained relatively steady over the same period on average at 9% of WTE worked. Bank continues to be used to cover enhanced care, vacancies and sickness cover.

5. Key Drivers of the Financial Position

b. Staff and WTE reconciliation - £





Agency costs have reached a plateau level since the decrease seen in 2023/24. Costs have increased in Month 4 and 5, some of which relates to industrial action for medical staff. Focus remains on the post by post deep dive to explore how this can be reduced which links to CIP delivery.

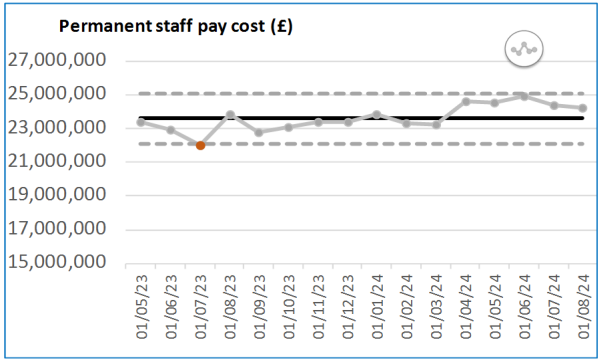
Bank costs have risen in August, mainly across medical staff. There has been a small reduction in nursing bank.

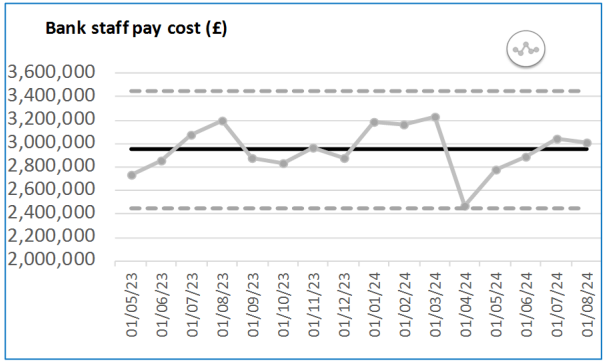
This supports the data shown in the SPC charts on the following slides.

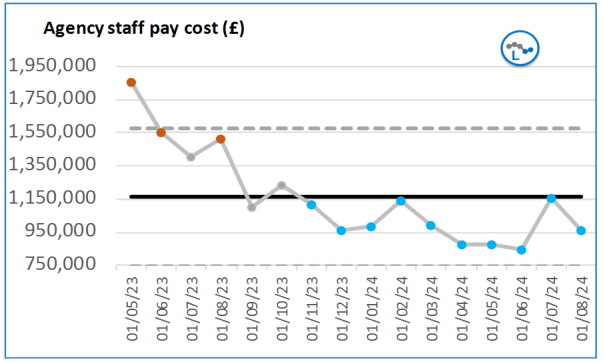
5. Key Drivers of the Financial Position

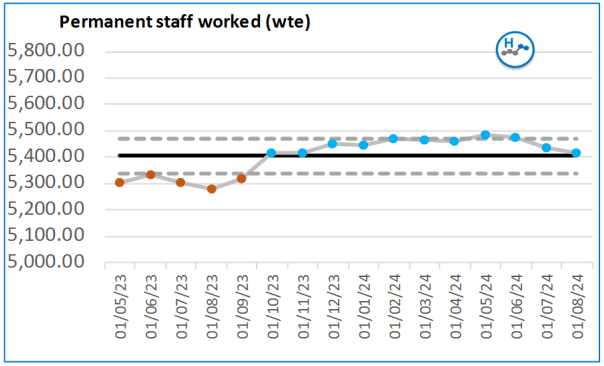
c. Temporary Staffing – All staff groups

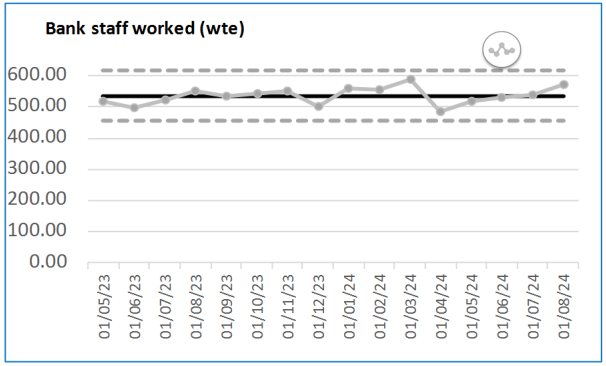
Stockport NHS Foundation Trust

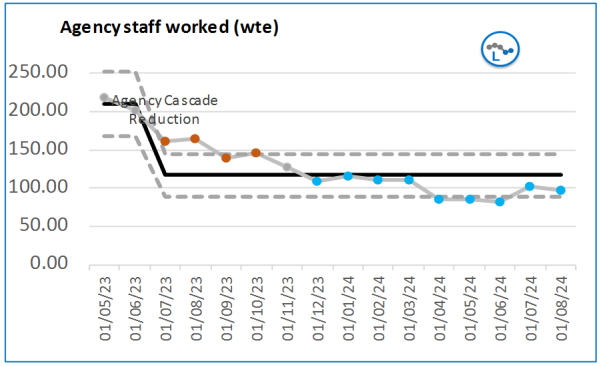












Month 2 includes the 2023-24 actual pay costs for the consultants. 2.1% has also been included to month 4 for the 2024-25 pay award in line with planning assumptions.

Month 3 and 4 includes costs and WTE covering the industrial action which took place on the 27th – 30th June 2024 (£384k – 10.39wte) and the 1st – 2nd July (£223k – 4.28 wte), and is predominantly medical staffing costs.

5. Key Drivers of the Financial Position

c. Temporary Staffing

Stockport NHS Foundation Trust

Previously reported actions continued to be delivered and are now business as usual. In addition to these the following work has continued and is currently underway to reduce agency and bank spend:

- NHSE have requested involvement in a review of medical locum rates as a project across GM and Cheshire & Mersey, in collaboration with our framework provider. We are awaiting further information.

- Workforce Efficiency Group (WEG) has been established with a primary focus on reviewing the premium expenditure and the drivers for high-cost agency usage with a view to significantly reducing agency and bank expenditure. The group meets monthly and is chaired by the Director of People & OD with Exec and Divisional representation.

- Engagement with NHSP Gateway Service has commenced, this service aims to deliver IMG Doctors from Foundation equivalent to Consultant, all Gateway Doctors are 'net new' to the NHS. We are exploring the opportunity to appoint doctors to our JCF and SCF gaps, as well as scoping CESR opportunities for hard to recruit to specialties.

- We have completed our registration for NHS Emeritus and continue with implementation phase, scoping out opportunities. We have identified several long-term Consultants, and the Emeritus team are working with the relevant services to identify suitable placements to replace the agency workers, where possible.

- We are engaged collaboratively with Tameside Integrated Care NHS Foundation Trust and our direct engagement providers Liaison to undertake an exercise with agencies to reduce rates and agree a standardised approach to commission, which will improve our compliance with the price cap.

6. Capital

Description	Month 5			Year To Date M5			2024-25		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Estates	1.4	1.7	0.3	6.9	6.4	(0.5)	20.9	41.3	20.4
Equipment	-	-	-	-	-	-	-	-	-
IFRS16	-	-	-	0.9	-	(0.9)	3.5	3.5	-
IT	-	0.2	0.2	-	0.9	0.9	4.7	6.0	1.3
Total	**1.4**	**1.9**	**0.5**	**7.8**	**7.3**	**(0.5)**	**29.1**	**50.8**	**21.7**

The Emergency Care Campus, new modular ward, MRI development and the network cabinet refresh make up the majority of spend at the year to date.

The forecast includes the cost of converting the modular ward into an Outpatients facility.

Continuing to progress schemes that were part of the original non-compliant plan will result in a gap of £21.7m between funding and expenditure. This will also present challenges with cash, as the Trusts cash position would not be able to support this additional expenditure without external support.

There is a possibility that funding of £6m will be received for the purchase of the Meadows, this is currently not reflected in the budget, and if received would see the gap reduced to £15.7m.

Forecasts continue to be monitored and reviewed closely and updated to the Capital Programme Management Group.

The variance of £0.9m on IFRS16 is due to timing, once agreements are finalised and transacted this will be back in line with plan.

7. Recommendations

The Board of Directors are asked to:

- Note the financial position of the Trust to M05 and the key drivers within the position
- Acknowledge the cash and capital risks for 2024/25 and beyond
- Support the escalation of Divisions with significant overspends

This presentation is an extract of the report presented to the Finance & Performance Committee on the 19th September 2024

NHS Stockport NHS Foundation Trust

				Agenda No.	9.2
Meeting date	**3rd October 2024**	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Quarter 3 Revenue Support Application				
Director Lead	John Graham, Chief Finance Officer	**Author**	Lisa Byers, Associate Director of Finance – Financial Services		

Paper For:	**Information**		**Assurance**		**Decision**	x
Recommendation:	The Board is asked to receive the report of the Quarter 3 Revenue Support application for October 2024 and note the cash commentary supporting the application. The Board is asked to approve formal sign off of the application by the Chair and Chief Executive of the Trust.					

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of

		Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/not agreed	Whole paper
Regulatory and legal compliance	Whole paper
Sustainability (including environmental impacts)	N/A

Executive Summary

The purpose of this report is to inform the Board of Directors the position regarding the Quarter 3 Revenue Support application for October 2024; submitted on the 19th September 2024.

Revenue Support PDC is available to the Trust to support its revenue expenditure as part of a robust and defined process by the Capital and Cash team at NHS England.

The application process for Quarter 3 has been updated and requires providers to submit applications for the quarter but also updated on a monthly basis.

The Trust is aware of the communication by NHS England regarding deficit support at system level and guidance on the pay award funding for 2024/2025; however, as confirmation of the payment arrangements for deficit support and pay award funding is outstanding, no additional income forecast has been included in this submission. If further clarification is issued the application can be updated to reflect income notifications and adjust the request for cash support accordingly.

Without this support the Trust anticipates that it will require cash support in October 2024 of £4 million. The commentary setting out the Trust's cash position and mitigations is attached for review and

discussion.

The Chair and Chief Executive of the Trust must approve any PDC Revenue Support request by the Trust in the form of a letter. (This is a change from previous submissions where Board resolutions have been required). This paper will formally ask for the Board to approve the application and the formal signature by the Chair and Chief Executive on its behalf.

Recommendation

- The Board is requested to ratify the Quarter 3 Revenue Support application and specifically £4 million in October 2024.
- The Board is asked to approve signature of the letter attached in Appendix 1 by the Chair and Chief Executive to be submitted to the NHS England Capital and Cash Team to support the October and Quarter 3 Revenue Support application.

1. Purpose

1.1 This paper sets out to inform the Board of Directors of the Quarter 3 application for Revenue Support PDC to the Department of Health and Social Care (DHSC).

1.2 The Board is asked to review the Trust cash forecast for Quarter 3 and approve the application for revenue support PDC of £4 million in October 2024.

2. Introduction / Background

2.1 In line with the NHSE Capital and Cash timetable the Trust was required to submit requests for support in Quarter 3 of 2024/25 by the 19th September 2024.

2.2 There is a defined Revenue Support PDC process that all providers must follow with a monthly timetable for the submission of revenue support documentation. This includes cash forecasts, working capital information, approval of memorandum of understandings, cash utilisation requests and receipt of cash into the bank.

2.3 To date the Trust has accessed Revenue Support PDC as follows:

Revenue Support PDC		**£m**
2023/24	Mar-24	5.041
2024/25	Apr-24	5.382
	Jul-24	1.724
	Sep-24	8.457
	Total	**20.604**

2.4 The Trust forecast deficit is £44.032 million with the plan to October 2024 being £29.9 million. The application for support must be within the cumulative Plan deficit. The October application meets this requirement.

3. Matter under consideration

3.1 The Trust cash forecast up to the 31st January 2025 is presented further below.

3.2 This application is submitted without the inclusion of non-recurrent deficit support or pay award funding. Guidance for the GM system £175 million non-recurrent deficit allocation and its distribution to Trusts was received on the 18th September. However, no detail on dates for receipt of the funding was included within this guidance. Similarly general guidance that the pay award will be paid in October has been received but the amount of funding from the

ICS to the Trust has yet to be confirmed. Without certainty on the flow of funds an application has been prepared for October 2024 for £4 million.

3.3 In the submission to the NHS England Capital and Cash team it has been acknowledged that the application will be revised if further certainty on the timing of funding support is received.

Trust Name	Stockport NHS Foundation Trust				
Trust Code	RWJ				
	£000	£000	£000	£000	£000
	September	October	November	December	January
Opening Balance	4,767	3,523	1,779	1,746	1,950
Monthly Income					
NHS Receipts	31,371	35,093	31,556	31,769	31,971
Non NHS Receipts	2,435	2,930	2,982	2,707	2,841
Receipts for Capital	7,700	2,850	1,881	2,099	2,331
TOTAL	41,507	40,873	36,420	36,575	37,143
Monthly Payments					
Payroll Payments	(27,224)	(33,494)	(35,253)	(28,487)	(29,300)
NHS Payments	(2,673)	(2,739)	(2,059)	(3,515)	(2,449)
Non NHS Payments	(8,950)	(6,853)	(6,764)	(7,794)	(7,774)
Capital Payments	(8,508)	(3,366)	(1,651)	(3,858)	(4,389)
Loan Payments	-	-	(245)	(579)	-
PDC Dividend Payments	(3,691)	-	-	-	-
Other Payments	(163)	(165)	(187)	(152)	(129)
Total	(51,208)	(46,616)	(46,159)	(44,385)	(44,042)
Balance	(4,934)	(2,220)	(7,960)	(6,064)	(4,949)
Revenue Support PDC Receipts	8,457	4,000	9,706	8,014	7,320
Adjusted Balance	3,523	1,779	1,746	1,950	2,371

3.4 In September the transaction for the Meadows is assumed with £6.05 million PDC receipt and equivalent capital expenditure for the purchase of the facility.

3.5 The above cashflow demonstrates that the Trust cash balance is now at or close to its minimum cash balance of £1.746 million.

3.6 The Trust continues to follow rigorous cash management policies including its monthly cash monitoring and debtors' reduction groups, enforcement of its No PO No Pay Policy and weekly review of the supplier payment run to maintain the minimum cash balance.

4. Recommendations

4.1 The Board is requested to ratify the Quarter 3 Revenue Support application and specifically £4 million in October 2024.

4.2 The Board is asked to approve signature of the letter attached in Appendix 1 by the Chair and Chief Executive to be submitted to the NHS England Capital and Cash Team to support the October and Quarter 3 Revenue Support application.

Appendix 1

Karen James OBE/Marisa Logan-Ward
Chief Executive/Interim Chair
Stockport NHS Foundation Trust
Oak House
Stepping Hill Hospital
Poplar Grove
Stockport
SK2 7JE

Telephone: 0161 419 5000
Email address: Karen.James@stockport.nhs.uk
Email address:Marisa.LoganWard@stockport.nhs.uk

NHS England

Provider Revenue Support

25th September 2024

Dear Provider Revenue Support team,

As Chief Executive and Chair of Stockport FT, we confirm approval of the Trust's 2024-25 Quarter 3 Revenue Support application for October for a value of £4 million.

We can confirm that the cash position of the Trust has been discussed at the Board of Directors on the 3rd October 2024 and the risk highlighted as part of the Finance Report, the significant risk register and the board assurance framework.

Yours sincerely,

Karen James OBE
Chief Executive

Marisa Logan-Ward
Interim Chair

Appendix 2

Stockport NHS Foundation Trust

Request for Provider Revenue Support PDC in October 2024

Introduction:

For October 2024 Stockport NHS Foundation Trust submits a request for £4 million Revenue Support PDC. This submission is subject to revision/withdrawal following confirmation of additional funding to be received for the 2024/25 pay award and receipt of further system funding into Greater Manchester.

The Trust's forecast cumulative deficit for 2024-25 is £43.8 million (prior to the 20242/5 pay award). This also includes a cost improvement programme of £24.6 million. The profiled deficit to October is £29.9m.

The request for PDC Revenue Support is within the full year forecast deficit of £43.8m and so meets the terms for applying for deficit support set out at *page 2 of the 'Process and Guidance' document.*

Up to Month 6 the PDC Revenue Support drawdown is £15.6m, with this further application for Month 7 bringing total support in year to £19.6m

Cash Flow Forecast

The Cash Flow forecast template has been updated and is attached to this application and confirms the Trust hitting its minimum cash balance.

Factors Driving the Need for Revenue Support PDC:

The Trust has a forecast deficit Plan of £43.8 m. This is based on the latest Plan submission dated the 12th June and is the driver behind the need for revenue support.

The Trust cashflow forecast is informed by the latest contract file information available from commissioners for contract income in 2024-25. The ICS continues to support the Trust with payment of the core monthly contract on the 1st working day of the month of £26.5m.

The Trust has forecast the costs of the 2024/25 pay award (and 2023/24 for Junior Doctors) to be £19.8m with arrears to be paid to staff in October. The Trust is still awaiting details of additional income and further no additional funding for the pay award has been included in this submission.

The Trust is aware of the conversations regarding deficit support at system level; however, as we are awaiting confirmation of the payment arrangements for deficit support no additional income forecast has been included in this submission.

Board Approval:

A letter of support for the Q3 October application following the discussions will follow shortly from the Chief Executive and Chair.

Mitigating factors being undertaken by the Trust:

For 2024-25 the Trust has set target for a £24.6 million Cost Improvement Programme. CIP Plans are in progress with each Division to meet the forecast deficit outturn.

The profiled CIP plan for Month 1-5 has been achieved.

Receivables Management:

At the end of M5 aged debt was £4.9m of which £2.8m related to NHS debtors. There is a separate Debt Reduction Group to specifically review the Trust Aged Debt and escalate actions for outstanding invoices.

Payables Position:

The Trust prioritises its BACS payment runs to ensure it remains above its minimum cash balance. At the end of M5 purchase ledger payables was £6.2m, an increase of £5.6m as at the end of March 2024.

Cash Recovery Plan:

Without further system support and pay award funding current income is not sufficient to meet all Trust outgoings and there is a continued need for cash support. Discussions are ongoing with the ICS how this support can be provided to Stockport FT and other Trusts in the GM system in a similar position.

Capital Funding and Expenditure:

This revenue support request will not be used for capital purchases.

The Trusts planned capital expenditure in 2024/25 excluding IFRS16 is £25.6m. Planned Capital PDC support for the year is £12.1m with internal support at £13.2m and Charity Contribution £0.3m.

Further discussions are underway in respect of further funding to support the delivery of a new Outpatients facility following the unexpected closure of the previous Outpatients Department in November 2023.

Regional Contact:

Sarah Howard: sarah.howard13@nhs.net

NHS Stockport NHS Foundation Trust

				Agenda No.	10
Meeting date	**03 October 2024**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors, Public Meeting				
Report Title	Stepping Hill Hospital Estate: Update Report				
Director Lead	Paul Featherstone Director, Estates and Facilities	**Author**	Paul Featherstone Director, Estates and Facilities		

Paper For:	**Information**	**X**	**Assurance**	**X**	**Decision**	

Recommendation:

The Board of Directors are asked to note:

1. The Trust has recently taken receipt of the new 2024 Six-Facet survey from Oakleaf Surveying Group ("Oakleaf").
2. The newly estimated 5-year backlog maintenance expenditure requirements for the Stepping Hill Hospital site are in the region of £84m nett, £134m gross.
3. The new 2024 Six-Facet survey reveals a further deterioration of the Stepping Hill Hospital estate with an approximate additional 15% of the estate by floor area now falling into the "Significant Risk" backlog maintenance risk grade.
4. The Trust has in place robust arrangements to comply with and discharge the requirements of HTM 00.
5. The Trust's Premises Assurance Model self-assessment is up-to-date and currently lodged with DHSC awaiting feedback.
6. There is in place a mature and effective estates and facilities governance structure to help ensure matters are regularly assessed, reviewed and escalated where appropriate.
7. Output from the Six-Facet survey, HTM 00 and PAM processes, along with other local knowledge, directly informs the development of estates and facilities risks.
8. Clinical Divisions will attend the estates and facilities Risk and Governance Group so that appropriate clinical risk linkages can be made to assist with divisional emergency planning.
9. The Board Assurance Framework as it pertains to estates and facilities risks is regularly reviewed and updated by the Director of Estates and Facilities.
10. There is insufficient capital to invest adequately in the SHH estates meaning that the risk profile of the estate will continue to increase.

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
X	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

X	Safe		Effective
	Caring		Responsive
	Well-Led	X	Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards

	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
X	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The paper builds upon previous papers presented to the Private Board earlier in 2024.

The paper informs the Board of:

- The outcome of the recent 2024 Six-Facet survey and projected 5-year backlog maintenance investment requirement along with the associated overall backlog maintenance risk classification for the Stepping Hill Hospital (SHH) estate;
- Governance processes pertaining to the on-going management of the Stepping Hill Hospital estate;
- The process undertaken with respect to risk assessments;
- Links with business continuity plans; and
- The process by which the Trust's limited capital is allocated.

Stepping Hill Hospital Estate: Update Report

1. Introduction

This paper provides the Board of Directors with detail in respect of:

- The outcome of the recent 2024 Six-Facet survey and projected 5-year backlog maintenance investment requirement along with the associated overall backlog maintenance risk classification for the Stepping Hill Hospital (SHH) estate;
- Governance processes pertaining to the on-going management of the Stepping Hill Hospital estate;
- The process undertaken with respect to risk assessments;
- Links with business continuity plans; and
- The process by which the Trust's limited capital is allocated.

2. Six-Facet Survey

Further to papers presented earlier in 2024 to the private meeting of the Board of Directors, information is reproduced below for the public section of the Board which captures and summarises the recent output of the Trust's Six-Facet survey, as it pertains to the condition of SHH estate. In doing so, it is noted that the Six-Facet survey data represents only one-element of the Trust's estates management and governance arrangements (which later sections of this paper expand upon).

It is essential that the physical condition of the Trust estate is accurately reviewed and maintained to ensure it is fit for purpose and remains safe for patients and staff.

A core methodology in achieving this objective is the regular assessment, establishment and management of backlog maintenance and associated costs.

In accordance with NHS guidance, the Trust regularly undertakes a Six-Facet property appraisal using expert property consultants who are familiar with NHS reporting requirements and hospital construction.

The most recent Six-Facet survey was undertaken earlier in 2024 by a company called "Oakleaf Surveyors;" the previous Six-Facet surveys to that were undertaken in 2021 and 2018 by the same company.

The Six-Facets surveyed include:

- Physical Condition;
- Functional Suitability;
- Space Utilisation;
- Quality;
- Statutory Compliance; and
- Environmental.

It is the output from the Physical Condition and Statutory Compliance elements of the Six-Facet survey that predominantly inform the Trust's backlog maintenance requirements, where backlog maintenance is the action required and the costs associated with bringing elements of the estates fabric that are below acceptable

standards in terms of their physical condition, or which do not comply with safety requirements, up to an acceptable condition.

It should be noted that backlog maintenance is distinct from Planned-Preventative-Maintenance (PPM) which is the regular servicing of estates assets to ensure day-to-day serviceability and compliance; reactive maintenance which remedies estates fabric that has already failed; or targeted property refurbishment / improvement which concentrates upon asset reconfiguration and adaptation, often in response to changing service needs.

The survey output in respect of the Physical Condition and Statutory Compliance components of the overall 2024 Six-Facet survey has been analysed and reviewed with support from Oakleaf.

As the Board will recall, backlog maintenance costs are graded as low, moderate, significant, and high risk. Table 1, below, compares the 2021 and 2024 Six-Facet surveys in respect of estimated backlog costs per risk grade:

Table 1: Estimated Backlog Maintenance Costs Per Risk Grade

Backlog Maintenance Risk Grade	2021 Survey[1] £m (nett)	2021 Survey £m (gross[2])	2024 Survey[3] £m (nett)	2024 Survey £m (gross)
Low Risk	2.6	4.2	1.05	1.69
Moderate Risk	31	49.6	27.23	43.56
Significant Risk	18.8	30.1	50.61	80.98
High Risk	3.1	5.0	4.96	7.94
TOTAL	55.5	89	83.85	134.17

It can be seen that the latest 2024 survey data shows a large increase in the Significant Risk backlog cost quantum. Broadly speaking, this reflects further deterioration in the condition of the SHH estate, continued underinvestment in backlog maintenance resulting in a reclassification in a number of previous Low and Moderate backlog risk items into the Significant Risk category, along with the identification of new “wants of repair” by Oakleaf.

Building condition categories for the NHS were first defined in the DH document “Estatecode” ranging, in broad terms, from Category A through to Category D, whereby:

- Category A: is as new, and can be expected to perform adequately over its expected shelf life.
- Category B: is sound, operationally safe and exhibits only minor deterioration.

[1] 2021 Survey Data expressed @ 2024 estimated costs.

[2] The Trust Director of Estates and Facilities has verified with the NHSE Regional Director of Estates and Facilities the current recommended “uplift” to backlog maintenance “nett” figures to include for VAT, fees, enablement and contingency - this is confirmed to be an additional 60%.

[3] 2024 survey data expressed as 2024-2028 (5 year) total estimated backlog maintenance expenditure requirements.

- Category C: is operational, but major repair or replacement will be needed soon, that is, generally within three years for building elements and one year for engineering elements.

- Category D: runs a serious risk of imminent breakdown.

It is noted that Category B is considered to be the operationally acceptable standard for all NHS building and engineering elements.

Table 2, below, details the approximate percentage of the Trust hospital estate assessed by Oakleaf as falling in to the various condition categories:

Table 2: Hospital Estate Condition Categories

Condition Category	2021 Survey % Gross Internal Area	2024 Survey % Gross Internal Area
A	1%	0%
B	43%	33%
C	46%	61%
D	10%	6%

Key movements are:

- In the 2021 survey, the Trust had 2 overall block areas identified as Category A. Those areas were Block 13 (Substation BML) & Block 14 (Kitchen). It is noted that the 2024 survey has no Category A accommodation.

- There is an approximate additional 15% of the SHH estate by floor area now falling into the “Significant Risk” Category C backlog maintenance risk grade.

- The 2024 survey identifies 13 areas with an overall Category D status; 8 of which were previously Category C or better. These 8 are:

  Beech House (IT)
  Mortuary
  Lime Suite
  Magnolia Suite
  Ward B5/C5
  Chest Clinic
  Ash House
  Gas Meter House / Electric Substation (Poplar Grove)

  The remaining 5 areas were identified in the 2021 survey as Category D and are:

  Block 30 (Pathology)
  Block 44 (Bobby Moore Unit / Outpatient C - Wards B6 /C6)
  Block 46 (currently closed with no permitted access)
  Block 54 (supported Interns Cabin)
  Block 59 (Aspen House)

The Board will recall that given the recent failure of the Outpatients B building (itself a “Condition D” asset), the Trust decided to supplement the regular Six-Facet surveys

by commissioning Marston and Grundy Structural Engineers to undertake more detailed structural surveys for those buildings identified as Condition D.

Given the emergence of 8 new Condition Category D assets identified by Oakleaf in their 2024 survey, Marston and Grundy have now been approached to undertake further structural surveys of these areas.

3. Health Technical Memoranda (HTM)

Critical to establishing robust arrangements for the management of the Trust's critical estate systems and infrastructure is compliance with a range of Health Technical Memoranda (HTMs).

HTMs provide comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

In the area of core Estates Systems and Infrastructure, the relevant HTMs are:

- HTM 00 Policies and principles
- HTM 01 Decontamination
- HTM 02 Medical Gases
- HTM 03 Heating and Ventilation systems
- HTM 04 Water Systems
- HTM 05 Fire Safety
- HTM 06 Electrical Services
- HTM 08 Specialist Services - Lifts

HTMs are applicable to new and existing sites, and healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are being managed effectively. In this regard, HTM 00 is the reference point that supports all the other HTMs because it:

> *"provides specific advice and guidance on the design, installation and effective operation of a healthcare facility from an engineering technology perspective (which) aims to ensure that everyone concerned with the management, design, procurement and use of the healthcare facility understands the requirements of the business critical building and engineering technology in order to ensure optimum safety for all who are present and use healthcare facilities."*

Further, HTM 00 anticipates that by following the HTMs:

> *"and applying it to the particular needs of their local healthcare organisation, boards and individual senior managers should be able to demonstrate compliance with their responsibilities and thereby support a culture of professionalism."*

HTM 00 provides a recommended structure and responsibility framework which considers the principles, standards and common features that need to be in place as a core approach and the following roles are anticipated:

- Duty Holder (DHol): carries ultimate responsibility for a safe and secure healthcare environment.

- Designated Person (DP): Provides the essential senior management link between the organisation and professional support. The DP will also provide an informed position at board level and is appointed by the DHol.

- Senior Operational Manager (SOM): Has operational and professional responsibility for operational (estates) services and is appointed by the DP.

- Authorising Engineer (AE): Acts as an independent professional adviser, to be appointed with a brief to provide services in accordance with the relevant HTM. The relevant AE acts as an assessor and makes recommendations for the appointment of Authorised Persons (APs), monitors the performance of the service and, importantly, provides an annual audit to the Trust.

- Authorised Person (AP): Has the key operational responsibility for the specialist service. This person will be qualified and sufficiently experienced and skilled to fully operate the specialist service. They will be nominated by the AE and appointed by the SOM. HTM 00 further stipulates specific tasks that the AP needs to undertake.

- Competent Person (CP): This person provides skilled installation and / or maintenance of the specialist service. The CP will be appointed, or authorised to work (if a contractor), by the AP.

Attached as Appendix 1 to this paper is a structure chart showing current arrangements per HTM area for the Trust. It is the opinion of the author that the Trust has in place strong arrangements to comply with and discharge the requirements of HTM 00.

4. Premises Assurance Model

The NHS Premises Assurance Model (PAM) is a self-assessment management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estate and facilities services.

PAM captures various estates and facilities standards and requirements and breaks them down into a series of Self Assessment Questions (SAQs) covering specific technical areas, such as water safety and electrical safety. This provides a structured framework to self-assess and measure compliance with each of the requirements.

The main objectives of the NHS PAM are to:

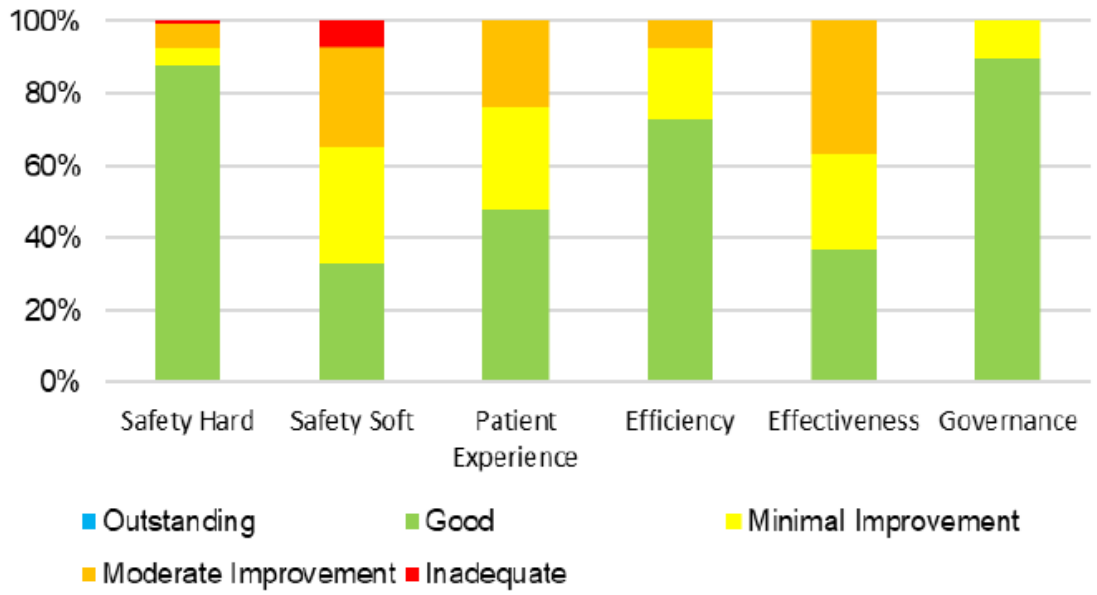
- Allow NHS providers to demonstrate to their patients, Commissioners and Regulators that robust systems are in place to assure that their premises and associated services are safe;

- Provide a consistent basis to measure compliance against legislation and guidance, across the whole NHS estate; and

- Help NHS bodies prioritise investment decisions to raise standards in the most advantageous way.

PAM is regularly updated by the Department of Health and Social Care (DHSC), and Trusts are required to submit an annual reassessment via the NHS Estates and Facilities on-line portal. The Trust last submitted its PAM data on 10 September 2024 and a distribution of SAQ ratings across the six PAM domains is shown below in Table 3. Once submissions from all Trusts have been quality assured by DHSC and feedback provided, a further report will be submitted to the appropriate Trust committee for consideration.

Table 3: PAM SAQ Distribution



5. Estates and Facilities Governance Structure

There is in place a mature and effective estates and facilities governance structure to help ensure matters are regularly assessed, reviewed and escalated where appropriate.

A number of safety working groups exist for the topics identified in section 3, above, and these sit alongside other groups dealing with estates and facilities business.

The principal conduit for all these operational groups is the Estates and Facilities Quality and Performance Group which feeds out with the department into the Trust corporate governance structure (e.g. Risk Management Committee, Health and Safety Committee, Finance and Performance etc.)

Appendix 2 to this paper shows the current estates and facilities governance structure “organogram.”

6. Risk Assessment Process

Information and “output” etc. developed through the Six-Facet survey, HTM 00 process (principally AE reviews), and PAM self-assessment process, directly inform the development of estates and facilities risks. This is complemented, where necessary, by local knowledge where circumstances arise either between assessment cycles or in response to specific operational issues.

All estates and facilities risks are subject to regular structured review by the estates and facilities Risk and Governance, and Quality and Performance Groups and, where appropriate, escalated to the Risk Management Committee and other relevant Trust committees. The primary objective of this regular risk review is to provide assurance that all risks are being managed, measured and appropriately communicated.

There are currently 22 risks on the Trust risk register which relate directly to the condition of the estate or known risks associated with poor infrastructure and estate condition.

Additionally, the Director of Estates and Facilities regularly reviews relevant estates and facilities risks captured via the Board Assurance Framework (BAF).

It is noted that from November 2024, Clinical Divisions are invited to the estates and facilities Risk and Governance Group so that enhanced consideration can be given to identifying any clinical and operational consequences potentially arising from the manifestation of any captured estates and facilities risks with the intention of subsequently informing divisional emergency planning, to be supported by the Trust's EPRR manager.

7. Funding Constraints

Invariably, the targeted mitigation of many estates-related risks relies upon satisfactory levels of investment in the SHH estate. Lack of available capital is recognised on the BAF and also through estates and facilities Risk ID 2765 which talks about constraints in capital and revenue funding.

Model Hospital data recognises that backlog maintenance for SHH is one of the highest in the NHS and considerably higher than the peer median. This coupled with the known current very low levels of available capital means that it is inevitable that the risk-profile of the estate will continue to increase in the short to medium term.

Whilst the Trust is actively exploring a range of opportunities (such as working in partnership with the Local Authority to develop joint property solutions) the underlying and deteriorating condition of the SHH estate if of extremely high concern.

8. Summary and Recommendations

The Board of Directors are requested to note:

1. The Trust has recently taken receipt of the new 2024 Six-Facet survey from Oakleaf Surveying Group ("Oakleaf").

2. The newly estimated 5-year backlog maintenance expenditure requirements for the Stepping Hill Hospital site are in the region of £84m nett, £134m gross.

3. The new 2024 Six-Facet survey reveals a further deterioration of the Stepping Hill Hospital estate with an approximate additional 15% of the estate by floor area now falling into the "Significant Risk" backlog maintenance risk grade.

4. The Trust has in place robust arrangements to comply with and discharge the requirements of HTM 00.

5. The Trust's Premises Assurance Model self-assessment is up-to-date and currently lodged with DHSC awaiting feedback.

6. There is in place a mature and effective estates and facilities governance structure to help ensure matters are regularly assessed, reviewed and escalated where appropriate.

7. Output from the Six-Facet survey, HTM 00 and PAM processes, along with other local knowledge, directly informs the development of estates and facilities risks.

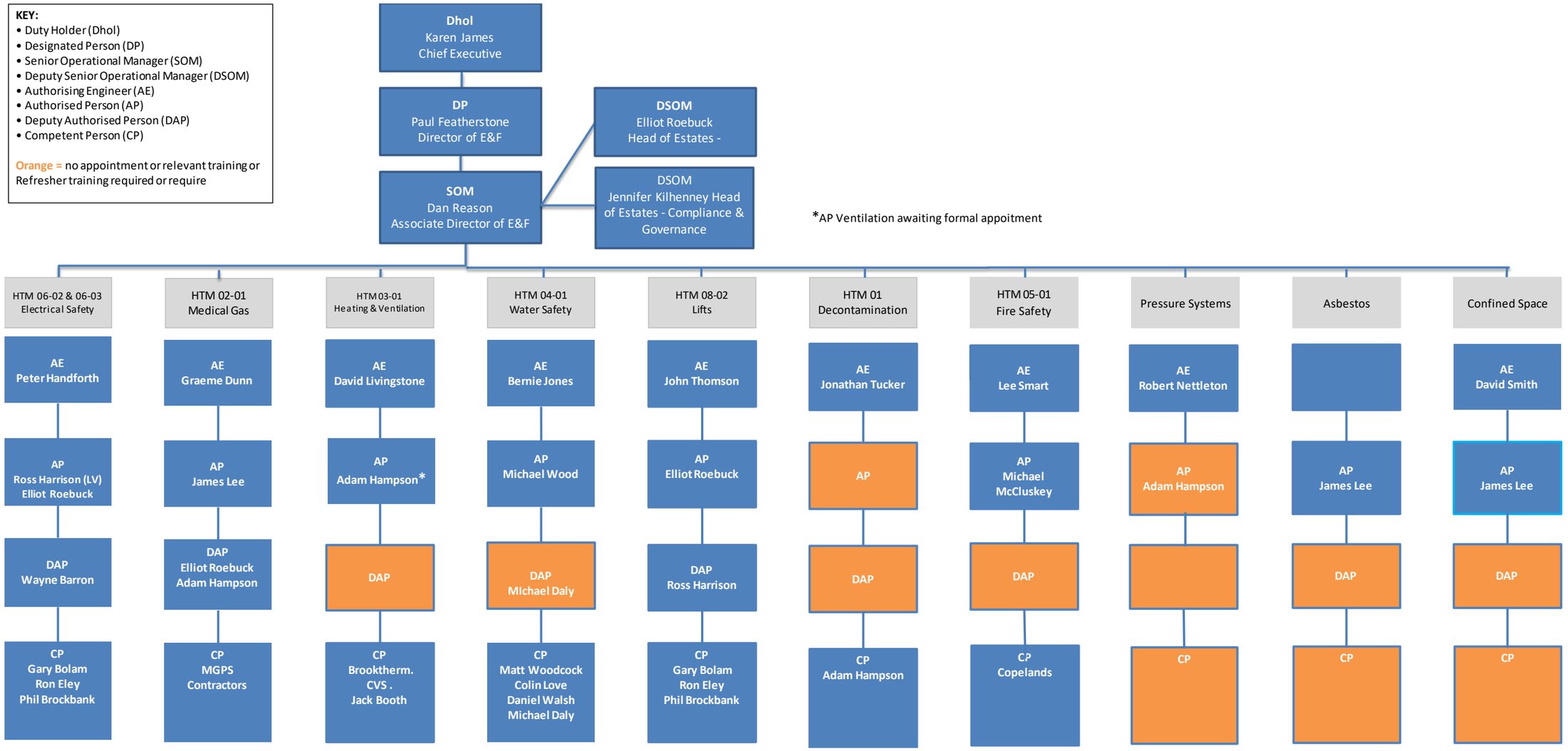
8. Clinical Divisions will attend the estates and facilities Risk and Governance Group so that appropriate clinical risk linkages can be made to assist with divisional emergency planning.

9. The Board Assurance Framework as it pertains to estates and facilities risks is regularly reviewed and updated by the Director of Estates and Facilities.

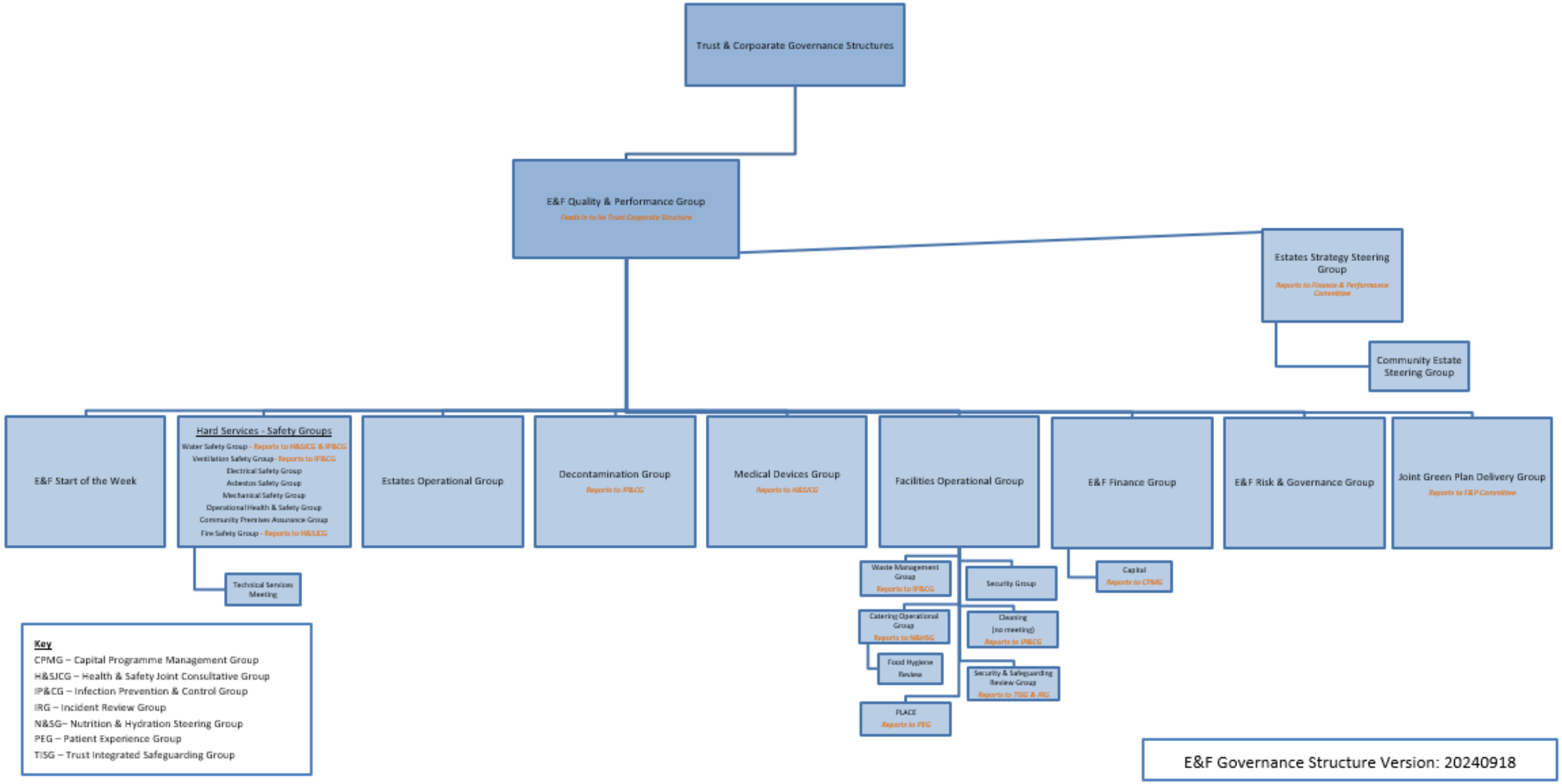
10. There is insufficient capital to invest adequately in the SHH estates meaning that the risk profile of the estate will continue to increase.

Paul Featherstone
Director of Estates and Facilities
September 2024

Appendix 1: HTM 00 Structure Chart



Appendix 2: Estates and Facilities Governance Structure Organogra



NHS Stockport NHS Foundation Trust

Meeting date	**3rd October 2024**	**Public**	**x**	**Agenda No.**	11
Meeting	Board of Directors				
Report Title	Freedom to Speak Up - Update				
Director Lead	Amanda Bromley, Director of People and OD	**Author**	Nadia Walsh – Freedom to Speak Up Guardian		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are recommended to note the contents of the report and the actions being taken to progress the Freedom to Speak Up agenda.					

This paper relates to the following Annual Corporate Objectives

x	1	Deliver personalised, safe, and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented, and motivated workforce to meet future service and user needs
x	5	Drive service improvement through high quality research, innovation, and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains.

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks.

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values

	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity, and inclusion impacts	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

This report presents an update on the Trust's Freedom to Speak Up (FTSU) agenda and outlines the activities conducted by the Freedom to Speak Up Guardian (FTSUG) during the reporting period.

Overview of FTSU Role Activities: During this period, the FTSUG engaged in various activities to promote transparency and trust within the organization. This included meetings with key stakeholders such as the Chair, Non-Executive lead, and Senior leaders to strengthen rapport and reinforce the commitment to fostering open communication.

Additionally, five visits to different departments, wards, and teams were conducted, providing frontline staff with an opportunity to express their thoughts and concerns. Efforts were also made to raise awareness of FTSU among students and share information on areas of concern.

Three FTSU Champion meetings were chaired, with plans to increase the number of champions through a trust-wide campaign. The role of champions in supporting staff who wish to raise concerns was highlighted, with a total of two case contacts received during the quarter.

NGO Guidance and Webinars: Adherence to NGO guidance and participation in relevant webinars enhanced knowledge and skills, improving FTSU processes. Regular communication with guardians ensured a cohesive approach to FTSU activities. It is worth noting that the National Guardians' Strategy is currently being refreshed, which may impact the Trust's strategy. The goal is to align our approach with these updates, ensuring that our policies and practices remain effective and supportive for all staff.

Contact with Guardians: Regular communication with guardians facilitated information exchange and ensured a cohesive approach to FTSU activities.

Case Contacts: The number of cases received through FTSU channels stands at 33 case contacts, indicating a small drop in engagement. All issues raised were responded to within two to four days.

Updates:

Themes and Trends

Themes or trends continue to emerge across the FTSU data pool, with concerns originating from various sources both within and outside of the trust. Specific areas of Concern have been discussed at the PPC meeting.

Informal reporting vs Formal reporting:

Staff often encounter confusion due to the differing interpretations of what constitutes a formal concern versus an informal concern among leaders. This variability underscores the importance of establishing a unified understanding across the organization.

Inappropriate attitudes and behaviours:

A recurring theme that emerges monthly is inappropriate attitudes and behaviours. To address this issue, the Trust offers compassionate leadership courses and promotes the "Civility Saves Lives" initiative. Despite these efforts, staff members raising concerns have expressed sentiments such as, "You can't teach someone to have compassion," and "Civility—I don't think anyone knows what that means.

Freedom To Speak Up Strategy

The Freedom to Speak Up Strategy has been revised and updated to reflect the latest guidance from the National Guardian's Office, insights from other trusts' strategies, findings from last year's self-assessment tool, and our current understanding of Freedom to Speak Up cases within our organization. The updated strategy is available in **Appendix 1** of this document for your review.

Freedom to Speak up Month:

October is Speak Up Month, and this year's theme is "Listen Up!" We have several initiatives planned to engage staff and promote the importance of listening. Key events include Wear Green Wednesday on 9th October, a poetry competition, an Information stand W/C 7th October and a travelling post box and the Tiny Turtle Awards

Equality and Diversity:

Over the past six months, we've gathered twenty-four completed Equality and Diversity forms out of fifty-two. Outcomes are highlighted in the tables provided in section six.

Feedback:

I received feedback from six out of twenty-five feedback forms sent out to staff who had raised concerns via FTSU. Five of which indicated a willingness to speak up again in the future. Please see positive feedback below

"I was instantly filled with confidence and reassurance. I will not hesitate in reaching out again should I feel the need."

"Thank you again, you are the best, honestly don't know where I'd be without you".

“You did what you said you would when others didn’t, thank you for that”.

Capacity: Capacity constraints were noted, with an average of 2.5 to 3 days spent at Stockport due to increasing workload demands, resulting in reduced allocated time at Tameside. This has not affected the quality of service provided to Staff who have raised a concern.

Recommendations: The Committee is encouraged to acknowledge the report's contents and the ongoing efforts to advance the FTSU agenda within the Trust.

1. Introduction

The purpose of this report is to provide the People and Performance Committee with an update on the Trust position in relation to the Freedom to Speak Up (FTSU) agenda and assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG).

2. Overview of FTSU Role Activities

During the reporting period, I have met with the CEO, Chair, the Non-Executive lead, and Senior leaders to establish and strengthen rapport. These interactions served to reinforce our commitment to promoting transparency and trust within the organisation.

I have conducted five visits to various departments, wards, and teams as part of our ongoing efforts to foster open communication and identify potential concerns. These visits allowed for direct engagement with frontline staff, providing them with an opportunity to express their thoughts and feedback in a supportive environment. Visits included Hazel Grove Health Visiting Team, Theatre Team, Audiology, Neo Natal, and AFU. Three site walkabouts provided insights into daily operations and challenges faced by teams and participation in regional meetings and the NGO buddy sessions facilitated knowledge sharing and collaboration with peers from other organisations.

Freedom to Speak up Champions: I have trained a further eight FTSU Champions within the organization bring our total champion count to eleven. The FTSU Champions are distributed across nursing, midwifery, administration, additional clinical services, and Allied Health professions.

The role of a Freedom to Speak Up champion is vital within our organization. While they may not directly handle cases, their primary responsibility lies in serving as a point of contact and support for staff members who wish to raise concerns or provide feedback. They play a crucial role in signposting individuals to appropriate channels and ensuring that every voice is heard and respected. We continue to promote our champions and raise awareness of the Freedom to Speak Up initiatives across all levels of the organisation and aim to recruit more FTSU Champions in October as part of Speak Up month.

NGO Guidance and Webinars: I have kept abreast of the latest updates via the latest NGO guidance, and I have participated in relevant webinars to enhance knowledge and skills. I have applied the insights gained from external resources to improve FTSU processes. An example of this would be a refresher webinar on Collecting Freedom to Speak up Data that is in line with new guidance. It is worth noting that the National Guardians' Strategy is currently being refreshed, which may impact the Trust's strategy. The goal is to align our approach with these updates, ensuring that our policies and practices remain effective and supportive for all staff.

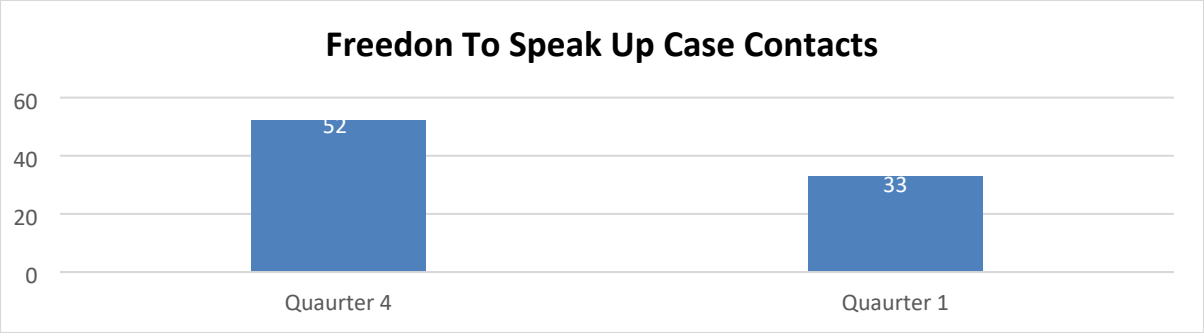
Contact with Guardians: I have maintained regular communication with guardians to exchange insights, share updates, and address challenges. Facilitated information exchange to ensure a cohesive approach to FTSU.

3. Case contacts

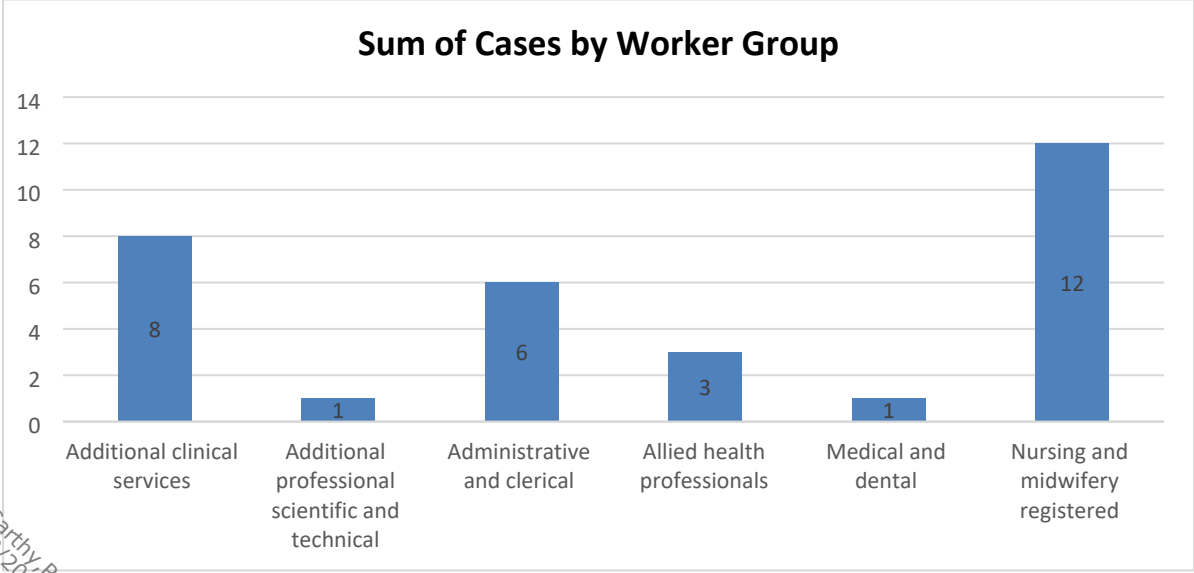
The table below details the number of cases received through the Freedom to Speak Up channel. In quarter four, there were fifty-two cases, while quarter one of the new financial year saw thirty-three. This drop in case contacts indicates a minor decrease in engagement.

From a Freedom to Speak Up perspective, several factors could explain this decline. For example, Stockport had significantly more cases in quarter four, which required substantial time and resources to resolve and close. Consequently, visibility and availability were reduced during quarter one.

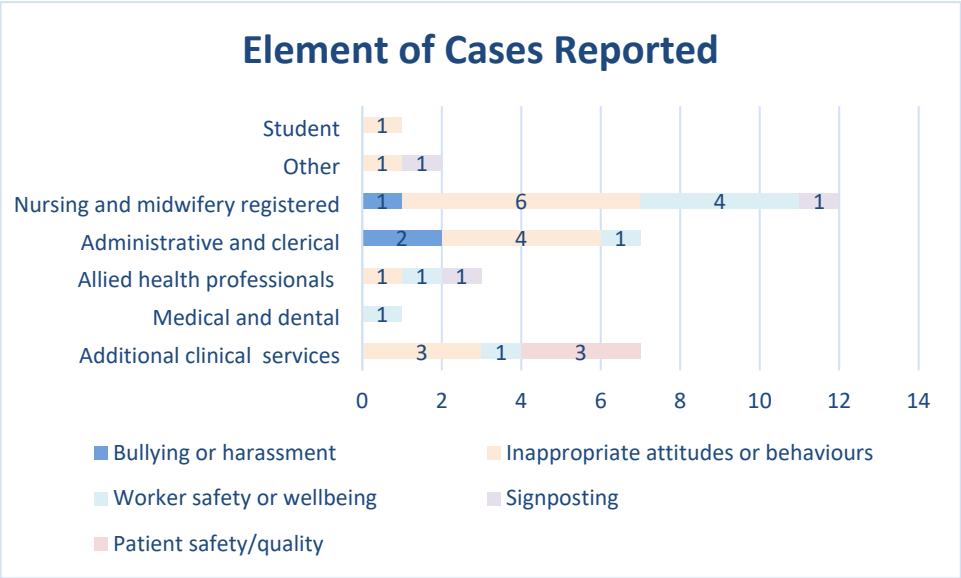
It is important to note that case numbers do not always accurately reflect the staff's ability or willingness to raise concerns. A lower number of cases this quarter does not necessarily mean that staff are not using other routes to raise their concerns. The engagement and confidence in the Freedom to Speak Up process remain priorities, and efforts are continually made to ensure accessibility and support for all staff.



The sum of cases by professional/worker groups have been highlighted below for a clearer understanding of the distribution across different segments.

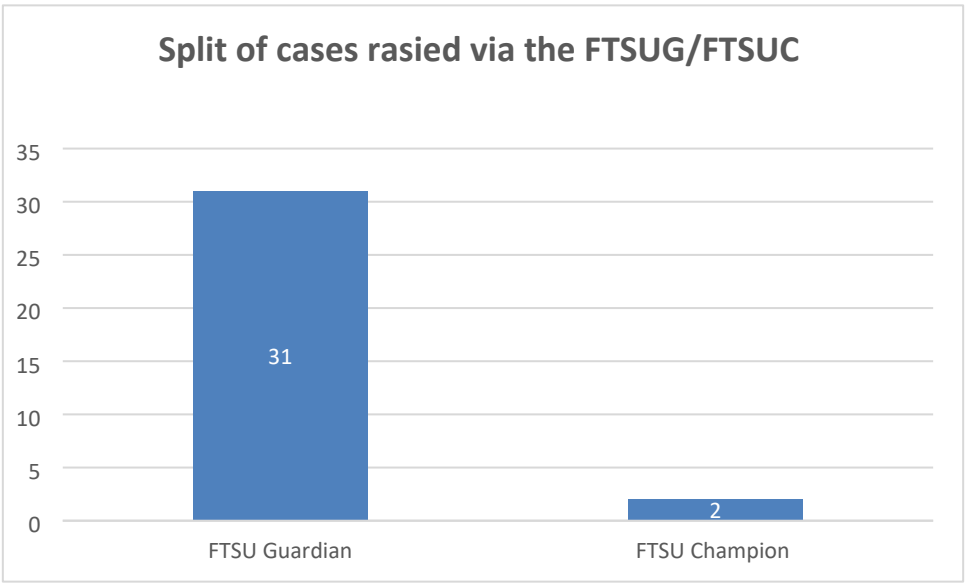


Additionally, the breakdown of cases based on the reporting element has been incorporated below.



While the aim is to respond to concerns raised within twenty-four hours, this quarter saw a deviation from this, with response times ranging from two to four days.

4. Cases raised via a Freedom to Speak up Champion.



In quarter one, two cases were raised with the FTSU Champions. One case originated from the administration and clerical team, and the other from the additional clinical services team. Both cases concerned inappropriate attitudes and behaviours.

5. Updates:

5.1 Updates on Open Cases:

There are currently no open cases for this quarter.

5.2 Themes and Trends:

Themes or trends continue to emerge across the FTSU data pool, with concerns originating from various sources both within and outside of the trust. Specific areas of concern have been discussed at the PPC meeting.

5.3 Informal reporting vs Formal reporting

Staff often encounter confusion due to the differing interpretations of what constitutes a formal concern versus an informal concern among leaders. This variability underscores the importance of establishing a unified understanding across the organization.

Varying approaches among managers add to this uncertainty; while some promptly address concerns informally, others may suggest using the grievance process. This inconsistency can lead to feelings of unease and discouragement among staff seeking resolution.

It's crucial to empower staff to raise any concern they have, fostering an environment where all concerns are treated seriously, regardless of their classification as official or unofficial. This approach promotes transparency and trust, ensuring that every staff member feels supported in addressing workplace issues effectively.

5.4 Inappropriate attitudes and behaviours

In our Freedom to Speak Up report, a recurring theme that emerges monthly is inappropriate attitudes and behaviours. To address this issue, the Trust offers compassionate leadership courses and promotes the "Civility Saves Lives" initiative. Despite these efforts, staff members raising concerns have expressed sentiments such as, "You can't teach someone to have compassion," and "Civility—I don't think anyone knows what that means." Another common comment is, "We can provide people with the knowledge, but we can't make them use it." These reflections highlight the ongoing challenge of fostering empathetic and compassionate behaviours in the workplace.

6. Freedom To Speak Up Strategy

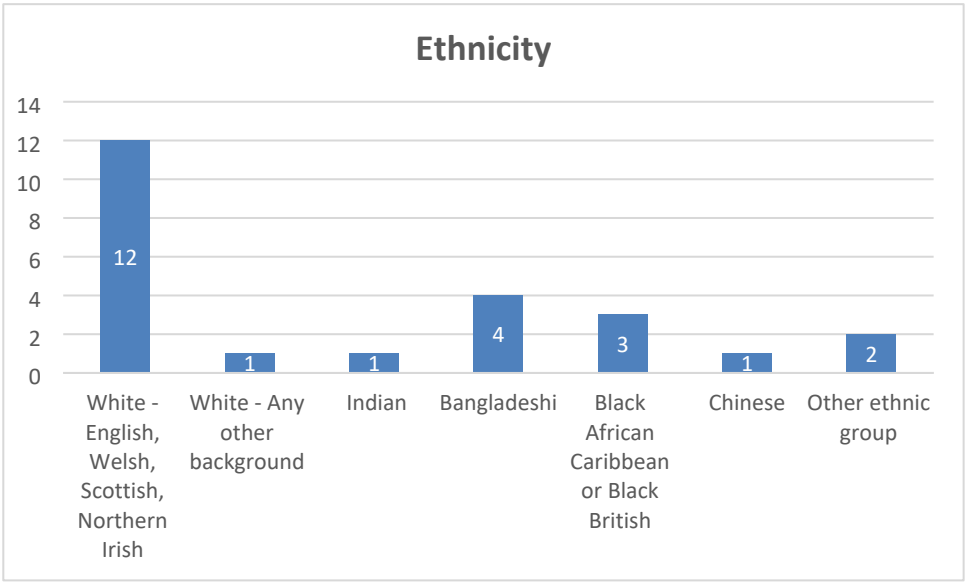
The Freedom to Speak Up Strategy has been revised and updated to reflect the latest guidance from the National Guardian's Office, insights from other trusts' strategies, findings from last year's self-assessment tool, and our current understanding of Freedom to Speak Up cases within our organization. The updated strategy is available in **Appendix 1** of this document for your review.

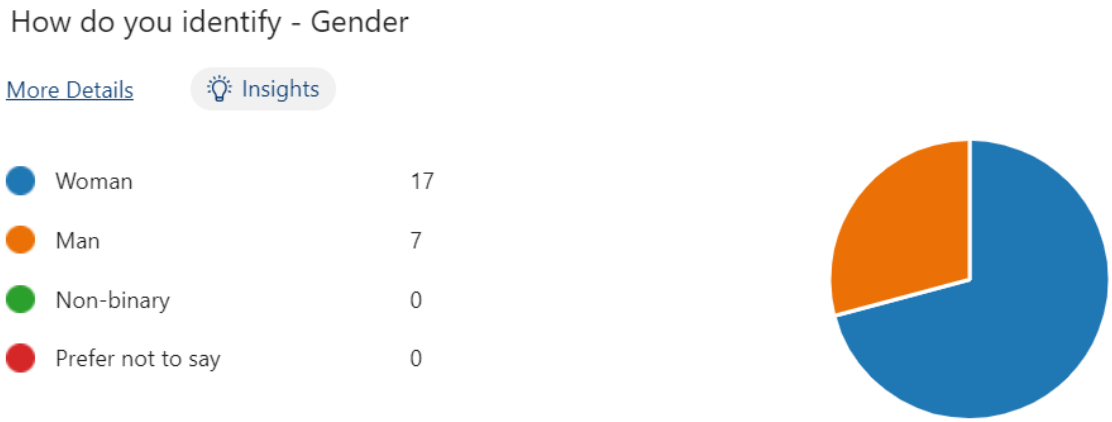
7. Freedom to Speak up Month.

October is Speak Up Month, and this year's theme is "Listen Up!" We have several initiatives planned to engage staff and promote the importance of listening. Key events include **Wear Green Wednesday** on 9th October, where staff are encouraged to dress in green to show support for Freedom to Speak Up, and a **Poetry Competition** focusing on the theme of listening, with prizes for the best entries. From 7th October, an **information stand** will be available outside the restaurant, providing resources and information about FTSU. Additionally, a **Travelling Post Box** will be moving across the Trust, allowing staff to share feedback and ideas on speaking up. Finally, we are introducing the **Tiny Turtle Awards**, celebrating colleagues who demonstrate excellent listening skills and support others. Nominations are anonymous and require the nominee's name, department, and a short reason for their recognition.

8. Equality and Diversity:

Over the past six months, we've gathered twenty-four completed Equality and Diversity forms out of fifty-two. Outcomes are highlighted below.





McCarthy Rebecca
03/10/2024 10:39:15

Do you consider yourself to have a disability or health condition

More Details Insights

Yes	6
No	12
Prefer not to say	6

What is your sexual orientation?

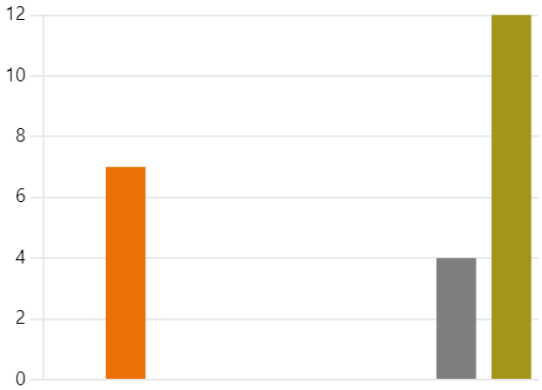
More Details

Bisexual	0
Gay or Lesbian	2
Hetrosexual/Straight	20
Term not Listed	0
Prefer not to say	2

What is your religion or belief?

More Details

Buddhist	0
Christian	7
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Religion or Belief not listed	0
No religion or belief	4
Prefer not to say	12



9. Feedback

I received feedback from six out of twenty-five feedback forms sent out to staff who had raised concerns via FTSU. Five of which indicated a willingness to speak up again in the future.

It's worth noting that a perceived negative outcome in terms of the resolution of a concern can significantly impact their overall experience and perception of the service. Unfortunately, the staff member who advised they would not speak up again did not specify their reasons which limits my ability to use this feedback for service development.

In response to this feedback, I have created an FTSU "What You Need to Know" fact sheet. This document aims to clearly outline what FTSU is, how it can assist, and its limitations, ensuring transparency about the role and its boundaries. Enclosed below are some excerpts of the positive feedback received.

"I was instantly filled with confidence and reassurance. I will not hesitate in reaching out again should I feel the need."

"Thank you again, you are the best, honestly don't know where I'd be without you".

"You did what you said you would when others didn't, thank you for that".

10. Capacity

I have worked on average 2.5 to 3 days at Stockport due to work demands. The demand at Stockport has been steadily increasing since October, resulting in Tameside occasionally receiving less than the allocated fifteen hours a week.

11. Resources

The Guardian currently works part-time – two days a week at both Stockport and Tameside & Glossop Integrated Care NHS Foundation Trust. The time commitment for the role is considered on an annual basis as part of the yearly review of the Trust's FSU arrangements.

Currently In the absence of the Guardian, staff raise concerns with the Director of Communication and Engagement, who is the executive lead for FSU and an experienced former Guardian.

12. Recommendations

The Board of Directors are recommended to note the contents of the report and the actions being taken to progress the Freedom to Speak Up agenda.

Appendix 1

Freedom to Speak Up Strategy 2024-2027

1. Introduction

At SFT, we are committed to creating a culture where all staff feel safe and empowered to raise concerns. This strategy outlines our vision to ensure that the voices of our staff are heard and acted upon, leading to improvements in patient care, staff safety, and the overall performance of the Trust. Our approach is inspired by the findings of **Sir Robert Francis's Freedom to Speak Up Review**, which emphasized the importance of fostering an open culture to prevent failures in care.

2. Where We Are Now

We are actively working to raise awareness of the Freedom to Speak Up (FTSU) processes and build staff confidence in raising concerns. While many staff members are aware of how to speak up, some remain hesitant, often due to fears of repercussions or doubts about whether their concerns will be addressed.

To address this, we have already taken important steps, including:

- Strengthening leadership commitment to creating an open and transparent environment.
- Increasing the visibility of the Freedom to Speak Up Guardian (FTSUG).
- A commitment to recruiting and training more FTSU Champions to work alongside the FTSUG to support staff in raising concerns and promoting awareness.
- Developing clearer and more accessible reporting channels.

While these are significant improvements, we recognize that more needs to be done to foster a culture where all staff feel fully supported and where speaking up is embraced as a positive driver for change.

3. What We Know So Far

From the concerns raised to date, we have learned several key lessons:

- **Improved Awareness**: Many staff are aware of the mechanisms to raise concerns, but more needs to be done to build trust in the process and reassure staff that they will not face retaliation.
- **Leadership Engagement**: Staff are more likely to raise concerns when they see leaders actively promoting and responding to issues.
- **Barriers to Speaking Up**: Some staff still feel anxious about potential repercussions or believe their concerns won't lead to meaningful changes.

4. Our Vision

Our vision is to ensure that staff feel safe to speak up and feel supported and encouraged to do so.

- **Every staff member** feels confident and supported in raising concerns.
- **All concerns** lead to clear, visible action and improvements.

- **The Trust leadership** is actively engaged in creating a culture of openness and transparency.

Key Components of the Vision:

- **Raising Awareness**: We will increase awareness across the Trust about the importance of speaking up and the processes available to do so. This includes regular training, visible communications, and accessible reporting mechanisms.
- **Leadership Support**: Leaders will demonstrate commitment to the Freedom to Speak Up agenda by engaging directly with staff and visibly responding to concerns.
- **Psychological Safety**: We will promote a culture of psychological safety where staff feel secure in raising issues without fear of retaliation or detriment.
- **Timely and Transparent Actions**: Concerns raised will be acknowledged promptly, with clear and timely actions taken. The outcomes will be communicated back to staff in a transparent manner, ensuring confidentiality is maintained.
- **Learning and Improvement**: We will incorporate feedback and lessons from concerns into our business intelligence, driving improvements in patient safety, staff well-being, and service quality.

6. Monitoring and Accountability

To ensure the effectiveness of this strategy, we will implement robust monitoring and reporting mechanisms:

- **Regular Reporting to the Board**: The Board will receive quarterly updates on the number of concerns raised, the nature of those concerns, and the actions taken in response.
- **Data Analysis**: We will track and analyse trends in the concerns raised, identifying areas for improvement, and ensuring systemic issues are addressed.
- **Staff Surveys**: Annual staff surveys will include specific questions about confidence in raising concerns and perceptions of safety, helping us measure progress and adjust our approach as necessary.
- **Feedback Loops**: We will ensure regular feedback to staff through the **'You Said, We Did'** process, demonstrating how their concerns have led to tangible changes in the organization.

Review Date: September 2027

Safer Care (Staffing) Report – September 2024

Report of:

Nicola Firth	Andrew Loughney
Chief Nurse	Medical Director

Contents

Stockport NHS Foundation Trust

1. Introduction

NHS Stockport NHS Foundation Trust

This report provides the Board of Directors with an update on the following:

- Staffing assurances
- Current challenges regarding staffing levels and risk mitigations, and the actions being taken to mitigate risks and financial impacts identified
- Safer staffing governance monitoring led by evidence-based decision-making on safe and effective staffing is a requirement for all NHS organisations
- The NHS has produced a comprehensive long term workforce plan. This is a collective plan for the NHS and sets out a clear direction. The certainty of confirmed funding up to 2028 allows for actions locally, regionally and nationally to address the gaps in the current workforce and meet the challenge of a growing and ageing population
- The Trust strives to provide outstanding care whilst developing flexible approaches and innovative ways of working. This is a challenging time but brings significant opportunities for workforce development
- We recognise that these ongoing pressures require health systems and boards to make tough decisions to ensure services achieve the best outcomes at a time of financial challenge. Boards must ensure that this does not have an adverse impact on the quality of care, as well as patient, service user and staff experience

2. Workforce Safeguards

NHS Stockport NHS Foundation Trust

To ensure the welfare of nursing staff and patient's welfare, nurse to patient ratios were introduced :

Deploying staff effectively
This is to advise the Trust's board of their responsibilities in ensuring staffing arrangements are safe, sustainable and productive. It also considers emerging roles such as nursing associates (NAs), physician associates and Advanced Clinical Practitioners (ACP) who are all integral to the future NHS workforce.

Useful guidance
The National Quality Board's (NQB) guidance explicitly requires the Trust meets the following expectations :

- deploying the right staff
- with the right skills
- at the right place and time

These set the foundations on which any workforce plan should be based while not ignoring other organisational development needs such as values and behaviours.

In addition, the Cavendish Report 4 highlights that well-performing organisations use their workforce as a strategic asset. This underlines the need to deploy the workforce effectively and efficiently.

3. Healthroster

NHS Stockport NHS Foundation Trust

The Trust uses Safecare Live at the twice daily staffing meetings to review staffing levels in conjunction with the acuity levels of patients.

The newly introduced Rostering dashboard provides trend data for the Key Performance Indicators (KPIs) which can be used as evidence in report/requests for data. From the information it has been reported :

- Net hours have reduced in most clinical areas
- Red flags have been configured on Safecare, to ensure safer staffing governance has a robust process in place
- Total unavailability have reduced from 24.1% to 23.1%
- Reduction in the changes to rosters since approval from 27.8% to 18.4, this is now within the expected target%

4. Vacancies

NHS Stockport NHS Foundation Trust

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	57.56	0.57	12
Corporate Services	100.57	2.30	21
Integrated Care	255.83	-28.73	12
Medicine , Urgent Care &ED	540.98	-75.75	21
Surgery	445.12	-29.66	27
Women & Children	399.57	-21.45	49
Total	1799.63	-152.72	142

The above data covers the positions of registered nurses (RNs), registered midwives (RMs), nursing associates (NAs), newly registered nurses and midwives awaiting PINs in July 2024.

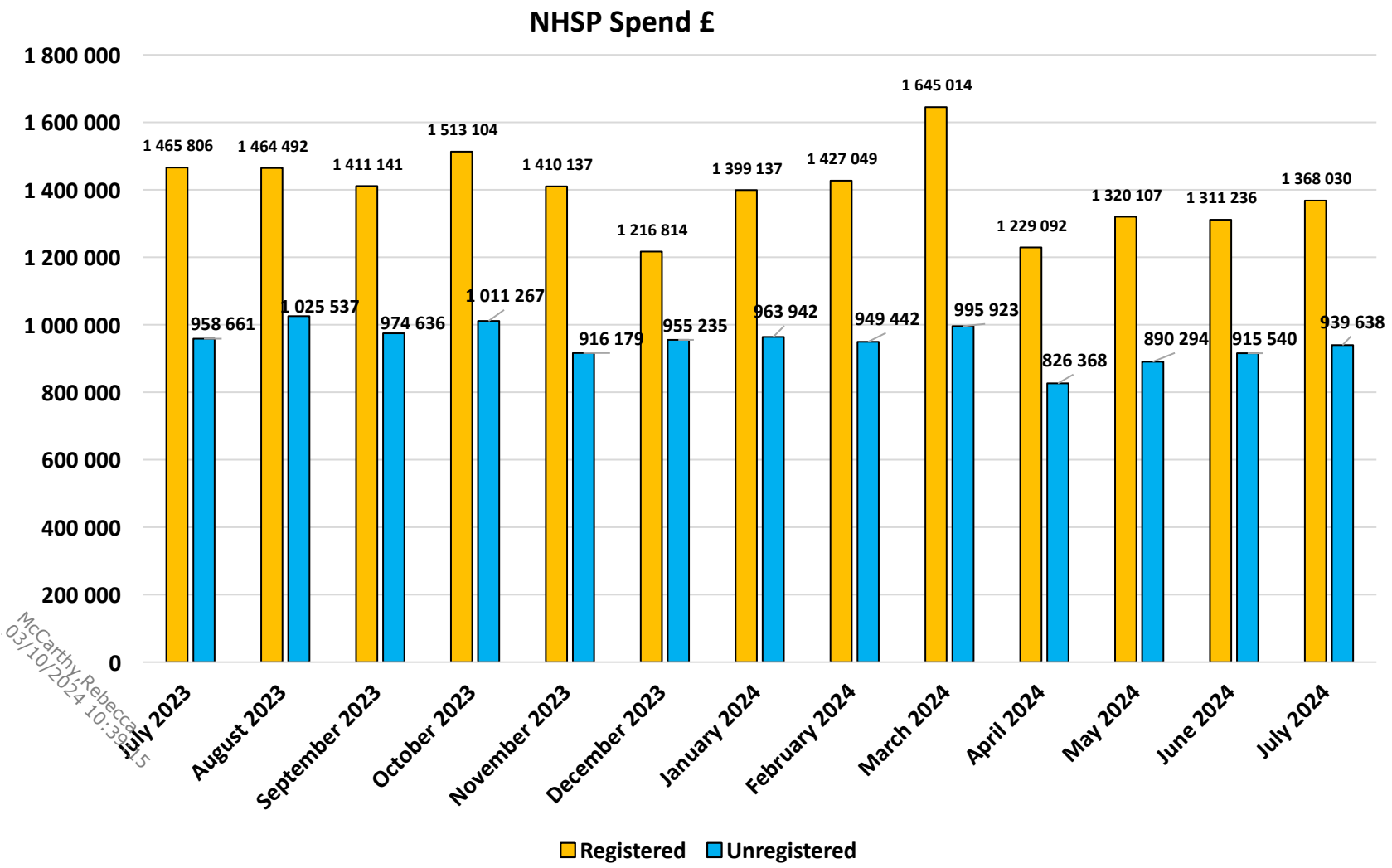
In June 2024, 216 were in the recruitment process with a percentage awaiting start dates. In July 2024, the figure was 142. It is expected that in September/October 2024 the number of nursing staff joining the Trust will increase due to the number of nursing students completing their courses and becoming registered practitioners.

The process for recruiting nursing students has been agreed by all the Divisional Nursing Directors (DNDs), Head of Learning & Education and Workforce, and is scheduled to be presented to the Nursing, Midwifery & AHP (Allied Health Professionals) Meeting in October 2024 for final approval. The SOP aims to ensure nursing students are supported throughout their interview and appointment, HR recruitment process, induction and as they transfer from learner to practitioner. This process will be led by the Pastoral Care Lead & Matron for Workforce in collaboration with the Learning and Education Team.

Data provided by Workforce

5. Temporary Staffing Spend

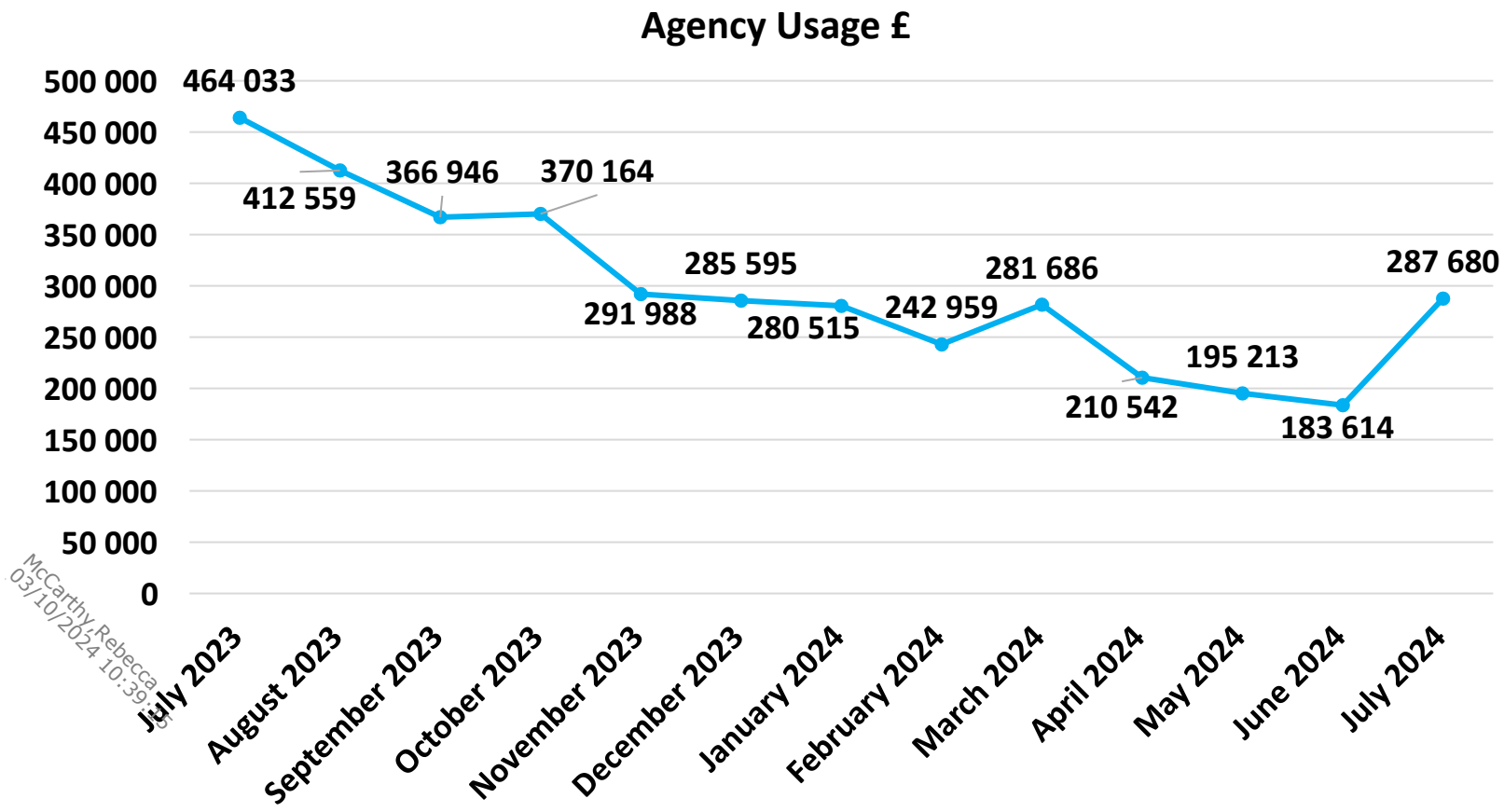
The table below illustrates the ‘month on month’ cost to the Trust of NHSP bank RNs, RMs and unregistered staff.



Data provided by People Analytics

6. Agency Spend

The information below illustrates the cost of agency usage month-on-month and the increase from June to July. It is recognised that there is often an increase in agency usage at this time of year as there are more staff taking annual leave over the summer months/school holidays.



Data provided by NHS Professionals

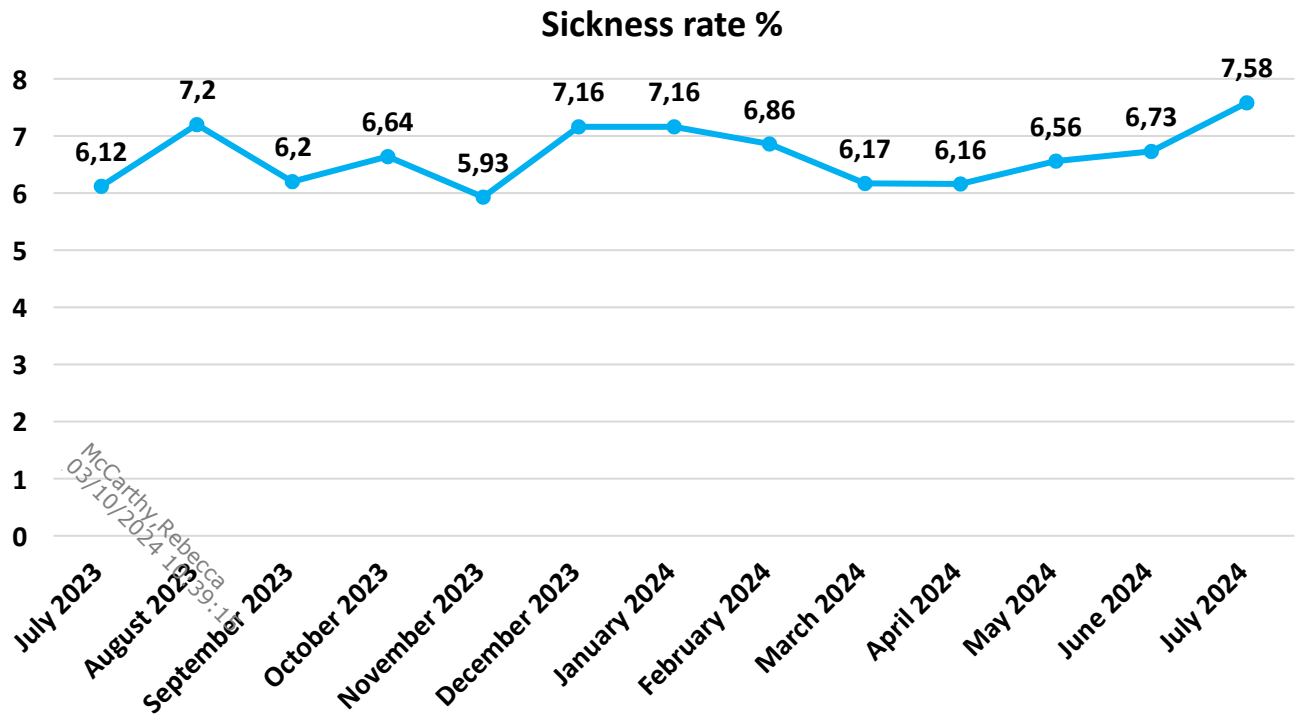
7. Absences/Sickness

NHS Stockport NHS Foundation Trust

The chart below illustrates the absence rates for registered nurses, registered midwifes and AHPs.

An absence from work can be the result of many factors for example short-term sickness due to colds/virus, long term condition, carers leave and it is recognised that the highest absence rates are during school holidays. 'Looking after our people' **NHS People Plan**. The Trust absence target is set at 6%.

Role	Sickness %
AHPs	4.50%
RNs & RMs	6.61%



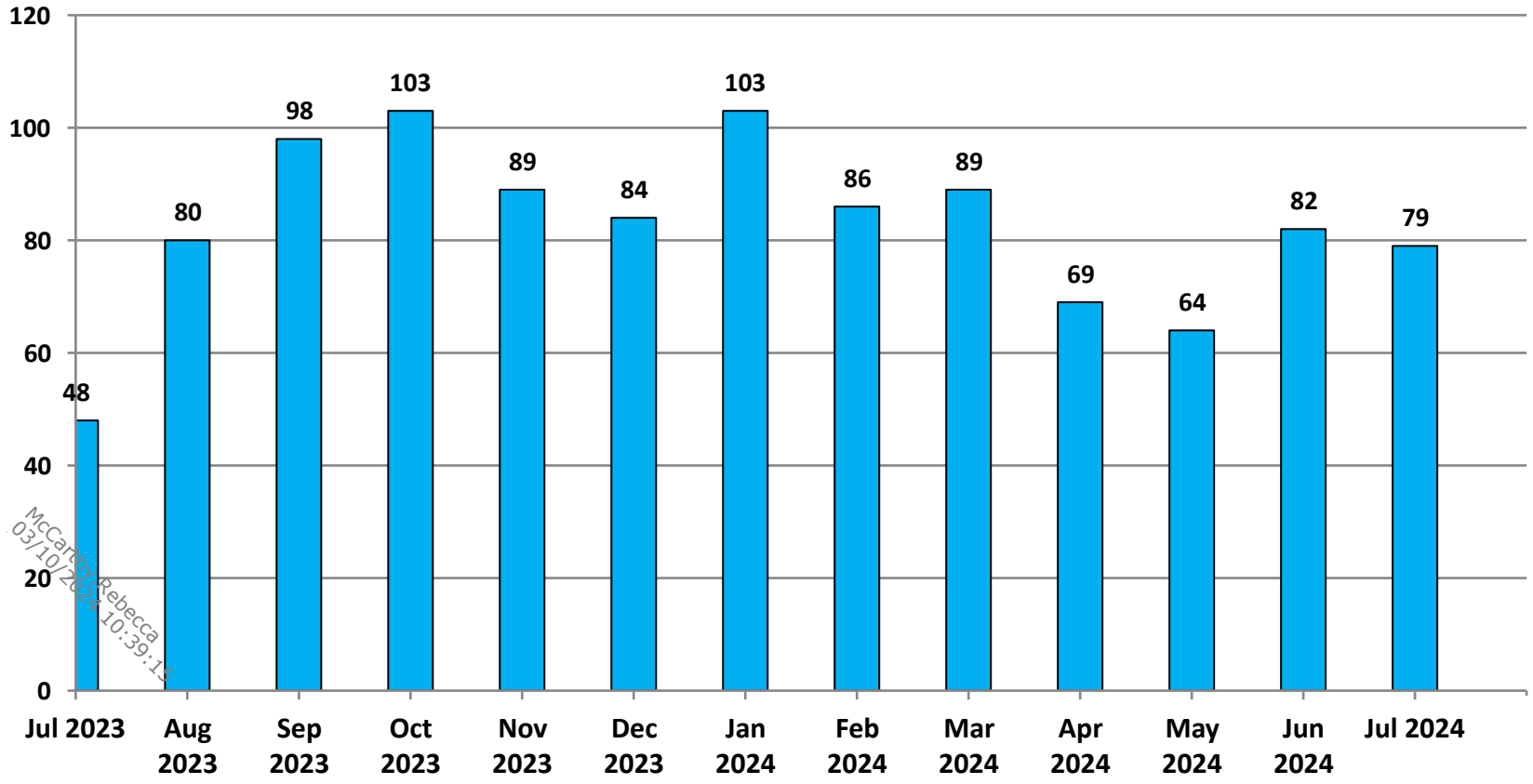
- The reasons for reported absence remains for Anxiety, Stress and Depression
- There is a close working relationship with, Occupational Health and SPAWS to support the work life balance of our employees
- Professional Nurse Advocates (PNAs) are on hand to provide coaching

Data provided by People Analytics & Workforce

8. Risk Highlights

The Trust actively encourages all employees to report incidents of staffing shortfalls. There was a considerable increase in incidents throughout June and July 2024 which may have been contributed to by the junior doctors strikes and the increased number of staff taking annual leave during the summer months/school holidays.

Reported number of staffing shortfalls

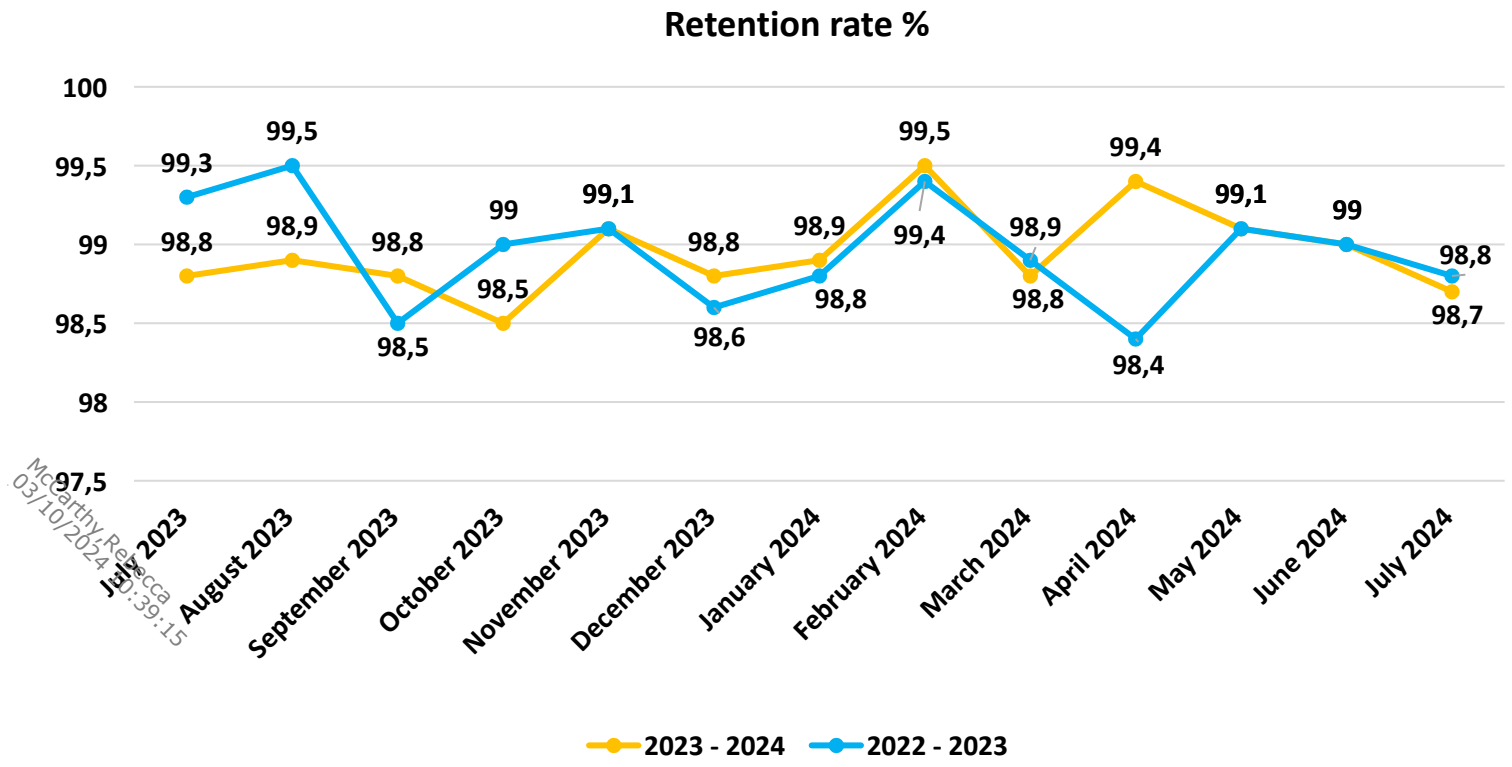


Data provided by Datix

9. Retention

The chart below illustrates the Trust's staff retention rate 'month on month' from July 2023 – July 2024.

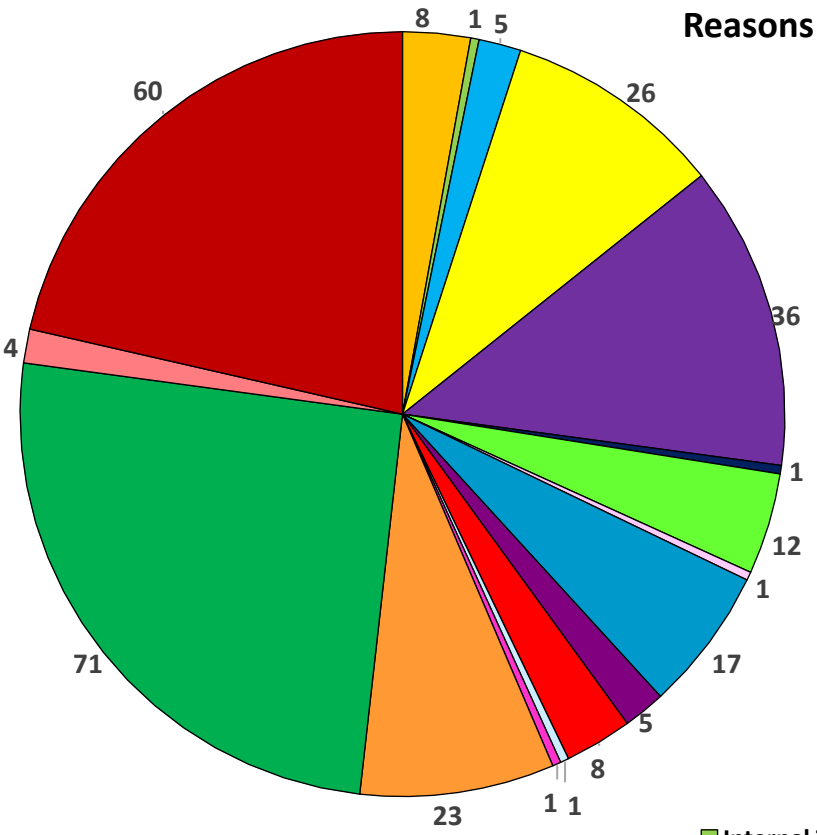
There has been a slight decline in staff retention from May – July but it is anticipated that the retention figures will improve as the role of the Pastoral Care Lead will focus on supporting new starters from interview through the recruitment process, and their initiation on the wards. The Trust values career development and invests in staff by providing training opportunities and supporting secondments to enhance career development. This plan, builds on the valuable work in both the NHS People Plan and the NHS People Promise.



Data provided by People Analytics

10. Reasons for Leaving

Stockport NHS Foundation Trust



Reasons for leaving the Trust July 2023 – July 2024

- Dismissal
- End of Fixed Term Contract
- Retirement Age
- Voluntary Resignation - Child Dependants
- Voluntary Resignation - Health
- Voluntary Resignation - Lack of Opportunities
- Voluntary resignation - Pay and Reward Related
- Voluntary Resignation - Relocation
- Voluntary Resignation - Work Life Balance
- Internal Transfer
- Flexi Retirement
- Voluntary Resignation - Adult Dependants
- Voluntary Resignation - Better Reward Package
- Voluntary Resignation - Incompatible Working Relationships
- Voluntary Resignation - Other/Not Known
- Voluntary Resignation - Promotion
- Voluntary Resignation - To undertake further education

Data provided by People Analytics

11. Nursing & Midwifery Recruitment

NHS Stockport NHS Foundation Trust

- The Pastoral Care Lead when appointed will be supporting support at recruitment events
- Divisions are running their own bespoke recruitment events, supported by Workforce and Human Resources (HR)
- On the 11th September 2024 interviews and assessments for Care Support Worker Development Programme will take place

12. Training Pathways

Stockport NHS Foundation Trust

Registered Nurse Degree Apprenticeship (RNDA) and Trainee Nursing Associate (TNA)

There are currently 10 RNDAs who are due to qualify in March 2025 and 7 TNAs due to complete in early 2025. They will be employed as Registered Nurses or Registered Nursing Associates upon successful completion and registration.

6 RNDAs completed the programme in March 2024 & have remained in substantive employment in the Trust.

In September 2024 10 TNAs will start their training and in February 2025 10 RNDAs will join their programme.

Preceptorship Programme

There are currently 351 staff showing active portfolios on the Preceptorship Programme; of these, 77 commenced between December and April 2024 and are within the 12 month period of Preceptorship, 6 have withdrawn from Programme, 3 left the Trust and 3 have been cancelled by their managers.

Work is on-going to support and encourage the 61 preceptees who were identified as disengaged, with visits to all areas being increased. The Legacy Mentor post has now come to an end, and a review of the role has been submitted to Educational Governance.

Internationally educated nurse (IEN) forums have commenced within the Trust to provide additional preceptorship support to this cohort of newly registered practitioners

13. Healthcare Scientists

NHS Stockport NHS Foundation Trust

Laboratory Medical

- **Microbiology** consultants remain the largest risk. There have been 2 retirements without being able to recruit to the posts. Current mitigation is recruitment of 3 speciality doctors and 1 locum consultant. Of the two substantive consultants one is on sabbatical for 5 months. This increases the pressure on the service. Support from Manchester Foundation Trust (MFT) has been received to cover the on-call provision; and the recruitment of an additional part time consultant is proving challenging. There is pressure on the daily rota and on-call provision. Currently this is covered but will require close management.
- **Histopathology** consultant workforce has been brought up to 11 Consultants with all new starters now in post, the performance of the department has seen the benefit of this.
- **Blood sciences** there is an additional day to backfill consultant clinical scientist to provide capacity for the replacement LIMS project. There has been no additional resource for the significant increase in workload seen since Covid, with yearly increases above 10% growth. Growth continues at 6% year to date and no additional resource has been provided.

Histology Laboratory

- **Biomedical Scientists (BMS)** It has not been possible to appoint to Two additional Band 6 post on 12 month contracts, to progress these posts need to be made permanent. There are 3 team members recruited at Band 5 to fill Band 6 vacancies and training up to a Band 6 level, due to lack of Band 6 staff in the recruitment market. Locums have been required to match the daily workload in department and with them in post the case cutting backlog has been reduced from 500 to 50 cases.
- **Medical Laboratory Assistants (MLA)** – Cancer Tracker post is currently in the recruitment process. Staffing numbers are below that required as highlighted in the paper to executives and an increase in establishment is required.

14. Healthcare Scientists

NHS Stockport NHS Foundation Trust

Blood sciences

- **Biomedical Scientists (BMS), Bands 5-8s** Recruitment has been successful to the high level of turnover in Biochemistry for this staffing group and the induction and training of these staff is going well. There is a requirement to rely on overtime from the established staff to maintain the 24/7 service whilst new staff are trained to the lone worker competency level required, this will take 3-6 months dependent on the individual.
- **Medical Laboratory Assistants (MLA), Bands 2-4** Supervisor role in Pathology Reception has been job matched to a band 4 by the AfC panel (increased from band 3), once recruited to this will hopefully allow a greater level of stability in the role. Additional staffing will be required whilst the Blood sciences analysers and automation is replaced as there will be no automation support for this period. There is a historically a high turnover for the MLA staff in the Pathology Reception and this is seen to be continuing. This is due to it being a stepping stone entry position within laboratory services.

Microbiology Laboratory

- **Biomedical Scientists (BMS), Bands 5-8s** the laboratory technical head will return from maternity leave in September. There is a lack of sufficient staff in this area, though recruited to establishment and this is a pressure point as microbiology remains a very manual process.
- **Medical Laboratory Assistants (MLA), Bands 2-4** Workload against staffing level is a significant pressure for this group.

Summary

Pathology has seen a year on year workload increase between 6-10% across the disciplines far exceeding the annual growth prior to Covid & has past the point of saturation of the staffing resource. A business case has been submitted for an increase in staffing. This has been agreed in principle, but funding is yet to be sourced. Recruitment remains an obstacle for experienced BMS staff and in-house training has been required to bring people to qualification and through their specialist portfolios.

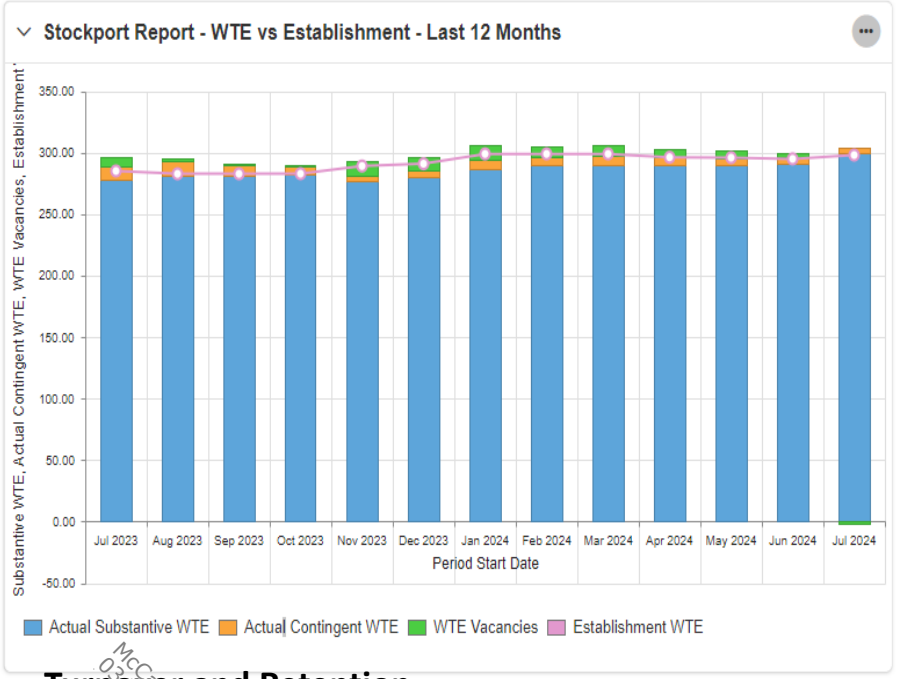
Data provided by Pathology

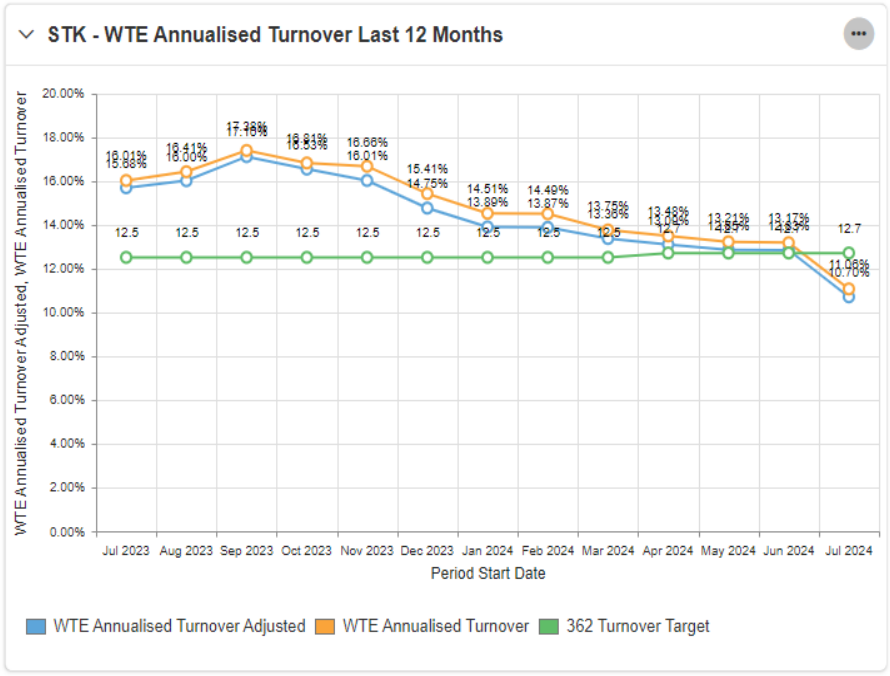
15. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

Recruitment

In the last report it was highlighted that there was a reduction in vacancies to 6.32 WTE with almost consistent month on month reductions from a peak of 11.86 WTE in November 2023. June & July 2024 saw further reductions with no vacancies being reported in July 2024 (see below, left). In July 2024, the Division had an actual substantive 300.1 WTE.





Turnover and Retention

Turnover has further dropped & now sits below the Trust target (12.5%) at 10.7% (see above, right). With focus on the quality of supervision & appraisals, support for secondments, career development opportunities, well controlled & managed flexible working opportunities and staff survey listening events and pragmatic action plans are among the multiple workforce strategies in place within the Integrated Therapies Directorate to authentically make this the preferred place of employment for our AHPs.

Data provided by Integrated Therapies & Boroughwide Services

16. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

Orthotics & Speech and Language Therapy remain our 2 most significant areas of concern with regards to staffing.

Orthotics

3 bank Orthotists support the acute Patient Appliances service.
We are monitoring activity closely to ensure that the reduction in waiting lists is tangible although the impact of the long NHSP process has caused delays.

Speech and Language Therapy (SLT)

SLT remains a risk, predominantly due to the large number of senior staff currently on maternity leave – this is unchanged from the last report. We expect to see the staffing levels and skill mix stabilise between now and October 2024 when 2 Clinical Leads are scheduled to return. The successful move of agency staff onto NHSP has been positive in ensuring safe staffing numbers, despite the challenges.

Apprenticeships

In addition to the existing AHP Support Worker, Physiotherapy, Occupational Therapy and Dietetics apprentices a substantive SLT Support Worker commenced the apprenticeship in September 2024. We are delighted to have retained an excellent member of staff at Stockport NHS FT through this career development opportunity.

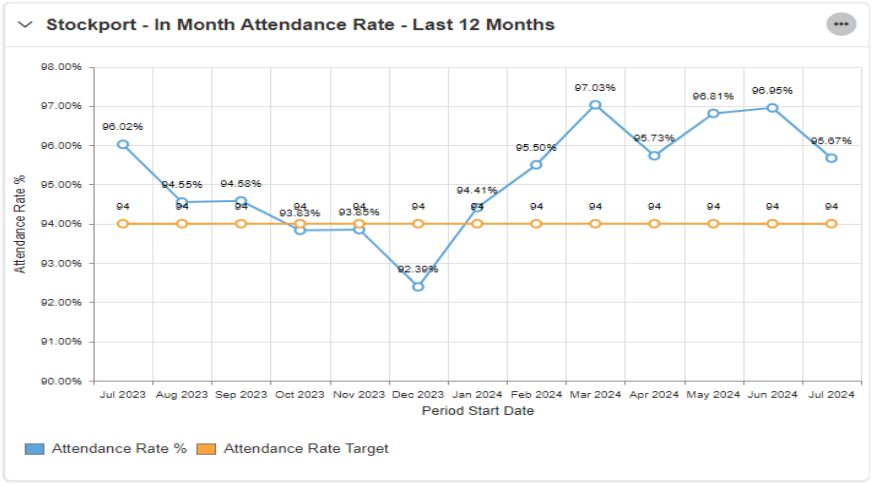
Data provided by Integrated Therapies & Boroughwide Services

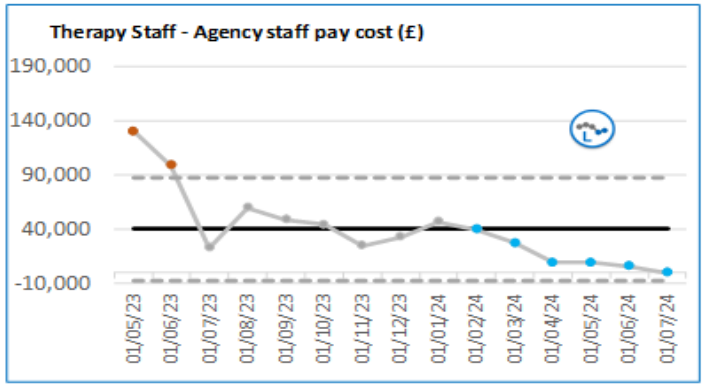
17. Allied Health Professionals (AHPs) – Integrated Therapies

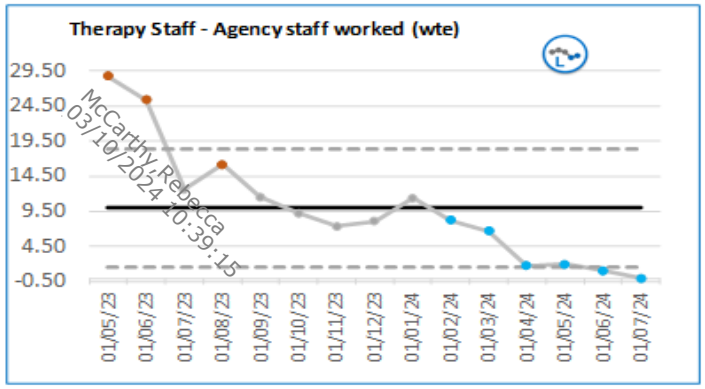
NHS Stockport NHS Foundation Trust

Attendance

- Attendance has been above the Trust target for 7 consecutive months at 95.67% at the end of July 2024 (see right). Malignancy accounts for the highest number of absences. Regular managerial reviews of all long term sickness took place with no concerns raised.







Agency Trajectory and Temporary Staffing

- A further reduction in agency spend was achieved through June (1.04 WTE). From 1st July 2024 there has been no further agency spend & Speech and Language Therapy locums have moved voluntarily to NHSP (see left). This concludes the current workstream to manage temporary staffing within Integrated Therapies. There has been an associated upturn in NHSP costs & all shifts are costed to ensure within the service's financial envelope and only used to support vacancies.

Job Planning

- The deadline for job plan completion took place on 31st August 2024 with steps to ratify and sign off any > or < than 5% of the recommended DCC:SPA template splits will then take place, with final approval planned for September 2024.

Data provided by Integrated Therapies & Boroughwide Services

18. Midwifery Update

NHS Stockport NHS Foundation Trust

The Maternity Unit is currently staffed in line with NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE 2015) and the latest Birth Rate plus (BR+) midwifery staffing review (March 2023).

Obstetrics cover

- 24/7 Consultant obstetric cover on delivery suite
- 2/day 7 day/week Consultant ward rounds in place
- Audit from February 2024 – June 2024 demonstrates compliance with RCOG certificate of eligibility guidance for short term locums
- Quarterly audits undertaken demonstrate 100% compliance of consultant attendance for clinical situations listed in RCOG workforce document.

Registered Midwives		
WTE Actual	**WTE Vacancies**	**Post WTE Recruited to TRAC**
165	**Vacancies 3.12 Mat Leave 9**	**14.2**

Challenges

- Current registered vacancy, inclusive of Inpatient and Outpatient, is 3.12 WTE & 9 WTE on maternity leave. This equates to a total deficit of 12.2 WTE.
- Midwifery Support Workers (MSWs) 4.65 WTE & maternity leave 0.88 WTE. This equates to 5.53 WTE.

Actions

- Weekly planned roster scrutiny meetings/E-Roster training sessions - continue
- Recruitment event took place 20th April – 15.24 WTE offers made, 14.2 WTE offers accepted
- Engage with trust pre-employment programme for Health Care Assistants (HCAs).

Assurance

- All shift co-ordinators have supernumerary status – monitored daily by MOD & incorporated into monthly dashboard. In July 100% compliant.
- July showed Maternity achieved 98.4% one to one care in labour (1 BBA & 1 fully dilated on admission)
- Fully engaged with MSW Framework Working Group
- Engaged with the International Educated Midwifery (IEM) recruitment programme. Four commenced in post all now have NMC PIN.

Data provided by the Division of Women & Children's

19. Medical Staffing

NHS Stockport NHS Foundation Trust

The Tiers below describe the directly employed Medical Workforce within the Trust:

Tier 3: ***Expert clinical decision makers*** These are clinicians with overall responsibility for patient care. In the Medical Workforce these are our Consultants.

Tier 2: ***Senior clinical decision makers*** These are clinicians capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment. For the medical grades this is largely SAS Doctors and Senior Clinical Fellows.

Tier 1: ***Competent clinical decision makers*** These are clinicians capable of making an initial assessment of a patient. For the medical grades this is largely Foundation Doctors and Junior Clinical Fellows.

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	264.6	230.11	34.49
Tier 2	130.35	113.93	13.92
Tier 1	137.18	153.8	26.18
Total	532.13	497.84	-34.29

N.B. *The Trust is also a host employer on behalf of the Lead Employer, St Helens and Knowsley NHS Trust, for specialty, core and general practice trainees and we host a further 165 trainee doctors working at the Trust across our specialties.*

Data provided by Medical Staffing

20. Medical Staffing

NHS Stockport NHS Foundation Trust

Consultant Recruitment

- Medical Staffing continue to work with closely with divisions to target recruitment campaigns in advance of when doctors in training are set to become eligible to work as consultants. This has seen recent success with the appointment of a number of consultants in:
    - Histopathology
    - Radiology
    - O&G
    - Paediatrics
    - Medicine/DMOP
    - Gastro
    - Anaesthetics/Critical Care
- Interviews are scheduled for July to recruit to Gastro and Anaesthetics/Critical Care posts.
- Medical Staffing are actively working with divisions to recruit to consultants to Microbiology, General Medicine/DMOP & Stroke.

Data provided by Medical Staffing

21. Medical Staffing

NHS Stockport NHS Foundation Trust

Medical Workforce Group Update

- **Senior Medical Recruitment**

  The group monitors the workforce and seeks to assist divisions with, for example those difficult to fill specialties, and ensures that all options are being explored.

- **Senior Medical Locum Expenditure**

  This is also being monitored by the group who work on reducing staffing costs whilst also focusing on ensuring safe staffing levels and patient safety. This exercise has already demonstrated significant financial savings and cost avoidance for the Trust.

- **GMC Survey and Mandatory Training**

  The group have placed great emphasis on improving the GMC Survey Results and mandatory training compliance rates in 2024. The latest information shows that there have been improvements in both areas which will aid in attracting doctors to the Trust.

- **CESR Support and Workforce Planning**

  The group have undertaken research into what support can be provided to doctors wishing to undertake CESR and eligible for consultant posts to help with workforce planning, particularly in those difficult to fill areas. A paper will be presented to the group, followed by the Trust Executives, giving recommendations on next steps.

Data provided by Medical Staffing

22. Good news

NHS Stockport NHS Foundation Trust

- The Division of Maternity are to start using the acuity tool Safe Care and are currently undergoing training
- In the AHP Division there was an agency spend of 1.04 WTE in June 2024. In July 2024 there was no agency spend and all Speech and Language Therapy locums migrated to NHSP
- Working with NHSP a pathway has been created which enables NHSP HCAs to apply directly to vacancies within the Trust, this ensures a quick and streamline recruitment process

23. Going forward

NHS Stockport NHS Foundation Trust

- Chief Nurse plans to attend Salford University in September 2024 to meet the student nurses
- Agency usage for July was 10.1% and August ended on 7.9%. The increase during the month of July maybe seasonal, impacted by summer/school holidays, and strikes by the junior doctors
- Working with NHSP in co-ordinating an interview & assessment day for the Care Support Workers Development Programme
- The Emergency Department are running a recruitment event for Band 5 and 6 registered nurses on Saturday 12th October
- Workforce Matron to visit Manchester Metropolitan University to talk to the nursing students about the role of a matron and provide advice on interview techniques

NHS
Stockport
NHS Foundation Trust

				Agenda No.	12
Meeting date	3rd October 2024	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Safer Care (Staffing Report)				
Director Lead	Nic Firth, Chief Nurse Dr Andrew Loughney, Medical Director	**Author**	Helen Howard, Deputy Chief Nurse		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are asked to receive the report and confirm action taking place to support safe staffing.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

X	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's

		wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	

Executive Summary

This paper provides the assurances and risks associated with safe staffing and the actions in progress to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

The Trust is assessed on the compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Boards' guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

We continue to experience high levels of operational demand within the acute and community services which we are aware is having an impact on patient experience and staff experience. The demands within the Emergency Department remain significant, impacted on by large numbers of patients who do not require a hospital bed any longer. This demand is operationally managed by our senior teams and on call colleagues with a continual dynamic risk assessments being carried out.

NHS
Stockport
NHS Foundation Trust

				Agenda No.	13
Meeting date	3rd October 2024	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	2023-2024 Annual Submission to NHS England North-West: Appraisal, Revalidation and Medical Governance.				
Director Lead	Mr Andrew Loughney	Author	Mr Andrew Loughney Dr Gordon Yuill Zuzana Boys Spencer Mckee		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to approve the recommendation from the People Performance Committee and support the annual submission to NHS England North-West: Appraisal, Revalidation and Medical Governance to be signed by the Chief Executive.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

X	Safe	X	Effective
X	Caring	X	Responsive
X	Well-Led	X	Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
*	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	1F (v) Page 25
Financial impacts if agreed/not agreed	1A (ii) Page 2
Regulatory and legal compliance	1B Page 5
Sustainability (including environmental impacts)	1A (ii) Page 2

Executive Summary

The Trust is required to submit the 2023-2024 Annual Submission to NHS England North-West.

This report has been reviewed via the People Performance Committee and is attached with the purpose of providing NHS England with assurances that the Trust has appropriate arrangements in place with regards to the Appraisal, Revalidation and Medical Governance for the doctors that we employ.

The Trust has complied with national requirements during this period that has seen growth in the number of doctors that we employ. This is positive to note and can be credited to the hard work of those working in this field of work.

The Trust does need to recruit additional Medical Appraisers in 2024/25 to maintain the required levels of staffing in this area. The report highlights the plans that are in place to address this.

1. Purpose

1.1 The committee is asked to review the paper and support this being returned to NHS England North-West.

2. Introduction / Background

2.1 At NHS Trusts:

A. Doctors are required to have a Medical Appraisal every year in order to be able to revalidate with the General Medical Council (GMC) every five years.
B. Trusts must have the required staff, systems, processes and policies in place to enable this. This includes mandatory roles such as a Responsible Officer.
C. NHS England requires NHS Trusts to submit an annual submission to provide assurances regarding the above.
D. This report provides assurances that Trust has the required staff, systems, processes and policies in place. It demonstrates that the Trust has maintained high levels of Medical Appraisal compliance throughout this period, and that it is complying with national requirements.
E. There is currently a shortfall in the number of required appraisers that the Trust does need to address. The report highlights how this matter will be addressed.

3. Matter under consideration (change/add subheadings as needed)

3.1 Page 2-27 details the Trust response to the specific questions from NHS England and provides assurances that the Trust is managing these areas appropriately and as required.

3.2 Page 28-29 details the summary, including actions that need to be undertaken.

3.3 As stated in 1B (iv) on page 4 the Trust has seen an increase in the number of Medics that it employs. This has naturally led to a requirement for the Trust to undertake more Medical Appraisals. The Trust has though maintained high levels of Medical Appraisal compliance throughout this period which is positive to note.

3.4 Please refer to point 1A (ii) on page 2. This highlights that there is currently a shortfall in the number of required appraisers which the Trust needs to address. This report highlights how this matter will be addressed.

4. Recommendations

4.1 The Board of Directors is asked to review the paper and approve recommendation from People Performance Committee to support this being returned to NHS England North-West to be signed by the Chief Executive.

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Stockport NHS Foundation Trust
What type of services does your organisation provide?	Acute Services

	Name	Contact Information
Responsible Officer	Mr Andrew Loughney	Andrew.Loughney@stockport.nhs.uk
Medical Director	Mr Andrew Loughney	Andrew.Loughney@stockport.nhs.uk
Medical Appraisal Lead	Dr Gordon Yuill	Gordon.Yuill@stockport.nhs.uk
Appraisal and Revalidation Manager		
Additional Useful Contacts		
Medical HR Manager	Spencer McKee	Spencer.McKee@stockport.nhs.uk
Medical HR Officer/ Appraisal & Revalidation Co-Ordinator	Zuzana Boys	Zuzana.Boys@stockport.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None.
Comments:	The Responsible Officer (RO) is Mr Andrew Loughney. He has been trained to undertake the role and he attends the regular RO update meetings run by NHSE. He was appointed in October 2020.
Action for next year:	To continue with the above.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:	None.
Comments:	The Trust has: A Responsible Officer/Medical Director (Full-time). A Medical Appraisal Lead (1PA). A Medical HR Officer who is the Appraisal & Revalidation Co-Ordinator (ARC) (0.8, Band 4), supported by a Medical HR Manager. The following appraisers are currently trained and delivering appraisals at the Trust: ➢ 11 Super Appraisers (0.75 programmed activity allowance) conducting fifteen appraisals per year. ➢ 29 Appraisers (0.25 programmed activity allowance) conducting 5-8 appraisals per year.
Action for next year:	To continue with the above, and to note the following actions: 1. The Trust is currently facing a shortage of appraisal slots for the current 2024/25 cycle and will therefore continue with regular recruitment rounds to appoint new appraisers, as required. The next recruitment round is scheduled for Autumn 2024. Three new expressions of interest have been received in 2024 and these doctors are due to undergo an in-house training course in October 2024. 2. To create a 'central funding pot' for funding Medical Appraisers (currently funded from divisional budgets) so that funds are readily accessible for the appointment of Medical Appraisers, as required. This will help remove barriers for appointing to the roles, as the funding will be readily available. 3. To review the Medical HR Officer/Appraisal & Revalidation Co-Ordinator (ARC) role.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None.
Comments:	The records are held on GMC connect, and in the automated Appraisal & Revalidation System, the Trust currently uses the Premier IT System.
Action for next year:	To continue with the above, but noting the following action: 1. The Trust is currently undertaking a review of the current Appraisal & Revalidation System and is exploring other providers in the market before deciding on what system to use beyond 2024/25. The aim of this review is to ensure that the Trust has procured and is utilising the best system that is available in order to help further enhance the Appraisal and Revalidation services.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None.
Comments:	The Trust has a full suite of the policies that are required to support Medical Revalidation. This includes an in-date Appraisal & Revalidation Policy. The Trust has a range of other policies that are linked to and required to support the Appraisal & Revalidation process. This includes a Handling Concerns about the conduct, performance, and health of Medical and Dental Staff Policy, Recruitment Polices and a Job Planning Policy. Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation.
Action for next year:	To continue with the above.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To resume peer reviews.
Comments:	The Trust's last formal peer review process was previously completed in 2018, and this was reported in the 2018/19 report. Collaboration with East Cheshire NHS Trust and The Christie NHS Foundation Trust has now been resumed. Appraiser refresher events are taking place, the most recent event taking place on the 16/05/2024 which was organised by East Cheshire NHS Foundation Trust, via MIAD.
Action for next year:	1. To continue our collaboration with East Cheshire NHS Trust and The Christie NHS Foundation Trust. 2. To undertake a fresh peer review in 2024/25.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None.
Comments:	The Trust continues to offer a 'primer' appraisal to all such doctors, including those new to the NHS or to the UK. These are offered to doctors shortly after they have started with the Trust via an overall appraisal welcome email and are carried out by the Trust Medical Appraisal Lead. They offer an opportunity to discuss Good Medical Practice 2024, the principles of Appraisal and Revalidation, the expected evidence for appraisals, guidance on how to use the IT systems, and how to contact the Appraisal and Revalidation Co-Ordinator.
Action for next year	To continue with the above.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None.
Comments:	The average Trust annual compliance rate in the 2023/24 year was 92.37%. All but one doctor due to appraise in 2023/24 completed their appraisal, or had a formal postponement approved (due to long-term sickness absence or maternity leave). Importantly, the doctor with an outstanding appraisal is being supported by the Trust Medical Appraisal Lead in working towards completion. The appraisal covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in our organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. Improving the timeliness of appraisals has been supported through the early intervention of the Appraisal and Revalidation Co-Ordinator who holds regular review meetings with the Trust Appraisal Lead and Revalidation Officer.
Action for next year:	Continue with the above.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	All appraisals are to be looked at individually by the Appraisal and Revalidation Co-Ordinator and the Medical Appraisal Lead in regular review meetings to ensure that early intervention/help is provided where necessary, or as appropriate escalation to the Division/Responsible Officer is initiated.
Comments:	The progress of all appraisals is tracked by the Appraisal and Revalidation Co-Ordinator on a weekly basis, with individual reminders being sent to doctors and/or appraisers where needed. All late appraisals are looked at individually by the Appraisal and Revalidation Co-Ordinator and the Medical Appraisal Lead in weekly review meetings. This helps to ensure that early intervention/help is provided where necessary, and as appropriate, escalation to the Division/Responsible Officer is initiated. Appraisal compliance figures are communicated with each Division, the Medical Director/Responsible Officer and the Medical Appraisal Lead on a monthly basis.
Action for next year:	Continue the above process.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	None.
Comments:	The Trust has an in-date Appraisal and Revalidation Policy that is compliant with the national policy. Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation.
Action for next year:	Continue with the above.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Maintain the necessary number of trained appraisers, noting that the number of doctors eligible for an appraiser continues to rise.
Comments:	Despite this rise in the number of doctors employed, the Trust has ensured that all eligible doctors were able to appraise in 2023/24. Currently, there are 451 doctors requiring an appraisal. The Trust currently has thirty-nine trained appraisers providing 386 appraisal slots. This means that in 2024/25 the Trust is currently facing a shortage of appraisal slots. The issue has been escalated to the Responsible Officer, Medical Appraisal Lead and the Trust Medical Workforce Group. This group have advised that divisions must fund their allocation of the costs based on the number of appraisees that they have. A communication is set to go out advising divisions of this, and that the money will go into a central funding pot. The shortage has also been entered on the Risk Register.
Action for next year:	1. Continue with regular recruitment rounds to appoint new appraisers, as required, with the next one being scheduled for October 2024. 2. To create a 'central funding pot' for funding Medical Appraisers (currently funded from divisional budgets) so that funds are readily accessible for the appointment of Medical Appraisers, as required.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	None.
Comments:	The Industrial Action for doctors in 2023/24 caused significant disruption to Acute Trusts. This impacted on the number of Appraisal Support Groups that the Trust could run. The last Appraisal Support Group meeting that took place in 2023/24 was on the 18/09/2023. In the 2024/25 period a further Appraisal Support Group meeting has taken place on the 08/05/2024. The Trust has an additional meeting scheduled to take place on the 23/09/2024. These meetings have now been changed to hybrid meetings to enable increased attendance through both face-to-face and remote attendance. The Trust also runs regular Appraiser Refresher Training sessions, both group and one-to-one sessions. A 'buddy' system is offered to all newly trained appraisers. A joint appraiser refresher training session run by MIAD was organised by Macclesfield NHS Trust for both Macclesfield and Stockport appraisers and took place on 16/05/2024. An appraisal feedback questionnaire form is an integral part of the appraisal process and must be completed by all appraisees for their appraisal to complete on the online system. All appraisers are provided an appraiser feedback report by the Appraisal and Revalidation Co-Ordinator so that they can reflect on this during their own medical appraisal.
Action for next year:	1. To improve the frequency of Appraisal Support Group meetings to quarterly. 2. To ensure attendance is recorded and that appraisers are reminded of the requirement to attend at least 2 Appraisal Support Group meetings per appraisal cycle year.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None.
Comments:	There are three ways in which the Trust Quality Assures (QA) the appraisal process: 1) Appraisees feedback on the appraisal process via an appraiser feedback questionnaire which is an integral part of the appraisal process. 2) There is a formal Quality Assurance process using the ASPAT tool. 3) Appraisers are expected to attend the quarterly Appraisal Support Group. In addition, an annual report is provided to the Trust Board for information, assurance and comments. A Quality Assurance exercise was completed in 2022/23, and feedback was provided to appraisers at the Appraisal Support Group that was held on the 18/09/2023.
Action for next year:	1. The Trust plans to undertake a new Quality Assurance exercise in 2024/25.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None.
Comments:	The systems, processes, policies and structures that are detailed within this document enable recommendations to be made to the GMC about the fitness to practice of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales. This includes the identification of and reporting of any doctors where there are concerns about fitness to practice. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any fitness to practice concerns and if so, take appropriate action that is in line with national requirements. No recommendations were made to the GMC in 2023/24 that highlighted any fitness to practice concerns.
Action for next year:	Continue with the above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The systems, processes, policies, meetings and structures that are detailed within this document enable this. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any fitness to practice concerns and if so, take appropriate action. Doctors identified as at risk of deferral or non-engagement are contacted at the very earliest opportunity on an individual basis to offer support and advice. Where a deferral cannot be avoided, the doctor is advised of the reasons prior to the recommendation being made and is advised of the actions that are needed in order to ensure that a positive recommendation can be made at the time of a revised revalidation due date.
Action for next year:	To continue with the above.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None.
Comments:	Standard clinical governance processes are in place in the Trust and individual doctors identified in complaint, incidents and safeguarding concerns are escalated to the Responsible Officer. Doctors undergoing disciplinary processes are discussed with the PPA, and the GMC.
Action for next year:	To continue with the above.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None.
Comments:	The systems, processes, policies, meetings and structures that are detailed within this document enable this. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any concerns and if so, take appropriate action. The appraisal documentation requires all doctors to declare their 'whole scope of practice' and appraisers are reminded at Appraisal Support Groups that there must be supporting evidence from all the areas of practice discussed. The Trust has a full suite of policies to aid monitoring the conduct and performance of all doctors working in the Trust. This includes an in-date policy for 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff' Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. The policy gives reference to the groups that oversee the monitoring of such matters and how these should be managed. This includes a monthly meeting that takes place between the Medical Director, Director of Medical Education and HR Leads to discuss all concerns. The Responsible Officer has met with the private hospitals which employs some of our consultants and has agreed that, if the appraisal output form does not specifically refer to the supporting evidence supplied by that organisation, then a further meeting between the appraiser and appraisee is required or the practicing privileges at that organisation will be removed.
Action for next year:	To continue with the above.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None.
Comments:	Doctors are advised and enabled to: ➢ Refer to their ESR record for mandatory training compliance report. ➢ To consult with their Clinical Governance Team regarding their incidents report. ➢ To consult with the HED team regarding their HED report if one is available for them. This enables the doctors to have the required access to the information that they require.
Action for next year:	To continue with the above.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None.
Comments:	The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any concerns and if so, take appropriate action. The Trust has a in date policy for 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff'. Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. The above policy gives reference to the groups that oversee the monitoring of such matters and how these should be managed. This includes a monthly meeting that takes place between the Medical Director, Director of Medical Education and HR Leads to discuss all concerns. The Trust also has a quarterly liaison meeting with the GMC liaison officer.

	This facilitates the appropriate monitoring and management of such matters to enable the Trust to comply with both national and legal requirements.
Action for next year:	Continued with the above.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None.
Comments:	The systems and processes for responding to concerns are well established at the Trust. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any concerns and if so, take appropriate action. The Trust has a full suite of policies to aid in monitoring the conduct and performance of all doctors working in the Trust. This includes an in-date policy for 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff' Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. The above policy gives reference to the groups that oversee the monitoring of such matters and how these should be managed. This includes a monthly meeting that takes place between the Medical Director, Director of Medical Education and HR Leads to discuss all concerns. The Trust also has a quarterly liaison meeting with the GMC liaison officer. Such data on doctors being taken through e.g. a disciplinary process is presented to the Board of Directors. High level information is provided to the Private Trust Board, whilst adhering to information governance requirements. This helps enable good practice and compliance with employment law and applicable national requirements.

Action for next year:	To continue with the above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Responsible Officer to Responsible Officer communications must be completed in a timely manner.
Comments:	The systems and processes for responding to concerns are now well established. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any concerns and if so, take appropriate action. This communication is now effective, and evidence is available to demonstrate that this is completed in a timely manner.
Action for next year:	To continue with the above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	HR colleagues to formally review the protected characteristics of the staff about whom concerns are raised to identify any bias and this process includes medical staff.
Comments:	The Trust Medical Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. Every policy agreed would have undertaken relevant EDI assessments in order to ensure that it is fit for purpose for all staff so that they are fair and free from bias and discrimination. The policy and procedure for 'Handling concerns about the conduct, performance and health of medical and dental staff' is inclusive for all medical staff groups that this impacts. All staff have access to this guidance and the medical staff groups that this impacts are all required to comply with this policy in order to comply with their own professional responsibilities as doctors. The above policy gives reference to the groups that oversee the monitoring of such matters and how these should be managed. This includes a monthly meeting that takes place between the Medical Director, Director of Medical Education and HR Leads to discuss all concerns.

	The Trust also has a quarterly liaison meeting with the GMC liaison officer. Such data on doctors being taken through e.g. a disciplinary process is presented to the Board of Directors. High level information is provided to Private Trust Board, whilst adhering to information governance requirements. The Just Culture approach at the Trust is a resource for assessing the seriousness of the concerns and what the response to it should be. Unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly addressed through these processes in order that concerns can be shown to be founded or not. This helps enable good practice and compliance with employment law and applicable national requirements.
Action for next year:	To continue with the above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	None.
Comments:	Full engagement with peers regularly takes place. This includes Trust attendance at all relevant regional and national meetings, including fortnightly Medical Director meetings and quarterly Responsible Officer meetings. A peer review meeting is also in place. The clinical governance systems of the Trust give due focus to safety, effectiveness and patient experience and are reported through the Board Quality Committee. Each forum/committee has a horizon scanning function including gleaning information from and responding to items in the news and reports from medically relevant enquiries. The Trust Medical Policies are monitored and agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. Every policy agreed would have undertaken relevant EDI assessments in order to ensure that it is fit for purpose for all staff.

	Discussions and outcomes from these groups and meetings inform Trust policies and procedures as required.
Action for next year:	Continue with the above.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	None.
Comments:	There are robust systems, policies, processes, meetings and training models in place that are well established. There is an Appraisal and Revalidation Policy that applies to all doctors. The Trust has a 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff' that applies to all doctors. The Trust has a Job Planning Policy which maps out the programmed activity model for appraisers. The Trust has a set of Recruitment Policies that enable appropriate employment checks. Policies are agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. Training and support networks are provided to both appraisers and appraisees. The Appraisal and Revalidation Co-Ordinator regularly meets the Responsible Officer and Medical Appraisal Lead to review all doctor's appraisal and revalidation matters, and will review whether there are any concerns and if so take appropriate action. There are management frameworks in place to manage concerns raised with regards to professional standards. This includes a monthly meeting that takes place between the Medical Director, Director of Medical Education and HR Leads to discuss all concerns. The Trust also has a quarterly liaison meeting with the GMC liaison officer. The Trust provides professional leadership training at each level of the organisation in the different divisions (in house and outsourced), measuring performance, and giving focus to the diversity of our leadership teams. The Trust also has a range of wider groups and committees including the Trust Education Board that continuously reviews such matters and ensures appropriate plans are in place. Appraisal and Revalidation is also on the Medical Workforce Group Work Plan that has both medical workforce and medical HR input, but also wider input from general HR and operational staff. Such groups and committees look at sharing good practice across all areas of the Trust for employees.

	This helps ensure consistent application of policy, processes and procedures across the organisation.
Action for next year:	Continue with the above.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None.
Comments:	The Trust has appropriate policies in place to monitor this and provide necessary assurances. This includes Recruitment Policies. Policies are agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation, and other Trust forums where required. NHS Employment Checks including qualifications and experience are assessed at the interview and/or all pre-employment checks are conducted by the recruitment department in line with NHS Employment Check Standards www.nhsemployers.org/recruitment/employment-standards-and-regulation. All external locum/agency doctors will be validated by their individual agency and/or Temporary Staffing Department. Medical HR was audited by Mersey Internal Audit Agency (MIAA) in 2024 which included a review of our recruitment policies and processes and the function was awarded 'significant assurance'.
Action for next year:	To continue with the above.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None.
Comments:	The Trust has a set of organisational values and standards that all employees are required to adhere to, and employees are reminded of these at their induction and appraisal. Fairness and respect messages are also embedded into all staff inductions including inductions for medical staff. Doctors are encouraged to report any negative experiences they may have in these respects, and they are advised of a range of mechanisms to do this e.g. Freedom to Speak Up Guardian and Guardian of Safe Working (as applicable). The Trust OD function supports the provision of a number of courses, programs, and teachings to help achieve this aim. Support is offered to the Medical Leadership Team which is cascaded down to the doctors within their divisions to ensure that high standards are adhered to, as well as consistency. All doctors are required to undertake mandatory training within the Trust that maps out the levels of knowledge required and the standards that are to be adhered to. This includes for example the provision of a Civility Saves Lives course for all staff. This reminds employees that everyone must be treated with dignity and respect, and it also highlights what to do if you do have concerns about behaviours and/or standards. The Trust has a range of groups and committees including an Education Board that continuously reviews such matters, and then ensures appropriate plans are in place to deliver the required goals as well as meet any required national and employment law requirements.
Action for next year:	Continue with the above.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None.
Comments:	The Trust has a set of organisational values and standards that all employees are required to adhere to, and employees are reminded of these at their induction and appraisal. Fairness and respect messages are also embedded into all staff inductions including inductions for medical staff. Doctors are encouraged to report any negative experiences they may have in these respects, and are advised of a range of mechanisms to do this e.g. Freedom to Speak Up Guardian and Guardian of Safe Working (as applicable). The Trust OD function supports the provision of a number of courses, programs, and teachings to help achieve this aim. Support is offered to the Medical Leadership Team which is cascaded down to the doctors within their divisions to ensure that high standards are adhered to as well as consistency. All doctors are required to undertake mandatory training within the Trust that maps out the levels of knowledge required and the standards that are to be adhered to. This includes for example the provision of a Civility Saves Lives course for all staff that reminds employees that everyone must be treated with dignity and respect, and it highlights what to do if you do have concerns about behaviours and/or standards. The Trust has a range of groups and committees including an Education Board that continuously reviews such matters, and then ensures appropriate plans are in place to deliver the required aims. The Trust actively promotes and celebrates different events e.g. religious festivals and LGBTQ events. It is also pro-active in ensuring that overseas doctors events take place both in terms of formal teaching and social events as a way of the Trust being inclusive.
Action for next year:	Continue as above.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None.
Comments:	The Trust has a set of organisational values and standards that all employees are required to adhere to, and employees are reminded of these at their induction and appraisal. Fairness and respect messages are also embedded into all staff inductions including inductions for medical staff. Doctors are encouraged to report any negative experiences they may have in these respects, and are advised of a range of mechanisms to do this. This includes the Freedom to Speak Up Guardian, Guardian of Safe Working, and others. Reports are provided to the Board from such key roles to provide necessary assurances and comply with legal and national requirements. All doctors are required to undertake mandatory training within the Trust that maps out the levels of knowledge required and the standards that are to be adhered to. This includes for example the provision of a Civility Saves Lives course for all staff that reminds employees that everyone must be treated with dignity and respect, and it highlights what to do if you do have concerns about behaviours and/or standards. A learning culture is being extended through the Trust's new PSIRF response to clinical incidents.
Action for next year:	Continue as above.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None.
Comments:	The Trust is proactive at inductions and appraisals whereby employees are reminded that if they have any concerns these can be raised through a number of ways, including the below. This includes the Freedom to Speak Up Guardian, Guardian of Safe Working, and others. Reports are provided to the Board from such key roles to provide necessary assurances and ensure compliance with legal and national requirements. A learning culture is being extended through the Trust's new PSIRF response to clinical incidents. Multiple feedback mechanisms are in place including active listening events. For example, the Trust operates Junior Doctors Forums, Educational Boards, Medical Workforce Groups and Joint Local Negotiating Committee whereby matters can be raised. The Trust also has a 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff' Policy. The Trust has a full range of formal policies in place which include the ability for employees to raise grievances should they wish to do so. The Guardians and Medical Directors can also be contacted directly as appropriate. Reports are provided to the Board to provide necessary assurances and comply with legal and national requirements.
Action for next year:	Continue as above.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None.
Comments:	The Trust has policies in place for management of such issues. This includes a policy for 'Handling Concerns about the conduct, performance, and health of Medical and Dental Staff' was reviewed in July 2023 and remains in date and fit for purpose. Policies are agreed via the Joint Local Negotiating Committee (JLNC) which has Staff Side and BMA representation. When writing policies due consideration must be given to EDI matters. The policy gives reference to the groups that oversee the monitoring of such matters and how these should be managed. Such matters are reported through to the Trust Board for monitoring so that we can help ensure that no discriminatory processes exist, and so that the Trust can ensure compliance with legal and national requirements.
Action for next year:	Continue with the above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None
Comments:	Full engagement with peers regularly takes place. This includes attendance at all relevant regional and national meetings. For example, the Medical Director attends fortnightly regional Medical Director meetings, and the Responsible Officer attends regional quarterly meetings as well as attending national forums. A peer review meeting is also in place.
Action for next year:	Continue with the above.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	452

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	411
Total number of appraisals approved missed	9
Total number of unapproved missed	1

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	70
Total number of late recommendations	9
Total number of positive recommendations	60
Total number of deferrals made	10
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	25
Total number of trained case managers	2
Total number of new concerns registered	3

Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March	On 31 March 2024- 5.4.23 - ongoing

Median duration of concerns processes closed	8 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	150
Number of new employment checks completed before commencement of employment	150

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	N/A
Total number of appeals against the designated body's professional standards processes made by doctors	N/A
Number of these appeals upheld	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The Trust has completed the required actions from the last report, this includes recruiting additional appraisers. However, the Trust does still have a pressing need to recruit additional appraisers to ensure that all appraises have an appraiser in 2024/25.
Actions still outstanding
The Trust needs to recruit additional appraisers to help ensure that all appraises have an appraiser in 2024/25.
Current issues
A high priority for the Trust is that it needs to recruit additional appraisers so that each appraisee has an assigned appraiser. In order to assist with the above, the Trust does need to create a central funding pot, so that funding is readily available to enable this. The Trust is currently exploring whether to continue using the appraisal system used (Premier IT) or whether it needs to consider using other systems that may further enhance the services.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
The Trust will continue with the systems and processes that are in place, whilst also noting the following specific points: 1A (ii) and 1B (iv) Ensure that Trust has recruited additional appraisers so that each appraisee has an assigned appraiser. Ensure that there is a central funding pot so that when divisions have appraisers ready and willing to undertake the role, the funding is available. To review the ARC role. 1A (iii) Review the appraisal system used that is used to administer the appraisal process (currently Premier IT). 1A (iv) To continue our collaboration with East Cheshire and The Christie, and also undertake a peer review in 2024/25. 1B (v) To improve the frequency of ASG meetings to quarterly. In addition, ensure attendance is recorded and appraisers reminded of the requirement to attend at least two ASG meetings per appraisal cycle year. 1B (vi) To undertake a QA exercise in 2024/25.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
It is positive to report that all but one doctor due to appraise in 2023/24 completed their appraisal, or had a formal postponement approved (due to long-term sickness absence or maternity leave). Importantly, with regards to the one outstanding appraisal, this is being supported by the Medical Appraisal Lead in working towards completion. This is a great achievement when factoring in: A) The Industrial Action that took place during this period. B) The increasing numbers of medics that the Trust now employs. A high priority for the Trust for 2024/25 is now to recruit additional appraisers. A recruitment campaign will take place in August 2024, and the Trust is creating a central funding pot to remove barriers to recruitment. It is critical that both are aims are achieved.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

				Agenda Item No.	14
Meeting date	03/10/2024	**Public**	✓	**Confidential**	
Meeting	Board of Directors				
Report Title	Infection Prevention & Control Service Annual Report				
Director Lead	Nic Firth Chief Nurse/DIPC	**Author**	Nesta Featherstone AND for IP&C		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	The annual infection prevention & control report summarises the IPC activities from the previous year and is provided for review by the group					

This paper relates to the following Annual Corporate Objectives

x	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities

	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	None
Financial impacts if agreed/not agreed	None
Regulatory and legal compliance	All Objectives
Sustainability (including environmental impacts)	None

Executive Summary

The annual infection prevention & control report summarises the IPC activities from the previous year. It shows that: -

Criterion 1: Systems to manage and monitor the prevention and control of infection.

- The Trust carried out the National mandatory reporting of healthcare associated infections and met the National trajectory for Klebsiella and internal trajectory for Methicillin Sensitive Staphylococcus Aureus (MSSA)
- The Trust exceeded the National mandatory requirement for surgical site surveillance by undertaking surveillance in each quarter with low rates of infections.
- There was a decrease of 81.6% in cases of influenza compared with the previous year.
- There was an increase of norovirus outbreaks from the previous year.

Criterion 2: Provide and maintain a clean and appropriate environment.

- Water safety and ventilation groups continued to ensure compliance with National legislation and guidance continues.
- The hospital sterilisation and decontamination unit (HSDU) and endoscopy decontamination unit (EDU) successfully past their accreditation by the British institute.

- The Trust displayed STAR ratings for cleanliness against the National Standards of Healthcare Cleanliness outside wards and departments.
- The Trust undertook their first paperless Patient Led Assessment of the Care Environment (PLACE) with the food domain remaining above National average.

Criterion 3: Ensure appropriate antimicrobial stewardship.

- The Trust saw a 20% reduction in IV antibiotics doses and achieved the antimicrobial resistance CQUIN.

Criterion 4: Provide suitable accurate information.

- Patients continued to have access to patient information leaflets and information displayed on notice boards across the Trust.

Criterion 5: Ensure early identification of individuals who have or are at risk of developing an infection.

- There was a substantial development of the Vascular Access Device (VAD) Service with an increase in the number of referrals and successful insertions.

Criterion 6: Systems are in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection.

- The IP&C team had another successful twitter campaign during December with our Elf antics.
- Divisions engaged with campaigns and training throughout the year.

Criterion 7: Provide or secure adequate isolation precautions and facilities.

- Due to the old estate, isolation facilities remain a challenge but managed by the clinical site co-ordinators.

Criterion 8: Provide secure adequate access to laboratory/diagnostic support as appropriate.

- The pathology laboratory service remains on site with 24 hours microbiology advice.

Criterion 9: Have and adhere to policies.

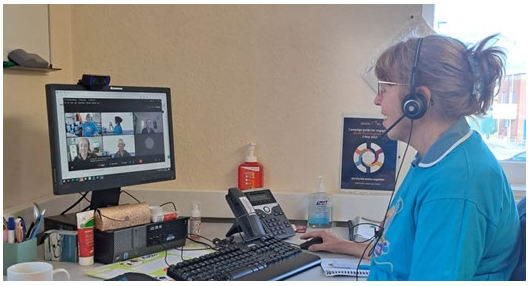
- Policies, SOPs and guidelines were updated in line with national guidance and approved through the IP&C group.
- Aseptic Non-Touch Technique (ANTT) key assessors' assessments continued which included 4 medical fellows.
- There was variable compliance of IPC audits throughout the year, the Trust introduction a new vascular access device audit to monitor compliance.

Criterion 10: Have a system in place to manage occupational health needs.

- The Trust saw a decrease in the seasonal influenza vaccine rate for frontline staff.
- There continues to be a robust fit testing service available, for easy access to staff although uptake remains variable.

INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2023- March 2024



Contents

Foreword

2023-24 remained a challenging year as we continued to feel the after-effects from the pandemic, alongside the age and condition of the estate and the increasing ageing population in Stockport.

Fundamentally, preventing the spread of organisms that cause healthcare associated infections (HCAI) and ensuring optimal antimicrobial use is important. The prevention and control of infection remains a top priority for the Trust and is central to how services are planned and care delivered to maintain a safe journey for our patients/service users.

I am proud to introduce Stockport NHS Foundation Trust's (SNHSFT) Annual Infection Prevention and Control Service Report for the period 2023-24.

This report follows the format of the infection prevention and control board assurance framework demonstrating progress with the requirements associated with the criteria.

Finally, the report outlines the key objectives for 2024-25.

Nic Firth

Chief Nurse/DIPC

Introduction

This report provides the Trust board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention & Control (IP&C) Service Team over the past 12 months.

The Trust recognises that effective prevention and control of Healthcare Associated Infections (HCAI's) is essential to ensure patients using our services receive safe and effective care. Effective prevention and control are both integral parts of everyday practice and the Trust is committed to ensure this is applied consistently to ensure the safety of our patients.

Key Achievements 2023-24

The following is a summary of the key achievements over the last twelve months:

- The Trust has seen a reduction in Methicillin Sensitive Staphylococcus Aureus, E. coli and Klebsiella infections.
- The Trust has seen a reduction in blood culture contaminants.
- Hospital Sterilisation and Decontamination Unit (HSDU) & Endoscopy decontamination unit (EDU) were successful in passing their BSI and JAG accreditation.
- The Trust exceeded the mandatory requirements for surgical site surveillance.
- The Trust saw an 81.6% decrease in the number of cases of the influenza virus.
- The antimicrobial resistance CQUIN was achieved.

Compliance with the IPC Board Assurance Framework (BAF)

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other service users may pose to them.

Governance Structure

Infection Prevention and Control (IP&C) Service

The Infection Prevention & Control Service covers Stepping Hill Hospital and 2 other Specialist centres covering 912 inpatient beds, as well as 24 Community Health Service across Stockport and over 6,000 staff.

The Infection Prevention & Control Service played a key role during 2023-24 by providing staff with robust expertise, advice, and guidance to improve the safety and quality of care delivered to patients. In the period of 2023-24 the team consisted of:

DIPC	
Associate Nurse Director- IP&C	1.0 WTE
Matron – IP&C	1.0 WTE
IP&C Service Nurses	4.0 WTE
IV Nurse Practitioners	1.0 WTE
IP&C practitioner	1.0 WTE
IP&C support practitioners	5.53 WTE
IP&C Team Administrator	1.0 WTE
IP&C Information Analyst	1.0 WTE
Consultant Microbiologists	3.0 WTE
Antibiotic Pharmacist	1.00 WTE (consisting of 2 PT staff)

All the above is supported by a CPA accredited Microbiology Laboratory.

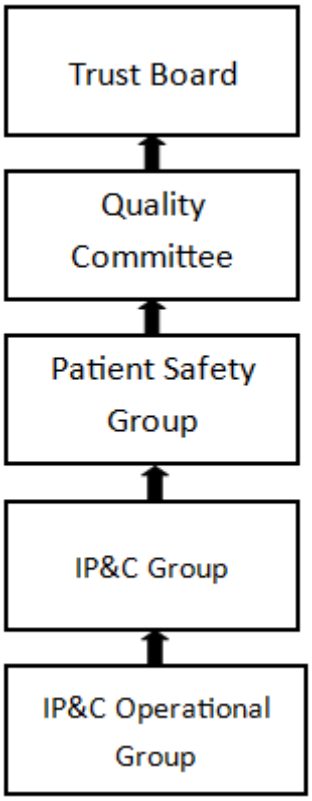
Infection Prevention and Control (IP&C) Operational Group

The IP&C operational group is chaired by the IP&C matron. It is the key forum to progress and monitor the operational implementation of the IPC board assurance framework and provide key issues to the IP&C group.

Infection Prevention and Control Group

The IP&C group is a mandatory requirement and chaired by the Director of Infection Prevention and Control (DIPC). It is the key forum for providing assurance that the Trust has structures and arrangements in place to meet all statutory requirements for IP&C.

The chart below demonstrates the IP&C reporting arrangements:



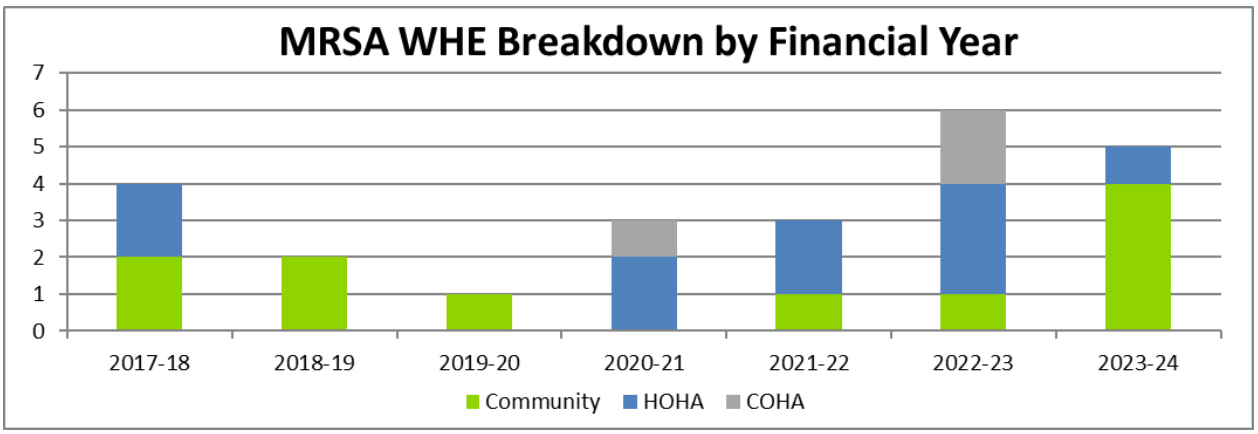
Surveillance of Alert Organisms & Mandatory Reporting

In accordance with Department of Health guidelines, IP&C Teams carry out mandatory reporting of clostridium difficile and bacteraemia's associated with MRSA, MSSA, E. coli, Pseudomonas aeruginosa and Klebsiella sp.

Mandatory cases for 2023-24 are reported as a combination of Hospital-onset healthcare-associated (HOHA) and Community-onset healthcare-associated (COHA) for all isolates.

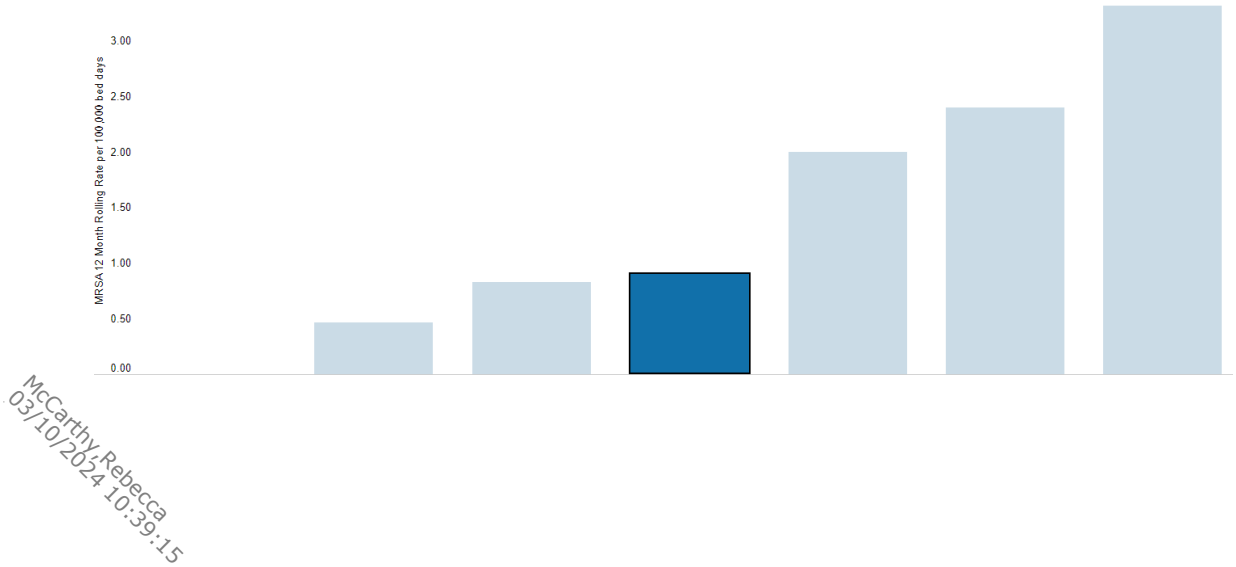
MRSA Bacteraemia

The national tolerance for MRSA bacteraemia cases continues to be zero. In 2023-24 there were 5 MRSA bacteraemia cases, 4 were attributed to the community as they were Community Onset, Community Associated (COCA) cases and 1 case was attributed to the Trust as it was a Hospital Onset, Hospital Associated (HOHA) case.



A Post Infection Review (PIR) investigation was undertaken for the HOHA case and was presented to the Trusts Health Care Associated Infections (HCAI) panel for their consideration. This case was complex with several comorbidities, learning from the case has been shared with other divisions.

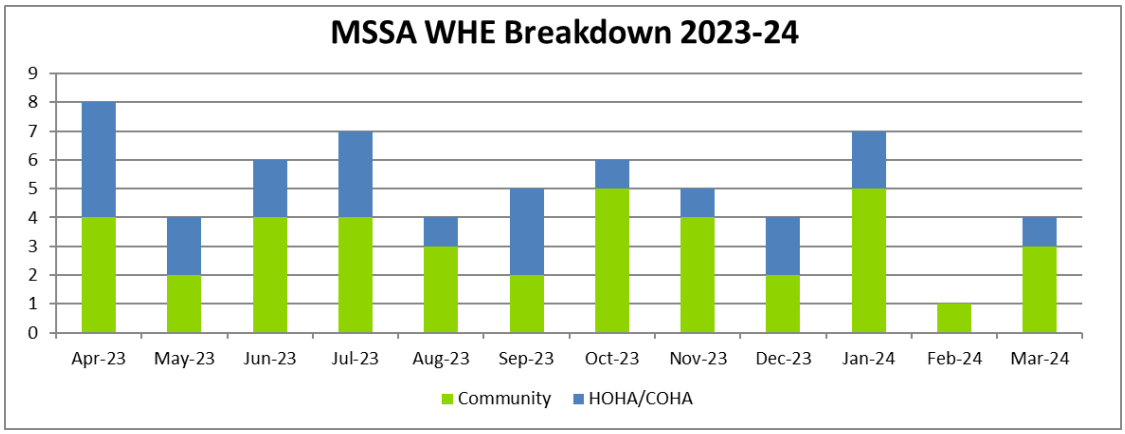
Peer Group Comparison: The Trust monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust (highlighted in Blue) in comparison with its peers for MRSA Bacteraemia's.



Action: To implement learning from the case to prevent further MRSA bacteraemia cases during 2024-25.

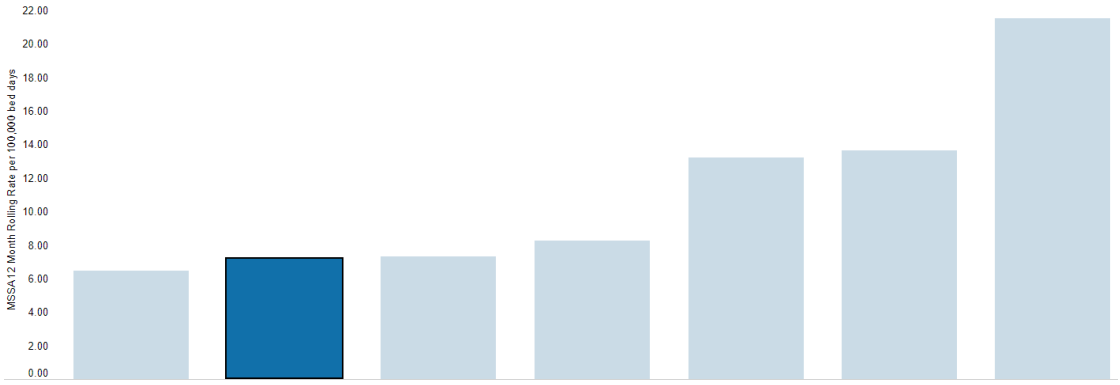
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

In 2023-24 the Trust had 17 Hospital Onset, Healthcare Associated (HOHA) cases and 5 Community Onset, Healthcare Associated (COHA) cases, totalling 22 cases. This is a decrease of 6 from the previous year.



For 2023-24 the total threshold was set at 24 cases allowing 6 per quarter. The Trust finished under this threshold by 2 cases.

Peer Group Comparison: The Trust monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust (highlighted in blue) in comparison with its peers for MSSA Bacteraemia's.



Action: To reduce the number of MSSA cases

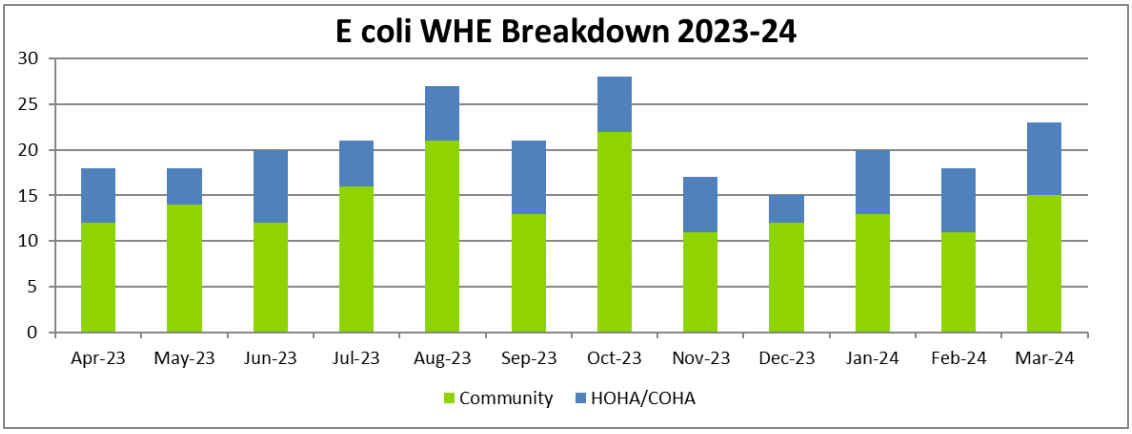
Gram negative blood stream infection (GNBSI)

GNBSI includes all positive blood cultures for Escherichia coli, Klebsiella species and Pseudomonas aeruginosa.

Escherichia coli (E. coli) Bacteraemia

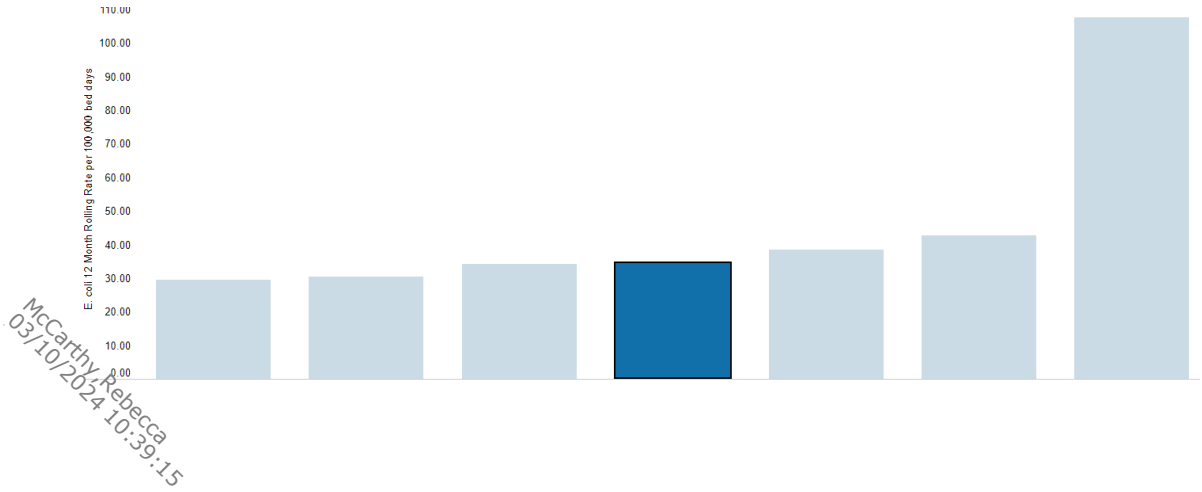
E. coli data collection continued with the predominant cases being community acquired.

In 2023-24 the Trust had 52 Hospital Onset, Healthcare Associated (HOHA) cases and 22 Community Onset, Healthcare Associated (COHA) cases, totalling 74 cases a decrease of 20 from the previous year.



The UK Health Security Agency (UKHSA) threshold for 2023-24 was set at 46 cases allowing 11.5 per quarter. This threshold was exceeded by 28 cases.

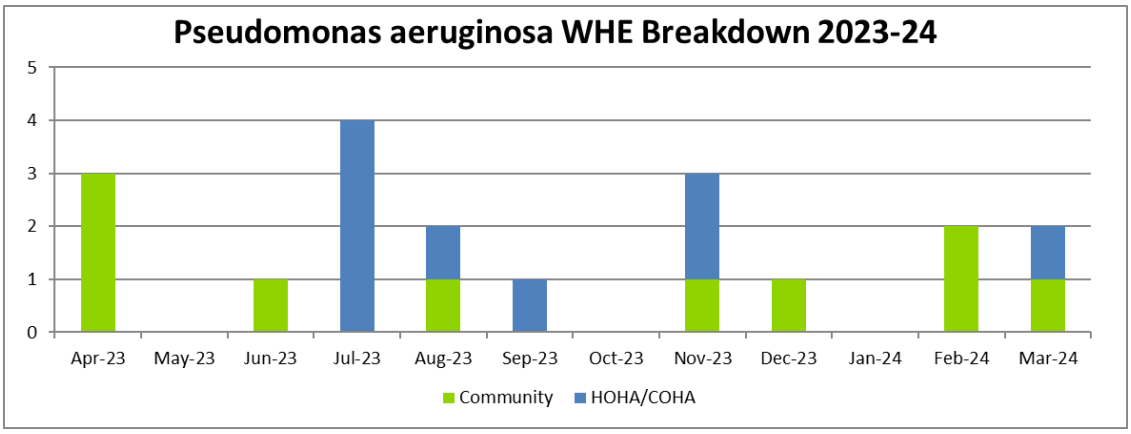
Peer Group Comparison: The Trusts monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust in comparison with its peers for E. coli Bacteraemia.



Action: To reduce the number of E. coli cases

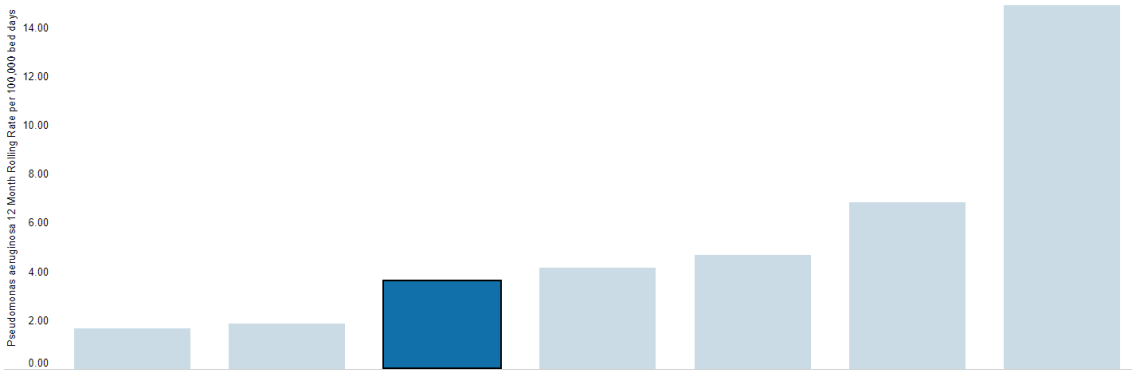
Pseudomonas aeruginosa

In 2023-24 the Trust had 8 Hospital Onset, Healthcare Associated (HOHA) cases and 1 Community Onset, Healthcare Associated (COHA) cases, totalling 9 cases an increase of 2 from the previous year.



The UKHSA threshold for 2023-24 was set at 3 cases allowing 0.75 per quarter. This threshold was exceeded by 6 cases.

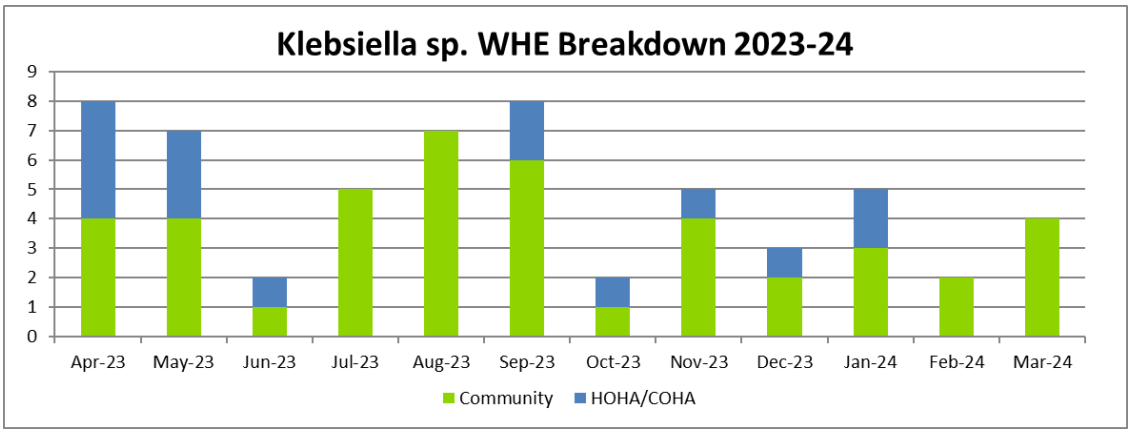
Peer Group Comparison: The Trusts monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust (highlighted in blue) in comparison with its peers for pseudomonas aeruginosa Bacteraemia.



Action: To reduce the cases of Pseudomonas aeruginosa

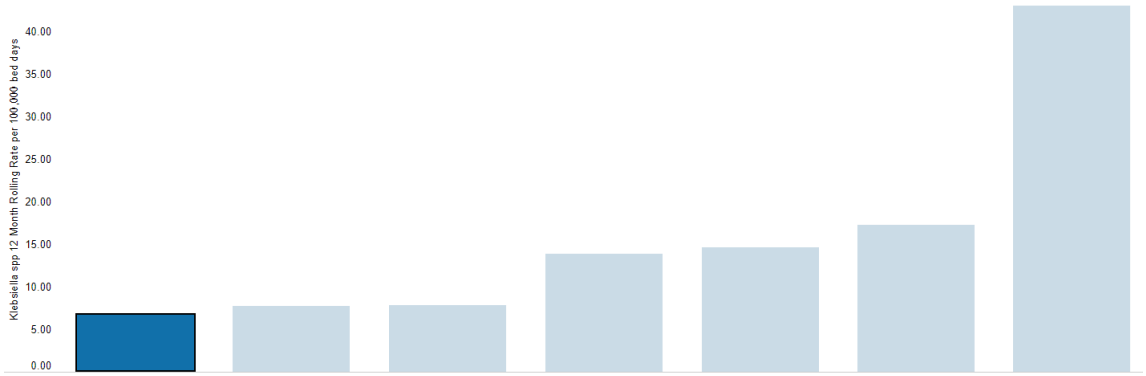
Klebsiella sp.

In 2023-24 the Trust had 12 Hospital Onset, Healthcare Associated (HOHA) cases and 3 Community Onset, Healthcare Associated (COHA) cases, totalling 15 cases a decrease of 11 from the previous year.



The UKHSA threshold for 2023-24 was set at 22 cases allowing 5.5 per quarter. The Trust finished under this threshold by 7 cases.

Peer Group Comparison: The Trusts monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust (highlighted in blue) in comparison with its peers for Klebsiella sp. Bacteraemia.

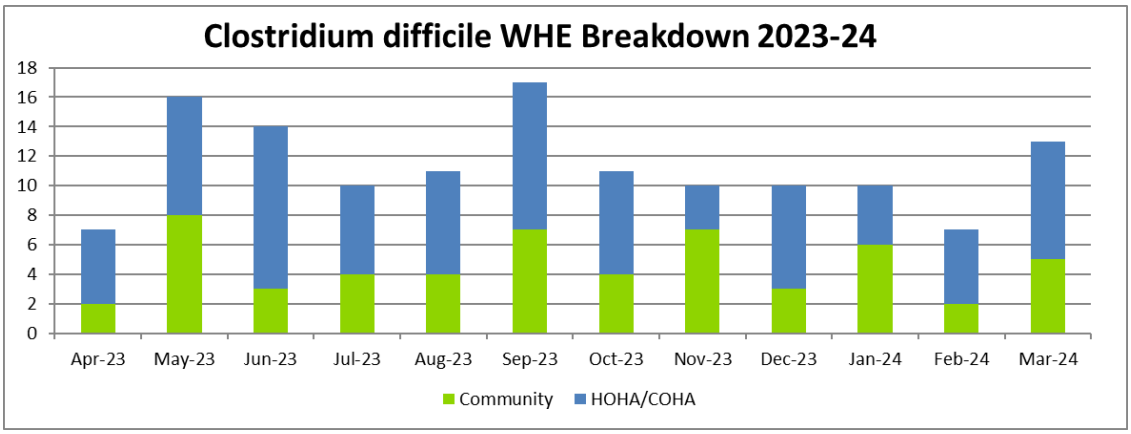


Action: To reduce the number of Klebsiella cases.

McCarthy Rebecca
03/10/2024 10:39:15

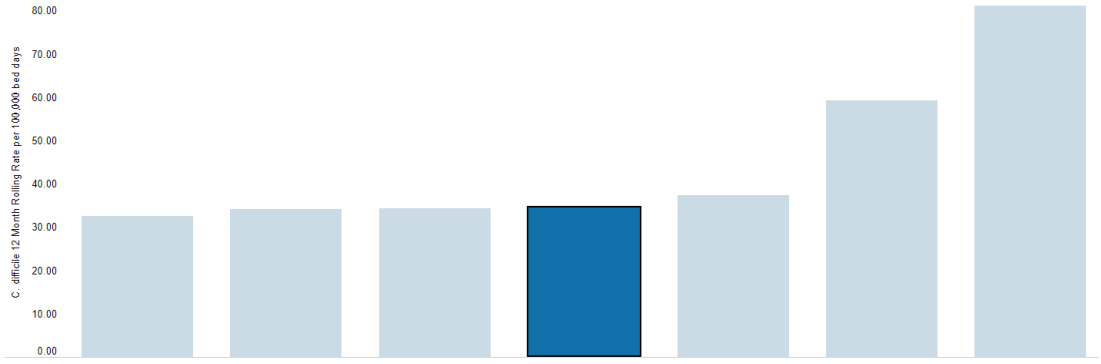
Clostridium difficile

The UKHSA threshold for 2023-2024 was set at 40 cases. In 2023-24 the Trust had 62 Hospital Onset, Healthcare Associated (HOHA) cases and 19 Community Onset, Healthcare Associated (COHA) cases. The threshold was exceeded by 41 as a total of 81 cases were recorded which is an increase of 6 cases from the previous year.



All Trust attributed cases underwent a root cause analysis investigation and were presented to a Healthcare Associated Infection panel (HCAI) for review. The panel is chaired by the DIPC alongside the IP&C doctor, IP&C Associate Nurse Director and an Antibiotic Pharmacist who determined that 10 cases were deemed avoidable.

Peer Group Comparison: The Trusts monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust in comparison with its peers for Clostridium difficile.

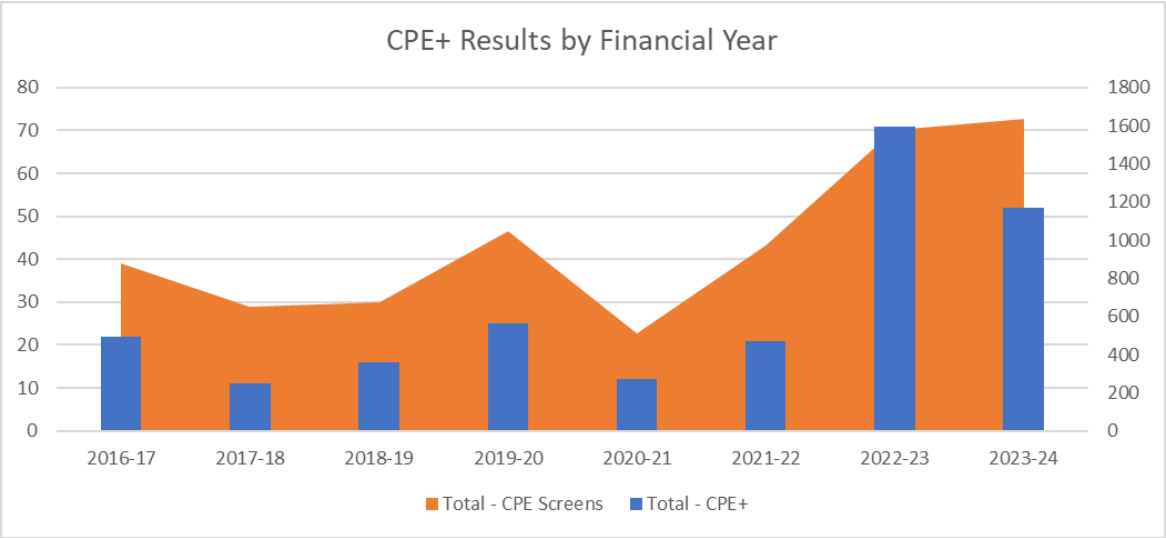


Actions: To reduce the number of clostridium difficile cases

Carbapenemase Producing Enterobacteriaceae (CPE)

There is no mandatory surveillance or National threshold for CPE.

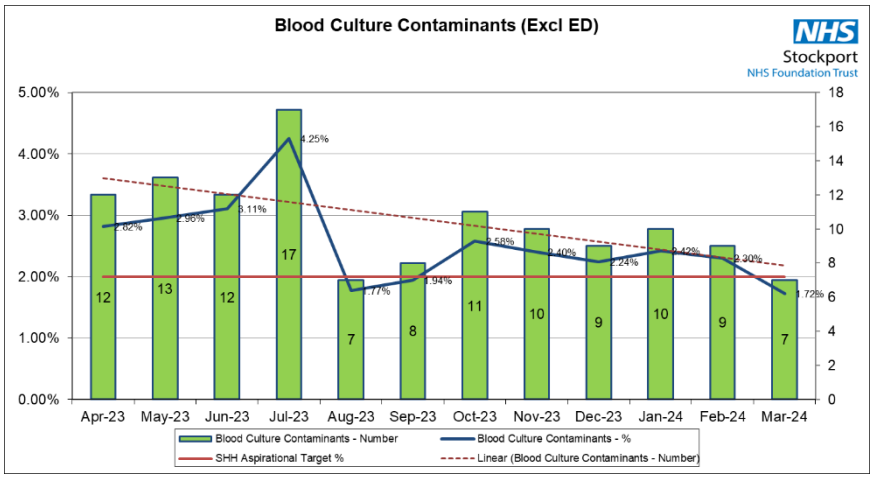
During 2024-25 there were 52 new CPE cases. 29 were hospital attributed and 31 were community apportioned a decrease of 17 cases on the previous year. 1596 CPE screens were processed, an increase of 2.8% in screening activity. Positive case rate is 3.25% for the financial year.



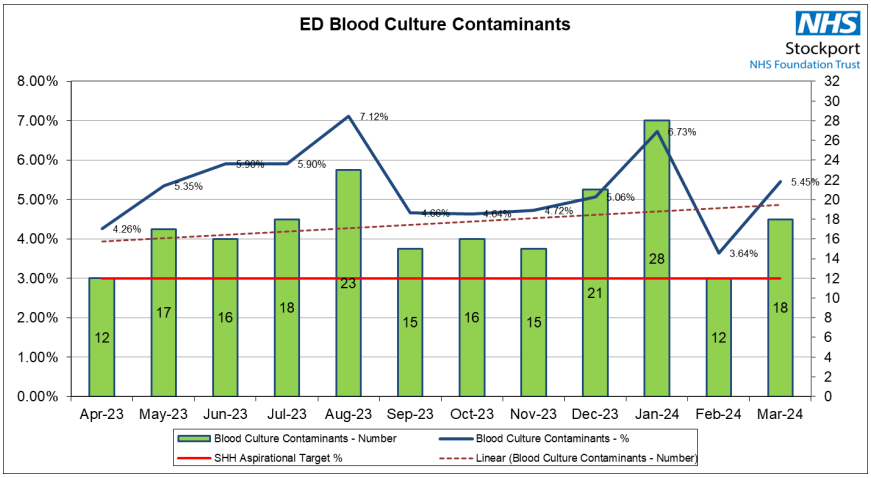
Action: To reduce the number of hospital CPE cases.

Blood Culture Contaminants

The average rate of blood culture contaminants for the Trust (Excluding ED) was 2.54% against a Trust aspirational target of 2% which is a decrease of 0.86% from the previous year.



The average rate of blood culture contaminants for patients within the Emergency Department (ED) was 5.29% a decrease of 0.08% from last year against our Trust aspirational target of 3%.



Action: To continue to reduce number of blood culture contaminants.

Mandatory Orthopaedic Surgical Site Surveillance Infection (SSSI)

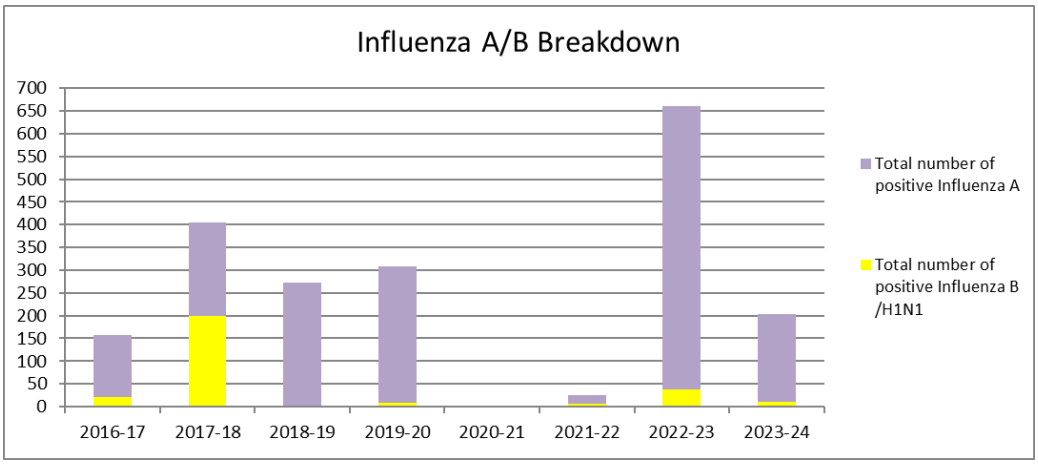
The mandatory requirement of the UKHSA is to survey one orthopaedic procedure for a period of 3 months. During 2023-24 our surveillance exceeded the mandatory requirements by undertaking surveillance in each quarter as shown in the table below.

Report Quarter	Procedure	No. of Operations	No of Surgical Site Infections	% Infection Rate
April – June 2023	Hip Replacement	72	0	0%
	Knee Replacement	50	1	2%
July – September 2023	Repair of neck of femur	102	0	0%
October – December 2023	Hip Replacement	55	0	0%
	Knee Replacement	38	1	2.6%
	Repair of neck of femur	112	1	0.9%
January – March 2024	Unknown – report not yet available	-	-	-

Outbreak reports.

Influenza

During 2023-24, the Trust saw an 81.6% decrease in the number of cases of the influenza virus. These cases were effectively managed within the Trust isolation framework. There was 1 outbreak associated with confirmed influenza across the Trust.



COVID-19

During 2023-24 COVID-19 numbers decreased and were more prominent during the winter period where respiratory viruses are more prolific.

The table below shows distribution of positive and negative tests analysed by the Trust's pathology department in 2023-24.

2023-24		
Positive	234	10.5%
Negative	2001	89.5%
Total Tests	**2235**	

The total number of positive COVID-19 patients who were discharged or died at the end of their inpatient stay during 2023-24 is shown in the table below.

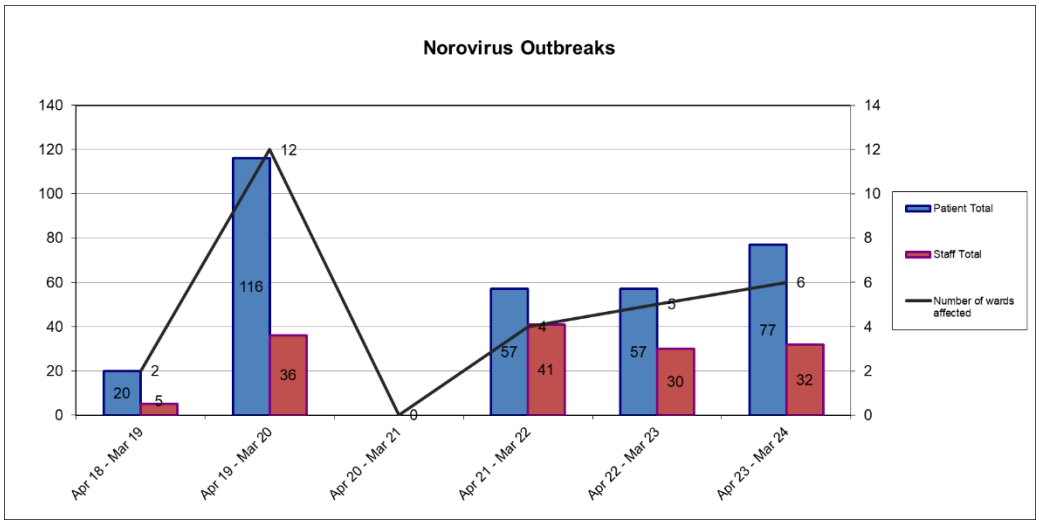
Inpatient Discharges	Inpatient Deaths
173	22

Any patient who developed a hospital acquired (nosocomial) COVID-19 infection and subsequently died were investigated to determine any learning and actions to be undertaken.

Action: - To continue to follow national guidance

Norovirus

During 2023-24 there were 6 ward outbreaks associated with diarrhoea and vomiting across the Trust which is an increase of 1 from the previous year.



All ward outbreaks were confirmed Norovirus. Five outbreaks occurred during November 2023, the other occurred in March 2024. It is difficult to determine where the outbreaks originated from as norovirus is highly contagious and can be spread via multiple routes.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Water Safety

During 2023-24 the Water Safety Group (WSG) met and reported on a quarterly basis to the Infection Prevention and Control Group. The purpose of this group is to ensure the Trust is compliant with national legislation and guidance and to develop, manage, and monitor appropriate system of controls in relation to water safety.

The WSG provides assurance to the Infection Prevention & Control Group on all aspects of water safety and resilience required for the safe operation and development of the Trust's healthcare premises.

In 2023-24, the group ensured any positive legionella or pseudomonas samples were traced with appropriate remedial actions taken in line with national standards. The group ensured that a compliant temperature-control program was in place by working with stakeholders to ensure contract specifications were being adhered to and that suitable and sufficient risk assessments had been undertaken throughout the site, and that hazards identified within the risk assessments were managed appropriately.

Ventilation

During 2023-24 the Ventilation Safety Group (VSG) met and reported on a quarterly basis to the Infection Prevention and Control Group. The purpose of this group is to ensure the Trust is compliant with national legislation and guidance and to develop, manage, and monitor appropriate schemes of controls in relation to Trust ventilation systems.

The VSG provides assurance to the Infection Prevention & Control Group on all aspects of ventilation safety and resilience required for the safe operation and development of the Trust's healthcare premises.

In 2023-24 the group further developed the Trust's ventilation strategy, which is intended to inform the capital planning programme. The group ensured that a program for statutory maintenance was in place and managed appropriately. In addition, any ventilation failures/incidents were logged, discussed, and appropriate remedial measures agreed upon and actioned.

Decontamination Services

During 2023-24 the Trust decontamination services, both sterile services and Endoscopy Decontamination continued to strive to deliver the best possible service. The main focus over the past 12 months has been achieving the best possible quality of product to patient, delivering safe and reliable care.

Both the Hospital Sterilisation and Decontamination Unit (HSDU) and Endoscopy Decontamination Unit (EDU) were successful in passing their accreditation by the British Standards Institute providing the Trust with assurance of quality and safety for our patients.

The Endoscopy Decontamination Unit also successfully achieved green status on their Joint Advisory Group (JAG) annual accreditation. The Decontamination unit provided additional service provision at times, which very much supported the trusts recovery position.

Action:

- To continue to provide service delivery assurance against national guidance and regulations through the Trust decontamination group, reporting through the Trust IPC group.
- To continue striving for improvements and innovation, but most importantly best practice.

Cleaning Services

Adherence to the National Standards of Healthcare Cleanliness (2021) continued during 2023-24 with all assessed star ratings publicly displayed in all areas across the Trust. All areas are monitored through audit to ensure correct standards and timescales are achieved, with auditors receiving annually refresher training. Cleaning schedules are regularly reviewed, updated and displayed so all staff are aware of the schedule and the national colour coding requirements to follow to ensure safe, IPC compliant practices.

A primary aim of the introduction of the National Standards of Healthcare Cleanliness was to ensure success through effective collaborative working between Domestic and Clinical staff. This continued to be successful throughout 2023-2024, clearly demonstrating excellent teamworking. Equally the Domestic Service Team continue to work closely with the IP&C team who provided invaluable advice and support, especially during infection outbreaks and cleaning post estate-related incidents or capital schemes.

Despite many challenges over the past 12 months, the Domestic Service Team have continued to deliver cleaning to expected high standards to protect patients, visitors, and staff.

PLACE (Patient Led Assessment of the Care Environment)

As active members of the national PLACE working group, the Facilities team were pleased to have the support of the Trust's Infection Prevention and Control Team, governors and other specialist matrons to complete this year's annual PLACE inspection.

2023 was our first year going paperless, utilising only the 'PLACE mobile' facility, completing the assessments as live submissions via a tablet device. This enabled the trust to support its green agenda but also reduced time spent completing the manual data entry, allowing more time to focus on debriefing and findings. Areas across the Trust were visited, spanning all services and Divisions to ensure a broad assessment. Each team also completed a food tasting assessment taking the final tray from the meal trolley to reflect the experience of the last patient to receive a meal.

The PLACE results for 2023 were disappointing as the Trust was below the national average in all but 1 of the 6 domains. The domain of food remained above the national average, and the Trust saw an increase on the 2022 result.

Action: To develop a comprehensive action plan in response to the assessment findings.

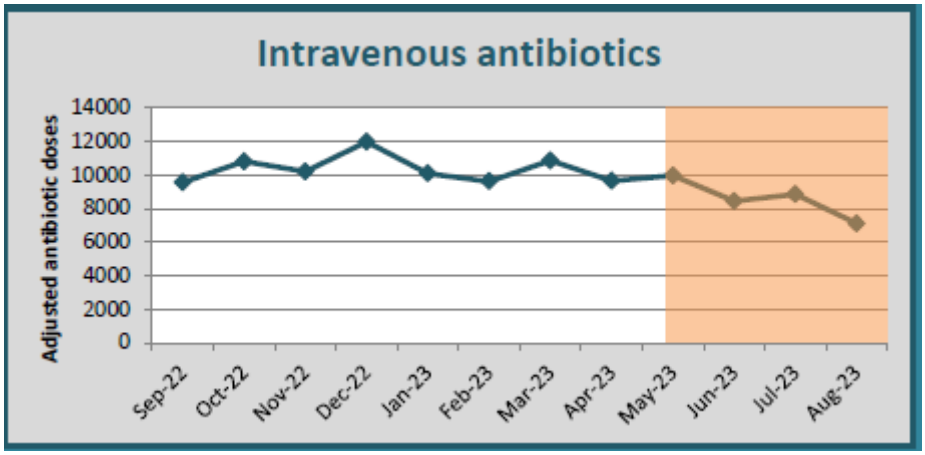
Criterion 3: Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Stewardship

During 2023-24 the antimicrobial stewardship team built on previous work to improve antimicrobial prescribing and reviews across the Trust.

During 2023-24, to reduce the number of patients prescribed long courses of unnecessary IV antibiotics a default duration of 48 hours was assigned to the electronic prescriptions. To ensure daily reviews of IV antibiotics, with an active decision to continue a variety of communications and teaching sessions were arranged for prescribers.

The table below shows how this change saw a 20% statistically significant reduction in IV antibiotic doses compared with the previous 12 months.



The antimicrobial resistance CQUIN for 2023/2024 was IV to oral switch for antibiotics. All 4 quarters for the CQUIN were achieved.

During 2023-24, the Trust invested in a new app for the antimicrobial guidance to enable changes to be implemented easier to keep guidance in date and relevant.

The Trust participated during 2023-24 in the National Point-Prevalence Survey (PPS) on healthcare-associated infections (HCAI), Antimicrobial Use (AMU) and Antimicrobial Stewardship (AMS). This was a huge undertaking for both the antimicrobial pharmacists and infection prevention team however, the data and benchmarking will support changes and focus for 2024-25.

Action:

- To continue to provide education and discussion around antimicrobial stewardship.

Criterion 4: provide suitable accurate information on Infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.

A variety of methods are used to communicate the IP&C message to service users, staff and other providers. The IP&C annual report and other relevant documents are available on the Trust website. IP&C notice boards are prominent is all areas and updated regularly to promote key messages.

Criterion 5: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.

Vascular Access Device (VAD) Service

2023-24 saw a substantial development in the VAD service. The service received 198 referrals with 88 (44%) being appropriate and a line successfully inserted. The service also supported and cared for a further approximately 80 lines of patients admitted to the Trust with a line in-situ.

The team supported the implementation of new equipment and documentation as well as providing training in several formats including Toolboxes, monthly drop-in sessions and Masterclasses to upskill and educate staff in the care and management of lines.

Action:

- To progress the inpatient nurse led VAD service.

Criterion 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Part of the recognised role of the IP&C team is training and education. Face to face sessions on practical training being crucial to ensure staff practice aspects of IP&C alongside the mandatory infection prevention E-learning.

The Trust training compliance for IP&C mandatory training at the end of 2023-24 was 96.64%. During 2023-24, 756 toolbox training sessions were provided by the IP&C and VAD teams which is a substantial increase from the previous year.

During December 2023 the IP&C team took to twitter with our own Elf-Care-Assistant. Each day a different message or video was portrayed showing what was not good practice. The team were overwhelmed with positive responses, discussion, and re-tweets.

Divisional groups

Surgery

One action during 2023-2024 was to focus on a Multidisciplinary Team (MDT) approach to investigating and learning from Healthcare Associated Infection Panel (HCAI) reviews. While the division saw some improvement in this area, the 2024-2025 action plan will continue to focus on the MDT approach and engage medical colleagues.

The Division is committed to a collaborative approach to IP&C and works closely with the IP&C team. Assurance walkarounds, spot checks with ward managers and matrons, and toolbox training sessions are conducted to ensure an optimal environment for patient care and mitigate the risk of infection.

Maintaining uniform compliance is a top priority for our division. To achieve this goal, we have implemented peer-to-peer challenges during safety huddles to support our staff in assessing compliance. In addition, we have increased senior nurse walk rounds to ensure that we are meeting high standards of uniform compliance.

Action:

- Our division's focus for improvement in 2024-2025 is the care and management of Vascular Access Devices. We have consulted with the Head of IP&C and VAD Service lead and agreed that all Band 6, 7, and 8a staff must attend a Masterclass in Vascular Access Device Management. This will enable ward / units in the division to take ownership of improvements and sustain quality care.

Medicine & Urgent Care

Performance across 2023-24 presented challenges and successes throughout the year. Staff continue to work hard to strive to achieve the required standards.

Although our environment continues to challenge us, there is a robust process for joint estates, facilities, IPC and clinical walk rounds of the areas; and we are pleased with the cleanliness star rating achieved monthly. The action from last year to embed this has been achieved.

Our Quality metrics data has seen an overall maintenance in compliance with Hand Hygiene and PPE for our ward teams, but disappointingly there is still the need to challenge when the senior team visit the clinical areas. This is also triangulated with the evidence in the infection prevention standard in the StARS accreditation process which indicates improvement is required in PPE and uniform adherence. All clinical areas have current actions in place to continue to develop peer challenge.

We have a continued focus on ANTT compliance with both our nursing and medical teams sharing actions and learning in our Quality Boards. Improvement is still required and will continue to be evident on our actions for the coming year.

Reducing blood culture contaminants has been area of action in 2023-24, with the focus on improving individual practice and ensuring contaminant information is shared and learnt from. This work is ongoing but has shown improvements which with continued focus over the coming year we will aim to sustain and further reduce.

As a division we continue to share assigned actions following the HCAI panel with both nursing and medical teams to improve future practice.

Actions:

- To improve ANTT compliance in all disciplines of staff.
- Improve compliance in PPE and Uniform standards from all staff in clinical areas.
- Disseminate and share learning from blood culture contaminants to further reduce incidences.

Emergency Department

2023-24 has been a challenging time for the Emergency Department with the huge amount of building work to increase capacity and improve isolation facilities.

During this challenging time, the IP&C team have supported the department with weekly visits so any concerns are acted upon by the department.

The action set for 2023-2024 was to ensure that all cleaning standards and environmental checks are maintained. There have been some periods of improvement within the environment however there is a re-focus on the maintenance of these standards for the emergency department.

There has been some sustained improvement with the IP&C quality metrics and hand hygiene data however this does not always correspond with the senior walk rounds and the observations of the department especially during periods of increased demand. The senior walk rounds have proved to be beneficial to continue to improve with the environment and cleaning standards.

Actions:

- 2024-2025 will have a re-focus on the daily oversight for IP&C standards within the Emergency Department and to share the actions and learning from a review of blood culture contaminants throughout the year.

Women & Children

The division of Women and Children continues to review any blood culture contaminants and meets with associated individuals to review and ensure appropriate action is taken and training is in place. There has been one confirmed community acquired MRSA bacteraemia in the past year within the paediatric directorate.

There has been a focus across the Women's and Children's division in relation to measles with a small number of cases being admitted to the Childrens unit. The school nursing and immunisation team have supported MMR vaccination drop ins across Stockport and within schools to target children who have had not had both MMR doses.

Integrated Care

There continues to be a Multidisciplinary Team approach to improving and sustaining 5 moments of hand hygiene compliance and infection prevention and control. The division has seen a slight improvement for hand hygiene compliance cross the Acute areas, all team members are aware of their role and responsibilities to challenge non-compliance and continue to do so with escalation for staff members that have to be continually reminded. Continued focus will continue to drive improvements in hand hygiene compliance with an aim of achieving 100% in all areas.

The division continues to monitor and learn from health care associated infections. Unfortunately, the division exceeded their trajectory for Clostridium difficile with 12 cases of which 2 were deemed avoidable following HCAI panel review. The findings from these investigations have been shared with the multi-disciplinary teams for learning and subsequent action plans created. The Division reported zero MRSA bacteraemia. Work continues to embed IP&C standards, in particular PPE and commode cleanliness.

The teams have continued to see high standards of cleanliness, with all acute (inclusive of AHP areas) achieving 5-star ratings. Further work is ongoing with NHS properties to have the respective reporting across our community sites.

In addition, all acute areas continue to ensure all clinical responsibilities are completed with regards to the decontamination of equipment and the use of Clinell labels. The Matrons and Ward Managers continue to spot-check this.

All areas in the division are above 90% with ANTT.

In community areas 'Yellow Folder' audits continue to be completed monthly. End of clinic checklists assure compliance with appropriate use of Clinell tape, use of PPE, ANTT training compliance, and environmental issues such as hand wash sinks being free form inappropriate items etc.

Compliance is generally good and when 100% is not met immediate action is taken by the auditor and team leaders alerted and further actions put in place.

Clinical Support Services (CSS)

These services include patient facing areas (Endoscopy / Outpatients / Radiology) and non-patient facing areas (Pathology / Pharmacy) however all areas are still required to implement IP&C practices and undertake IP&C audits. A significant amount of engagement work has taken place within the CSS division supported by the IP&C team. IP&C is embedded within the CSS Quality Group monthly agenda where areas of good practice are celebrated and areas that require focus are discussed with the offer of support from the senior team. CSS has presented 2 divisional action plans to the IP&C group to date which have provided a comprehensive overview of IP&C practice within this diverse group of specialities. Accreditation by external inspectors for Pathology and Pharmacy are recorded appropriately according to policy and held in central governance. The intention over the next 12 months is to further enhance the culture of infection prevention within CSS.

Action:

- During 2024-25 work closely with the IP&C team to adapt and embed IP&C practice.

Criterion 7: Provide or secure adequate isolation precautions and facilities.

Isolation facilitation is managed by the clinical site co-ordinator (CSC) team, during 2023-24 to develop the CSC team knowledge around IP&C, the IP&C team spent time working alongside the team.

Action:

- To continue to support and develop teams.

Criterion 8: Provide secure adequate access to laboratory/diagnostic support as appropriate.

The laboratory support team being on site remains invaluable providing a fast turnaround of results enabling timely movement of patients to ensure they are in the right place.

The IP&C team work closely with the laboratory team with 24-hour microbiology advice being available.

Criterion 9: Have and adhere to policies designated for the individual's care and provider organisation that will help to prevent and control infections.

Policies and procedures are essential to ensure all staff have access to evidence-based information aimed at ensuring high standards of IP&C.

During 2023-2024 policies, SOPs and guidelines were updated in line with national guidance and approved through the IP&C group.

All Infection prevention policies, SOPs, guidelines and related documents have been uploaded to the IP&C microsite and the Trust intranet.

Action:

- To update policies, SOPs and guidelines in line with evidence-based practice and national guidance.

Audit Activity

Aseptic Non-Touch Technique (ANTT)

ANTT remains a central component in safeguarding patients who undergo procedures which breech the skins natural defence system, including the insertion, removal or manipulation of indwelling devices.

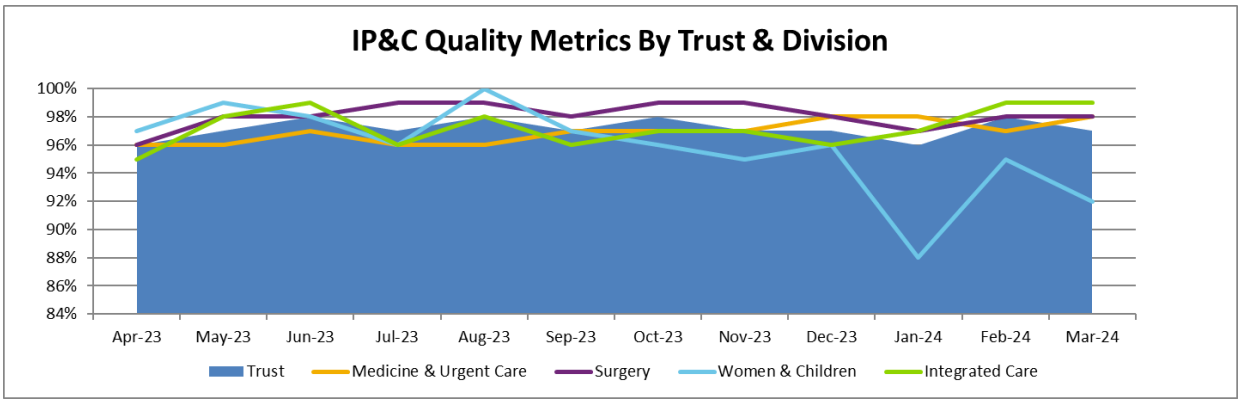
During 2023-24 the IP&C Service team conducted 179 ANTT assessments for key assessors including 4 medical fellows. These key assessors ensure within their department, staff who require ANTT compliance competency are assessed and practice safely.

Action:

- To assist divisions with ANTT training of key assessors.

IP&C Quality Metrics

Divisional Matrons undertake the IP&C Quality Metrics monthly. The average compliance for the Trust during 2023-24 was 97% for IP&C which is the same as the previous year.



Action:

- Divisions to review questions within the IP&C metrics where compliance is consistently lower and provide actions against them.

IP&C Spot Audits

During 2023-24 the IP&C team undertook spot audits on Hand Hygiene, Personal Protective Equipment (PPE) and Commode Cleanliness across areas where an increase of HCAI's was noted. Below are the results:

	No. Spot Audits	Average Compliance
Hand Hygiene	227	82%
PPE	232	72%
Commode	221	78%
Trust	680	77%

In 2023-24 the IP&C Service implemented bespoke sessions for new starters and provided 148 tailored training sessions over the year.

To increase knowledge and education around vascular access devices a cannula audit was introduced for completion by the wards monthly. For quality assurance purposes the VAD and IP&C teams conducted 396 and provided feedback to the teams.

Action:

- To continue to undertake spot audits to provide compliance and assurance to the IPC group.

Sharps Audit

A sharps audit undertaken by Daniels an external company was undertaken during 2023-24. The results from the audit and the one prior are outlined below.

	Incorrectly assembled	**Items above fill line**	**On floor or unsuitable height**	**Unlabelled whilst in use**	**Had significant inappropriate contents**	**Temporary closure not in use when left unattended or during movement**
Percentage achieved 2022-23	0.00%	0.81%	0.00%	1.62%	1.35%	5.14%
Percentage achieved 2023-24	1.88%	0.00%	0.00%	1.64%	1.17%	2.58%
Direction	↑	↓	→	↑	↓	↓

Action:

- To work with the divisions on the two areas where improvement has not been achieved.

Criterion 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection.

Trust employees encounter several infectious agents which may theoretically be passed from patients/service users i.e., Hepatitis B, Tuberculosis, Measles and Mumps.

New employees attend Occupational Health for an immunity check; a vaccination programme is then commenced as necessary.

The Occupational Health team provide support and advice to Trust employees and managers on specific additional measures that might be required following an incident where exposure to an infected individual, pathogen or contaminated instrument occurs.

Influenza Vaccination

National data collection of staff uptake for the seasonal influenza vaccine during the 2023-24 was 28% for frontline staff (a decrease from the previous year which was 39%). The CQUIN target set for 2024-25 is 80% for frontline staff with 100% of staff being offered the seasonal influenza vaccination.

Action:

- To achieve the CQUIN target.

Inoculation Injuries

The recording of inoculation injuries is undertaken with Occupational Health (OH) software and the numbers for the whole year were reported to the divisional leads and the Infection Prevention & Control Group. All injuries are reported via the Trusts incident reporting system.

Divisions and the IP&C group are provided data monthly for learning and dissemination.

The number of inoculation injuries to staff (including bites, scratches and splashes) was 104 which is an 22.4% decrease on the previous year.

Sharps related incidents remain one of the common types of injuries to staff totalling 59. 31 injuries occurred whilst the sharp was in use, a decrease of 41.5% from the previous year and 28 injuries occurred before disposal, an increase of 75% from the previous year.

Action:

- To minimise inoculation injuries within divisions

Fit Testing Service

The FIT testing service continues to be delivered by the IPC team and is available to all staff.

The online booking system continues to provide an easily accessible system for all staff to arrange their own appointments. The system includes advice on actions to take prior to the appointment to enable the best use of their time and reduce the number of wasted appointments.

Increased demand for fit testing occurred at points during the year and were related to increases in covid/flu and measles in our local community.

The fit testing team supported the service at Tameside and Glossop NHS Trust undertaking supportive sessions and re-education.

During 2023-24, 1307 appointments were made of which 837 staff attended (64%) and of those 551 were successful (66%) for either 1 or 2 masks. Divisional monitoring of compliance is undertaken by the IPC operational group however focus is required to increase the number of staff successfully tested for 2 masks and to maintain testing throughout the year.

During 2023-24 National competencies were implemented for recording all staff passes following a FFP3 fit test.

Action:

- To continue to provide a robust fit testing service for the Trust following the withdrawal of the national support.

Conclusion

2023-24 remained a challenging year with the Trust managing an ageing estate and population. The Trust is disappointed that national trajectories weren't achieved but are pleased with the decrease in the number of HCAI's from the previous year. The Trust is proud of its overall achievements in other areas and progress against objectives.

Key Objectives for 2024-25

- Meet or end within the HCAI thresholds set internally by the Trust.
- To further develop the nurse led vascular access device service.
- To maintain the IPC Board Assurance Framework (BAF)
- To continue aligning the NHS patient safety incident response framework (PSIRF) within IP&C.

Infection Prevention &Control (IP&C) 2 year strategy

Nesta Featherstone
Associate Nurse Director IP&C

Barzo Faris
Consultant Microbiologist

Nic Firth
Chief Nurse

AIM	HOW?
To support the health & wellbeing of our community by having no preventable HCAIs by March 2026	• Support transition to Patient Safety Incident Response Framework (PSIRF) • Support Facilities with new research and development around a clean environment. • Promote IP&C practice with patients and visitors.
To transform and improve the nurse-led vascular access device (VAD) service and incorporate a community VAD service by March 2026	• Support the Trust with the new out of hours service development review. • Review the workforce, ensuring improved patient outcomes by timely insertion of CVADs. • Review/research products to ensure an effective and efficient service.
To transition IPC to supporting sustainability and the Trust route to net zero	• Embed existing IPC led improvements i.e., gloves off campaign. • Implement best practice i.e., reusable instead of single use.
To further develop an effective partnership with Tameside IPC team by March 2026	• Teams cross working • IP&C leads working on the same national IP&C strategy.
To develop a skilled IPC workforce to meet future IPC service needs by March 2026	• Review national and local IP&C courses specific for IP&C practitioners. • Embed the IP&C education framework.

Infection Prevention & Control

2023-24 Annual Report

Stockport NHS Foundation Trust

IP&C 2 Year Strategy

Nesta Featherstone
Associate Nurse Director IPC

Barzo Faris
Consultant Microbiologist

Nic Firth
Chief Nurse

AIM	HOW
To have no preventable healthcare acquired infections by March 2024	Embed IPC practice across Trust and community Provide an IPC appropriate environment Enhance surveillance
To develop a nurse-led central vascular access device (CVAD) service to improve patient outcomes by March 2024	Improve clinical standards for management of CVAD's Improve patient outcomes by timely and appropriate insertion of CVAD's Have a robust sustainable seven day service
To enhance the collaborative working with Tameside and MacclesfieldIPC teams by March 2024	To work in partnership with other IPC teams across the Northwest Streamline policies
To enhance staffs' ability and confidence to promote the principles and practices of IPC to patients, visitors and colleagues across the trust by March 2024	Ensure all policies, SOP's and guidelines are in date and evidence based Develop a safety culture
To develop a robust effective antimicrobial stewardship program that delivers and changes practice to improve patient safety by March 2024	To enable prompt initiation of necessary and appropriate antibiotics to treat infections To strengthen data collection and ownership To assist clinicians to improve the quality of patient care and improve patient safety through better infection cure rates

Making a DIFFERENCE every day

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Innovative
Passionate
Collaborative

Successes

- HSDU & EDU were successful in passing their BSI accreditation.
- EDU received their JAG accreditation.
- New cleaning standard star ratings electronically displayed in ED and all inpatient areas.
- First paperless PLACE visit with the food domain remaining above national average.
- Set the IPC 2-year strategy for 2024-26.

IP&C Strategy: Aim 1

- The threshold for MSSA and Klebisiella were met
- The Trust exceeded the mandatory requirement for SSI surveillance

IP&C Strategy: Aim 4

- IP&C eLearning compliance 96.64%
- IP&C Elf on the shelf, interactive sessions positive feedback
- Divisional engagement
- IP&C spot audit results improved
- Great engagement from divisions

IP&C Strategy: Aim 5

- 20% reduction in IV antibiotic doses
- Achieved antimicrobial resistance CQUIN
- Participated in National Point Prevalence Audit

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Innovative
Passionate
Collaborative

McCarthy Rebecca 03/10/2024 10:39:15

Challenges

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Innovative
Passionate
Collaborative

- Increase in outbreaks associated with D&V.
- PLACE results below national average in all but 1 of 6 domains.
- Isolation facilities & old estate.
- Sharps audit compliance.
- The overall uptake of the seasonal Influenza vaccine amongst frontline staff was 28%

INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2023- March 2024

NHS Stockport NHS Foundation Trust

IP&C Strategy: Aim 1

- Trajectories not met
  - MRSA, E. coli & Pseudomonas aeruginosa Bacteraemia's
  - Clostridium difficile
- Blood culture contaminant rate over target
- Mandatory ANTT for medics

IP&C Strategy: Aim 2

- Increase in referrals for longlines
- Increase in masterclasses
- Delays remain for patients requiring longlines

IPC Strategy: Aim 3

- Fit testing team supported T&G

McCarthy Rebecca 03/10/2024 10:39:15

Benchmarking against GM

- 7 Trusts across GM
- Best position is 1st
- Worst position is 7th

Infection Type	End of year position
Clostridium difficile	4th
E. coli	3rd
Pseudomonas aeruginosa	3rd
Klebsiella	2nd
MRSA	2nd
MSSA	3rd

IP&C 2 Year Strategy

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Innovative
Passionate
Collaborative

Infection Prevention &Control (IP&C) 2 year strategy

Nesta Featherstone
Associate Nurse Director
IP&C

Barzo Faris
Consultant Microbiologist

Nic Firth
Chief Nurse

AIM	HOW?
To support the health & wellbeing of our community by having no preventable HCAIs by March 2026	• Support transition to Patient Safety Incident Response Framework (PSIRF) • Support Facilities with new research and development around a clean environment. • Promote IP&C practice with patients and visitors.
To transform and improve the nurse-led vascular access device (VAD) service and incorporate a community VAD service by March 2026	• Support the Trust with the new out of hours service development review. • Review the workforce, ensuring improved patient outcomes by timely insertion of CVADs. • Review/research products to ensure an effective and efficient service.
To transition IPC to supporting sustainability and the Trust route to net zero	• Embed existing IPC led improvements i.e., gloves off campaign. • Implement best practice i.e., reusable instead of single use.
To further develop an effective partnership with Tameside IPC team by March 2026	• Teams cross working • IP&C leads working on the same national IP&C strategy.
To develop a skilled IPC workforce to meet future IPC service needs by March 2026	• Review national and local IP&C courses specific for IP&C practitioners. • Embed the IP&C education framework.

Stockport
NHS Foundation Trust

McCarthy Rebecca 03/10/2024 10:39:15

2024-25 position

April – August

- **Internal trajectories set in April 2024**
- **New apportionment criteria for 2024-25**
  - **Decision to Admit (DtA) in ED now starts the clock**
  - **Virtual wards**
- **Standard contract published August 2024**
  - **Our internal trajectories remain the same**

	24-25 Trajectory	Case Numbers (Apr-Aug)	Current Position against Trajectory	Case numbers based on old apportionment	Trust Current Position Within GM (July 24)
MRSA	0	0	☺	0	1st
MSSA	19	11	☹	11	4th
C difficile	73	34	☹	32	3rd
E coli	70	31	☹	31	3rd
Klebsiella	13	11	☹	11	2nd
PAE	8	6	☹	6	4th

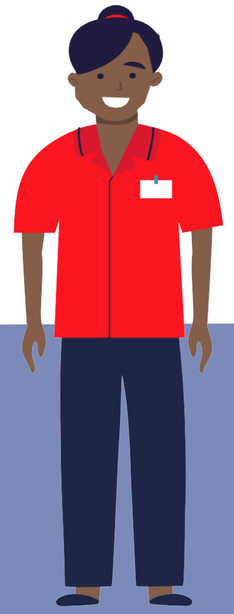
IF YOU HAVE ANY QUERIES OR

REQUESTS PLEASE CONTACT

IP&C Tel: 114669 or by email at
Infection.prevention@stockport.nhs.uk

NHS
Stockport
NHS Foundation Trust

INFECTION PREVENTION & CONTROL



Making a DIFFERENCE every day

NHS
Stockport
NHS Foundation Trust

				Agenda No.	15
Meeting date	3 October 2024	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Health Inequalities Self-Assessment				
Director Lead	Andrew Loughney, Medical Director	**Author**	Annie Lowe, Public Health Registrar		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to: -Review and approve the Health Inequalities Self-Assessment Report -Review and approve the recommended next steps -Re-confirm its commitment to tackling health inequalities in the community that it serves.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
X	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring	X	Responsive
	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	X
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

Introduction

As an NHS provider, Stockport NHS Foundation Trust has a responsibility to identify, address and mitigate for health inequalities. A self-assessment tool, developed by NHS Provider's as part of their package, *Reducing Health Inequalities: a guide for Boards'* has been completed by the executive team to understand and assess the Trust's current response to health inequalities. By identifying the strengths and weaknesses of our current response, we can take steps to formulate a trust-wide health inequalities approach to ensure that we are providing equitable services that address the needs of our patients and population.

This report builds on heath inequalities board development day delivered by Stockport Metropolitan Borough Council's public health team in March 2024. The self-assessment has been reviewed and approved in the Executive Team meeting prior to board.

Results

The health inequalities self-assessment tool includes 25 questions across 4 key domains, which represent key enablers for the Trust to effectively address health inequalities. The tool provides a score and maturity rating for each domain. The results are summarised in table 1.

***Table 1**: Maturity level and completion rate for each enabling domain, September 2024*

Theme	Percentage Complete	Maturity Level
1 – Build public health capacity and capability	38%	Developing
2 – Data, insight, evidence and evaluation	21%	Emerging
3 – Strategic leadership and accountability	33%	Developing
4 – System partnerships	60%	Maturing

These results are derived from the responses given against the 25 questions, which have been used to generate the overall percentage and maturity level for each domain and set out detail within this paper. The results highlight key areas for improvement particularly within domains 1-3, that are required in order to upkeep our responsibilities around health inequalities. In addition to the moral obligation to address and mitigate for health inequalities, the Trust has legal and regulatory requirements as stated in Code of Governance for NHS Provider Trusts, CQC Single Assessment Framework, National Oversight Framework, NHSE Priorities and Operational Planning Guidance and the NHS Standard Contract. If action is not taken to address health inequalities, these requirements will not be met.

Next Steps

- A public health registrar is in post until August 2025, to support the executive lead for health inequalities to drive forward this agenda and embed a health inequalities approach as part of core business.
- The board has also made a commitment for executive and non-executive representation to attend the GM Health inequalities Board Development programme.
- The self-assessment results will be used to develop the Trust's approach to health inequalities and recommended actions.
- The Health Inequalities Executive Lead and Public health registrar will deliver a health inequalities focused board development day in November 2024 to explore to Trust's health inequalities role and responsibility and explore next steps.
- The self-assessment will be repeated (minimum of annually), to measure and monitor progress against recommended standards.

Recommendations

- The Board of Directors is asked to review and approve the health inequalities self-assessment and the proposed next steps and re-confirm its commitment to tackling health inequalities in the population that it serves.

Health Inequalities Self-Assessment Report

September 2024

Introduction

As an NHS provider, we have a responsibility to identify, address, and mitigate health inequalities among our patients, staff, and the local population[1]. The NHS Providers' support package, *Reducing Health Inequalities: A Guide for Boards*, offers a self-assessment tool to help Trusts evaluate their progress in tackling health inequalities[2].

In August 2024, we utilised this tool to review the Trust's current activities, highlighting both strengths and areas for improvement. The insights gained will guide our next steps in integrating a health inequalities approach into the Trust's core operations.

This work builds on the health inequalities board development day, led by the Council's public health team in March 2024.

What are health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups in society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions, or social determinants, influence the chances of people getting ill, their ability to prevent illness and their opportunities to act and access healthcare when illness occurs.

The causes of health inequalities are complex, and largely driven by the social determinants of health, however, access to and quality of healthcare accounts for 20% of health inequalities. The way in which health services are designed, delivered and funded, and the quality of clinical care received, can all drive health inequalities[3]. The NHS plays an essential role in mitigating against the impact of the social determinants of health and in reducing healthcare-based inequalities.

Methodology

The NHS Providers' health inequalities self-assessment includes 25 questions across four domains:

1. Building public health capacity and capability
2. Data, insight, evidence and evaluation
3. Strategic leadership and accountability
4. System partnerships

[1] NHS England » Code of governance for NHS provider trusts
Responsive - Care Quality Commission (cqc.org.uk)
[2] Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org)
[3] Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org)

These four domains are recognised as key enablers for Trusts to effectively address health inequalities[4]. On completion of the questions, the tool provides a score and maturity rating for each domain (Table 1). The questions and recommendations are based on NHSE policy and guidance documents, alongside recommendations gathered from trusts that have experience in population management and reducing health inequalities[5].

Table 1: Maturity ratings and Scoring System

Percentage	Maturity Rating
0	Not started
1-24	Emerging
25-49	Developing
50-74	Maturing
75-100	Thriving

The health inequalities self-assessment was completed in collaboration with executive directors, and other members of staff, who were able to provide insight into the current activity across the organisation.

Each question can be answered with 'yes,' 'no,' or 'partial,' based on the perceived level of activity. It was agreed that a 'yes' would only be awarded when the response to health inequalities was fully satisfactory. Therefore, the threshold for assigning a 'partial' score was intentionally low, to highlight areas with for improvement.

The completed self-assessment will be taken to the Executive Team Meeting for discussion and scrutiny, followed by the Board of Directors for final sign off.

Results

Overview

Table 2 shows the overall scores in relation to each enabling domain.

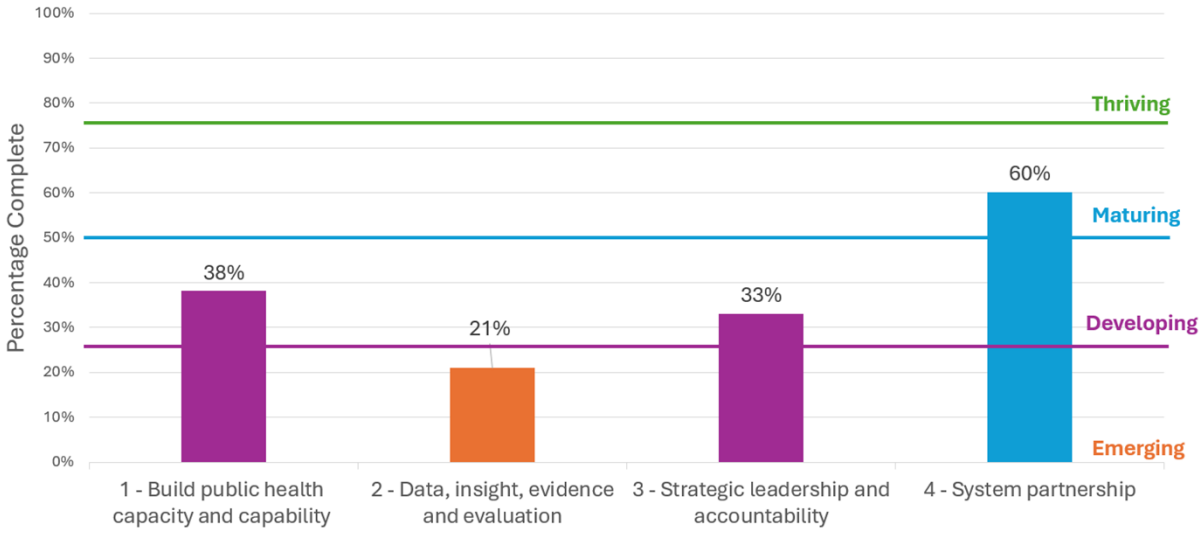
Table 2: Health Inequalities Self-Assessment Results : Overview

Theme	Percentage Complete	Maturity Level
1 – Build public health capacity and capability	38%	Developing
2 – Data, insight, evidence and evaluation	21%	Emerging
3 – Strategic leadership and accountability	33%	Developing
4 – System partnerships	60%	Maturing

Figure 1, provides a visual representation of our scores in relation to the maturity levels. We can use this to help set goals and monitor in the future.

Figure 1: Maturity levels across each health inequalities domain, September 2024

[4] Institute for Clinical Systems Improvement – Going Beyond Walls: Solving Complex Problems (2014)
[5] Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org)



- Our most notable achievements are in system partnerships where we achieved 60% completion and a 'maturing' status.
- Lower maturity levels are seen across domains 1-3, where the majority of questions were answered as 'partial' or 'no' activity.
- Table 3, provides a list of all 25 questions, their allocated score and rationale. 10% (2) of questions were answered yes, 56% (14) questions were answered as partial and 36% (9) were answered no.
- For public health capability and capacity, there is room for improvement around staff training, quality improvement work and public health workforce development and recruitment.
- For data, insight, evidence and evaluation, several areas had no activity, leading to a lower score. Areas that require the most attention include: the breakdown of performance data by ethnicity and deprivation, engagement with communities to inform work on health inequalities, ensuring care pathways enable equitable access, experience and outcomes and digital and health literacy.
- For strategic leadership and accountability, several areas had no activity for example, we have no clear governance structure for health inequalities work, there is no use of a health inequalities impact assessment tool within the business case process, health inequalities are not considered in the allocation of trust resources and the trust does not currently use or implement NHS England's Core20PLUS5 framework.
- For system partnerships, a high score was achieved due to our representation and activity on appropriate integrated care system groups, our work as an anchor organisation and our programmes in place to improve access to employment in underrepresented groups. However, for most areas there was agreed room for improvement.

Table 3: Health Inequalities Self-Assessment Complete Results

Question	Self-Assessment	Evidence
Domain 1: Building public health capacity and capability		
1. Has your board received training and/or development on health inequalities?	Partial	• Board development session held on 7th March 2024, led by Stockport MBC focussed on Population Health - Drivers of Population Health, Role of NHS Trusts and Stockport's Population. • HI focused board development day scheduled for November 2024. • 1 exec director and 2 non exec directors are planning to attend GM organised training around the health inequalities self-assessment and actions. • There are no current plans for regular training

2. Does your trust deliver regular training to all staff groups on health inequalities?	No	• No consistent/formalised training around health inequalities for all staff.
		• Training delivered by Jan Sinclair, Public Health Specialist Nurse:
		  ○ Ad hoc training around health promotion.
		  ○ Training session is delivered as part of the preceptorship programme 3-4 times per year which includes information on public health, health inequalities, MECC and brief interventions.
		  ○ Training for Locally Educated Doctors (LEDs) around health promotion and lifestyle conversations (no specific focus on health inequalities)
		• EDI is a mandatory training topic for all staff, there is a small element around health inequalities. However, it is suspected that staff would not identify that they have had training in this area.

3. Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Partial	Work completed in 2023/24 as per annual report: • Maternity Dept: improving health outcomes for minority ethnic communities • Public Health Community nurse -work around supporting vulnerable children and reducing health inequalities in families who had missed out on post-natal groups during the pandemic and asylum seekers. • School nursing toolkit developed to support young LGBTQ+ people.

		• Family Hubs (in collaboration with SMBC) in areas of Stockport with the greatest need. Work that is ongoing: • Co-production work in maternity around service development and improvement, in partnership with Maternity and Neonatal Voices partnership. • Pre-op smoking cessation work in Trauma and Orthopaedics (Jan Sinclair) The transformation team have several workstreams, some of which have elements of addressing health inequalities. However, agreement from the team is that this is not a primary focus and could be strengthened. Current work programmes with the potential for a HI focus: • Cancer scheme -faster diagnosis, prevention, personalised care, improving outcomes • Theatres improvement programme -improving efficiency • Opioid stewardship programme -reducing high use and supporting weaning post surgery • Frailty improvement programme -part of the provider partnership, intended to address health inequalities. • CYP -walk in/walk out offer, mental health • Pain co-design project -ensuring that the patient voice informs pathways. Looking at triage and self-service. Working with an evidence based co-design facilitator. • Urgent and emergency care -how do we improve processes and streamline pathways • Single point of access referral route -for all community services • Continence improvement process -improve services, personalised care • Cardiology services -one stop shop ?links to CORE20Plus5 Provider Partnership • Lead for frailty

		• Involved in all: Alcohol related harm, diabetes, CVD • Unclear to what extent these work streams are focusing on HI
4. Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise?	Partial	• Senior Healthcare Public Health Nurse in post. • Public Health Registrar currently in post August 2024 - August 2025. • Smoking cessation team • Alcohol Specialist Nurse -Helena
Domain 2: Data, insight, evidence and evaluation		
1. Is your trust's data on patient ethnicity accurate and comprehensive?	Partial	• This is the data quality metric that we struggle the most with, however nationally we score high for data quality overall.
2. Does your trust board routinely receive performance data broken down by ethnicity and deprivation	No	• In 2021/22 and 2022/23 the board received an annual breakdown of waiting lists by different demographics, but there are no plans to reinstate this currently • This does not occur routinely e.g. this is not included in performance reports.
3. Does your trust use existing population health data (e.g. population demographics and index of multiple deprivation) in your analysis of trust-level data?	Partial	• This does not happen routinely at a Trust level. • However, data analysis is not uncommonly done by BI to inform service improvement e.g. transformation team. • Whilst the analysis happens, it is unclear if action is then taken to address any inequalities identified.
4. Has your trust taken part in any research related to health inequalities?	Partial	• Supporting projects that seek to address healthcare inequalities has been a key focus of the RDI team for 2023/24. • Ring fenced funding from NIHR to support UK-wide projects to tackle inequalities in key areas, including maternity research • GM NIHR project using data to understand the demographics of our patients -Stockport FT have supported to develop research projects that suit our community. • Support national projects that address healthcare inequalities -e.g. progression through cardiac rehabilitation in underrepresented groups, prostate cancer research exploring outcomes by ethnicity, digital inclusion in rheumatology patients.
5. Has your trust carried out engagement with communities to inform work on health inequalities?	No	• Involve health watch in decision making, but health inequalities is not a specific focus. • No one on the councillor of governors has a HI role • Some engagement with the public but not with a HI focus or approach

6. Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes?	No	• Patients are prioritsed based on clinical urgency and waiting time length. • There is a formal process to expedite staff • But care pathways have not been reviewed in relation to equitable outcomes in access, experience and outcomes
7. Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population?	No	
Domain 3: Strategic leadership and accountability		
1. Does your trust have commitments to reducing health inequalities within its strategy documents?	Partial	• Referenced in the Trusts Strategy > under the strategic objective 'working with others for our patients and communities' -'contribute to narrowing health inequalities and supporting health and wellbeing.' There are a number of references to HI, for example recognising the presence of HI across the borough, our role in working in Stockport Locality to reduce HI, but no specific commitment regarding what actions we will take. • Unclear to what extend it is included in enabling strategies: estates, digital, equality, people, research, mental health. • There is no HI Plan to underpins our strategic commitments
2. Does your trust have a named board-level Executive Lead for health inequalities?	Yes	Medical Director
3. Does your board have health inequalities objectives set in your annual review process?	Partial	Annual corporate objectives: "3. Develop effective partnerships to address health and wellbeing inequalities" • Key outcome measure: "As part of our role as an anchor organisation, continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people." • There is commitment but no plan behind the objectives to deliver on this. No clear actions to show a trajectory of improvements. • No consideration for wider role in relation to health inequalities i.e. outside of partnership working.
4. Is your Executive lead for health inequalities providing strategic	Partial	• HI and prevention raised in board and exec meetings but more work could be done to strengthen this approach.

leadership and embedding an equity lens into cross-organisational work?		• Raised as an issue/for awareness but not currently informing action.
5. Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight?	No	• Public Health nurse reports to the Clinical Effectiveness Committee, which reports to Quality Committee. However, there is not one single committee that has oversight of health inequalities in its broadest sense, acknowledging this incorporates access (Finance & Performance) , experience and outcomes (Quality Committee). • The Board Work Plan 24/25 includes biannual reporting on Place Locality Provider Partnership which focuses on four integrated pathways - Diabetes, Frailty, Alcohol Related Harm and CVD, aligned to Stockport Health & Care Plan 2024-29. • No HI group
6. Does your trust/board use a health inequalities impact assessment tool in your business case process?	No	• Follow current NHS Green Book and/or better business cases training. • Equality impact assessment tool used, but not consistently. • Equality and Health Inequalites impact assessment tool/ HEAT not currently used.
7. In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?	No	
8. Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members?	Partial	• EDI Strategy - Overarching strategy aimed at improving staff experience overall and for those with protected characteristics. There is a pillar around increasing number of staff from local population, improving career progression and development, and reducing discrimination. Some aspects of Health inequalities covered. • Health and wellbeing strategy and action plan -aimed at all staff with generic offer with opportunities to strengthen HI focus.
9. Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities?	No	
Domain 4: System Partnerships		

1. Is your trust represented on appropriate Integrated Care System group(s) to contribute to population health decision making in your region?	Partial	• Exec team attend all groups. Unclear to what extent we are contributing in terms of decision making and evidencing our population health impact.
2. Is your trust contributing to anchor institution working?	Partial	• Some input into workforce and employment and but not in housing or social value • More work could be done e.g. procurement.
3. Does your trust have programmes in place to improve access to employment to underrepresented groups in your organisation?	Yes	• Yes part of the EDI Strategy and the Widening Participation work we undertake. We work with local colleges and take Cadet/T Level Students. Run Intern programme. • Range of activities and widening participation paper that goes to people performance committee -whole programme of work.
4. Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Partial	• Provider partnerships work -focus on specific patient populations, but extend to which a HI lens is applied unclear.
5. Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Partial	• Full partner in Stockport locality work and priority workstreams. • Provider partnerships involvement in all streams and leading frailty. • Jan links with National Provider Public Health Network and Healthy Hospitals

Risks

In addition to the moral obligation to address and mitigate for health inequalities, the Trust has legal and regulatory requirements as stated in Code of Governance for NHS Provider Trusts, CQC Single Assessment Framework, National Oversight Framework, NHSE Priorities and Operational Planning Guidance and the NHS Standard Contract. If action is not taken to address health inequalities, these requirements will not be met.

If health inequalities are not addressed, there is a risk of poor patient experience and outcomes, which will widen health inequalities. Health inequalities worsen the health of the overall population leading to an increase in demand on health services.

Next Steps

- The Trust has a public health registrar in post for approximately 12 month, to support the Medical Director, as executive lead for Health Inequalities, to drive forward this agenda and embed a health inequalities and a population health approach as part of core business. (August 2024 – August 2025)
- The board has made a commitment for one executive director and one non-executive director to attend the Greater Manchester Health Inequalities Board Development Programme to upskill board members to tackle health inequalities. (Approx. September 2024 – September 2025)
- A health inequalities focused board development day is scheduled for November 2024. This session will explore the Trust's responsibility in relation to health inequalities and develop a vision for what our health inequalities and population health approach should look like, as well as what our key next steps should be. (November 2024)
- The self-assessment results (score and associated recommendations) will be reviewed alongside national requirements, the evidence-base, good practice and local context to develop a trust-wide approach to health inequalities, with corresponding actions. (September – December 2024)
- The self-assessment should be repeated regularly (minimum of annually) to measure and monitor progress. (August 2025)

Recommendations

- The Board of Directors is asked to review and approve the health inequalities self-assessment and the proposed next steps, and re-confirm its commitment to tackling health inequalities in the population that it serves.

NHS Stockport NHS Foundation Trust

				Agenda No.	16
Meeting date	**3 October 2024**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Stockport Locality Update				
Director Lead	Paul Buckley, Director of Strategy & Partnerships	**Author**	Paul Buckley, Director of Strategy & Partnerships		

Paper For:	**Information**		**Assurance**	**X**	**Decision**		
Recommendation:	The Board of Directors is asked to receive the Stockport Locality Update.						

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
X	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
X	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

Purpose of this report is to bring to the Board a greater awareness of the collaborative working arrangements within Stockport that the Trust participates in and the focused work that is being taken forward within the borough that relates to health and care.

This first report provides background details of the overall place-based collaborative working structure, relevant strategies and plans that exist, an update on the progress being made within the provider partnership and concludes with a note of the Director of Public Health report for Stockport.

Stockport Locality Update

1. Context

The Health and Care Act 2022 (the Act) contained a number of reforms for the NHS, the majority of which focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs).

Each of the ten Greater Manchester (GM) localities has a committee established to undertake the functions of the Act and brings together senior leaders from the NHS (primary, secondary, community and mental health), local authority and the Voluntary, Community, Faith & Social Enterprise sector (VCFSE).

2. Structures

The ONE Stockport Health and Care Board is Stockport's locality board where all of the key partners in the borough come together. The ONE Stockport Health and Care Executive supports the work of the Board. The Provider Partnership is led by the Trust. The Trust's Chief Executive, Chief Finance Officer and Director of Strategy and Partnerships along with other Trust colleagues are members of these groups. **Appendix 1** provides an organogram of these and the range of other local structures in place.

3. The Stockport Locality

Within Stockport there are a range of long-term plans in place that the Trust has had input into and participates in the various delivery plans.

- **ONE Stockport Borough Plan** was developed in 2021 and is the overarching strategy that sets out our shared strategic aspirations for Stockport in 2030. It has three overall strategic ambitions of which ONE Heart is where much of health and care matters are incorporated.

- **ONE Stockport Health and Care Plan** sets the strategic direction for delivering on One Heart, which details how partners will deliver against the priorities of the GM ICS as well as localised Stockport priorities. These include a focus on:
  - Mental Health
  - Neighbourhoods and Prevention
  - Safe and Timely Discharge
  - Cost-of-Living
  - Primary and Community Care
  - Elective Care

- **ONE Stockport: ONE Future** was developed in 2024 and is the next phase of the borough plan that will look towards 2040. It has five big things as its focus:

Best Health and Care and Thriving Neighbourhoods are where the Trust has a greater focus on. There are two notable aspect within this priority area

- **The St Thomas' development** is an integrated health and care centre, which is now in development and is due to open in approximately 2 years. The work to further develop the business case and the formal agreement between the local authority and the Trust is continuing. An integral to this is the operational model for the service and ensuring demand modelling has been carried out to ensure sufficient capacity is in place for the local population. A further update to the Board is now scheduled for December 2024.

- **The proposed new hospital development** gives the Trust and other partners the opportunity to design the health and care provision for the future. The hospital alongside the new primary care health hub will give access to a range of services to the local population. The current scope of the Project Hazel is in the process of being reviewed with a potential focus as an elective hub, which is in recognition of the current works addressing the provision of outpatients, emergency and urgent care on the Stepping Hill site.

4. The Provider Partnership

The Trust leads the provider partnership in place for Stockport and there are four priority areas of work, which have been in place for over a year. These are:

- Alcohol Related Harm
- Cardiovascular
- Frailty
- Diabetes

A summary highlight report for each is included in **Appendix 2**.

5. Other Matters

The publication of an independent annual report on the health of the local population is a statutory duty of the Director of Public Health. The 2023 report for Stockport has now been published and draws attention to the stark health inequalities that exist locally and recommends wide-ranging actions for Stockport partners.

The topic of Health Inequalities was specifically identified because of the wide and entrenched inequalities that persist for which a system response is needed to reduce them.

The report is an important document for the Trust to consider as it develops a new strategy for the organisation.

6. Summary

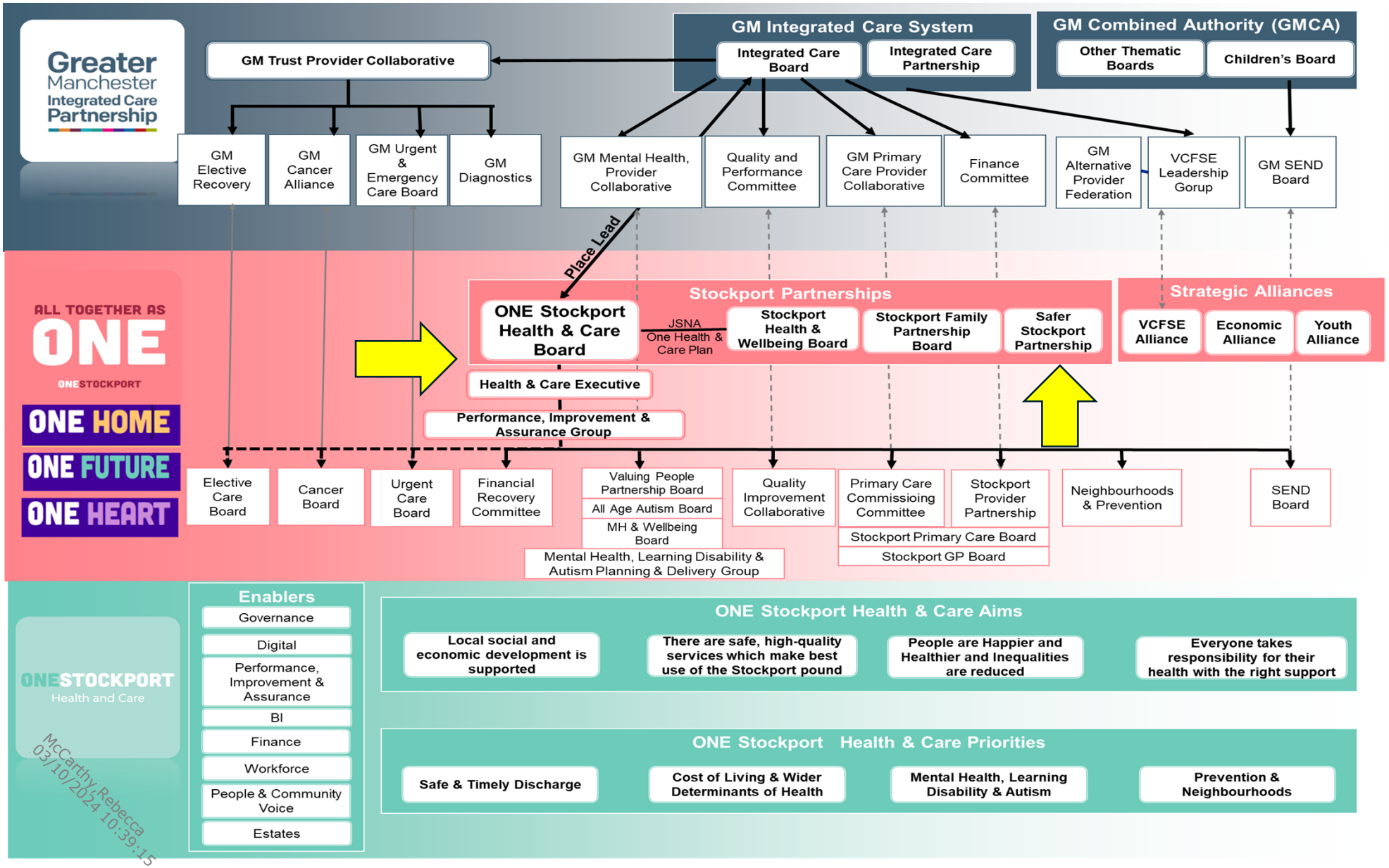
The Trust is committed to collaborative working with a range of partners, to identifying opportunities to improve services, tackle unwarranted variation and health inequalities, and strengthen resilience through its partnership endeavors.

Senior leaders and operational teams participate in work and invest time in building relationships through the formal structures within place-based partnerships, working with providers and other primary and social care forums. There are good governance arrangements in place for these local partnerships.

7. Recommendation

The Board is asked to receive the Stockport Locality Update.

Appendix 1 - Greater Manchester and Stockport Locality Partnerships Organogram



Stockport Provider Partnership Update September 2024

ONESTOCKPORT Health and Care

Stockport Integrated Care Partnership

Alcohol Related Harm

SRO: Heidi Shaw/Ben Fryer

Pathway support: Rebecca Simmons, Annie Lowe

AIM: Reduce harm caused by alcohol to a minimum for the people of Stockport.

OUTCOMES TO IMPROVE:

- Decrease the number of alcohol-related attendances at Stockport Emergency Department
- Decrease the number of alcohol-specific and alcohol-related hospital admissions (narrow measure) for Stockport residents
- Decrease alcohol-specific and alcohol-related mortality, including mortality from alcoholic liver disease and chronic liver disease

McCarthy Rebecca 03/10/2024 10:39:15

PROGRESS TO DATE:

- We have identified our phase 1 workstreams which will focus on primary, secondary and tertiary prevention and include: Licencing, Primary Care and Secondary Care.
- **Licencing:** A workstream lead has been identified. Since January 2024, PH have reviewed 34 licensing applications and submitted 2 representations. One of the licenses was granted with the condition that 'all transactions will take place via a lit hatch and night pay window which is covered directly by CCTV' and the other license was revokedA work plan is being developed to support the revision of the council's licencing policy.
- **Primary care:** conversations are underway to explore how the partnership can support the evaluation and expansion of Brinnington's alcohol harm test of change.
- **Secondary care:** there is agreement to launch an alcohol-related working group within the Trust. A pilot is underway to increase START referrals from the ward. A grant application has been submitted for £75,000 for an intervention on the gastro ward.

RISKS & ISSUES

- The Licencing Act does not currently include Public Health as an objective or support assertive actions on licencing applications.
- Brinningtonhas unique assets that mean interventions may be less effective elsewhere. An evaluation would need to think explore what has been successful and why, to help to determine if/how the approach is transferrable.Resources available are limited.
- There is currently no ringfenced funding for an Alcohol Support team at Stockport Emergency Department
- There are risks associated with working in partnership with community organisations that are funded by suppliers/producers of alcohol.

NEXT STEPS:

- Agree workstream leads, work plans and process measures for the three workstreams, and begin implementation.
- Launch Stockport FT's Alcohol-related harm working group.
- Continue to collaborate with GM colleagues on GM alcohol related harm strategy
- Agree the partnerships position on working in partnership with organisations that are funded by the suppliers/producers of alcohol

Stockport Provider Partnership–Update Sept 2024

ONESTOCKPORT Health and Care

Stockport Integrated Care Partnership

Cardiovascular Disease

SRO: Jilla Burgess-Allen/Dr Monica Saksena Joye

Pathway Lead: Kimberly Roberts

AIM: Reduce premature CVD mortality with a particular focus on disadvantaged groups

OUTCOMES TO IMPROVE:

- Reduced smoking prevalence in deprived areas (and narrowing gap between areas)
- Increase % of patients in primary and secondary care with smoking status recorded, and % of smokers offered support
- Health checks, particularly in EDI groups
- % of AF patients known to be at high risk of stroke treated to target
- % of hypertension patients treated to target
- % of patients with high CVD risk treated with statins

PROGRESS TO DATE:

- New NHS health check programme mobilised April 2024
- Mapping of Stockport wide behaviour change services undertaken and communicated to Health Care Professionals
- Workplace CVD bid successful, to deliver 4,000 BP checks in workplaces Oct24-Mar25
- 2 Stockport Primary Care Networks actively working on the proactive care GM programme focussing on CVD
- CVD prevent data being utilised to identify target cohorts
- CVD high risk reviews mobilised within the Stockport GP local quality contract 2024/25
- Initial scoping of Stockport Cardiac Rehab pathway undertaken

RISKS & ISSUES:

- System partners capacity to participate in this workstream due to other pressures and competing priorities
- There may be limitations to deliver improvements in some areas due to GP collective action

NEXT STEPS:

- Finalise and agree driver diagram as shared theory of change
- Align Stockport priorities to the GM draft multi -year prevention plan/GM CVD plan
- Recruitment of staff for workplace CVD programme
- Map attendees of GM meetings related to CVD/Cardiac to understand current representation and identify any gaps
- Prepare presentation content for the CVD and Diabetes prevention locality meeting with NHS GM colleagues (16 th October 2024)
- Task and finish groups to be set up to deliver improvements in identified priority areas

Stockport Provider Partnership–Update September 2024

ONESTOCKPORT Health and Care

Stockport Integrated Care Partnership

Diabetes

SRO: Viren Mehta

Pathway Support: Kimberly Roberts

AIM: To implement a model of care and pathway that will enable all systems partners to improve outcomes for those at risk of or with Diabetes

OUTCOMES TO IMPROVE:

- Increase % of people attending National Diabetes Prevention Programme and structured education
- Increase % of people having all 8 care processes
- Reduce proportion of people experiencing Diabetes related complications
- Increase proportion of people achieving treatment targets
- Improve the experience of Diabetes services for those living with the condition

PROGRESS TO DATE:

- A cross-system, multi-disciplinary workshop held on 15th May 2024 undertaking an end-to-end review of current Diabetes care in Stockport
- Locality assurance in place to manage the GLP1 shortage
- Mapping of Stockport wide behaviour change services undertaken and communicated to Health Care Professionals
- NHS GM Diabetes dashboard being utilised to drive improvements
- Increased uptake into National Diabetes Prevention Programme
- Diabetes high risk reviews included in Stockport GP Locally Commissioned service 2024/25

RISKS & ISSUES:

System partners capacity to participate in this workstream due to other pressures and competing priorities

NEXT STEPS:

- Stockport oversight group to meet on 19 th September to agree next steps, with T&F groups to be mobilised to lead on improvement work in the 5 priority areas: Prevention & early intervention, optimisation, managing complexity and complications, maternity & paediatric, reducing health inequalities
- Align Stockport priorities to the GM draft multi -year prevention plan, GM Diabetes Strategy and Transition strategy
- Map attendees of GM meetings related to Diabetes due to a recent change in governance structures to understand current representation and identify any gaps
- Prepare presentation content for the CVD and Diabetes prevention locality meeting with NHS GM colleagues (16 th October 2024)

Stockport Provider Partnership– Update September 2024

Frailty

SRO: Jane Ankrett (Interim SRO)

Pathway Support: Hannah Spurr, Senior Transformation Manager, SFT

AIM: To implement a model of care and pathway that will enable the whole system to improve outcomes for frail people, including those in their last twelve months of life

OUTCOMES TO IMPROVE:

- Identification and recording of the Rockwood CFS for patients over the age of 65 across the system (Primary Care, Secondary Care, Stockport Community Services)
- Frailty Assessments completed for 50% of those Over 75s and/or on Frailty Register and/or on Dementia Register.
- Reduction in admission rates for patients with a Rockwood 8/9
- No. of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up (Previous national CQUIN target – 30%)
- No. of Emergency hospital admissions due to falls in people aged 65 and over and directly aged standardised rate per 1000 (Public Health Outcomes framework data OHID)

PROGRESS TO DATE:

- Frailty Implementation workshop May 2024 to reflect on the past 12 months achievements and prioritise the next 12 months
- Re aligned workstreams to four
  - Proactive and Independence
  - Acute Care
  - Long Term Care at Home
  - Last 12 Months of Life
- NHS England (ECIST / GIRFT) UEC visit July 2024 – supported highlighting priorities and opportunities for the system wide frailty pathway
- Collaborative work with GM ICB BI leads to support Stockport locality system data collection and analysis
- Shared learning with Cheadle Hulme / Bramhall PCN re opportunities to capture CFS at multiple touch points in a patients journey
- A Frailty Core Capabilities Training Framework in development to support training and education opportunities

RISKS & ISSUES:

- Lack of Geriatrician for Stockport Locality across the system – BC in final development
- Providers capability to release capacity to participate in the delivery of workstream objectives
- SFT operational and clinical leads capacity to support in the delivery of workstream objectives

NEXT STEPS:

- Review Stockport locality system data to enable single point of truth and standardisation. Support data validation.
- Align ECIST / GIRFT recommendations within the Frailty programme workstream objectives
- Scope newly aligned workstreams next 12 month objectives
- Review areas of opportunity across Stockport community services to increase consistency and standardisation approach to capture the CFS score at initial assessment
- Complete a self-assessment utilising the Frailty Toolkit assessment template
- T&F group with system wide partners to establish the last 12 month of life priorities and focus
- Revise the frailty pathways to maximise proactive care plans / advanced care plans once CFS score captured

NHS Stockport NHS Foundation Trust

				Agenda No.	17
Meeting date	3rd October 2024	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Board Assurance Framework 2024/25 – Quarter 2				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to review and approve the Board Assurance Framework 2024/25 as at Q2, including action proposed to mitigate risks.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
X	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
X	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
X	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
X	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
X	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
X	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	PR 4.2
Financial impacts if agreed/not agreed	PR 6.1 & 6.2
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	PR 7.3

Executive Summary

The Trust maintains a Board Assurance Framework (BAF) as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board.

Principal risks within the BAF 2024/25 have been assigned to a relevant Board assurance committee for oversight, with review of risks having taken place during September 2024. Principal Risks 2.1, 3.1, 3.2, 3.3 and 5.1 are overseen by the Board of Directors due to the cross cutting nature of the risk and consideration of such matters via the Board of Directors – these risks have been reviewed by the lead Director. In reviewing all principal risks and determining risk score, consideration was given to the key controls and assurances in relation to each, any gaps and required actions.

The risk associated with the Trusts ageing estate remains the highest scoring risk on the BAF. Other significant risks (risk score 15+) relate to operational performance, specifically non-elective care; finance, including delivery of the annual financial plan and future financial sustainability; and quality of care, the latter largely impacted by the estate challenges.

Albeit the risk score relating to the quality of care risk is significant, this score has reduced from the Opening/Q1 position based on assurances received that patient safety has been maintained throughout the recent estate's incidents, alongside a reduction in the number of quality related risks on the Trust's operational significant risk register. Furthermore, there has been a reduction in risk score for principal risks relating to elective care restoration and recruitment & retention, based on improvement in relevant operational performance and people related metrics respectively.

The risks are prioritised as set out in table below and presented in full in the BAF 2024/25 (Appendix 1) as at the end of Q2.

No.	Principal Risk	Q4 23/24	Q1 24/25	**Q2 24/25**	Target Score
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	20	25	**25**	8
PR7.4	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus	20	20	**20**	8
PR1.2	There is a risk that patient flow across the locality is not effective	16	16	**16**	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	16	16	**16**	8
PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan	16	16	**16**	8
PR1.1	There is a risk that the Trust does not deliver high quality care to service users.	12	20	**15**	8
PR1.3	There is a risk that the Trust does not have capacity to deliver elective restoration.	16	16	**12**	8
PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing.	12	12	**12**	8
PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities.	NEW	12	**12**	8
PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised.	NEW	12	**12**	8
PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values	16	16	**12**	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability.	12	12	**12**	8
PR7.1	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy.	9	12	**12**	6
PR2.2	There is a risk that the Trust does not actively participate in	9	9	**9**	6

	local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes.				
PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport.	9	9	**9**	6
PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	9	9	**9**	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes.	9	9	**9**	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes.	6	6	**6**	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in September 2024), are provided at Appendix 2 to ensure alignment between operational and principal risks. The significant risks relate to the following areas:

Risk Subtype	**No of Risks**	**Risks Identified**
Environment	7	- Pathology estate not fit for purpose (15) - Electrical capacity (15) - Cooling in Beech House Data Centre (16) - Dangerous & obstructive car parking on hospital site (15) - Constraints in capital and revenue funding resulting in inability to maintain safe, fully functioning hospital site (20) - Deterioration of the hospital site due to a significant increase in estate backlog Maintenance (16) - Risk of service disruption from leaks from the plant room above critical care (20)
Capacity and demand of services	2	- Patient delays transferring from ambulance to ED (16) - Capacity and demand in ED leading to overcrowding (16)
Staffing	1	- Employee relations/ possible strike action (16)
Financial	3	- Financial risk of providing care and support to vulnerable asylum seeking families (15) - Insufficient cash reserves (25) - Significant service disruption/ loss of beds/ asset – The Meadows (15)
Clinical Procedures	1	- Risk of the upper GI service not being able to deliver services due to a lack of nursing support (15)
Infection Prevention and Control	1	- Provision of robust service for VAD insertion (15)
Compliance with standards	1	- Paediatric Audiology (15)

Stockport NHS Foundation Trust

Board Assurance Framework

2024/25

Corporate Objectives 2024/25

1. Deliver personalised, safe and caring services.
2. Support the health and wellbeing needs of our community and colleagues.
3. Develop effective partnerships to address health and wellbeing inequalities.
4. Develop a diverse, talented and motivated workforce to meet future service and user needs.
5. Drive service improvement through high quality research, innovation and transformation.
6. Use our resources efficiently and effectively.
7. Develop our estate and digital Infrastructure to meet service and user needs.

1. Key to Board Assurance Framework

CONSEQUENCE MARKERS		LIKELIHOOD MARKERS		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	Risk target achieved
Gap score 1 - 5	Tolerable
Gap score 6 - 9	Close monitoring
Gap score 10	Concern
Gap score > 10	Serious

2. Risk Appetite Framework

Risk Level ➡ **Key Elements** ⬇	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

3. Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**5.2**	**3.1, 4.2, 5.1**	**7.3**	
4 - Major			**1.3, 2.1, 3.2, 3.3, 4.1, 7.1**	**1.2, 6.1, 6.2**	**7.4**
5 - Catastrophic			**1.1**		**7.2**

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**5.2**
Gap score 1 - 5	Tolerable	**1.3, 2.1, 2.2, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 7.1**
Gap score 6 - 9	Close monitoring	**1.1, 1.2, 6.1, 6.2, 7.3**
Gap score 10	Concern	
Gap score > 10	Serious	**7.2, 7.4**

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1				**Risk Appetite: Moderate**														
There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards.	Quality Committee	Quality Committee Subgroups established to direct policies and procedures relating to: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established. SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place for ED (2022) and Maternity (2024) Board approved Patient Safety Incident Response Plan, Aug 2023 PSIRF Policy (March 2023) Implementation commenced from April 2024 Established process for managing and learning from: - Incidents including Serious Incidents and patient flow associated harms. - Duty of Candour - Complaints - Legal Claims Mechanisms in place to gather patient experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and locally prioritised audit based on risk assessment. - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths Review process - Medical Examiner Team - Freedom to Speak Up process established. New governance system for end of life care established, including internal group	Impact of employee relations & industrial action issues Impact of continuing operational pressures Poor quality of estate including closure of Outpatients B and additional estate failures. Ineffective system for control of clinic outcome i.e., patient discharge v's clinical follow up required.	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) **Level 2 – Corporate** Quality Committee: - Quality IPR - Key Issues Reports: o Patient Safety (Serious Incidents & Duty of Candour including review of harms from each industrial action) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - CQC Inspection – Maternity Services – High Level Feedback (Report Pending) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all improvement/action plans including: CNST, Saving Babies Lives, Continuity of Carer, Ockenden Report, Maternity Safety Support Programme (MSSP) - LMNS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly) - Management of External Visits, Inspections & Accreditations Report Board of Directors: - IPR - Safe Care Report including nurse establishments/E-roster (Quarterly) and Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** GM Clinical Quality & Effectiveness Group provide high level surveillance for harm. Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey	Indirect or subtle harm from operational pressures or poor quality of estate may be difficult to identify.	Patient Follow Up - Task and Finish Group to oversee determined action: Divisional focus on review of highest risk cohort. Risk stratification of patient list through AI validation (Report via Patient Safety Group) Plan for development of refreshed Quality Strategy	Q3 2024/25 September 2024	5	3	15	12	20	15			4	2	8

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		reporting to Stockport End of Life Care forum. External Visits & Accreditations Register Learning from Industrial Action Reviews established. StARS – Ward and Community Assurance & accreditation process established. Also established for: Paediatrics, Maternity, Theatres, Community. Safe Staffing - Defined Nurse Establishments - Defined Medical Establishments - Medical Job Planning process in place - Medical Appraisal & Revalidation process in place including quality assessment Maternity Improvement/Sustainability Plan in place and Maternity Strategy. Executive & Non-Executive Maternity Safety Champions in place, visits & meetings schedule. Trust & GM Command & Control Process established - Before, During and After Strike Action. Established Quality Impact Assessment in place for CIP – Sign off by Medical Director, Chief Nurse and Director of People & OD, Director of Operations QIA process part of all Business Cases – All Business Cases reviewed by Exec Team		- National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2022-23: - Risk Management (Substantial) - Clinical Audit (Substantial) - StARS (Substantial) - Quality Spot Checks (Substantial) MIAA Internal Audits 2023-24 - Medical Staffing (Substantial) - Quality Spot Checks (Limited) GMC Medical Trainees Survey													
Principal Risk Number: PR1.2						**Risk Appetite: Moderate**												
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent & emergency care McCarthy Rebecca 03/10/2024 10:39:15	Finance & Performance Committee	Established models of emergency and urgent care in place in line with national standards. Rapid Ambulance Handover process in place. 'Programme of Flow' established. Reporting via Service Improvement Group Virtual Ward established. Weekly ED Performance Meeting Chaired by Director of Operations Weekly – Locality Patient Flow meeting established. System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient flow management plans). Locality Action Plan in place following recommendations from ECIST.	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside (NCTR). High levels of delayed discharges. Significant increase in unfunded non-elective demand due to levels of patients with NCTR. Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients. Locality Plan relating to intermediate care	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report ED Attendance Overall bed occupancy rate Patients No Criteria to Reside ED 4 Hour Target Performance Ambulance Handover times ED 12 hour waits Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review				4	4	16	16	16	16			4	2	8

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Bed Modelling – 18 Month Plan Workforce models in place – Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission - Delayed discharge Patient Flow Associated Harms – Review via Quality Committee. Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.	capacity not agreed with Trust – Reduction in capacity for Pathway 1 and Pathway 2.	Urgent & Emergency Care GIRFT – Chaired by Medical Director ECIST & GIRFT Tier 1 Action Plan - Monitored weekly via 4 Hour Clinical Standard Improvement Group Integrated Performance Report – Board (Bimonthly)													
				Level 3 – Independent Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care ECIST & GIRFT Tier 1 Deep Dive Report – Action Plan		NHSE Follow Up – Further support. Offer to be reviewed. Best Practice Learning Visits - Chelsea & Westminster FT & Bolton FT	October 2024 October 2024									
Principal Risk Number: PR1.3					**Risk Appetite: Moderate**													
There is a risk that the Trust does not have capacity to deliver elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards for elective care.	Finance & Performance Committee	Biweekly Trust Performance Meeting. Escalation process in place with Performance Team – 65+ week wait patients and any P2/cancer patients that are not dated. Cancer Quality Improvement Board established chaired by Lead Cancer Clinician GIRFT Programmes in place for all Surgical & Medical Specialties. Booking & Scheduling centralisation Board approved Expanding Elective Care Business Case – In year scheme 2024/25.	Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Delivery of national access standards predicated on availability of GM mutual aid Significant increase in referrals for elective care, including from out of area. Cumulative impact of industrial action (Consultants & Juniors) having significant adverse impact on unbooked and cancelled appointments. Loss of Outpatients B Department	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation Activity Management Group – Data review of elective activity				4	3	12	16	16	12			4	2	8
				Level 2 – Corporate Divisional Performance Review (Quarterly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) 52+ week waits 65+ week waits Overall RTT waiting list size (Including monitoring review of Expanding Elective Care Business Case) Cancer 2ww Cancer 62 day Diagnostic waits Quality Committee Patient Safety Report including review of harms (4 x year) Integrated Performance Report (Operational Performance) – Board (Bimonthly)		Finalise recurrent investment to expand elective capacity – to achieve sustainability of elective access GM and Regional Team discussion re Tiering status	Q3 2024/25 Q3 2024/25									

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
				Level 3 – Independent SFT Tier 1 Elective Restoration Monitoring NHSE – Activity Returns GM & National productivity ranking.														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.1				**Risk Appetite: High**														
There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high quality care.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession Planning Approved Organisational Development Plan 2023-2025 Approved Health and Wellbeing Plan 2024. Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Vaccination programmes for both Influenza, Covid and MMR established. Comprehensive staff wellbeing programme established including staff psychology and wellbeing service and staff menopause service. Collaborative Occupational Health Service with T&G – including Staff Counselling Service & Physio Fast Track Service.G2 eOPAS IT system upgrade complete. Dying to Work Charter Big Conversation programme established. Process to improve response rate of 'reason for leaving' in place. Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans in place. Confirmed approach to flexible working. Industrial Action Planning Group in place Regular deep dive review sickness absence led by Deputy Director of People & OD established.	Embedded approach to Wellbeing Conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational & external/internal financial pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports - Health & Wellbeing Plan 2024 – Workstream Reports - Health and Wellbeing Steering Group Equality Diversity & Inclusion Steering Group - EDI Strategy Industrial Action Planning Group **Level 2 – Corporate** Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly) **Level 3 - Independent** CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey MIAA Staff Wellbeing Review, February 2024 – Substantial Assurance.		National Flexible Working Policy approved to be discussed at PDG and JCNC. Staff Survey 2024 roll out with Comms Plan	November 2024 Sept 2024	4	3	12	12	12	12			4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.2				**Risk Appetite: Moderate**														
There is a risk that the Trust does not actively participate in and progress local collaborative programmes and neighbourhood working leading to suboptimal improvement in primary and secondary health and well-being outcomes.	Board of Directors	Operational & Winter Planning processes established with system arrangements. Capacity & demand modelling for community services Established joint community Health & Well Being programmes e.g. Waiting Well, Active Hospitals, Stop Smoking CURE project. Integrated service models established including: Adults: District Nursing Teams – Work across 7 PCNs with GPs, Social Care, VCSE Children's: Stockport Family – Health, Social Care & Education Adult's: Neighbourhood Leadership Group established with multi partner representation. Children's: Joint oversight groups established with multi partner representation (SEND, Public Health, Safeguarding, Mental Health) Trust represented on the ONE Stockport Health & Care Board (Locality Board) for Stockport via the CEO, Chief Finance Officer and Director of Strategy & Partnerships. Locality Provider Partnership (led by SFT) operational with defined workstreams and focus on population health. ONE Stockport Health and Care Plan & Delivery Plan/Outcomes developed with focus on reducing inequalities and improving population health outcomes. ICS employed Locality Deputy Place Lead in post.	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources. Alignment of Community Services to PCNs – Potential change to PCN geographical footprints	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report Adult's: Neighbourhood Leadership Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board	Community Services Dashboard	Align Trust community services & workforce to PCNs	Ongoing	3	3	9	9	9	9			3	2	6
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Locality Provider Partnership (Monthly) Locality Board (Monthly)		Board of Directors – Place Collaboration Report	October 2024											
				Level 3 – Independent Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
Principal Risk Number: PR3.1					**Risk Appetite: Significant**													
There is a risk the Trust does not contribute to effective place-based partnership arrangements that support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board, leading to a delay in the delivery of models of care, which support improvements in health inequalities in the local population.	Board of Directors	Locality ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care Board (Locality Board) operational. Membership includes CEO, Chief Finance Officer and Director of Strategy & Partnerships ONE Stockport One Future Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership chaired by SFT CEO Provider Partnership identified four key workstreams based on population health metrics. Operational Planning Guidance and Priorities for 2024/25 in Trust Operational Plan Public Health Registrar (0.4WTE) in post 1st Aug 24	Controls not yet established in full for the management of the ONE Stockport Health & Care Plan Provider Partnership workstreams are at different stages of development	**Level 1 – Management** Four workstreams meetings and workshops Locality Executive Meeting (Monthly) **Level 2 – Corporate** Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports (6 monthly) and as required and CEO Report including key strategic developments - ICS - Stockport ONE Health & Care Plan Joint system meetings on ONE Stockport One Future plan Locality Provider Partnership (Monthly) Locality Board (Monthly) ICS Executive Meeting (Monthly) **Level 3 – Independent** Health & Wellbeing Board	Priorities and metrics for each of the four workstreams Robust neighbourhood data to enable Provider Partnership to measure improvement in population health outcomes Completion of NHS providers Health Inequalities Self-Assessment Tool	Develop a plan for each workstream with identified improvement metrics Neighbourhood profiles to be produced by Local Authority / GM BI Board of Directors – Place Collaboration Report & Health Inequalities Self-Assessment Report	Q3 2024/25 Q2 2024/25 October 2024	3	3	9	9	9	9			3	2	6
Principal Risk Number: PR3.2					**Risk Appetite: Significant**													
There is a risk that the Trust does not contribute to, and as part of the Greater Manchester Integrated Care System (GM ICS) collectively deliver on the collaborative working opportunities that exist within GM leading to limited-service resilience, unwarranted variation of services and inequality in health outcomes for the populations served.	Board of Directors	GM Trust Provider Collaborative GM (TPC) established. Chaired by SFT CEO Relevant SFT Directors part of GM TPC System Boards (Cancer, Elective, Urgent & Emergency Care, Diagnostics, Mental Health and Sustainable Services) GM TPC Director Groups established (Chief Data Officers, Chief Information Officers, Chief Nurses, Chief Operating Officers, Executive Medical Directors, HR Directors, Directors of Finance, Directors of Strategy) East Cheshire Programme Board and weekly operational meetings	No capital or revenue funding identified from commissioners/ICB GM Single Improvement Plan and Sustainability Plans to be developed	**Level 1 – Management** Weekly East Cheshire operational meetings **Level 2 – Corporate** Monthly TPC and Director Group meetings Workplans for each Director Group in place **Level 3 – Independent** Oversight and engagement with the ICB and NHSE		Refreshed ECT Case for Change based on Joint Clinical Strategy GM Single Improvement Plan & Sustainability Plan to be presented to Provider Boards including GM Acute Provider Collaboration	Q3 2024/25 TBC	4	3	12	New Risk	12	12			4	2	8
Principal Risk Number: PR3.3					**Risk Appetite: Significant**													
There is a risk that the Trust does not deliver on the collaborative working opportunities that exist with Tameside and Glossop Integrated Care Trust (TGICT) leading to suboptimal pathways of care for the populations served	Board of Directors	Clinical Service Partnership Group in place between both Trusts. Corporate services collaborative working in place. Joint Executive Director and Senior Manager roles in place.	Failure to gain key support from staff and agreement on the resulting service by service Case for Change. Currently no funding for the programme of work for 2024/25	**Level 1 – Management** Clinical Service Partnerships group **Level 2 – Corporate** Executive Team - Oversight of Key Issues Board of Directors Report **Level 3 – Independent** Awareness and engagement of the ICB and NHSE		Case for change for clinical services	Ongoing	4	3	12	New Risk	12	12			4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
and/or limited-service resilience across the footprint of both Trusts			financial year and use of existing capacity No current revenue or capital or recurrent funding identified to support future service changes in 2024/25.															

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
Principal Risk Number: PR4.1				**Risk Appetite: High**														
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	National Long Term Workforce Plan Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment. E-Rostering Workforce Group established. Medical Workforce Group established. Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Weekly Staffing Approval Group (SAG) Workforce Efficiency Group established. Bank & Agency Usage Deep Dive Undertaken. Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available with enhancements of leadership and development offer continuing as identified within OD Plan. Local/ Regional/National Education partnerships Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programmes. Workforce Strategy & Divisional Workforce Plans Refreshed Appraisal Process in place	National workforce shortages particularly for some medical posts exist (e.g. Radiologists, Acute/Stroke Physicians) work continues to attract to these roles/consider alternatives Embedded system for identifying and managing talent not yet available Restrictions on staff capacity to attend and participate in mandatory/statutory training. Bank and agency staff costs above target. Escalation areas remaining open – staffing additional areas required.	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Equality, Diversity & Inclusion Steering Group - Staff Networks **Level 2 – Corporate** People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly) **Level 3 - Independent** NHS National Staff Survey GMC Survey Health Education Visits Model Hospital and comparative benchmarking data Confirm and Challenge by NHSEI NW Regional Team		Refresh of Trust Values	June – Sept 2024	4	3	12	16	16	12			4	2	8
Principal Risk Number: PR4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning	Career Development Programmes for staff with protected characteristics	Level 1 - Management WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan		Establish cross-divisional WRES/WDES Group	October 2024	3	3	9	9	9	9			3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.		Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+ and Neurodiversity) Completed review of staff networks and relaunched under agreed improvement arrangements. Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics. Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme Civility Saves Lives Programme - Phase 1 Launched. Peer Review of Disciplinary Cases with TGH.	Development of Staff Network Chairs and the Staff Networks	Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan EDI metrics for applicants included in People Analytics dashboard Career Progression for All Task Group established – responsible for delivering key objectives within the EDI Action Plan.														
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually) - WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report	EDI metrics to be built into People Analytics Dashboard.	Inclusion of the wider EDI metrics in People Analytics dashboard to be scoped.	Q3 2024/25											
				Level 3 - Independent NHS National Staff Survey		Communication Plan to be developed for roll out of 2024 Staff Survey	September 2024											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
Principal Risk Number: PR5.1								**Risk Appetite: Significant**										
There is a risk that the Trust does not implement high quality service improvement programmes, as identified through Trust and locality prioritisation, which may lead to suboptimal improvements in quality of care for patients and staff.	Board of Directors	Director of Transformation working across SFT and Tameside & Glossop (utilising experience and knowledge of system-wide transformation programmes across other localities) Trust transformation programmes identified through a formal process of prioritisation linked to corporate objectives (Aims, KPIs, Milestones) Standardised governance & assurance in place for Trust transformation programmes - Service Improvement Group (SIG) chaired by the Chief Executive. External resource in place to support Trust identified improvement programmes. Senior Responsible Officer, Clinical & Operational Lead in place for each Trust transformation programme Transformation Team supporting Stockport Provider Partnership (SPP). SPP identified key priority workstreams (Diabetes, Frailty, Cardiovascular & Alcohol Related Harm) for pathway redesign. Continuous Improvement Strategy developed to build capability across the organisation.	Capacity of operational teams to implement change due to operational pressures.	**Level 1 – Management** Transformation - Programme Boards Provider Partnership Key Priority Areas – Programme Boards				3	3	9	9	9	9			3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Stockport Provider Partnership (Monthly) - Priority Workstreams Review Board Report: Transformation Programme (Biannually)	Stockport Provider Partnership priority workstreams at various stages of implementation.	PLACE/Locality Provider Partnership Board Report	October 2024											
				Level 3 - Independent														
Principal Risk Number: PR5.2								**Risk Appetite: Significant**										
There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements.	Quality Committee	SFT Research Team established. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy) Annual research programme in place. Review of the RD&I team structures across SFT, and T&G and joint governance structures commenced. Input of RD&I to development of Cancer Strategy Review of RD&I financial provision by Finance Teams – 5 year financial stability projection.	SFT does not have control of RD&I governance at T&G. GM Clinical Research Network (CRN) merging to form a North West Research Delivery Network in 2024/25 with potential destabilising impact.	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report				3	2	6	6	6	6			3	2	6
				Level 2 – Corporate Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2023-24														
				Level 3 - Independent DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: PR6.1				**Risk Appetite: High**														
There is a risk that the Trust does not deliver the 2024/25 financial plan leading to increased regulatory intervention	Finance & Performance Committee	Annual financial plan 2024/25 submitted – Confirmed deficit as part of GM control total Indicative SFT Capital Plan 2024/25 submitted. Annual cash plan 2024/25 in place – Subject to confirmation of cash support. Board of Directors approval of all cash support applications. Opening Budgets 2024/25 in place based on submitted financial plan. Delivery of budget holder training and enhancements to financial reporting Established STEP Programme (CIP) and oversight of delivery including STEP deep dive per Division. SFI's & Scheme of Delegation in place including authorisation limits – Revised & Board approved. Workforce Efficiency Group – Oversight of temporary staffing spend. Divisional Performance Review process - including financial escalation actions based on control totals for divisions. SFT Finance Improvement Group established, chaired by Chief Executive Stockport System Finance Recovery Group established (Monthly) GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE) and supported by NHSE Investigation & Intervention.	Lack of certainty regarding cash provision. Lack of clarity on mechanism for accessing cash support within GM Implementation of recurrent CIP Plan Financial impact of further industrial action Financial impact of Outpatients B Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Derbyshire ICB planning expectation on savings, resulting in reduction in income. Finance workforce capacity to support regulatory submissions.	**Level 1 – Management** Division Operation Board - Finance Metrics Divisional CIP Meetings Finance Training Group – Training Materials Cash Action Group (Monthly) - Cash flow monitoring Financial Position Review Group (Monthly)	Visibility of ERF target			4	4	16	16	16	16			4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Financial Improvement Group (Monthly) Activity Management Group (Monthly) Staffing Approval Group (Weekly) Executive Team (Weekly) Finance & Performance Committee Finance Report (Monthly) CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly) Stockport System Financial Recovery Group (Monthly)		Ongoing actions from each GM Productive Oversight Meeting (POM) Discussion with NHS England on CDEL for Outpatients B and The Meadows Discuss with GM ICB cash arrangements within GM	Monthly Q3 2024/25 Q3 2024/25									
				Level 3 - Independent **External** Internal Audit Reports - Key Financial Systems (Substantial) 2023/24 - HFMA Financial Sustainability Review - Confirmation of Self-Assessment. - Provenance of Data (High) **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. Monthly Provider Oversight Meeting (Information Pack) **NHSE**												

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3.													
Principal Risk Number: PR6.2								**Risk Appetite: High**										
There is a risk that the Trust does not develop and agree with partners a Trust (3 year recovery plan) and GM Sustainability Plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group Established Trust planning processes - Triangulates activity, workforce and cost. Internal review of drivers of financial deficit review including benchmarking data and levels of efficiency. Refresh of drivers of deficit and loss making services presented to FPRM (Jan 24) Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Prioritisation of investments linked to planning priorities. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency GM business case assessment process in place. GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE) and supported by NHSE Investigation & Intervention.	Underlying financial deficit Lack of certainty regarding system funding beyond 2024/25 including reductions due to convergence factor. Requirement for increased % CIP (recurrent/non-recurrent) Elective Recovery Fund (ERF) remains unclear) – Trust not at activity levels compared to 2019/20. Growth in demand not recognised.	**Level 1 - Management**				4	4	16	16	16	16			4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) Financial Improvement Group (Monthly) Stockport System Financial Recovery Group (Monthly)		Future Funding Flows Group (GM DoFs) – Review of alignment of work undertaken and contract funding. Stockport Locality review of contracts with particular focus on community services.	Ongoing Ongoing										
				Level 3 - Independent Provider Director of Finance GM Meeting **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM Provider Oversight Meeting (Monthly) **NHSE** NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3	GM commissioned SFT drivers of deficit review to be completed	Review of GM drivers of deficit review and development of required actions. Engagement with GM ICS re development of GM Sustainability Plan in line with Enforcement Undertakings.	Q3 2024/25 Q3 2024/25										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
Principal Risk Number: PR7.1				**Risk Appetite: Significant**														
There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	Digital Strategy 2021-2026 Capital plan in place for funding of Digital Strategy and receipt of capital funding for core elements of the Digital Strategy from 2023/24 Robust project management infrastructure in place. Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy Major incident plan in place. Change control processes in place. Process in place to respond to Care Cert notifications. Annual penetration tests in place. Anti-virus updates & spam and malware, all user email notifications. Network accounts checked after period of inactivity – Disabled if not used. Digital & Informatics Group established Terms of Reference & Work Plan approved by F&P Committee. Bimonthly reporting.	No capital plans for hardware replacement. Significantly reduced capital availability in 2024-25.	**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				4	3	12	9	12	12			4	2	8
				Level 2 – Corporate Finance & Performance Committee - Digital & Informatics Group established Bimonthly - Digital Strategy Progress Report - Capital Programmes Management Group – (Monthly): Including digital capital Board of Directors - Biannual Digital Strategy Progress Report		On-going actions from MIAA internal audit of Data Security and Protection Toolkit, and Medical Devices Management review from 2023/24	Q4 2024/25										
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification – Achieved November 2023. DCB 1596 Secure Email Standard Accreditation – Achieved February 2024. MIAA Internal Audit Report June 2024 - Data Security and Protection (DSP) Toolkit Assessment 2023/24 - Achieved "Substantial Assurance" against the veracity of the self-assessment and "Moderate Assurance" against the 10 National Data Guardian Standards. Annual Data Security and Protection Toolkit 2023/24 self-assessment submission 30 June 2024 – Achieved "Standards Met".		Develop and implement action plan for Data Protection & Security Toolkit Assessment 2024/25.	Q4 2024/25										
Principal Risk Number: PR7.2				**Risk Appetite: Moderate**														
There is a risk that the estate is not fit for purpose and does not meet national/regulatory standards, partly due to increasing maintenance requirements, which may lead to: - Inefficient utilisation of the estate to support high quality of care. - Significant disruption to clinical activity. - Poor patient/staff experience.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance Six-Facet survey in place – 2024 Survey completed. Additional structural surveys completed for Category D and poor condition property assets by Structural Engineers. Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics)	2024 Six Facet survey highlights further deterioration of the estate, with a greater proportion of the estate now falling into the Significant Risk backlog maintenance grade. Inability to deliver required levels of estates maintenance due to lack of funding. Inability to deliver required upgrades due to access limitations	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Joint Consultative Group - Compliance with regulatory standards Health & Safety Incidents				5	5	25	20	25	25			4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report - Estates Strategy Steering Group Key Issues Report		Board of Directors review of 2024 Six Facet Survey outcome. Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel	September 2024 March 2025										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
- Increased requirement to undertake contingency works with increased revenue expenditure. - Increased health & safety incidents and litigation/claims. - Breach of NHS standards/statutory regulations/ resulting in statutory /regulatory intervention - Loss of Trust reputation.		Site Development Strategy in place. Joint working arrangements with SMBC established to develop community based solutions to support short to medium term development strategy. Project Board and Senior Responsible Officer identified for major capital developments	related to clinical activity pressures Delivery/Transition plan to address highest risk capital stock and decompression of site. .	- Site Development Strategy Progress Report - Estates & Facilities Assurance Report Board of Directors - Site Development Strategy Progress Report **Level 3 - Independent** Estates Return Information Collection (ERIC) Model Hospital Data Set		Continue to make case for appropriate levels of targeted investment in the Trust real estate.	March 2025										
Principal Risk Number: PR7.3								**Risk Appetite: Moderate**										
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Mechanisms in place to explore and develop sustainability approach across Stockport locality. Joint appointment of Sustainability Manager between Stockport and Tameside	Inability to deliver required levels of environmental and sustainability improvements due to lack of funding. Decarbonisation Plan	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities **Level 2 – Corporate** Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually) **Level 3 - Independent** Estates Return Information Collection (ERIC)		Decarbonisation Plan Establish Joint Green Group for SFT & T&G Develop new joint Green Plan SFT & T&G	Q4 2024/25 September 2024 Q4 2024/25	3	4	12	12	12	12			3	2	6
Principal Risk Number: PR7.4								**Risk Appetite: Moderate**										
There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed. New Hospital Building Programme Expression of Interest submitted – Project Hazel Established governance structure to develop Outline Business Case Project Hazel Business Case ~~in~~ produced and approved by Board of Directors. Site Development Strategy to support and inform immediate site development and maintenance aspirations	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel. DHSC has confirmed that the Trust has been unsuccessful in securing necessary support from the New Hospital Building Programme. New Hospital Building Outline Business Case	**Level 1 - Management** **Level 2 – Corporate** Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board **Level 3 - Independent**		Review of funding approach with partners	Ongoing	4	5	20	20	20	20			4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		New Hospital Project Board established, chaired by SFT Chief Executive. including representation from key external partners. Estates Strategy Steering Group (ESSG) established, reporting to Finance & Performance Committee. Joint working arrangements with SMBC established to explore strategic regeneration of the hospital campus.																

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at end September 2024)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
586	Estates & Facilities	There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	4	4	16	8	NEW
2746	Surgery	There is a risk of service disruption from leaks from the plant room above critical care.	4	5	20	4	NEW
101	Finance	There is a risk that the Trust will run out of cash and therefore have insufficient cash reserves to operate	5	5	25	5	↔
2765	Estates & Facilities	Constraints in capital and revenue funding resulting in an inability to maintain a safe, fully functioning hospital site.	4	5	20	4	↔
1711	Corporate – Workforce	Deterioration in employee relations and possible industrial action	4	4	16	4	↔
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	4	4	16	8	↔
2304	Medicine & ED	There is a risk of harm when patients cannot be transferred from ambulances to ED resulting in delays in diagnostics & treatment	4	4	16	8	↔
2713	Medicine & ED	There is a risk of patient harm due to capacity not meeting demand resulting in overcrowding in ED	4	4	16	8	↔
2452	Clinical Support Services	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔
2609	Women and Children	There is a financial risk to the Division of providing required care and support to vulnerable asylum seeking families	3	5	15	2	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
288	Corporate – Nursing	There is a risk of there being an inability to provide a robust service for the insertion of VADs	3	5	15	6	↔
2196	Estates and Facilities	Dangerous & obstructive car parking occurring across the SHH Site	3	5	15	6	↔
2770	Surgery	Risk of the upper GI service not being able to deliver services due to a lack of nursing support	3	5	15	3	↔
2516	Finance	Risk of significant service disruption / loss of beds / loss of the asset - The Meadows	5	3	15	5	↔
2650	Surgery	Risk of harm to paediatric patients if the audiology service does not comply	3	5	15	3	↔

		with best practice recommendations					

NHS Stockport NHS Foundation Trust

				Agenda No.	18
Meeting date	3rd October 2024	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Board Committee Assurance – Key Issues Reports				
Director Lead	Committee Chairs	**Author**	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to: – Review the key issues and matters for escalation provided via the Board Committees – Receive the Audit Committee Annual Review and approve the terms of reference and workplan.					

This paper relates to the following Annual Corporate Objectives

X	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
X	5	Drive service improvement through high quality research, innovation and transformation
X	6	Use our resources efficiently and effectively
X	7	Develop our estate and digital infrastructure to meet service and user needs

This paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in

		Stockport
X	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
X	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
X	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
X	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
X	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

The Board of Directors has established the following Committees:

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

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee and Audit Committee held during September 2024.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Non-Executive Director
Date of Meeting	11 September 2024
Quorate	Yes
The People Performance Committee draws the following key issues and matters to the Board of Directors' attention:	

Item	Key issues and matters to be escalated
People Integrated Performance Report	The Committee received the People Integrated Performance Report, which provided an update on appraisals, time to hire, statutory & mandatory training compliance, agency expenditure and attendance. The Committee confirmed performance in relation to sickness absence and agency spend was not within target, with all other metrics within target. The Committee received and noted the report, current performance and the actions being taken to continue to drive improvement.
Medical Appraisal & Revalidation Report	The Committee received a report detailing the Trust's medical appraisal and revalidation processes, its quality assurance (QA) mechanisms and the numbers of appraisals completed. The Committee confirmed that the Trust had generally robust processes in place for medical appraisal and revalidation, including positive engagement. It was noted, however, that the active recruitment of new appraisers was an ongoing area of focus. The Committee received and noted the report and confirmed the Trust's continued good performance with respect to the completion of medical appraisals and compliance with its medical revalidation requirements and recommended the annual return for sign off by the Chief Executive.
Values & Behaviours	The Committee received a report on the refreshing of the Trust's values and behaviours, undertaken in collaboration with Tameside & Glossop Integrated Care NHS Foundation Trust. The Committee welcomed the Board development session held on 5 September 2024, which had focused on exploring the refreshed set of behaviours and what they mean to Board members. The Committee noted the intention to launch the new values and behaviours at both organisations at the end of September / early October 2024.

Item	Key issues and matters to be escalated
Violence & Aggression Standard	The Committee received a report providing an update on progress made in relation to the Violence Prevention & Reduction Standard, including progress made against each section of the standards (plan, do, check, act). It was noted that compliance with the Violence Prevention & Reduction Standard continued to be monitored quarterly by the Health & Safety Joint Consultative Group, which reports to the Quality Committee, with an annual report provided to the People Performance Committee.
Freedom to Speak Up	The Committee received a report providing an overview of Freedom to Speak Up activities since the previous report. The Committee noted ongoing work to raise the profile of speaking up, the cases raised with the Freedom to Speak Up (FTSU) Guardian, and themes and trends observed. It was noted that the Trust's 'Civility Saves Lives' and Compassionate Leadership courses linked into the speaking up agenda and helped address inappropriate attitudes and behaviours. The Committee welcomed the recruitment of FTSU Champions to support the FTSU Guardian in her role.
General Medical Council Annual Trainee Survey	The Committee received a General Medical Council (GMC) Annual National Trainee Survey report. The Committee heard about areas where negative feedback had been received and noted associated mitigating actions. A detailed specialty-by-specialty analysis of the data was ongoing, with resultant action plans to be agreed with Clinical Directors and Senior Clinicians. It was noted that the action plans would be monitored by the Education Governance Group, which reported to the People Performance Committee.
Resourcing & Retention Programme	The Committee received a report providing an update on progress made with the Resourcing & Retention Programme, highlighting improvements made and actions in place to deliver our people priorities. Despite a challenging year, the Committee acknowledged good progress made in the following areas: • Turnover & retention • Vacancies & recruitment • Temporary staffing • Career development • Growing our own pathways.
Advancing Levels of Attainment E-Rostering and Job Planning McCarthy, Rebecca 03/10/2024 10:39:15	The Committee received a report providing an update on the delivery against the Advancing Levels of Attainment E-Rostering and E-Job Planning. The Committee noted that significant progress had been made with the achievement of the level of attainments for E-Rostering at Level 3. It was noted that a Workforce E-Rostering Group had been established with oversight of performance, system utilisation and achievement of the levels of attainment, with an in-house rostering dashboard developed to further enhance system utilisation and compliance.

Item	Key issues and matters to be escalated
	The Committee heard that work continued on E-Job Planning, with focused actions in place to achieve the levels of attainment. The Committee would receive an update on an annual basis.
Safer Care (Staffing) Report	The Committee received a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. It was noted that the report included information on the Pathology staff group, as previously requested by the Committee. The Committee acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Committee heard that robust staffing has been implemented ensuring that the Trust is safely staffed and able to provide high quality patient care throughout the industrial action.
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the three principal risks for 2024/25 assigned to the People Performance Committee. The Committee heard that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. The Committee also noted confirmation of the aligned significant risks from the Corporate Risk Register, which were included to ensure alignment with the principal risks. In view of current performance metrics and acknowledging that actions to support the continual reduction in agency expenditure continued to be delivered and were now business as usual, the Committee supported the reduction of the risk score for PR 4.1 regarding the Trust being able to recruit and retain optimal number of staff, from 16 to 12. It was confirmed that PR 2.1 relating to engagement and support for people's wellbeing and PR 4.2 relating to development of a representative workforce remained as previously scored, 12 and 9 respectively. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2024/25 to Board of Directors in October 2024.
Standing Committees	The Committee received and noted the following key issues reports: • People, Engagement & Leadership Group • Equality, Diversity & Inclusion Group • Educational Governance Group

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	19 September 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, performance against the four key standards (A&E) 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against some of the core operating standards, whilst improvement was being sustained particularly around elective and cancer care. The Committee noted improvements to the following metrics in month: • Although below trajectory, performance against the 4-hour A&E standard was showing an improving trend. • Cancer 62-day performance had achieved the national target for the second consecutive month and was well above trajectory. • Faster Diagnostic Standard 28-day performance had been challenged this month, but was still performing above trajectory. • RTT standards with significant improvements to overall wait times and 52- and 65-week breaches. The Trust was on trajectory to deliver treatment to all 65-week wait patients by the end of September 2024 in line with the requirements of the operational planning guidance. It was also expected that the Trust would formally exit the current Tier 1 monitoring in Q3 2024/25 as it was no longer an outlier for treatment waiting times. • With regard to diagnostics, MR had seen significant improvement, however echo demand continued to be a challenge, with mitigating actions underway. In line with the quality concerns, audiology remained a concern and still had an unmet mutual aid request from GM partners. Furthermore, the Committee heard that outpatient efficiencies flagged an issue with Did Not Attend (DNA) rates, with further work ongoing to understand causes. The Committee noted the community metrics included in the report, detailing opportunities for improved utilisation of the virtual ward. It was noted that the urgent community response team continued to support urgent care and attendance avoidance. It was noted that overall community activity was below plan in year, however this remained over 10% above the baseline year of 2019/20. The Committee heard that a

	review of community services was being undertaken in conjunction with NHS Stockport to understand activity versus the contract. The Committee noted that the loss of the Outpatient B facility had been largely mitigated, however mobilisation of additional capacity in Kingsgate remained behind plan and further outsourcing to the independent sector was being explored.
Cost Improvement Programme Unpalatable Schemes – Update on Quality Impact Assessment Process	The Committee received a report providing an update on the overall Trust position relating to Cost Improvement Programme (CIP) schemes which had been through or were going through the Quality Impact Assessment (QIA) process. The report also detailed next steps being undertaken to ensure all schemes have been considered through the QIA process in a timely manner. The Committee would undertake a CIP deep dive at its October meeting, with a particular focus on recurrent delivery.
Finance Report – Month 5 Position	The Committee received the Finance Report for Month 5 2024/25. The Committee heard that overall, the Trust position at Month 5 was a deficit of £22.4m which was £0.1m adverse to plan. It was noted that at this point the forecast for year-end was a deficit of £43.8m, which was in line with the annual plan for 2024/25. The Committee heard that the adverse variance to date related to Elective Recovery Funding (ERF) underperformance, unfunded industrial action costs offset by overachievement of the Stockport Trust Efficiency Programme (STEP). It was noted that the STEP plan for 2024/25 was £24.6m (£12.3m recurrent) and that £5.0m had been actioned to Month 5 (mainly non-recurrent), which was £0.9m favourable against plan. The Committee heard that the Trust had maintained sufficient cash to operate during August. It was noted that no revenue support had been requested in August, but an application for revenue support had been made for September. The Committee noted increased scrutiny and challenges regarding the cash position. It was noted that the Capital Plan for 2024/25 was £29.1m, which was now compliant. The Committee noted risks in this area due to the significant gap between funding and expenditure. The Committee received the report and noted the challenges and mitigating actions regarding the financial position.
Medium / Long Term Financial Recovery Plan	The Committee received a verbal update about the development of a GM Sustainability Plan, which was work in progress. The Committee received an update on the GM Future Funding Flows work, a programme reviewing the allocation of funding versus activity being delivered, in addition to a piece of work to understand the drivers of the deficit for Stockport NHS Foundation Trust. The Committee acknowledged that the Trust was unable to complete its own medium / long term financial sustainability plan until the GM work had concluded.
Contracts for Approval	The Committee recommended the award of the contract extension for the Blood Science Management Service to the Board of Directors for approval.

Elective Recovery Fund Overview 2023/24 and 2024/25	The Committee received a report providing an overview of Elective Recovery Fund (ERF) payments in 2023/24 and 2024/25, including the moving ERF position in 2023/24 and key issues for 2024/25. The Committee noted the Trust's estimate Month 3 ERF position, and heard that national figures were still awaited. The Committee acknowledged the risks to the delivery of the ERF plan and next steps required.
Service Line Activity Monitoring System for 2024/25 Contracts	The Committee received a report detailing how the Service Line Activity Monitoring (SLAM) system was being used in 2024/25 for monitoring contracts with the Integrated Care Boards (ICBs) and NHS England (NHSE). The Committee noted the changes to contracting in 2024/25, including changes in commissioners, and heard that SLAM was being used as part of the Future Funding Flows work with the GM ICB.
Estates & Facilities Assurance Report	The Committee received and noted the Estates & Facilities Assurance Report, which included a broader scope of Estates & Facilities compliance. It was agreed that future iterations of the report should include information about the governance structure relating to food and catering. The Committee heard about areas of success, as well as significant estate related risks and mitigating actions.
Green Plan Progress Report	The Committee received a report providing an update on progress made against the Green Plan, including current challenges and future opportunities. The Committee heard that the priority for the next quarter was the development of a new Joint Green Plan with Tameside & Glossop Integrated Care NHS Foundation Trust, which would be overseen by the new Joint Green Plan Delivery Group across the two Trusts.
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the eight principal risks for 2024/25 assigned to the Finance & Performance Committee. The Committee heard that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. The Committee also noted confirmation of the aligned significant risks from the Corporate Risk Register, which were included to ensure alignment with the draft principal risks. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2024/25 to Board of Directors in October 2024.
Standing Committees	The Committee received and noted the following key issues reports: • Estates Strategy Steering Group • Capital Programmes Management Group • Digital & Informatics Group Key Issues Report

NHS
Stockport
NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Susan Moore
	September 2024
Quorate	Yes

The Quality Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Quality Strategy Development Plan	The Director of Strategy and & Partnerships led a discussion with the Committee to consider the Trust's current Quality Strategy, that is due for renewal at the end of the calendar year. The aim was to review the existing strategy and consider if the aims and objectives have been achieved and to develop a further strategy to take us forward. The current Quality Strategy has four key aims for improvement: • Aim 1 – Start well – Improve first 1,000 days of life • Aim 2 – Live well – Reduce avoidable harm • Aim 3 – Age well – Reduce avoidable harm • Aim 4 – Die well with dignity – Improve last 1,000 days of life The Committee are aware there is an opportunity to develop the next strategy in collaboration with Tameside and Glossop however their current strategy runs through till 2026. Following an in-depth discussion the Committee agreed to: 1. Developing a refreshed strategy involving internal and external key stakeholders and will be supported by the Strategy and Partnerships Team 2. With the Trust working collaboratively with Tameside and Glossop Integrated Care NHS FT, on a comprehensive joint Strategy from 2026
Board Assurance Framework 2024/25: Principal Risks Review Q2	<u>Opening:</u> The Trust Secretary presented the quality related principal risks, to be included within the Q2 Board Assurance Framework (BAF) 2024/25. <u>Closing</u> The Committee reviewed and approved the quality related principal risks to be presented as part of the Board Assurance Framework 2024/25 to Board of Directors in October 2024.
Patient Safety Quarterly Report	The Deputy Director of Quality Governance presented this comprehensive quarterly report to provide members with assurance that lessons are learned and Improvements to practice are implemented, as a result of incidents, inquests, claims and complaints reported via the Trust's incident reporting system (Datix) for Quarter1 2024/25. To Note: • There were 5,785 incidents reported at a rate of 102.5 incidents reported per 1000

	bed days. • 'Pressure ulcers and skin conditions', 'Administrative Processes (Excluding Documentation)', and Patient 'Behaviour' where the types of incidents reported at the highest rate per 1000 bed days • There were 8 Patient Safety Incident Investigations (PSIIs) declared • There were 48 new inquests opened, which was a 20.0% decrease compared to Quarter4 2023/24, (60) • There were no Prevention of Future Death Reports received from HM Coroner during Quarter1 2024/25 • Communication remains the top theme regarding formal complaints • The complaint response rate was 97.9% • The PHSO contacted the Trust in relation to 2 new requests for information • The PHSO concluded no cases in Quarter1 2024/25. There are currently 10 ongoing cases that we are awaiting a decision The committee identified that poor estate and the closing of Out Patients B featured in a number of reports including this one. The committee discussed the opportunity to consider the impact in the round, including quality, patient and staff experience and cost, across Divisions. The Chair will raise this with Finance and Performance and other relevant Committees. There was detailed scrutiny of the Patient Safety Incident Investigations (PSSI's) including a Never Event for wrong site surgery. There was full compliance to theatre checklists in respect of the Never Event. It was noted there was a significant increase in Maternity Related Incident reporting; the Committee were assured that this related to retrospective data input following a change of guidelines. Now PSIRF has been implemented at the Trust, the Patient Safety Manager, supported by the Deputy Director of Quality Governance, will focus on the recruitment of Patient Safety Partners (PSPs) and the continued PSIRF training requirements, in line with national guidance. The PALS & Complaints Team continues to receive a high number of informal concerns/enquiries particularly from patients chasing their outpatient appointments, often expressing concern about the length of time they have waited.
Patient Safety Incident Investigation Approval McCarthy Rebecca 03/10/2024 10:39:15	This is the first Patient Safety Incident Investigation (PSII) presented to Quality Committee. The Patient Safety Incident Response Framework (PSIRF) supporting guidance in relation to oversight identifies that the responsibility of quality assurance of all PSII learning responses sits with the Board or leadership team of the organisation involved. At Stockport NHS Foundation Trust the Quality Committee has been delegated this responsibility. As the first PSII response presented to committee for final sign off following transition to PSIRF in April 2024. It is confirmed that the PSII response has been: • Reviewed via divisional sign off processes • Shared with family for review and comments who have approved the content of the report as complete and final • Reviewed by Patient Safety Incident Review Group at the Trust and signed off Quality Committee endorsed the final approval; the Trust will share a final version with

	family members. Please note that some actions remain ongoing however completion of all actions will be overseen by the PSIRG. Prior to PSIRF under the Serious Incident Framework, independent scrutiny of completed Serious Incident Investigations was undertaken by Quality Teams within the CCG/ICB and other external stakeholders as required. The Committee recognised that the level of independent scrutiny of this first PSSI took a significant amount of time and concentration, which could potentially impact on the Quality Committees agenda. It is likely that the Committee will be required to review increasing numbers as PSIRF become embedded. The Committee agreed that independent scrutiny and sign off was imperative and that an alternative to Quality Committee and or PSIRG for sign of be considered by way of a panel with NED input/chairing.
Maternity Services Report	The Deputy Director of Midwifery presented the report. The Maternity services highlight report incorporates an update on several of the elements the service is currently working towards, including: • CNST Year 6 • Saving Babies Lives Care Bundle V3 • Midwifery Continuity of Carer pathway (MCOC) • Three year delivery plan for maternity and neonatal services (2023) • LMNS/ICB Assurance visit – Progress against recommendations • Pregnancy Loss review (July 2023) • Perinatal quality surveillance dashboard highlight reports The update also includes an overview of Stockport's performance across GMEC using the Quality surveillance toolkit, ongoing work with the MNVP, Midwifery staffing, overview of incidents, Harm and risk, Equality and Equity plan, Perinatal mental health, StARS and maternity and perinatal safety champions. There is a requirement that the reports/evidence relating to safety actions from CNST Year 6 are reported to Trust board monthly/ or subcommittee, bi-monthly, Quarterly, or once during the MIS reporting period. These reports are on the Public Board Agenda
Verbal update on Maternity Rapid Quality Review McCarthy Rebecca 03/10/2024 10:39:15	<u>Rapid Quality Review</u> The Chief Nurse gave a verbal update on the Maternity National, Rapid Quality Review (RQR) which took place on the day prior to Quality Committee. As our maternity CQC rating remained Requires Improvement following an inspection this time last year, SFT were required to attend the virtual RQR process. This was chaired by a GM ICB Chief Nurse and had representatives from many national NHS and regulatory stakeholders, along with our Maternity Champions and leadership Team. Following a process of updates from both SFT and the RQR panel it was noted that progress on CQC actions were well progressed and therefore SFT were **not** required to step up onto the national Maternity Safety Improvement Programme.

Mental Health Plan Progress Report	The Mental Health Plan for Stockport NHS Foundation Trust supported by Pennine Care NHS Foundation Trust was presented by the Medical Director and Chief Nurse. The plan aims to deliver quality care for the benefit of service users of all ages, families and carers, living with mental health conditions who are accessing services at Stockport NHS Foundation Trust. It complements work already being carried out in the wider community. The mental health plan on a page update incorporated the metrics below: • Mental Health awareness • Learning from Experience • Collaboration There have been positive outputs for all Metrics within the plan. Learning from experience has been pivotal to the continued work to develop pathways for service users. However, it is recognised that mental Health training packages that are departmental/role specific require a longer programme to enable achievement that align with desired outcome for all teams and service users. Mental Health presentations to SFT ED continue to be a challenge. Quarterly data has been collated for Q4 (23/24) and Q1 (24/25) to monitor any trends to inform further work streams. Data review on presentation to ED includes: • Behaving strangely • Intentional overdose • Mental health • referred to psychiatry The data demonstrates that: • There has been an increase in patients presenting to ED with mental ill health. • Patients have been acutely unwell and required admission to mental health facilities. • Patients that present have had complicated complex needs with regards to their acute mental health presentation • There has been an increase length of stay in the department and has an impact on patient and Staff experience
Quality & Safety Integrated Performance Report	Quality & Safety Integrated Performance Report (IPR) was presented by the Medical Director and Chief Nurse. Quality Committee reviewed the Integrated Performance Report, which included specific update on quality and safety metrics that were not achieving target, alongside areas of sustained improvement and that were not covered elsewhere on the agenda. The committee noted the positive improvement in mortality measures, (Hospital Standard Mortality rate and Summary Hospital level Mortality Indicators) which are both well within control limits. SFT are no longer an outlier in GM for HSMR and agreed with the HSMR reporting being stood down from December 2024.
Annual PALS & Complaints Report 2023-24	Presented by the Deputy Director of Quality Governance, The report identifies activity and thematic analysis of PALS concerns and complaints across the Trust during 2023/2024.

	• There has been an overall increase in activity of 15.7% • General PALS enquiries have increased by 58.1% • Informal concerns have increased by 5.2% • Formal concerns have increased by 4.2% • A summary of PALS and Complaints compliance with response deadlines. • A summary of positive feedback received by Stockport NHS Foundation Trust. • A summary of complaint outcomes and lessons learned to improve patient care and experience • A summary of Parliamentary and Health Service Ombudsman (PHSO) investigations into Stockport NHS Foundation Trust complaints • PALS and Complaints Equality and Diversity information Of note: • 44% of complaints were not upheld • 42% were partially upheld • 14% were upheld It was highlighted that, despite an increase in written complaints, timely response times had been achieved.
	Regular key issues reports were received, reviewed, discussed and confirmed/noted. Many of the exceptions from the subcommittees are explored in detail during the main agenda of the Quality Committee. ➢ Patient Safety Group Key Issues Report ➢ Patient Experience Group Key Issues Report ➢ Health & Safety Joint Consultative Group ➢ Clinical Effectiveness Group Key Issues Report ➢ Integrated Safeguarding Group Key Issues Of note: Patient Safety Group, Audit of Stroke Pathway: Members were informed that 40 patients had been audited between April – May 2024 covering review of patient age, length of stay, stroke type, use of beriplex, discharge destination, palliative care, and outcome (including referrals where required).Outcome of the audit was reported to evidence good standards of management.
Escalation to Board	Maintenance of estate and medical devices continue to feature in Quality Committee reports. Particularly in relation to and reported by: Clinical and adverse Incidents, Patient Safety Group, Health and Safety Joint Consultative Group, Patient Experience Group, Staff Experience and Patient Stories. The sudden closure of Out Patients Department B (OPDB) also features in all of the above. Medical devices play a key role in healthcare, vital for diagnosis, therapy, monitoring, rehabilitation and care. Effective management of this important resource is required to satisfy high quality patient care, clinical and financial governance, including minimising risks of adverse events. Good medical device management will greatly assist in reducing their potential for harm. There has been a much increased focus on maintenance of medical devices over

	recent months including A Joint 5 Year Medical Devices Strategy drafted alongside TGICFT. A review of the Medical Devices Policy has taken place. In Qtr 1 2024, there were 111 reported incidents relating to medical devices In Qtr 1 2024, there were 10 incident resulting in harm In Qtr 1 2024, there were 2 incidents reported to the MHRA via Yellow Card The Quality Committee requests triangulation of medical devices with Finance and Performance Committee in consideration of any potential capitol end of year spend where there is risk of failing equipment. The Committee also requests that a triangulated review be undertaken to assess the far reaching Impact of OPDB closure to encompasses, quality, staff and patient experience, cost and risk.
Triangulation and Risk to Audit Committee	Audit Committee oversight for potential audits in relation to Medical Devices.

NHS Stockport NHS Foundation Trust

Board of Directors
2024/25 Annual Work Plan

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Standing Items														
Welcome and Apologies	Chair	Oral	✓		✓		✓		✓		✓		✓	
Patient Story	Chief Nurse	Film	✓		✓		✓		✓		✓		✓	
Declarations of Interest	All	Oral	✓		✓		✓		✓		✓		✓	
Minutes of the Previous Meeting	Chair	Paper	✓		✓		✓		✓		✓		✓	
Matters Arising	Chair	Paper	✓		✓		✓		✓		✓		✓	
Action Tracker	Chair	Paper	✓		✓		✓		✓		✓		✓	
Chairs Report	Chair	Paper	✓		✓		✓		✓		✓		✓	
Chief Executive Report	Chief Executive	Paper	✓		✓		✓		✓		✓		✓	
Board Committee Key Issues Reports - People Performance - Finance & Performance - Quality Committee - Audit Committee	Chairs of Committee	Paper	✓		✓		✓		✓		✓		✓	
Trust Planning														
Operational Plan (Draft / Final) • Activity • Workforce • Finance including Capital • Self Certification	Director of Strategy & Partnerships	Paper	✓				✓						✓	✓
Opening Budgets Approval	Chief Finance Officer	Paper	✓ (2025)				✓							
Annual Corporate Objectives & Outcome Measures (Approval and Mid-Year Review)	Director of Strategy & Partnerships	Paper	✓		✓						✓			
Strategy														
SFT Strategy Refresh	Director of Strategy & Partnerships	Paper												✓
GM Provider Collaboration	Director of Strategy & Partnerships	Paper	✓ (2025)						✓					
SFT & T&G Collaboration	Director of Strategy & Partnerships	Paper					✓						✓	

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
People														
NHS Staff Survey	Director of People & OD	Paper	✓											
Workforce Equality, Diversity & Inclusion Strategy Progress Report *(Including WRES, WDES, Equality Monitoring, Gender Pay Gap)*	Director of People & OD	Paper			✓									
Freedom to Speak Up Report	Freedom to Speak Up	Paper	✓		✓				✓				✓	
Well Being Guardian Report	Well Being Guardian	Verbal					✓						✓	
Guardian of Safe Working Annual Report	Guardian of Safe Working / Medical Director	Paper									✓			
Medical Appraisal & Revalidation Report	Medical Director	Paper							✓					
Staff Exclusions	Director of People & OD	Paper	✓		✓		✓		✓		✓		✓	
People & Organisational Development Plan Progress Report	Director of People & OD	Paper					✓						✓	
Safer Care Report	Chief Nurse / Medical Director	Paper	✓		✓		✓		✓		✓		✓	
Annual Nursing & Midwifery Establishments	Chief Nurse	Paper									✓			
Quality														
Annual Quality Strategy Progress Report	Chief Nurse	Paper			✓									
Annual Research, Innovation & Development Strategy Progress Report	Medical Director	Paper					✓							
Annual Safeguarding Report	Chief Nurse	Paper					✓							
Annual Health & Safety Report	Chief Nurse	Paper			✓									
Infection Prevention Control Report	Chief Nurse	Paper							✓					
Annual CNST Declaration/Submission	Chief Nurse	Paper											✓	
Annual Learning from Deaths	Medical Director	Paper					✓							
Annual EPRR Report - Core Standards and Statement of Compliance	Chief Finance Officer	Paper									✓			
Transformation / Continuous Improvement Strategy Report (Opening & Mid-Year)	Director of Transformation	Paper			✓						✓			
Place - Locality Provider Partnership	Director of Strategy & Partnerships	Paper	✓ (2025)						✓					

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Finance & Performance														
Integrated Performance Report	All	Paper	✓		✓		✓		✓		✓		✓	
Finance Report including Cost Improvement Programme and Capital	Chief Finance Officer	Paper	✓		✓		✓		✓		✓		✓	
Green Plan Annual Report	Director of Estates & Facilities	Paper			✓									
Site Development Strategy – Progress Report	Director of Estates & Facilities	Paper					(Deferred)	✓					✓	
Digital Strategy Progress Report	Director of Informatics	Paper					✓						✓	
Business Case / Contract Award Approval *(As Required)*	Executive Director Lead	Paper	-		-		-		-		-		-	
Governance														
Board Assurance Framework & Significant Risk Register	Chief Executive	Paper	✓				✓		✓				✓	
Risk Management Strategy & Policy	Chief Nurse	Paper					✓							
Annual Self-Certification (CoS7)	Trust Secretary	Paper			✓									
Code of Governance Annual Assessment	Trust Secretary	Paper	✓											
Going Concern	Chief Finance Officer	Paper			✓									
Standards of Business Conduct: - Fit and Proper Persons - Register of Directors' Interests - Non-Executive Director Independence	Trust Secretary	Paper											✓	
Register of Sealed Documents	Trust Secretary	Paper	✓											
Standing Financial Instructions & Scheme of Reservation & Delegation	Chief Finance Officer	Paper	✓											
Annual Report & Accounts (Additional Meeting)														
Quality Accounts	Chief Nurse	Paper			✓									
Annual Report including Annual Governance Statement	Trust Secretary	Paper			✓									
Annual Accounts	Chief Finance Officer	Paper			✓									
Charitable Funds Annual Report & Accounts *(Corporate Trustee Meeting)*	Chief Finance Officer	Paper									✓			
Any Other Business	Chair	Oral	✓		✓		✓		✓		✓		✓	
Board Work Plan and Attendance record	Chair	Paper	✓		✓		✓		✓		✓		✓	

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Date and Time of Next Meeting	Chair	Oral	✓		✓		✓		✓		✓		✓	

The Board Annual Work Plan sets out the scheduled reports to be presented to the Board of Directors throughout the year. Additional matters and items will be included as required, in recognition of key strategic developments and response to matters identified by the Board of Directors.

NHS Stockport NHS Foundation Trust

Board of Directors
2024/25 Annual Attendance

Member	Name	4 Apr 24	25 Apr 24	May 24	6 Jun 24	26 Jun 24	1 Aug 24	5 Sept 24	3 Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Interim Chair	Marisa Logan-Ward	Y	Y	Y	Y	Y	Y	Y						
Chief Executive	Karen James	Y	Y	Y	Y	Y	A	Y						
Chief Finance Officer/Deputy Chief Executive	John Graham	A	Y	Y	Y	Y	Y	Y						
Medical Director	Andrew Loughney	Y	Y	Y	Y	Y	A	Y						
Chief Nurse	Nic Firth	A	Y	A	A	A	Y	Y						
Director of Operations	Jackie McShane	Y	Y	Y	Y	A	Y	Y						
Director of People & OD	Amanda Bromley	Y	Y	Y	Y	Y	Y	Y						
Director of Strategy & Partnerships*	Paul Buckley	Y	Y	Y	Y	Y	Y	Y						
Director of Communications & Corporate Affairs*	Caroline Parnell	Y												
Senior Independent Director/Non-Executive Director	Louise Sell	Y	Y	Y	Y	Y	Y	Y						
Non-Executive Director	Samira Anane	Y	Y	A	Y	Y	Y	Y						
Non-Executive Director	Tony Bell	Y	Y	Y	A	Y	Y	Y						
Non-Executive Director	Beatrice Fraenkel	Y	Y	A	Y	A	Y	Y						
Non-Executive Director	David Hopewell	Y	Y	Y	Y	Y	Y	Y						
Non-Executive Director	Mary Moore	A	Y	Y	Y	Y	Y	Y						
*Non-Voting														
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**						
Key														
Y	= Present													
A	= Apologies													
A(D)	= Attended as Deputy													