SFT Public Board Meeting - October 2025

Thu 02 October 2025, 09:30 - 12:10

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

09:30 - 09:35
5 min

3. Staff Story (Verbal)

Information *Amanda Bromley*

09:35 - 09:40
5 min

4. Minutes of Previous Meeting - held on 7 August 2025 (Paper)

Decision *David Wakefield*

04 - Public Board Minutes - 7 August 2025.pdf (11 pages)

09:40 - 09:45
5 min

5. Action Log (Paper)

Information *David Wakefield*

05 - Public Board Action Log - October 2025.pdf (1 pages)

09:45 - 09:55
10 min

6. Chair's Report (Paper)

Discussion *David Wakefield*

06 - Joint Chair Report - October 2025.pdf (4 pages)

09:55 - 10:05
10 min

7. Chief Executive's Report (Paper)

Discussion *Karen James*

07 - Chief Executive's Report - October 2025 KJ.pdf (7 pages)

FINANCE & PERFORMANCE

10:05 - 10:15
10 min

8. Finance & Performance Committee Alert, Advise & Assure Report (Paper)

Discussion *Anthony Bell*

08a - Finance & Performance Committee AAA Report - Front Sheet.pdf (2 pages)
08b - Finance & Performance Committee AAA Report - September 2025.pdf (3 pages)

10:15 - 10:35
20 min

9. Integrated Performance Report - Month 5 (Paper)

Discussion *Executive Directors*

09a - Integrated Performance Report - Front Sheet.pdf (2 pages)
09b - Integrated Performance Report - Month 5.pdf (27 pages)

10:35 - 10:45
10 min

10. Financial Position - Month 5 (Paper)

Discussion *John Graham*

- 10a - Financial Position Report Month 5 2025-26 - Front Sheet.pdf (3 pages)
- 10b - Financial position 2025-26 M05 Board.pdf (20 pages)

QUALITY

10:45 - 10:55
10 min

11. Quality Committee Alert, Advise & Assure Report (Paper)

Discussion *Louise Sell*

- 11a - Quality Committee AAA Report - Front Sheet.pdf (2 pages)
- 11b - Quality Committee AAA Report - September 2025.pdf (3 pages)

10:55 - 11:05
10 min

12. Infection Prevention & Control Annual Report (Paper)

Discussion *Nicola Firth*

- 12a - Infection & Prevention Control Annual Report 2024-25.pdf (39 pages)
- 12b - 2024-25 IPC Annual report presentation.pdf (7 pages)

11:05 - 11:15
10 min

BREAK

11:15 - 11:30
15 min

13. Maternity Services Report (Paper)

Discussion *Nicola Firth / Maternity Quadrumvirate*

- 13 - Maternity Perinatal Quality Report October 2025.pdf (39 pages)

PEOPLE

11:30 - 11:40
10 min

14. People Performance Committee Alert, Advise & Assure Report (Paper)

Discussion *Beatrice Fraenkel*

- 14a - People Performance Committee AAA Report - Front Sheet.pdf (2 pages)
- 14b - People Performance Committee AAA Report - September 2025.pdf (3 pages)

11:40 - 11:50
10 min

15. Medical Appraisal and Revalidation Report (Paper)

Decision *Dilraj Sandher*

- 15a - Medical Appraisal & Revalidation Report - Front Sheet.pdf (3 pages)
- 15b - Medical Appraisal & Revalidation Report.pdf (23 pages)

GOVERNANCE

11:50 - 12:00
10 min

16. Audit Committee Alert, Advise & Assure Report (Paper)

Discussion *David Hopewell*

- 16a - Audit Committee AAA Report - Front Sheet.pdf (2 pages)
- 16b - Audit Committee AAA Report - September 2025.pdf (2 pages)

12:00 - 12:10
10 min

17. Board Assurance Framework Q2 2025/26 (Paper)

Decision *Karen James*

- 17a - Board Assurance Framework Q2 2025-26 - October 2025.pdf (3 pages)
- 17b - SFT Board Assurance Framework Q2 2025-26.pdf (25 pages)
- 17c - Appendix 2 - Significant Risk Register - September 2025.pdf (2 pages)

CLOSING MATTERS

12:10 - 12:10
0 min

18. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:10 - 12:10
0 min

19. Thursday, 4 December 2025, 9.30am, Pinewood House Education Centre

12:10 - 12:10
0 min

20. 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".

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 7 August 2025, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Mr David Wakefield	Joint Chair
Dr Samira Anane	Non-Executive Director
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & OD
Mr Paul Buckley	Director of Strategy & Partnerships*
Mr David Curtis	Non-Executive Director
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 Karen James	Chief Executive
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
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 Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary
Ms Laura Swann	Sustainability Manager (for item 89/25)
Dr Peter Nuttall	Director of Informatics (for item 100/25)

Apologies:
None

** indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
79/25	**Apologies for Absence** The Joint Chair welcomed everyone to the meeting. There were no apologies for absence.	
80/25	**Declarations of Interest** There were no declarations of interest.	
81/25	**Patient Story** The Board watched a video describing a positive impact the use of the virtual ward had on a patients postnatal experience and treatment of hypertension. The story highlighted the positive patient experience, including a clear treatment plan and timely and safe care and discharge. The Board welcomed the good news story and encouraged the use of the story and other similar videos on the Trust's website to promote initiatives such as the virtual ward.	

	In response to questions from Board members regarding the virtual ward, it was noted that the Trust had undertaken a deep dive into the use of virtual ward with Manchester University NHS Foundation Trust, and further opportunities and promotion of the virtual ward were being progressed with the discharge planning team. The Board heard that the virtual ward was currently centrally funded and the link to the NHS 10 Year Plan was acknowledged. **The Board of Directors received and noted the Patient Story.**	
82/25	**Minutes of Previous Meeting** The minutes of the previous meeting held on 5 June 2025 were agreed as a true and accurate record.	
83/25	**Action Log** The action log was reviewed and annotated accordingly.	
84/25	**Chair's Report** The Joint Chair presented a report providing an update on national, regional and Trust developments, including: - Fit for the Future: 10 Year Health Plan for England - Independent review of patient safety across the health and care landscape - Tameside & Glossop Integrated Care NHS Foundation Trust (T&G) and Stockport NHS Foundation Trust (SFT) Collaboration - Key Trust Visits & Meetings The Joint Chair referred to the recent industrial action held by resident doctors. On behalf of the Board, he apologised to any members of the public who had been adversely affected by the industrial action and thanked all staff for their efforts in maintaining safe care. In response to a question from Dr Samira Anane, Non-Executive Director, querying patient engagement within the NHS 10 Year Health Plan, the Chief Executive and Chief Nurse confirmed that patient engagement was one of the eight workstreams and noted that further national guidance was awaited in the autumn. Mrs Beatrice Fraenkel, Non-Executive Director, advised that she had been invited to be part of an NHS Providers reference group in the shaping of the new legislation and offered to link in with Board members in this area. **The Board of Directors received and noted the Chair's Report.**	
85/25	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: - NHS England Urgent and Emergency Care Plan (UEC Plan) - NHS Performance Assessment Framework: Segmentation - Greater Manchester Integrated Care Board (GM ICB): Response to ICB Blueprint - Industrial Action - Trust Operational Pressures	

	- Key Successes & Celebrations In response to a question from Mr Anthony Bell, Non-Executive Director, the Chief Executive provided further clarity regarding the NHS Performance Assessment Framework segmentation. In response to a question from Dr Louise Sell, Non-Executive Director, regarding the final outcome and impact of the industrial action, it was agreed that the outcome, including numbers of patients affected by the industrial action would be reported via the Chief Executive's Report to the October Board meeting. **(ACTION)** In response to a question from Mr David Hopewell, Non-Executive Director, regarding potential impact of the ICB cost reduction plans on providers, the Chief Executive noted that the Trust had been clear that any transfer of headcount from the ICB to the Trust would require associated funding. Mr David Curtis, Non-Executive Director, stressed the importance of maintaining collaboration within the new Foundation Trust model. The Chief Executive echoed the comment and confirmed that the issue continued to be highlighted at national level. Mr David Curtis, Non-Executive Director, welcomed the new Acute Frailty Unit Therapy Garden and noted the positive impact on patients. **The Board of Directors received and noted the Chief Executive's Report.**	**Chief Executive**
86/25	**Finance & Performance Committee Alert, Assure & Advise (AAA) Report** Mr Anthony Bell, Non-Executive Director, presented the AAA report from the Finance & Performance Committee meetings held on 19 June 2025 and 17 July 2025. 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 AAA Report, including actions taken.**	
87/25	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Quality** The Chief Nurse and Medical Director 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 Medical Director advised that timely antibiotic administration remained a concern, with targeted education ongoing. The Board received assurance that no harm had occurred and noted continued transformation work in this area. The Chief Nurse briefed the Board on IPC performance, noting mitigating actions regarding Clostridium Difficile (C Diff) and E-Coli in particular. She advised that the Quality Committee would undertake a deep dive in October on the outcome of the system /national research regarding prevalence of C	

	Diff, recognising that the GM was an outlier in this area. The Chief Nurse reported a deteriorating position regarding community acquired pressure ulcers, while noting that investigations to date had confirmed that none had been due to lapses in care. **Operations** The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), community, outpatient efficiency, outpatient procedures and theatre efficiency metrics due to under-achievement in month. The Board heard that while the ED 4-hour standard continued to be challenging, performance for June was reported above the planned improvement trajectory. The Director of Operations reported the reduction in discharge to assess beds, and the Board noted the anticipated adverse impact on ED performance and flow, with the risk to winter performance acknowledged. The Director of Operations advised that paediatric audiology remained a significant concern and the Board acknowledged the consequent adverse impact on children, the diagnostic target and future sustainability of the service. It was noted that a separate report on this issue would be considered at the Private Board meeting. It was noted that cancer standards continued to perform well, albeit the latest 62-day and 31-day position was below the planned trajectory due to issues relating to capacity and increased demand. Improvements were noted regarding RTT performance. In response to questions from Dr Louise Sell and Mr David Hopewell, Non-Executive Directors, regarding ED performance, the Director of Operations highlighted challenges in this area due to significant increase in acuity and numbers, which had adversely impacted on flow and performance. She agreed to include further clarity on specific mitigations in relation to Urgent Care in the October IPR. **(ACTION)** The Joint Chair noted that the Finance & Performance Committee would continue monitoring the Trust's ED performance, and suggested that this should include further understanding of the increased acuity and any shared learning from T&G. Mr David Curtis, Non-Executive Director, provided an overview of a recent positive experience while attending ED, and commended the helpful and considerate staff. **People** The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted challenges and mitigating actions regarding appraisal rates and mandatory training due to under-achievement in month. The Board heard that the People Performance Committee was	**Director of Operations**

	considering the consequence of mandatory training non-compliance. **Finance** The Board received and noted 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.**	
88/25	**Finance Report** The Chief Finance Officer presented a report providing an update on the financial performance for Month 3 2025/26. The Board heard that the Trust has agreed a balanced financial plan for 2025/26 with a Cost Improvement Programme (CIP) of £29.2m. It was noted that overall, the Trust position at the end of Q1 was a deficit of £4.1m which was in line with plan and at this stage in the financial year the Trust was forecasting a balanced year-end position. The Chief Finance Officer advised that the Trust had delivered savings of £17.6m, which was 60% of the full year target of £29.2m. The Board heard that schemes had now been identified to deliver the full target, however this included high risk or technical non-cash releasing schemes offsetting the current £4.0m divisional shortfall. The Chief Finance Officer advised that agency expenditure in Month 3 continued to be above the target ceiling, and that in Q1 there had been an average reduction of 15% compared to the 30% target. It was noted that bank costs in June continued to be below the ceiling of a 10% reduction, with an average 16% reduction achieved in Q1. The Board heard that the Trust's cash balance at the end of June 2025 was £31.7m against a plan of £27.8m. The Chief Finance Officer advised that the Trust had spent £5.1m on capital costs in Q1 against a plan of £6.0m, noting that the Trust's Capital Plan for 2025/26 had increased by £2.0m and was £37.4m. The Chief Finance Officer highlighted anticipated changes to the deficit support funding going forward. The Board heard that unlike last year, deficit support funding would be conditional and earned quarterly based on performance. It was further noted that deficit support funding was likely to cease in 2026/27 and the Board acknowledged the significant risk to financial performance. It was noted that following detailed discussion at the Finance & Performance Committee, a further consideration of finance risks and mitigations would be undertaken at the Private Board meeting. In response to a question from the Joint Chair regarding the run rate, the Chief Finance Officer provided further clarity and highlighted focus on pay and headcount, noting that the position was closely monitored by the Workforce Efficiency Group.	

	The Board of Directors received and noted the Finance Report.	
89/25	**Green Plan:** **Green Plan Progress Report 2024/25** The Sustainability Manager presented a report providing an update on progress made against the Green Plan, including current challenges and future opportunities. She highlighted a key focus on reducing emissions from gas and electricity. In response to a question from Mr David Hopewell, Non-Executive Director, querying availability of grants and funding to enable delivery of the Green Plan, the Sustainability Manager advised that all funding options were being explored, including internal and external funding, in recognition of the financial constraints. In response to questions from the Joint Chair, the Sustainability Manager provided further clarity regarding the Clinical Waste Strategy and gas and electricity targets. **The Board of Directors received and noted the Green Plan Progress Report 2024/25.** **Approval of Joint Green Plan 2025 – 2028** The Sustainability Manager presented a Joint Green Plan report detailing the consultation and engagement process undertaken in the development of the new Joint Green Plan 2025-28 with T&G and outlining the NHS England guidance followed. She advised that the report provided an overview of the current position in each Trust, alongside planned actions required to reduce emissions and enable achievement of net zero targets. In response to questions from the Joint Chair, the Sustainability Manager noted that workstream leads were key in supporting the Green Plan and confirmed that air conditioning was factored within the plan to ensure the site was fit for the future. **The Board of Directors received and noted the report and approved:** • **The Joint Green Plan 2025-2028 between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust** • **The publication of the Joint Green Plan on the Trust website and for the link to be shared with NHS England, to confirm compliance with Green Plan Guidance.**	
90/25	**Quality Committee Alert, Assure & Advise (AAA) Report** The Chair of Quality Committee (Dr Louise Sell, Non-Executive Director) presented the AAA report from the Quality Committee meetings held on 24 June 2025 and 22 July 2025. She briefed the Board on the content of the report and detailed key quality related issues considered, highlighting the alert section of the report in particular. **The Board of Directors reviewed and confirmed the Quality Committee AAA Report, including actions taken.**	

91/25	**Annual Learning from Deaths Report** The Board of Directors received the Annual Learning from Deaths Report, acknowledging that a robust learning from deaths activity continued with around 32% of all in-hospital deaths having received a review last year, with effective processes in place. It was noted that there were no deaths graded as outcome 1 (evidence of serious failings in care), and 46 cases had rated as exemplary care. The Medical Director briefed the Board on themes that had been identified in relation to clinical practice, including delayed senior documentation, poor standard of handwriting in medical notes, and unnecessary investigations at end of life. The Board heard that work was ongoing to review the process for learning from deaths reviews to avoid duplication with other investigations. The Joint Chair sought further assurance that lessons learned from learning from deaths reviews were being embedded across the organisation. Dr Louise Sell, Non-Executive Director and Chair of Quality Committee noted that the Quality Committee would continue to monitor this through the quarterly learning from deaths reporting and Mr David Curtis, Non-Executive Director, highlighted the need for audits in this area to ensure recommendations were embedded across the organisation. The Medical Director acknowledged the comments received. He provided further context to the report, highlighting the methods for disseminating themes and learning from the process. He confirmed that specific action plans would be developed only when a death was referred to the patient safety incident response process, and acknowledged the potential for clinical audit of certain themes to provide assurance regarding learning, and confirmation within reporting that themes were not repeated. **The Board of Directors received and noted the Annual Learning from Deaths Report.**	
92/25	**Annual Safeguarding Report 2024/25** The Chief Nurse presented the Annual Safeguarding Report 2024/25 providing an overview of the Trust's safeguarding activity in 2024/25, assurance that the Trust was compliant with its safeguarding duties and outlining the key safeguarding priorities for 2025/26. It was noted that the report had been reviewed and supported by the Quality Committee. Mr David Curtis, Non-Executive Director, noted that he would welcome examples of positive outcomes in future reports to describe the work of staff. In response to a question from the Joint Chair querying the Trust's position regarding domestic abuse training, the Chief Nurse confirmed this as an area of focus for 2025/26 to ensure compliance with the Domestic Abuse Act 2021 statutory guidance. In response to a question from the Joint Chair, the Chief Nurse provided further clarity regarding the priority relating to the Trust becoming a Trauma Informed Organisation. **The Board of Directors reviewed and confirmed the Annual**	

	Safeguarding Report 2024/25 as supported by the Quality Committee.	
93/25	**Annual Health & Safety Report 2024/25** The Chief Nurse presented a summary of principal activity and outcomes relating to the Key Performance Indicators (KPIs) for health and safety within the Trust during 2024/25. She confirmed the data within the annual report brought together data reported to the Quality Committee throughout the year. In response to a question from the Joint Chair, the Chief Nurse provided an overview of the reasons for the increase in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting compared to the previous year. In response to a question from Mr Anthony Bell, Non-Executive Director, regarding issues with timely reporting, the Chief Nurse highlighted process issues outside of the Trust's control impacting on timely reporting and confirmed that the Trust had not been subject to fines in this area. **The Board of Directors received and confirmed the Annual Health & Safety Report, which has been reviewed and recommended by Quality Committee, in line with key issues reported to Quality Committee throughout 2024/25.**	
94/25	**Annual Research, Development & Innovation Report 2024/25** The Medical Director presented the Annual Research, Development & Innovation (RD&I) Report describing performance for 2024/25 in line with the Joint RD&I Strategy for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust (T&G). He highlighted organisational challenges including staffing. Furthermore, he provided an overview of an annual financial summary, key performance indicators, research delivery conduct and risk mitigations, research delivered, and a progress update against the joint RD&I Strategy, noting a key focus on collaboration between the two Trusts. In response to questions from the Joint Chair and Mr Anthony Bell, Non-Executive Director, querying scope for commercial RD&I growth, the Medical Director briefed the Board on opportunities in this area and noted that collaboration would provide greater scope for studies and associated income. Mr Bell highlighted the importance of capturing outcome measures from RD&I programmes. Mrs Beatrice Fraenkel, Non-Executive Director, highlighted the importance of RD&I in attracting high calibre staff and suggested exploring collaboration with universities. Dr Louise Sell, Non-Executive Director, noted opportunity for RD&I collaboration to be further explored as part of the development of a Joint Organisational Strategy with T&G. **The Board of Directors received the Annual RD&I Report 2024/25, confirming delivery in alignment with the Joint RD&I Strategy.**	
95/25	**People Performance Committee Alert, Assure & Advise (AAA) Report** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the AAA report from the People Performance Committee meeting held on 10 July 2025. She briefed the Board on the	

	content of the report and detailed key people related issues and associated key risks considered. **The Board of Directors reviewed and confirmed the People Performance Committee AAA Report, including actions taken.**	
96/25	**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, providing an overview of key achievements, challenges and strategic alignment with national workforce transformation goals. The Board heard that planning was underway for the next phase of the People & OD Plan, aligned with the NHS 10-Year Plan and local workforce needs. Mr Anthony Bell, Non-Executive Director, welcomed the key focus on equality, diversity and inclusion. **The Board of Directors received and noted the People & Organisational Development Plan Progress Report.**	
97/25	**Safer Care (Staffing) Report** The Chief Nurse and Medical Director 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 heard that the Trust was assessed on compliance with the triangulated approach to deciding staffing requirements described in the National Quality Board's guidance, combining evidenced based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. 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. In response to a question from the Joint Chair, the Medical Director and Chief Nurse briefed the Board on the pathology staffing position, noting a focus on collaborative work with partners, and confirmed that the staffing position was not currently scoring as a high risk on the divisional risk register. In response to a question from the Joint Chair, the Chief Nurse provided further clarity regarding the work-related stress risk stratification tool. **The Board of Directors received and noted the Safe Care (Staffing) Report.**	
98/25	**Audit Committee Alert, Assure & Advise (AAA) Report, including Annual Review 2024/25** The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the AAA report from the Audit Committee meeting held on 15 July	

	2025, detailing key issues considered. Furthermore, he presented the Audit Committee Annual Review 2024/25, including Terms of Reference and 2025/26 Work Plan, for Board approval. **The Board of Directors:** • **Reviewed and confirmed the Audit Committee AAA Report, including actions taken.** • **Approved the Audit Committee Annual Review, including Terms of Reference and 2025/26 Work Plan.**	
99/25	**Board Assurance Framework 2025/26** The Chief Executive presented the opening Board Assurance Framework (BAF) 2025/26. It was noted that the Corporate Objectives 2025/26 had been approved by the Board in March 2025, with outcome measures approved in May 2025, along with review and agreement of the Trust's risk appetite. The Chief Executive confirmed that the principal risks for the Opening/Q1 BAF 2025/26 have been considered via the Lead Director and/or the relevant Board Committees at meetings held in June and July 2025. Throughout the discussions at Finance & Performance Committee, People Performance Committee and Quality Committee, it was noted that the continuing operational and financial pressures were recognised as impacting or having potential to impact the breadth of strategic and operational risks. The Board heard that the significant risks related to environment, IT systems, capacity and demand, compliance with regulatory/clinical standards and infection prevention & control. **The Board of Directors reviewed and approved the Board Assurance Framework 2025/26, including action proposed to mitigate risks.**	
100/25	**Digital Strategy Progress Report** The Director of Informatics presented a report providing a 6-monthly update on the delivery of the Trust's Digital Strategy, including outcome measures. He briefed the Board on the content of the report and provided a progress update against the seven digital ambitions, highlighting workstreams relating to infrastructure changes and Electronic Patient Record (EPR) procurement. The Chief Executive proposed that the Board should receive an annual Digital Strategy Progress Report going forward. The Joint Chair acknowledged the proposal, noting that the Finance & Performance Committee would continue to receive 6-monthly updates against the strategy including progress against the key performance indictors and tangible benefits described within the strategy, supplemented by the monthly Digital & Informatics Group Alert, Advise and Assure Reports. In response to a question from Dr Louise Sell, Non-Executive Director, regarding EPR procurement, the Chief Executive, Director of Informatics, Medical Director and Chief Finance Officer briefed the Board on the procurement process undertaken to date, including responses to the tender. The Board acknowledged limited responses had been received. Dr Louise Sell, Non-Executive Director, informed the Board that the Lead	

	Governor had raised a question regarding patient entertainment systems and whether patients were required to use headphones to avoid disturbing others. The Director of Informatics agreed to ensure that this issue was addressed within the action plan. **The Board of Directors received and noted the Digital Strategy Progress Report.**	
101/25	**Any Other Business** The Joint Chair noted that this would be the last Board meeting held in public attended by Dr Andrew Loughney, Medical Director. He thanked Dr Loughney for his significant contribution to the Board of Directors during his tenure and wished him the very best for the future.	
102/25	**Date and Time of Next Meeting** Thursday 2 October 2025, 9.30am, Pinewood House Education Centre.	
103/25	**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
05/25	5 June 2025	60/25	Corporate Objectives and Outcome Measures	The Joint Chair requested that an update on virtual wards be presented to the Board of Directors in October 2025. **Update October 2025** – Update provided in Integrated Performance Report. Action closed.	Director of Operations	Closed
06/25	7 August 2025	85/25	Chief Executive's Report	It was agreed that the outcome of the industrial action, including numbers of patients affected by the industrial action would be reported via the Chief Executive's Report to the October Board meeting. **Update October 2025** – Information included in the Chief Executive's Report. Action closed.	Chief Executive	Closed
07/25	7 August 2025	87/25	Integrated Performance Report	The Integrated Performance Report to October Board to include further clarity on specific mitigations in relation to Urgent Care. **Update October 2025** – Improvement actions included in Integrated Performance Report. Action closed.	Director of Operations	Closed

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	2nd October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Joint Chair Report				
Director Lead	David Wakefield, Joint Chair	**Author**	Rebecca McCarthy, Trust Secretary		

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
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
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

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

This report highlights key matters for the attention of the Board, covering national, regional and Trust matters including:

- NHS Oversight Framework Segmentation & Ranking
- NHS Vaccination Campaign
- Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) Collaboration
- Key Meetings & Trust Visits

1. **Oversight Framework Segmentation & Rankings**

Following publication of the updated NHS England (NHSE) Performance Oversight Framework (NOF) 2025/26, the Trust has received confirmation that it has been placed in Segment 3 and ranked 86 of 134 acute trust based on aggregated metric rankings. (Tameside & Glossop Integrated Care NHS Foundation Trust is ranked 59)

As previously reported, any organisation reporting a financial deficit would be limited to Segment 3 (but could still be placed in Segment 4 or 5), with only 27 acute trusts in total placed in Segment 1 or 2.

The NHS Oversight Framework dictates a quarterly review of segmentation for providers. We must ensure oversight of the metrics within the NOF throughout the Board Committees, to support continuous improvement.

Furthermore, NHS England will assess NHS trusts' capability, alongside providers' NOF segmentation, to judge what actions or support are appropriate at each trust. All trusts are required to undertake a self-assessment on which NHSE oversight teams will form a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. Further discussion will take place on our self-assessment later in the meeting.

2. **NHS Vaccination Campaign**

1st September marked the start of the national 2025 Autumn/Winter vaccination campaign. Following a steady deadline in vaccination uptake post-pandemic, NHSE have emphasised the importance the flu vaccination as one of the best tools we have to protect the health of our patients and staff, easing winter pressures and reducing the risk of avoidable disruption to our services. In line with this, an essential pillar of Urgent and Emergency Care Plan 2025/26 is improvement in rates of staff vaccination. All trusts have been set an ambitious aim to improve uptake by at least 5 percentage points compared to last year's position.

I would encourage all colleagues to join Board members and I in getting jabbed, helping to protect both themselves and the communities we serve.

3. **Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) Collaboration**

We continue to develop our collaboration, with a further joint TG ICFT and SFT board development session in September. We reflected on the Board's role of inclusive leadership and brave governance, recognising that governance is only as strong as the candour it permits.

Furthermore, we continued discussions regarding the development of our new Joint Organisational Strategy, specifically considering implications of the Government's new 10 Year Health Plan. Discussion regarding the development of our collaborative governance options also continued, with the intention to enhance the effectiveness of both Trust's corporate governance arrangements and decision-making and deliver high quality assurance. Our new joint governance model will include a form of joint board and joint committees, with legal opinion on the appropriate vehicle now being progressed. It is anticipated new arrangements will be in place for 2026/27. In this light, updates will be provided regularly to the Board of Directors through formal meetings, development sessions and individual and collective discussions.

4. Trust Activities

I have attended several national and regional meetings, including attendance at the Greater Manchester (GM) Providers Chairs meeting with discussion focused on the significant financial challenges many provider trusts in GM are facing.

I have continued my many visits throughout the Trust, including a walkaround of the Stepping Hill Hospital site with the Director of Estates & Facilities, and visits to Audiology, Acute Frailty Unit, Outpatients A&E & Acute Medical Unit.

I continue to be impressed with the commitment, care and dedication shown by colleagues amidst the operational pressures faced

NHS
Stockport
NHS Foundation Trust

				Agenda No.	7
Meeting date	2nd October 2025	**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		

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
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
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

	All

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

This report provides an update on matters of interest, which have arisen since the last Board meeting including:

- Planning framework for the NHS in England
- Getting the basics right for resident doctors
- GM ICB Model Blueprint
- Neighbourhood Health Service Implementation Programme
- Impact of Industrial Action
- Trust Operational Pressures
- Stepping Hill Hospital Site Development Strategy
- Advantis IT Issues
- Success & Celebrations

1. Planning framework for the NHS in England

NHS England have published a planning framework in support of the 2026/27 planning round. The core of the plan is a shift from short-term annual planning to a continuous, rolling five-year planning horizon. This is designed to support the three transformations outlined in the 10-Year Health Plan.

The framework is built on five core principles and divided into two phases:

- **Outcome-focused:** Plans must deliver measurable improvements for patients and the public.
- **Accountable and transparent:** Clear roles and responsibilities are essential for decision-making.
- **Evidence-based:** Planning should be underpinned by robust data and analysis.
- **Multi-disciplinary:** It must involve staff from various functional areas, including finance, workforce, and clinical teams.
- **Credible and deliverable:** Plans need to be ambitious yet realistic, with clear resources and risk mitigation.

Phase One is a preparatory phase, running until the end of September, focused on setting up governance structures, building a robust evidence base (e.g., population needs assessment, financial analysis), and assessing organisational capabilities. Phase Two is the development of the full five-year plan beginning in October. As in previous years, plans must be integrated and triangulate across key areas: service, workforce, finance, quality, digital, and infrastructure.

The framework defines specific roles for NHS organisations. Trusts are responsible for developing strategic and operational plans to deliver on national and local priorities and must demonstrate collaboration with other partners when developing plans. ICBs will set out strategic commissioning expectations and coordinate system-level planning.

Key outputs of the new planning model include:

- Five-year strategic commissioning plans from ICBs, which will outline their strategy for improving population health.
- Five-year integrated delivery plans from providers 2026/27 – 2030/31, showing how they will deliver national and local priorities and achieve financial sustainability.
- Neighbourhood health plans, developed by local government, the NHS, and other partners, to design and deliver local services.

The Director of Strategy and Partnerships is leading the planning processes across each Trust working with Executive Directors and their teams. A review of the principles and an assessment of all required Phase One activities within the framework is being carried out as part of the preparatory phase. Throughout the planning round the Board of Directors will be engaged in the development and associated challenge of plans, a detailed update will be provided to Finance & Performance in the coming months and the Board of Directors in December 2025.

2. Getting the basics right for resident doctors

In August 2025, NHS England launched a 10-point plan to improve resident doctors working lives. The plan sets out expectations for both NHS England and Trusts, with a 12-week window to deliver initial actions and further milestones extending into 2026. Trust Boards are asked to take ownership of local improvements and develop

action plans. From Autumn 2025, NHS England will publish trust-level data on related indicators as part of the NHS Oversight Framework.

Our response is being led by the Chief Medical Officer and Deputy Medical Director. A task and finish group has been established including representation from Resident Doctors, Medical Education and the Guardian of Safe Working. This will be presented to the People Performance Committee, and onward to the Board of Directors, including confirmation of how Board governance and oversight will be taken forward.

3. Greater Manchester Integrated Care Board (GM ICB) Blueprint

I have previously provided information regarding the ICB blueprint, which reframes the core purpose, role and functions of ICBs in line with the forthcoming 10 Year Health Plan (10 YHP). The primary role of the ICBs will be improving population health as strategic commissioners.

GM ICB will retain its footprint and will not be merging with any other ICBs.

A Task and Finish Group, chaired by NHS GM's chair, Sir Richard Leese has been established with membership including GM ICB chief officer and senior leaders representing providers, Place and staff to oversee the reform required. GM ICB has stated its intention was to deliver a completely new organisational structure by the end of March 2026, which would go towards reducing operating costs by the required 39% and deliver a full year of savings in 2026/27. However, at present, no ICB, including GM, has permission to spend on redundancies, and therefore the launch of the planned voluntary redundancy scheme cannot proceed as it stands.

4. Regional Blueprint

The regional blueprint has now been published. Regional Teams along with ICB's will be reviewing the implications of the new framework whilst establishing plans to deliver the changes proposed.

5. National Neighbourhood Health Implementation Programme (NNHIP) – Stockport Place

Neighbourhood Health is central to the Government's ambitions outlined in the 10 Year Health plan. An open invitation for organisations to participate in a National Neighbourhood Health Implementation Programme (NNHIP) was issued in early July. The programme is a large-scale change programme that will gather and disseminate learning to create exemplars and support Places embed the culture and capability required to deliver a Neighbourhood Health service.

Stockport Place has been successful in its application to be part of the first wave of organisations in this programme, which includes 43 organisations. Rochdale is the only other Place in Greater Manchester that was successful in its application.

The programme will engage programme participants and respective ICBs and aims to explore new approaches to commissioning Neighbourhood Health Services and supporting the development of neighbourhood providers and multi-neighbourhood providers. The initial focus for the first Places will be creating Neighbourhood Health systems and processes for adults with multiple long-term conditions and rising risk before progressing to other areas.

This work will build on the successful work that has already been progressing in Stockport around the Live Well programme of work and development of Area Leadership Teams. The Trust will be engaging in this important programme of work through its continued support in the four system prevention priorities of frailty, diabetes, cardiovascular disease, and alcohol-related harm, and in addition as we consider our plans in relation to the 10 Year Health Plan.

The NNHIP will be overseen by a joint Task Force between DHSC and NHSE. The small steering group of the task force will contain people from the front line from local authorities, voluntary sector and health organisations who have already delivered some of the changes we want to see. The Chair of the Task Force will be Sir John Oldham, a GP by background who is experienced in introducing quality improvement methods into the NHS and designing and delivering large-scale change programmes. The programme has identified a local Place coach who will be assigned full time for 12 months to facilitate the programme, who as part of the national network of Neighbourhood Health project leads, will be supported directly by the national team.

6. Impact of Industrial Action

Resident doctors strike action took place from 25th - 30th July, with a 70% turnout. Plans were mobilised to minimise disruption to services and maintain patient safety ensuring staffing was at safe levels and at an appropriate level of seniority. Unfortunately, a total of 228 appointments were affected, primarily in Trauma & Orthopaedics and Endoscopy. We would like to apologise to our patients who experienced disruption or cancellation to their appointment and confirm cancelled appointments have been rebooked.

The industrial action did impact our temporary workforce levels with additional shifts utilised to maintain our services, and additional costs of more than £550k.

While the BMA has a legal mandate for further action until January 2026, no further resident doctor strikes are currently planned.

7. Stepping Hill Hospital Site Development Strategy

The Board is acutely aware of our estate challenges on the Stepping Hill Hospital site. Whilst the Trust has faced significant external financial and policy constraints, progress has been made against priorities set out in the Trust's short-to-medium-term Development Strategy (DS) for the Stepping Hill Hospital (SHH) site. The most notable milestone is the successful construction and opening of the new Outpatients B facility (referenced later in the report) following the closure and demolition of the previous structurally compromised building.

As previously reported, we have new and pressing issues, including the urgent need to address the forthcoming end-of-life of the hospital's metal deck car parks by 2026, and the parallel opportunities being explored with Stockport Metropolitan Borough Council (SMBC) to scope funding solutions.

Following the pause of the New Hospital Programme by the Labour Government pending review, the Trust is reframing its "Project Hazel" ambitions through the development of a new Estates Master Plan. This work is closely aligned to the clinical strategy and recognises the importance of strengthening both urgent and elective care provision. A particular focus is the creation of a Stockport Town Centre Elective Hub, in partnership with Stockport Metropolitan Borough Council (SMBC). The

ambition is to position the Trust to rapidly progress a business case should national, or regional capital opportunities emerge. We will keep the Board appraised on these developments.

8. Advantis IT Issues

As you will be aware, we have had a series of IT issues and disruption with our Advantis and other software systems. Most systems are now working, and the IT team is continuing to work through the remaining outstanding issues. We know this has been a difficult time for teams.

Issues are now almost resolved, and I would like to thank everyone for their patience during this time, and those who have worked tirelessly to fix this issue.

We will be holding a debrief session to ensure that lessons are learned from the incident, with colleagues able to share feedback through divisional structures to ensure that we can capture all feedback about this outage.

9. Successes & Celebrations

9.1 New Outpatients Building Opens

Our new Outpatients Building is now open, bringing outpatients services at the hospital together once more. Following sudden closure of the previous outpatients department, work began on the new outpatients building in January 2024. Building work was completed at a swift pace due to the innovative modular nature of the construction. The new building is a modern and efficient facility containing over 50 rooms, where patients, their families and carers can expect to receive high quality care. Services available from the facility will include orthoptics, optometry, dentistry, cardiology, neurology, oncology, pain, podiatry, rheumatology and more, becoming operational in the coming weeks.

The project used the latest modern methods of construction, which has been shown to produce less carbon emissions when compared to more traditional building solutions. The modules also meant using lighter weight materials, which in turn contributed to a reduction in transport requirements. This is in keeping with the Trust's Joint Green Plan with Tameside and Glossop Integrated Services NHS Foundation Trust, aimed at increasing the sustainability of both organisations.

9.2 UNICEF UK Baby Friendly Certificate

The Maternity Department has been awarded a Certificate of Commitment as its first step towards gaining recognition from the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative.

The Baby Friendly Initiative is a global programme which aims to transform healthcare for babies, their mothers and families as part of a wider global partnership between UNICEF and the World Health Organization (WHO). In the UK, the Baby Friendly Initiative works with public services to better support families with feeding and developing close, loving relationships in order to ensure that all babies get the best possible start in life. The Certificate of Commitment recognises that a health care facility is dedicated to implementing recognised best practice standards.

9.3 CURE team celebrates 1000th patient stopping smoking

The team who supports patients at Stepping Hill Hospital to stop smoking are celebrating their 1000th success. Darren Connolly was the 1000th patient to successfully stop smoking over the long term with the help of the CURE team, since they started their work in September 2020.

The Stockport CURE team are the local branch of Greater Manchester`s `Treating Tobacco Dependency`(TTD) program. TTD teams aim to ensures all active smokers admitted to hospital are immediately offered specialist support from the stop smoking team, together with nicotine replacement therapy and other medications for the duration of their admission, and after discharge too.

Darren, became the landmark 1000th patient after being admitted Stepping Hill Hospital from his GP in January this year.

NHS Stockport NHS Foundation Trust

				Agenda No.	8
Meeting date	2 October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Finance & Performance Committee – Alert, Advise & Assure Report				
Director Lead	Anthony Bell, Chair of Finance & Performance Committee	**Author**	Anthony Bell, Chair of Finance & Performance Committee Soile Curtis, Deputy Company Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Finance & Performance Committee including matters for escalation to the Board of Directors.					

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
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
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

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
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
	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
	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
X	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
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 an Alert, Advise and Assure 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 meeting of the Finance & Performance Committee held in September 2025, noting areas of alert, advice and assurance.

NHS Stockport NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Tony Bell, Non-Executive Director
Date of Meeting	18 September 2025
Quorate	Yes

The Finance & Performance Committee draw the following key issues and matters to the Board of Directors' attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • Operational Performance Report • Winter Board Assurance Statement • Finance Report – Month 5 • Productivity & Efficiency: - Cost Improvement Programme / Stockport Trust Efficiency Programme (CIP / STEP) Deep Dive – Month 5 2025/26 - Operational & Clinical Productivity Update • Wayfinding Project Proposal • Contracts for Approval • Stepping Hill Hospital Site Development Strategy Progress Report • Estates & Facilities Assurance Report • Board Assurance Framework and Aligned Significant Risks • Standing Committees Alert, Advise & Assure Reports: - Capital Programme Management Group - Digital & Informatics Group
2.	**Alert**	Concerns regarding the delivery of the 78% Emergency Department (ED) 4-hour trajectory by year-end, given historical performance in this area and the need for system flow improvement, as stated in the Trust's Operational Plan submission. Concerns regarding increased endoscopy demand and consequent adverse impact on financial and operational performance. Concerns regarding paediatric audiology and consequent adverse impact on children, the diagnostic target and future sustainability of the service. Concerns regarding reduction in discharge to assess beds which is anticipated to impact on ED performance and flow, with the risk to winter performance acknowledged. Concerns regarding the risk of non-achievement of the Financial Plan given significant associated risks.
3.	**Advise**	The Committee received the Finance Report for Month 5 and noted: • Overall, at month 5 the Trust was reporting a break-even position against plan to date and a net deficit of £5.6m. At this point the forecast for year-end was in line with plan, however there are some key risks in the plan which will be monitored throughout the year.

		• The STEP plan for 2025/26 was £29.2m (£20.5m recurrent). The Committee heard that STEP of £22.2m (76%) had been actioned against the in-year target, and year to date STEP was £1.0m ahead of the profiled efficiency plan. • The Trust has maintained sufficient cash to operate during August, however risk relating to the availability of support funding was acknowledged. • The Capital forecast for 2025/26 was £37.0m, an underspend of £0.4m due to IFRS16 recalculations. The Committee received the Operational Performance Report for Month 5, acknowledging 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 considered a Winter Board Assurance Statement and recommended it to the Board of Directors, with an acknowledgement that the Committee would continue to track the associated mitigation plans and further narrative would be provided to the Board to highlight risks and system interdependencies. The Committee received a CIP / STEP deep dive and an Operational & Clinical Productivity Update. The Committee noted positive progress on CIP delivery and heard that planning for 2026/27 had commenced. It was noted that benchmarking with Tameside was ongoing to understand productivity disparities. The Committee considered a Wayfinding Proposal, welcoming the inclusive engagement with stakeholders, and recommended it to the Board of Directors for approval. The Committee received a Stepping Hill Hospital Site Development Strategy Progress Report and an Estates & Facilities Assurance Report. The Committee noted associated significant risks and challenges, as well as positive developments. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2025/26 to the Board of Directors in October 2025. The Committee reviewed an Electronic Patient Record (EPR) Procurement Report and recommended to the Board of Directors the award of the preferred supplier for the EPR contract.
4.	**Assure**	The Committee acknowledged positive assurance regarding ED performance in month, with performance overachieving against the improvement trajectory, and improvements in Cancer 62-day and Referral to Treatment performance.
5.	**Referral of Matters/Action to Board/Committee**	The Committee reviewed a Winter Board Assurance Statement and recommended it to the Board of Directors, with an acknowledgement that the Committee would continue to track the associated mitigation plans and further narrative would be provided to the Board to highlight risks and system interdependencies.

		The Committee considered a Wayfinding Proposal and recommended it to the Board of Directors for approval. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2025/26 to the Board of Directors in October 2025. The Committee reviewed an Electronic Patient Record (EPR) Procurement Report and recommended to the Board of Directors the award of the preferred supplier for the EPR contract.
6.	**Report compiled by:**	**Anthony Bell, Non-Executive Director**
7.	**Minutes available from:**	**Soile Curtis, Deputy Company Secretary**

NHS Stockport NHS Foundation Trust

				Agenda No.	9
Meeting date	2nd October 2025	**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 2025

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, E. Coli Infections, Community Pressure Ulcers, Complaints, Incidents, and Maternity.

- Mortality rates continue to report below the expected threshold, with Stockport benchmarking well across GM.
- Sepsis performance measures for timely recognition shows a deterioration in performance, although remains above the 90% threshold. Antibiotic administration performance is showing some strong improvement, reported at the highest rate for August since reporting began.
- Reported infection rates for C. diff and MRSA are reported at or below their improvement trajectories. Rates of E. coli infection don't show any significant change and are above the planned improvement threshold.
- Hospital-acquired pressure ulcers are now measured as a rate of occupied bed days and show strong improvements in both overall rates and cases due to lapses in care. Numbers of community-acquired pressures ulcers show no significant change and are currently higher than the monthly threshold.
- Rates of formal and informal complaints are both reported lower than the target thresholds. Timely response has dipped below the 95% target, and the rate of re-opened complaints is above the target of 10%.
- Rates of patient safety incidents causing moderate and above harms do show an increasing trend and are currently above the 24/25 average. There were no reported patient safety alert breaches or duty of candour breaches in August.
- Smoking at time of delivery performance continues to report below the improvement trajectory set. Rates of 3rd and 4th degree tears are reported above the 2% national ambition, although has shown an improving trend over the last several months.

Operations Highlight

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

- Performance against the ED 4-hour standard shows strong improvement over the last several months. August has also seen a decrease in patients waiting more than 12 hours in department. Detailed actions plans have been developed to support performance improvement and are summarised within this report.
- The number of patients with no criteria to reside remains above the local threshold of 45, with an increasing trend seen since March 2025.
- Diagnostic performance shows no significant changes at Trust level but is reported below the planned trajectory. Performance is still challenged in Echo, Audiology and Endoscopy test types.
- Most cancer standards are reported as achieving their targets in August, except for the 31-day standard, which remains a challenge. Capacity in Urology Oncology and robotic theatre are still sighted as key contributing factors.
- RTT patients over 52-weeks continue to show strong improvement. 65-week waits are improving, with plans in place to achieve 0 by October 2025.
- Performance for Urgent Community Response has shown a strong deterioration and has dropped below the 90% target for the first time. Service review to be conducted by Director of Operations in this area.
- Performance in theatre capped touch time utilisation has seen a deterioration, although still reports above the GM average. Stockport average cases per session are reported as the best in the region, and in the top quartile nationally.

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 Appraisal rates.

- Monthly sickness absence rates continue to show strong improvement in the performance trend, with the latest position for August reported below the 5.5% target threshold.
- Workforce turnover has shown improvement month to month since September 2024 and shows strong improvement from January 2025 onwards.
- Appraisal rates show strong deterioration from January 2025 onwards. The decreased performance is as anticipated and is due to recent changes to the appraisal process.
- Mandatory training rates are showing a strong improvement in performance, with performance now just below the 95% target. Improvements reflect the sustained efforts to support colleagues, teams, and divisions in meeting their training obligations.
- Agency costs are now showing no significant changes but are still reported below the Trusts local threshold of 3.2%.

Curtis.Soile
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Finance Highlight

After 5 months of the financial year the Trust is reporting a break-even position against plan for system reporting purposes and a net deficit of £5.6m.

- The forecast at month 5 is that the Trust will achieve the annual plan.
- The Trust STEP target for 2025-26 is £29.2m, of which £20.5m (70%) is recurrent and £8.6m (30%) is non-recurrent. STEP of £11.4m has been delivered to date which is £1.0m ahead of the profiled plan. £22.2m (76%) of the full year £29.2m has been delivered, and £14.3m (69% of the recurrent requirement).
- The Trust has maintained sufficient cash to operate during August. Cash balances are anticipated to fall to approximately £30m by the end of September. The cash forecast has been updated based on current run rate, known cash commitments and risks. Trust cash balances are forecasting a significant variance from plan with a March 2026 outturn of £7.4m – which is a variance from Plan by £24.2m.
- The Trust submitted a capital plan for 2025/26 of £35.4m including £1.9m for IFRS16. This increased in May by £1.3m for the approved MacMillan information centre, plus a further £0.7m in June in respect of additional PDC for an approved diagnostics request (£0.6m) and additional estates safety (£0.1m). This takes the total plan to £37.4m. The Trust is forecasting a £0.4m underspend against the updated capital plan for IFRS16 following updates on the Marple Clinic lease which is now due to be undertaken in 2026/27.

Integrated Performance Report
Scorecard

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

	Reporting Period	Latest Target	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Jun-24 to May-25	≤ 100		↑	90	●	●
Sepsis: Timely recognition	Sep-24 to Aug-25	≥ 90%		↓	95.2%	●	●
Sepsis: Antibiotic administration	Sep-24 to Aug-25	≥ 90%		↑	78.4%	▲	▲
C.diff infection rate	Sep-24 to Aug-25	≤ 39.63		↗	38.55	●	●
MRSA infection rate	Sep-24 to Aug-25	≤ 0.92		↓	0.92	●	●
E. coli infection rate	Sep-24 to Aug-25	≤ 32.78		→	35.8	▲	▲
Hospital-Acquired Pressure Ulcers	Aug-25	≤ 74	17	↗	3	●	●
Rate of HAPU - Overall	Sep-24 to Aug-25	≤ 3.51		↑	2.66	●	●
Rate of HAPU due to Lapses in Care	Jun-25	≤ 30%	50%	↑	0%	●	●
Community-Acquired Pressure Ulcers	Aug-25	≤ 175	85	→	16	▲	▲
Rate of CAPU due to Lapses in Care	Jun-25	≤ 5%	4.5%	→	0%	●	●
Written Complaints Rate	Aug-25	≤ 9.3	9.05	↗	6.38	●	●
PALs and Informal Enquiry Rate	Aug-25	≤ 86.8	72.34	→	66.06	●	●
Timely Response to Complaints	Aug-25	≥ 95%	93.3%	↓	82.7%	▲	▲
Rate of Re-opened Complaints	Aug-25	≤ 10%	12.5%	↘	19.4%	▲	▲
Parliamentary & Health Service Omb..	Aug-25	≤ 0	8	→	1	▲	▲
Incident Rate - Moderate+ Harm	Mar-25 to Aug-25	≤ 2.7		↗	2.93	▲	
Patient Safety Alert Breaches	Aug-25	≤ 0	0	↑	0	●	●
Duty of Candour Breaches	Aug-25	≤ 0	1	↗	0	●	●
Never Event Incidence	Aug-25	≤ 0	0	→	0	●	●
Rate of Registrable Stillbirths	Aug-25	≤ 0	4.4	↘	8.3	▲	▲
Smoking at Time of Delivery (SOTD)	Aug-25	≤ 5.2%	2.8%	↗	3.2%	●	●
3rd or 4th degree tears	Jun-25 to Aug-25	≤ 2%		↗	3.3%	▲	▲
Postpartum Haemorrhage	Aug-25	≤ 2.5%	4.5%	→	2.5%	●	●
Avoiding Term Admissions	Aug-25	≤ 5%		→	1.8%	●	●

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	Reporting Period	Latest Target	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
4hr Standard	Aug-25	≥ 68.3%	69%	↑	69.4%	●	●
Patients in department over 12hrs	Aug-25	≤ 7%	9.9%	↗	8.1%	▲	▲
Ambulance handover time	Aug-25	≤ 22.52		↗	23.26	▲	▲
No criteria to reside (NCTR)	Aug-25	≤ 45	387	↘	82	▲	▲
Adult G&A Bed Occupancy	Aug-25	≤ 92%	95.5%	↗	94.8%	▲	▲
Timely discharge	Aug-25	≤ 80.1%	81.3%	→	81.4%	▲	▲
Average discharge delay	Aug-25	≤ 6.6		↓	8.9	▲	▲
Length of stay: Elective	Jan-25 to Jun-25	≤ 2.81		↑	2.17	●	●
Length of stay: Non-elective	Jan-25 to Jun-25	≤ 10.52		↑	10.39	●	●
Diagnostics: 6-week Standard	Aug-25	≤ 27%	23.5%	→	24.2%	●	●
62-day standard	Aug-25	≥ 71.7%	69.2%	→	76.3%	●	●
31-day standard	Aug-25	≥ 92.2%	89.6%	↓	86.4%	▲	▲
28-day standard (FDS)	Aug-25	≥ 78.6%	80%	→	82.8%	●	●
14-day standard (2WW)	Aug-25	≥ 93%	96.3%	→	96.6%	●	●
Incomplete pathways 18-week %	Aug-25	≥ 55.9%		↗	56%	●	▲
52-week breaches	Aug-25	≤ 1179		↑	831	●	●
65-week breaches	Aug-25	≤ 0		↑	4	▲	▲
52-week breach %	Aug-25	≤ 3.5%		↑	2.4%	●	●
Wait for first attendance 18-week %	Aug-25	≥ 64.4%	64.3%	↑	63.2%	▲	▲
Virtual Ward Utilisation	Aug-25	≥ 80%	65.3%	↗	82.6%	●	●
Urgent Community Response	Jul-25	≥ 70%		↓	63.9%	▲	▲
Outpatient DNA rate	Aug-25	≤ 6.3%	6.7%	→	6.5%	▲	▲
Outpatient clinic utilisation	Aug-25	≥ 90%	95.5%	→	94.2%	●	●
Patient initiated follow up (PIFU)	Aug-25	≥ 5%	5.9%	→	5.6%	●	●
OP First Attend and Procedure	Aug-25	≥ 43.2%	42.9%	→	42.4%	▲	▲
Capped Touch Time Utilisation	Aug-25	≥ 85%	78.3%	↑	77.6%	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Aug-25	≥ 90%	95.3%	↗	95.2%	●	●
Sickness Absence: Monthly Rate	Aug-25	≤ 5.5%	5.3%	↑	5.3%	●	●
Workforce Turnover	Aug-25	≤ 12.7%	11.4%	↑	11.2%	●	●
Appraisal Rate: Overall	Aug-25	≥ 95%	82.1%	↓	81.6%	▲	▲
Mandatory Training	Aug-25	≥ 95%	94.8%	↑	96.1%	●	●
Agency Costs %	Aug-25	≤ 3.2%	1.9%	→	1.5%	●	●
Finance Scorecard							
Capital Expenditure	Aug-25	≤ 10%		↘	136.3%	▲	▲
Cash Balance	Aug-25			→	37.2		
CIP Cumulative Achievement	Aug-25	≥ 0%		↗	9.1%	●	●
Financial Controls: I&E Position	Aug-25	≤ 0%		→	-4.3%	●	●

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%	95.2%	↓	M A M J J A	●
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%	78.4%	↑	M A M J J A	▲

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

- Achieved 100% performance with timely recognition for the month of August
- 12 month rolling figure 95%, ahead of trust target.
- 61/61 sepsis triggers were reviewed on time
- 18 suspected red flag triggers where 7 were treated as sepsis positive at clinician review
- 6 suspected amber flag sepsis where 2 were treated sepsis positive at clinician review
- 37 suspected sepsis triggers had no clinical suspension of infection

Antibiotic Administration

- 89% compliance with antibiotics administration for the month of August
- 12 months rolling figure stands at 78% for August, which is below Trust target, with a slight difference from 77% in July
- 8/9 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- Red flag sepsis: 6/7 were compliant
- Amber flag sepsis: 2/2 were compliant

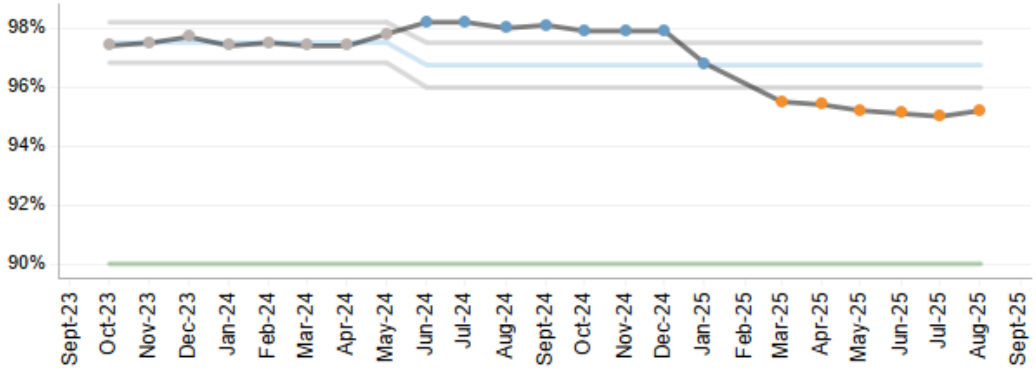
Key Events/Ongoing Issues

- 2222 use for suspected red flag sepsis has seen a significant improvement for the month of August during OOH
- Wards that achieved 100% both in timely recognition and antibiotic administration for August: M4, B4, E1, AMU, D2, B5, E3
- Latest Sepsis Link nurse meeting: 1st September
- Patientrack: ongoing work is still underway to update the current sepsis screening tool, which is now in the testing phase. Expected launch for September is delayed. Update will be given the soonest possible time.
- AMAT Audit: Final changes to AMAT audit have been made and pilot will start this September (initially planned for August).
- Sepsis roadshow will be running from 8-12 September with various planned activities for the whole week

Update provided by	Christe Bolanio
Executive Lead	Nic Firth

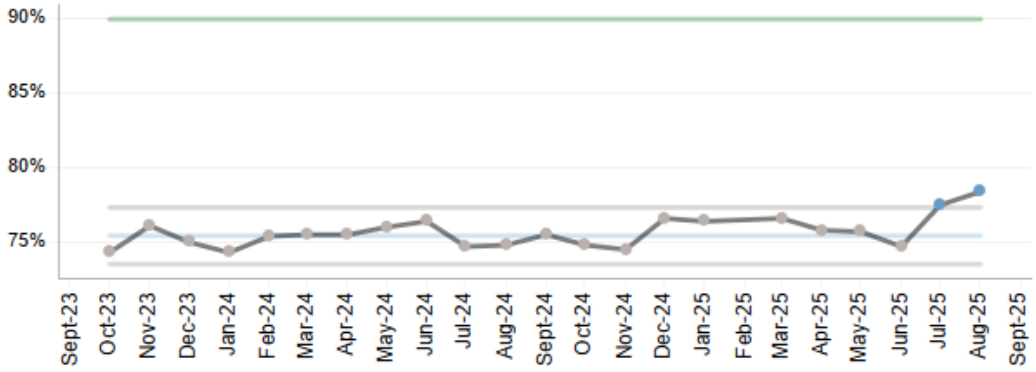
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Sepsis: Timely recognition



The latest data point is below the lower control limits. This could be viewed as a concern.

Performance for Sepsis: Antibiotic administration



The latest data point is above the upper control limits. This could be viewed as an improvement

Quality **Infection Prevention** E. coli

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 32.78	35.8	→	M A M J J A	▲

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.

There were 1 HOHA and 2 COHA cases in August totalling 38 YTD. The Trust is over the projected threshold of 28.75 for the end of August.

The latest National figures (June 2025) rank Stockport fourth out of the seven GM Trusts which is the same as the previous month.

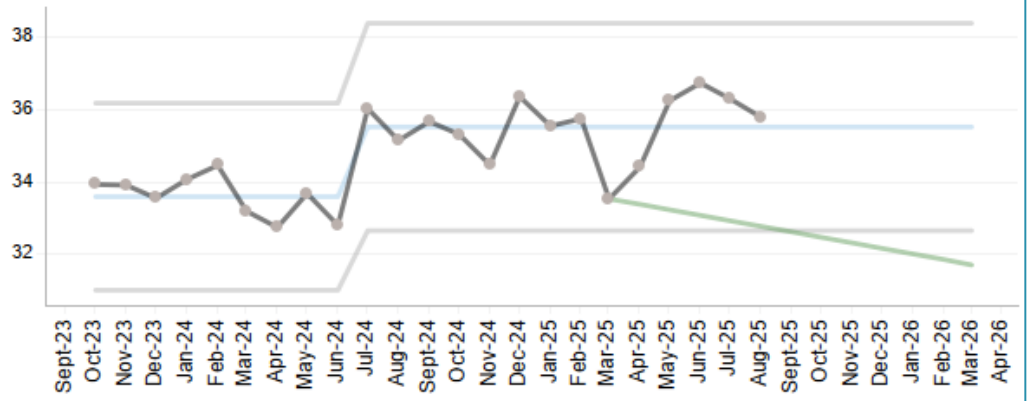
The urinary catheterisation policy has been ratified and awaiting the policy approval panel for uploading to the microsite. The Catheter risk assessment is now on the Urology microsite for staff to access.

Benchmark data for E. coli infections from NHSE – June 2025

Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

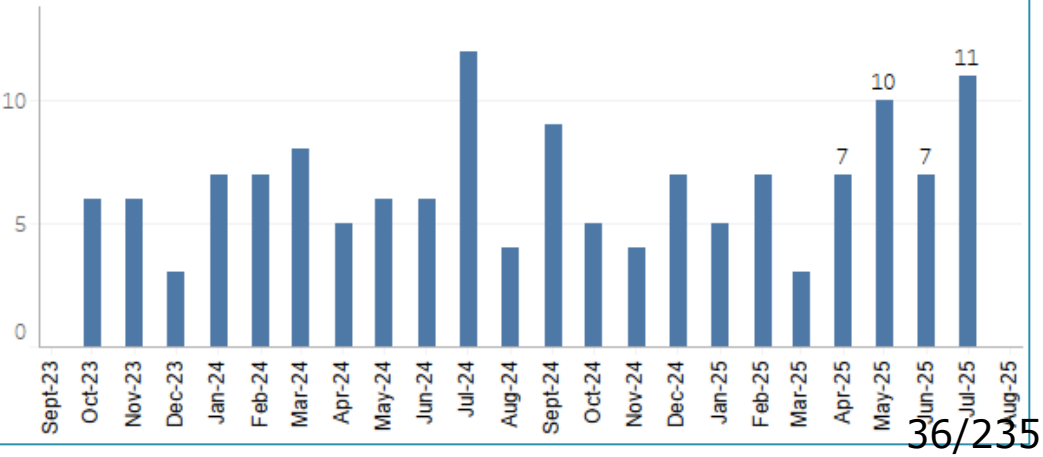
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for E. coli infection rate



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for E.Coli Infection Count



Integrated Performance Report
Exception

NHS Stockport NHS Foundation Trust

Quality **Pressure Ulcers** Community

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Community-Acquired Pressure Ulcers	Total number of pressure ulcers acquired in a community setting.	<= 14	16	→	M A M J J A	▲
Rate of CAPU due to Lapses in Care	Community-acquired pressure ulcers determined to be as a result of lapses in care, as a percentage of all community-acquired pressure ulcers.	<= 5%	0%	→	M A M J	●

The Trust has set a target to reduce the number of community-acquired pressure ulcers caused by lapses in care. Additionally, targets have been established for the timely investigation of pressure ulcer incidents, focusing on learning from these incidents according to the PSIR framework.

Performance

- This month (August), 16 pressure ulcers were reported (Ten Category 2, Six Category 3)
- We continue to see fluctuating numbers of pressure ulcers month on month, but no obvious trend or theme correlates with increase or decrease in numbers. We are currently over trajectory to meet our reduction target.
- So far this year the numbers of pressure ulcers related to lapses in care is markedly under target (2%).
- The main area of concern regarding community acquired pressure ulcers is the timeliness of investigation as we currently have 41% of pressure ulcers incidents with no outcome.

Trends

- The most common theme in pressure ulcers developing in our community patients is around patient or carer decision making (for example not following pressure ulcer prevention advice or using prevention aids).
- Work-streams continue to develop information sharing and communication strategies with patients to support them in their health promotion choices.

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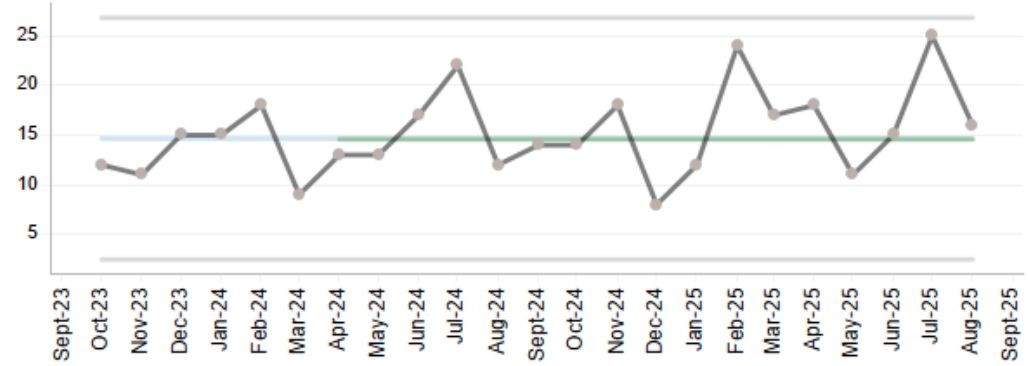
Pressure Ulcers Awaiting Investigation | by month of incident reporting

	Total	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Community acquired	43	3	1	0	4	0	3	2	6	12	12

Update provided by	Lisa Gough
Executive Lead	Nic Firth

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Community-Acquired Pressure Ulcers



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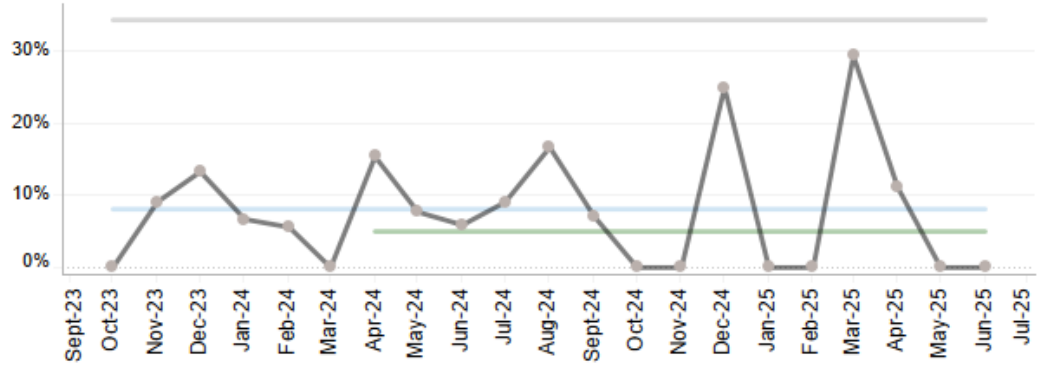
Performance for Rate of CAPU due to Lapses in Care



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Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Quality **Complaints** Other

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Timely response to complaints	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	82.7%	↓	M A M J J A	▲
Re-opened complaints	The number of formal complaints returned by the complainant where they were not happy with our response, as a % of total complaints received.	<= 10%	19.4%	↘	M A M J J A	▲
Parliamentary & Health Service Ombudsman Cases	The total number of open Ombudsman cases.	<= 0	1	→	M A M J J A	▲

Timely Response to Complaints

- There were 52 responses sent out in August 2025 with nine being sent outside of the agreed timeframe, resulting in a 82.7% response rate.
- The PALS & Complaints team are currently under extreme pressure due to due to two members of staff being on unexpected long-term sickness and this is having a significant impact on the team's capacity and resilience.
- The team are working hard and are continuing to try to maintain a high response rate.

Re-opened Complaints

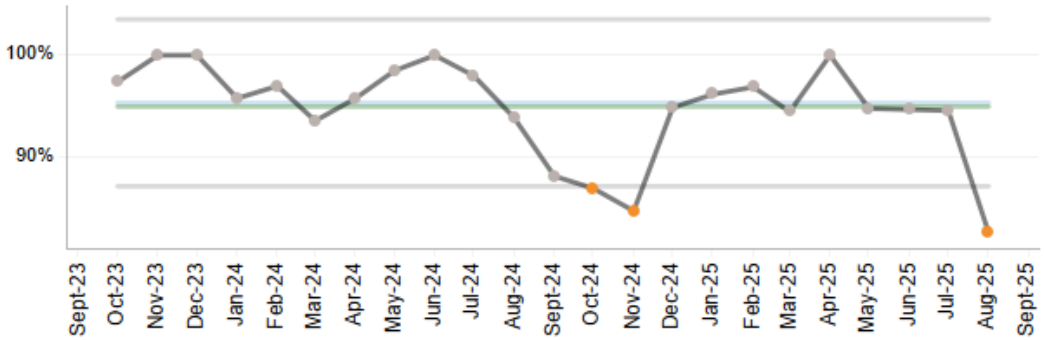
- Whilst the Trust conducts its investigations and aims to respond by 'getting it right first time', it is recognised that a complainant may sometimes remain dissatisfied with the Trust's response or the response may generate further questions. If a complainant is not happy with our response, or has further questions, they may contact their case officer within the complaints team to discuss this and the options available to them.
- There were seven cases re-opened in August 2025 - one for Integrated Care, two for Medicine & UC, two for Surgery and two for Women & Children.

Parliamentary & Health Service Ombudsman Cases

- If a complainant remains dissatisfied after the Trust's complaints process has been exhausted and considers local resolution concluded, they have the right to request that their complaint is reviewed by the Ombudsman. The Ombudsman will assess cases referred to them, taking an in-depth look at what happened in order to decide whether to proceed with an investigation.
- There was one new request for information from the PHSO in August 2025.
- There was one case, in August 2025, that the PHSO confirmed would not be proceeding with an investigation.
- There are 12 cases outstanding with the Ombudsman, seven of which are awaiting their decision on whether to undertake an investigation.
- We have received a further three provisional reports in August 2025 – one case is not being upheld, one case is being partly upheld and the third case is being upheld; we are still in liaison with the Ombudsman on these and on the other two case cases with provisional reports that are being partially upheld.

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Timely Response to Complaints



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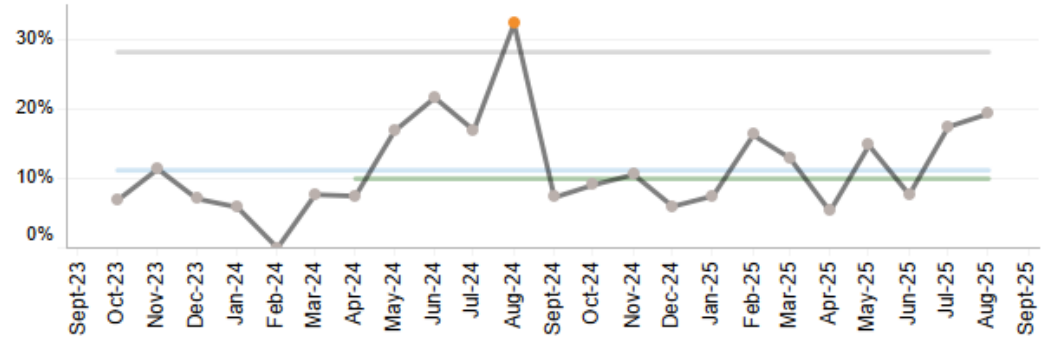
Performance for Rate of Re-opened Complaints



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Signed off by	Waseem Munir
Executive Lead	Nic Firth

Quality **Incidents & Risk**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Incident Rate - Moderate+ Harm	The number of patient safety incidents causing moderate+ harm, calculated as an incidence rate for every 10,000 bed days.	<= 2.7	2.93		M A M J J A	
Patient Safety Alert Breaches	The number of national patient safety alerts not completed to deadline.	<= 0	0		M A M J J A	
Duty of Candour Breaches	Total number of duty of candour breaches of regulation in month.	<= 0	0		M A M J J A	
Never Event Incidence	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur.	<= 0	0		M A M J J A	

Incident rate performance is based on data from a rolling 6-month period. Performance is based on date of incident reporting, not date of incident.

Patient Safety Incident Rate

- In August there has been a decrease in the overall number of patient incidents reported, but still within normal variance. However, there has been an increase in the number of moderate or above harm patient incidents reported, a number of these were reported in the last days of the month and the level of harm reported is still under review, some other incidents were identified following review/audit of patient notes but occurred in previous months.
- There was one fatal incident, which was not a result of lapses in care, with another severe level incident which is still under local review.
- The Incident Review Group meets weekly to review patient incidents, identify trends, escalate new issues, implement learnings, and take immediate actions.
- 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 related incidents are reviewed at the Security & Safeguarding Meeting on a weekly basis.
- Discharge incidents are reviewed at the Discharge Concerns Panel on a monthly basis.

Patient Safety Alert Breaches

- There were two National Patient Safety Alerts with a completion deadline in August 2025. Both alerts were completed by their deadline date.
- At the end of August there were no overdue National Patient Safety Alerts.

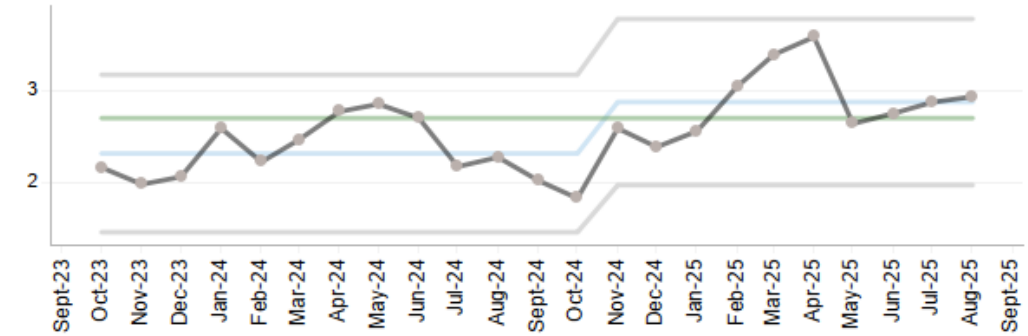
Duty of Candour Breaches

- There were 3 where letters opening Duty of Candour were due to be sent in August 2025.
- At the end of August there was no incident that breached their due date.

Signed off by	Waseem Munir
Executive Lead	Nic Firth

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Incident Rate - Moderate+ Harm | per 10000 bed days



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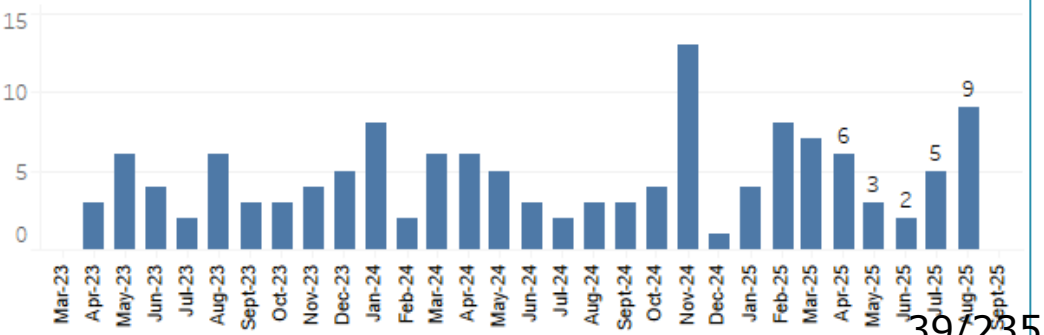
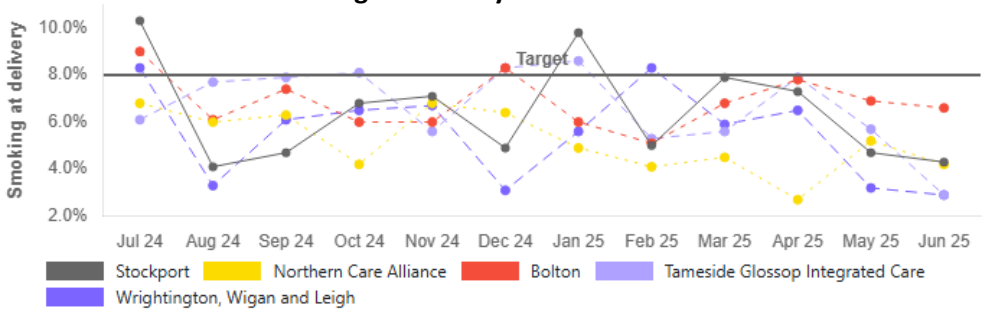
Number of Incidents - Moderate+ harm



Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Rate of Registrable Stillbirths	Calculated as a rate per 1000 registrable births.	<= 0	8.3	↘	M A M J J A	▲
Smoking at Time of Delivery (SOTD)	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 5.2%	3.2%	↗	M A M J J A	●
Avoiding Term Admissions	Number of full-term babies admitted to neonatal units, calculated as a percentage of all babies born. Based on babies born at 37 weeks or above only.	<= 5%	1.8%	→	M A M J J A	●

Benchmark data for Smoking at Delivery from Public View – June 2025



SATOD

- Public view is showing a rate of 4.3% for June 2025 SATOD, which relates to women delivered in May 2025. This is taken from MSDS data and is a rate just above the GM target of 4%.
- As this is a new format for the maternity data slides, and following the change from SATOD data being taken from manual reports to MSDS submissions, further investigation is being undertaken to understand the slight differences in metrics between local Euroking data and publicly published MSDS data. Local Euroking August 2025 data, for deliveries initially booked at SNFT, shows the SATOD rate as 3.2%, below the GM 4% target.

Stillbirths

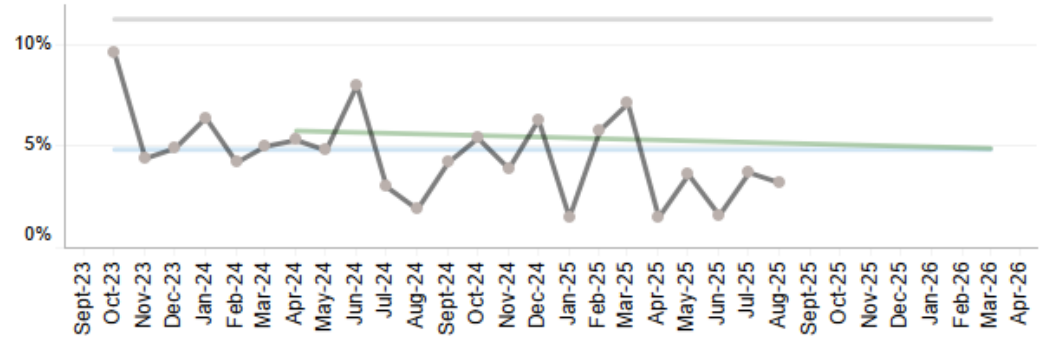
- X1 SB AP – 27+0 FDIU, smoker with cannabis use in pregnancy, under smoking cessation service, under FMU/MFT for FGR 1st centile with placental dysfunction, pre-eclampsia.
- X1 SB AP – 37+3 RFM – 2nd or more episode in a 21-day period, attended Triage, FDIU diagnosed.

ATAIN

- X4 babies from the Postnatal Ward to Neonatal Unit (x3 for respiratory distress, x1 for Jaundice) – our lowest ATAIN rate, well below target.

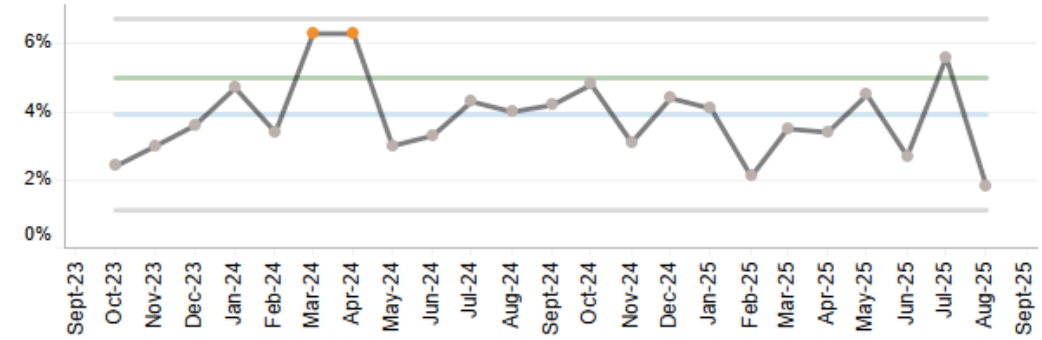
Update provided by	Steph Bray
Executive Lead	Nic Firth

Performance for Smoking at Time of Delivery (SOTD)



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Avoiding Term Admissions



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Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

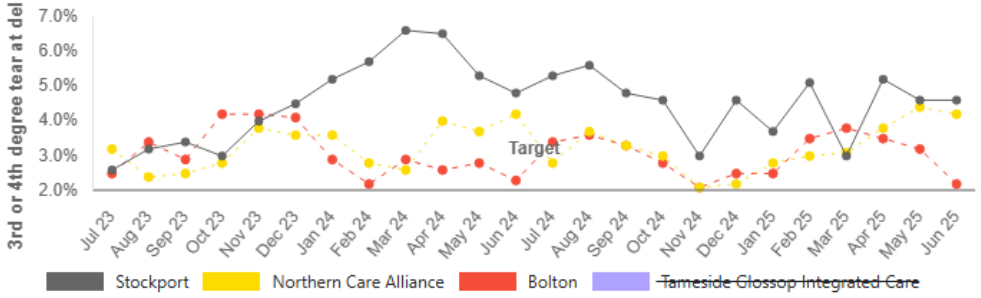
NHS Stockport NHS Foundation Trust

Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
3rd or 4th degree tears	The number of women who had a 3rd or 4th degree tear at delivery, calculated as a percentage of all women with a vaginal birth. Calculated as a rolling 3 months avera..	<= 2%	3.3%		M A M J J A	
Postpartum Haemorrhage	Number of women with a recorded postpartum haemorrhage of 1,500ml or more, calculated as a percentage of all women with submitted birth record.	<= 2.5%	2.5%		M A M J J A	

Performance for 3rd or 4th degree tears is based on data from a rolling 3-month period.

Benchmark data for 3rd/4th degree tears from Public View – June 2025



3rd/4th degree tears

Local Euroking data shows 4 deliveries with a 3rd degree tear in August 2025:

- X3 Instrumental deliveries
- X1 Normal Vaginal Delivery

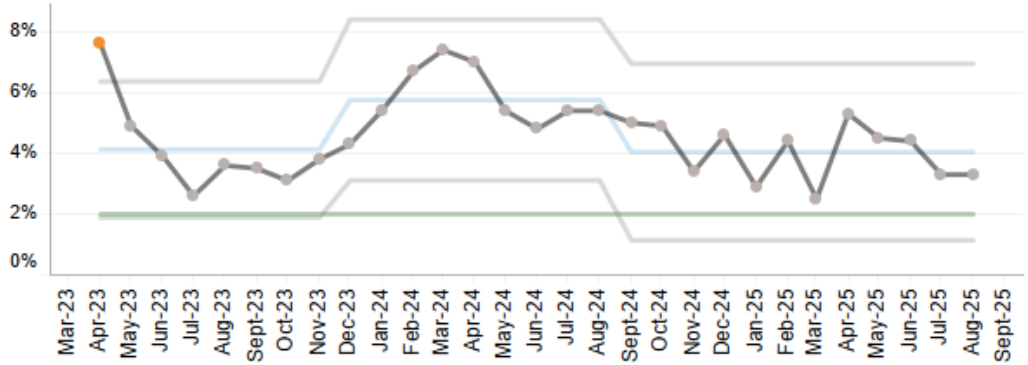
As a percentage of all vaginal deliveries for the month, this equates to 2.8%, closer to the 2% target and supporting a general downward trend across the past 4 months, compared to much higher rates in previous months.

Postpartum Haemorrhage

In August 2025 a total of 6 PPHs equal to or above 1500mL were diagnosed. A rate equal to the target of 2.5% and much lower numbers than previous months.

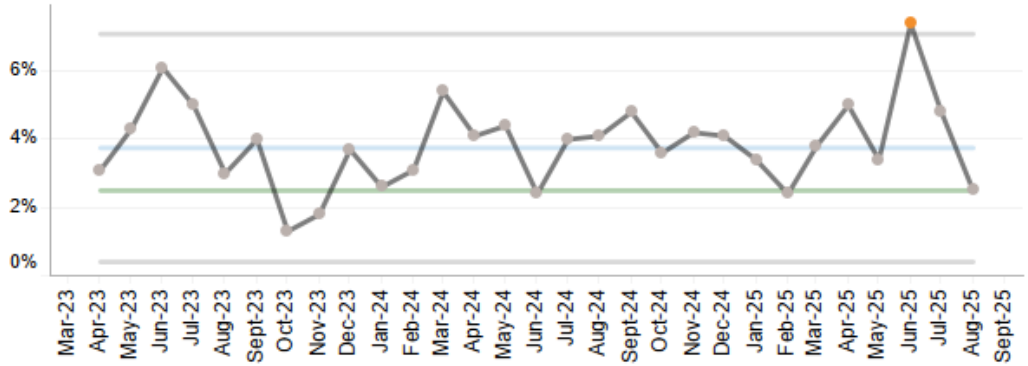
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for 3rd or 4th degree tears



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Postpartum Haemorrhage



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Update provided by	Steph Bray
Executive Lead	Nic Firth

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Emergency Department** 4-hour

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
4hr Standard	>= 68.3%	69.4%	↑	M A M J J A	●

The number of patients who were admitted, discharged, or leave ED within 4 hours of their arrival, as a percentage of all patients attending the ED.

Performance Summary

- In-hospital Weekly performance against the 4hr standard (not including Community UTC) maintains the improvements seen since the turn of the year, running a long-term process average that is higher than any point in the last two years. The same pattern is seen when performance against the 4hr standard for Type 1 attendances are considered in isolation.
- This Average daily attendances per week 10-11 higher than this point last year (309 vs 298), with much of this increase being seen as Type 1 attendances (272 vs 263). Weekly levels through August have run below this average, in line with seasonal expectations, albeit with a smaller drop than anticipated.
- At the monthly level, August and July attendance numbers were above trajectory (3.5% higher in August), however, performance remains above the improvement trajectory at 69.4%.

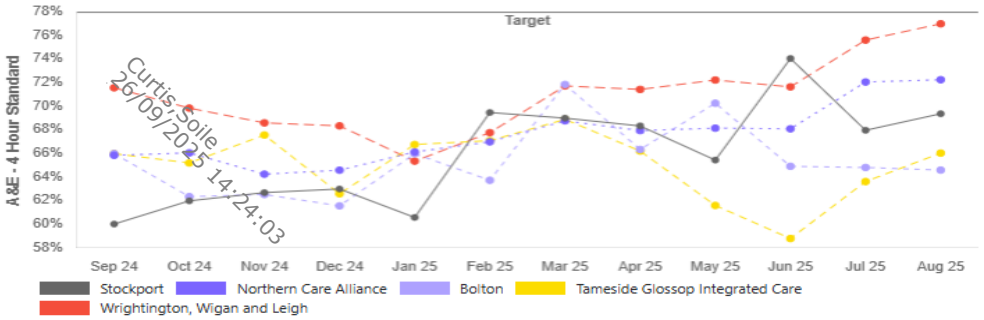
Risks and Issues

- IT disruption impact on time to be seen as paper systems slow processes
- Potential for future Resident doctor industrial action
- Mental Health model has reverted to an in-reach service

Actions and Mitigations

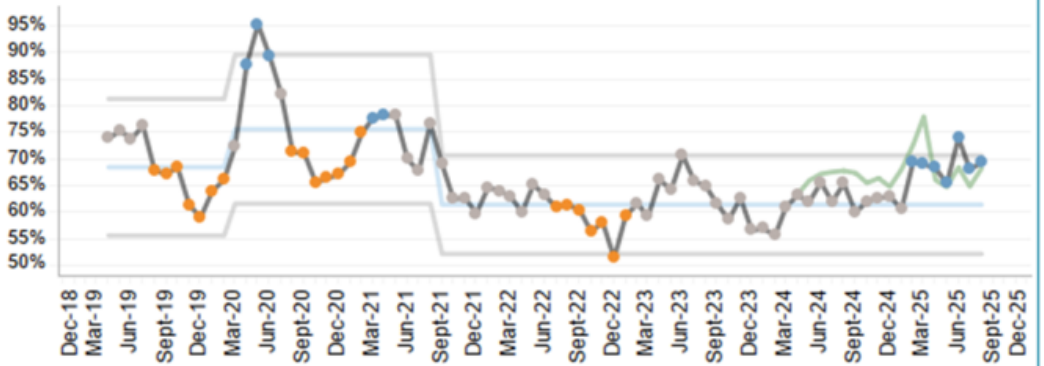
- Changes to the medical rota implemented
- Implementation of Health Rota for medical self rostering
- Digital changes enabling care by appointment for low acuity patients avoiding waiting overnight
- Weekly Trust 4hr clinical standards performance group is in place with full specialty representation with actions to improve position
- Awaiting the outcome of GM UEC bid to access funding to enhance SDEC coverage across the specialties and improved model for admission avoidance in ED
- Task and finish group established to implement new acuity tool to replace MTS triage model

Benchmark data for 4hr Standard from Public View – August 2025



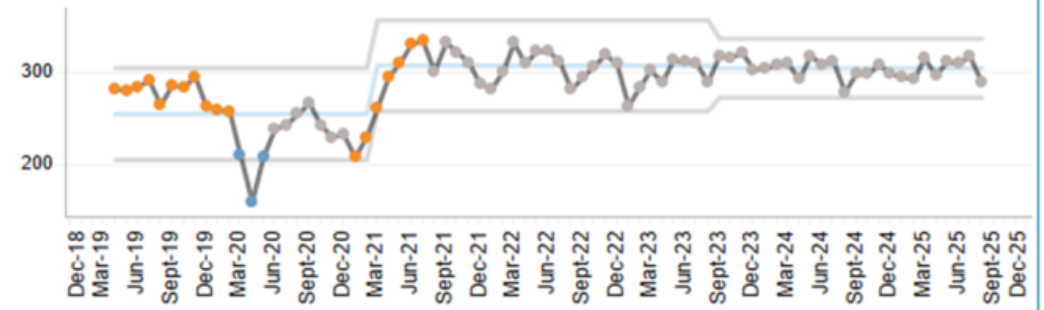
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for 4hr Standard



There have been 7 or more consectutive data points above the mean. This shift could be viewed as an improvement.

Performance for Average daily hospital attendances to department



Whilst the average number of in-hospital attendances has not changed significantly over the last several years, this is still a historically high level, representing an increase of almost 10% on numbers from 2019/20. Recent weeks have seen significantly high numbers attending the department, suggesting a potential increase in the daily average.

Signed off by	Ruth McNulty
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Emergency Department** 12-hour

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Patients in department over 12 hours	The number of type-1 patients spending 12 hours or more in department, as a percentage of all type-1 patients attending the emergency department.	<= 7%	8.1%		M A M J J A	
Ambulance handover time	The average ambulance handover time, from ambulance arrival to transfer of patient care to emergency department. Measured in minutes and seconds.	<= 22.52	23.26		M A M J J A	

Performance Summary

- Whilst numbers remain high, levels have retained the improvements made since the very high levels seen through winter 2023/24. The long-term weekly process average is just above 9%, significantly higher than the target of 3%

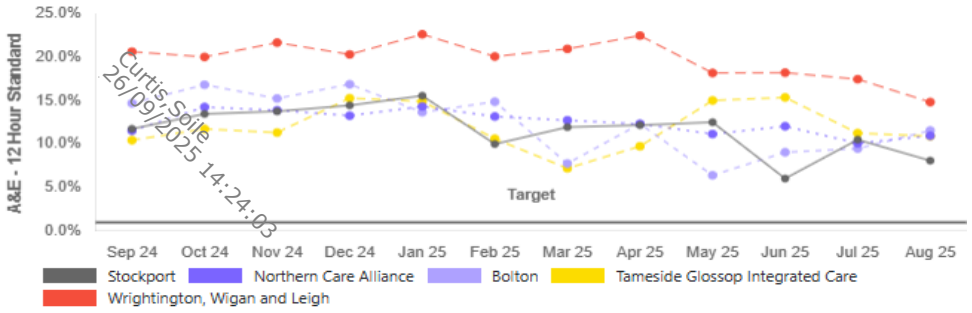
Risks and Issues

- HO45 – release to rescue impacts on congestion in the ED, implementing new validation process to ensure accurate handover data
- IT disruption impacts on patient flow from the specialty wards
- Potential for future Resident doctor industrial action
- Mental Health model has reverted back to an in-reach service
- Change in discharge profile and LOS towards end Aug/early Sept

Actions and Mitigations

- Weekly Trust 4hr clinical standards performance group is in place with full specialty representation with actions to improve position
- All patients who have breached a 12hr trolley wait now discussed at site capacity meetings for additional focus across all Divisions to drive improvement
- Ward by ward, patient level review to understand changes in the discharge profile
- Decision to admit audit programme
- Further development of SDEC pathways
- Awaiting the outcome of GM UEC bid to access funding to support additional resources over the winter period

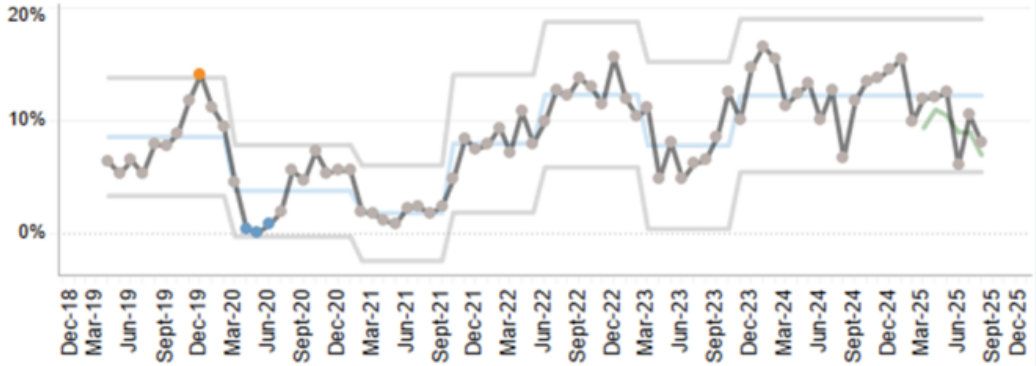
Benchmark data for 12hr Standard from Public View – August 2025



Signed off by	Ruth McNulty
Executive Lead	Jackie McShane

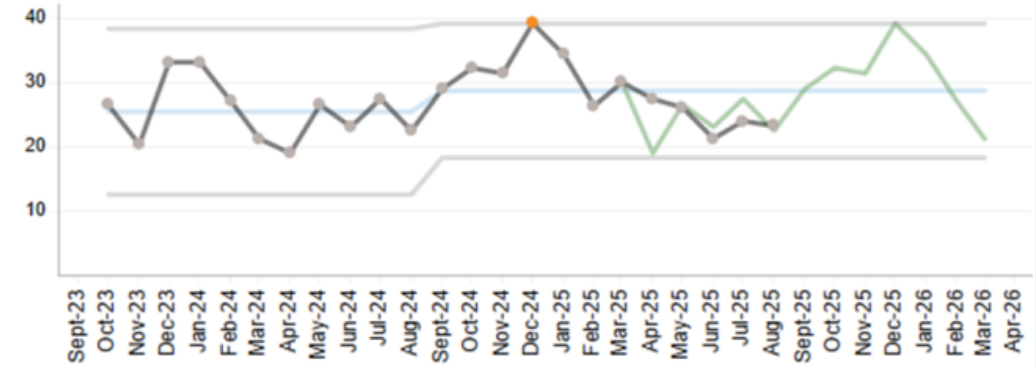
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Patients in department over 12hrs



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Ambulance handover time



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Operations **Emergency Department** Performance Improvement Actions

Key Actions	Key Workstreams	Expected Date of Delivery	Confidence in delivery (RAG)
Roll out of the NHS Acuity Tool to replace MTS	Deflection, Navigation & Triage	December 2025	Amber
Roll out of the Vocera System	Diagnostics	September 2025	Green
Care by appointment in the UTC	UTC	October 2025	Green
Development of 12hr wait and CDU activity dashboards	Reducing Long Waits	September 2025	Green
MSDEC & CDU pathway optimisation	UTC SDEC & Frailty	October 2025	Amber
Clinical rota changes in ED and SDEC to support increased senior decision making later into the evening	Reducing Long Waits	September 2005	Green
Opportunities to enhance earlier use of CDU via SDM at triage	Reducing Long Waits	October 2025	Amber
B7 in Rapid Assessment 24/7	Deflection, Navigation & Triage	October 2025	Amber
Review of delivery of frailty pathways	SDEC & Frailty	October 2025	Green
Over-recruitment in nursing to support predictable absence and requirement for escalation over winter	Reducing Long Waits	September 2025	Green
Divisional management team supporting inpatient pathway reviews	Reducing Long Waits	September 2025	Green
Trial of short HCR in Medicine to reduce on the day DC delays	Reducing Long Waits	October 2025	Amber

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Patient Flow**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 45	82	↘	M A M J J A	▲
Adult G&A Bed Occupancy	The total number of occupied adult general & acute bed days, as a percentage of all available adult general & acute beds.	<= 92%	94.8%	↗	M A M J J A	▲
Timely discharge	The number of patients discharged from hospital on the same day as their discharge ready date, as a percentage of all patients patient discharges.	<= 80.1%	81.4%	→	M A M J J A	▲

Performance Summary

- The average number of patients with a No Criteria to Reside increased to 82 in August, the 6th consecutive monthly increase since March 2025.
- Adult G&A bed occupancy for August was 94.8%, the lowest since January 2025. Medical bed occupancy remains consistently high at or around 98%.
- The percentage of discharges made on the Discharge Ready Date for August is 81.4% and has been above the monthly trajectory since April 2025. The average discharge delay has also shown improvement against the 6.7-day target.

Risks and Issues

- Community capacity in Pathways 2 - 3, for Stockport. (Bramhall Manor reducing D2A bed capacity from 15 beds to zero at the end of August.)
- Reduced Pathway 1 weekend discharge capacity as Stockport Adult Social Care (ASC) Reablement (REaCH) team only providing a 5 day offer for accepting referrals. (No weekend offer.)
- Community capacity in Pathways 1 - 3, for Derbyshire, East Cheshire and other areas.
- Ambulance availability for patients who cannot return to the community any other way.
- HCRs completed too late in the patient's stay, which then impacts on medication availability.

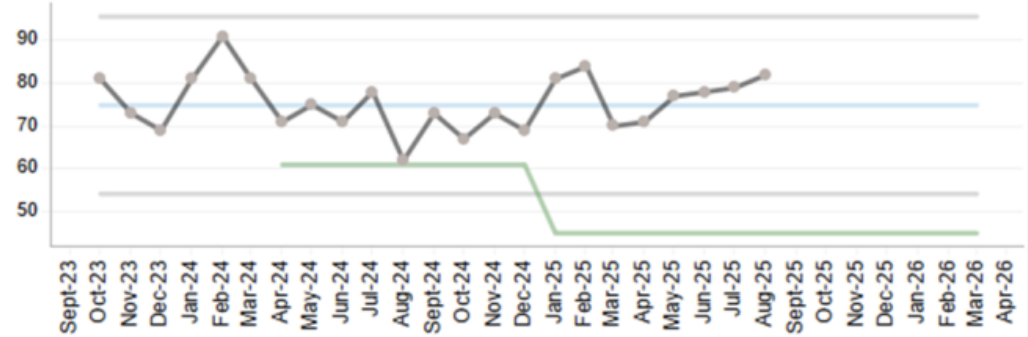
Actions and Mitigations

- System partner agreement for pathway 3 identified referrals to be discharged via Spot purchase and review team process to support the planned reduction of a further 15 D2A commissioned beds at Bramhall Manor.
- Continue twice weekly system meetings in place to review Pathway 2/3 delays over 48 hours.
- Stockport ASC Reablement team (REaCH) commencing operating from 1st September over 7 days; accepting patients at a weekend and directly on discharge from hospital. This will release the D2A team to accept other patients and increase the overall capacity for Pathway 1 discharges.
- Continued Programme of Flow on stroke wards to support earlier conversations with stroke patients and their families re discharge planning and ongoing therapy support.
- Programme of Flow involving ICB; reviewing transport arrangements for patients leaving D2A bed-based facilities, potentially freeing up transport for patients to leave hospital
- Opportunity to pilot use of a trust minibus for pathway 1 Stockport discharge for earlier in the day discharge ready patients. Minibus to be operated by D2A staff providing a better patient journey.
- Options appraisal re Saffron ward, Pennine Care, to understand what could be done differently to widen admission criteria and improve flow.

Updated provided by	Liza McIlvenny
Executive Lead	Jackie McShane

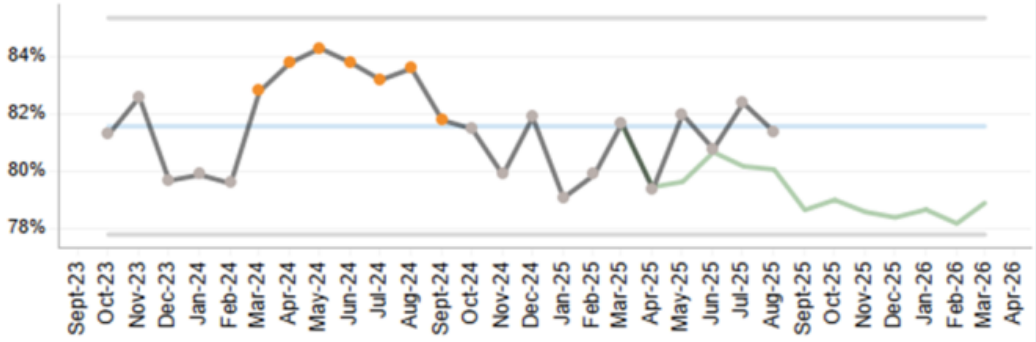
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for No criteria to reside (NCTR)



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Timely discharge



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Operations **Diagnostics** Audiology

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: Audiology	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 97.8%	98%		M A M J J A	

Risks and Issues

- Paediatric (5yrs and under) service remains paused
- Look back ongoing since November 2024 - resulting in further lost capacity for patients within the backlog
- Fragile workforce
- Mutual aid not available within GM
- MFT unable to offer additional support

Key Actions

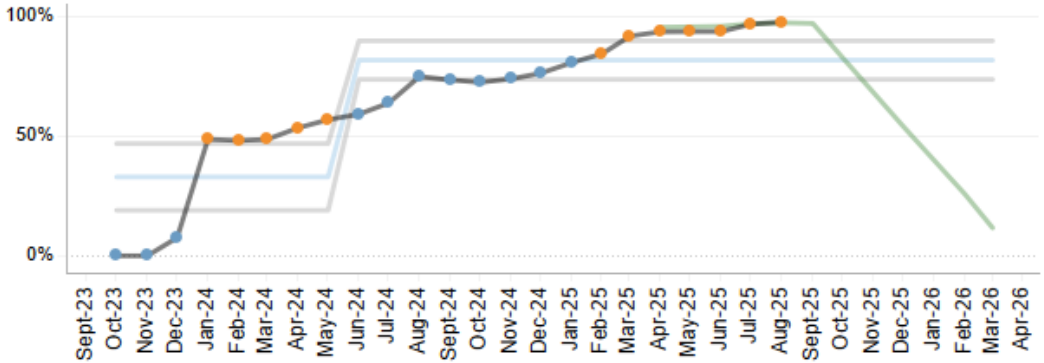
- Approval given to recruit a Service Lead (Band 8b)
- ICB have commissioned Health Harmonie (insourcing company). Implementation plan in hand, although this has slipped to 20th September 25, due to final SLA arrangements between ICB/HH
- Continual Monitoring of long waits , booking longest waits in order
- 3 audiologists completed their competencies, creating capacity for over 5's.
- Training to continue to ensure compliance with all Audiologist for over 5s
- Ongoing Strategy Meetings with ICB, Executive Team and Division

Number of diagnostic breaches reported by month

Diagnostic Description	31 Mar 25	30 Apr 25	31 May 25	30 Jun 25	31 Jul 25	31 Aug 25
Audiology - Audiology Assessments	1,318	1,357	1,377	1,367	1,370	1,393

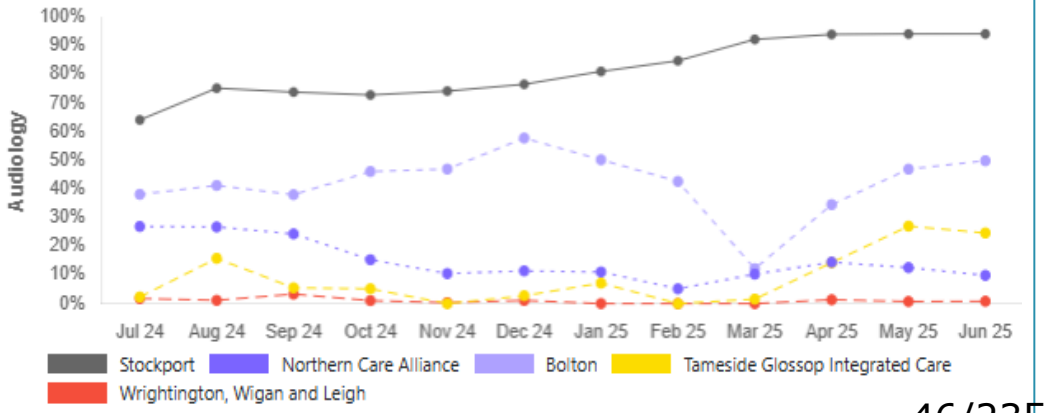
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Diagnostics: Audiology



There have been 7 or more consecutive data points above the mean. This shift could be viewed as a concern.

Benchmark data from Public View – June 2025



Updated provided by	Fiona Humphreys
Executive Lead	Jackie McShane

Operations **Diagnostics** Endoscopy

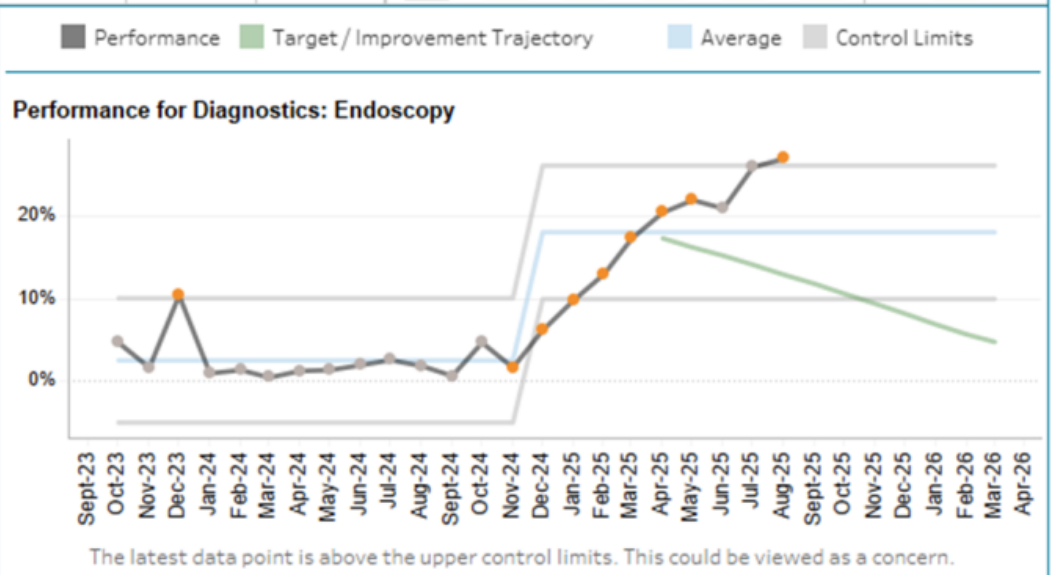
	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: Endoscopy — The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 12.9%	26.9%		M A M J J A	

Risks and Issues

- Bank holiday in August coupled with increased operator leave has meant that waiting list has remained static over this period.
- Estates issues in relation to the air handling unit continue to cause a service disruption in that Entonox gas can only be used in room 4 – plan in place to resolve with the installation of gas scavengers.

Key Actions

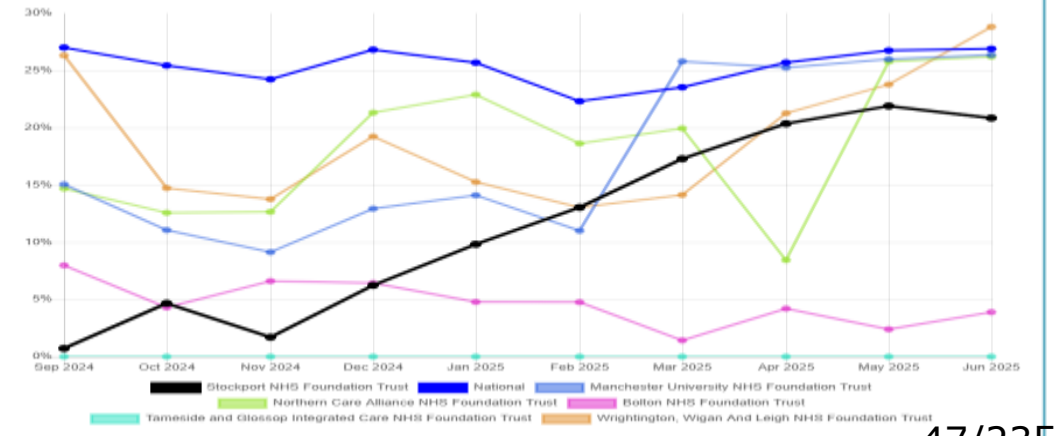
- New Consultant Endoscopist locum has commenced in post and will see an increase in lists per week during the next three months
- Focus on productivity and efficiency to maximise bookings – overbooking of lists to counter the challenge of DNA's appears to be having a positive effect and will be monitored closely
- Additional lists as WLIs delivered when operators available
- Activity remains significantly above plan



Number of diagnostic breaches reported by week

Diagnostic Description	27 Jul 25	03 Aug 25	10 Aug 25	17 Aug 25	24 Aug 25	31 Aug 25
Endoscopy	**251**	**270**	**305**	**271**	**271**	**266**
Colonoscopy	133	134	155	137	137	134
Flexible sigmoidoscopy	28	34	47	40	40	27
Gastroscopy	90	102	103	94	94	105

Benchmark data from HED – June 2025



Signed off by	Mike Allison
Executive Lead	Jackie McShane

Operations **Diagnostics** Echo

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: Echo	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 4.8%	11.6%		M A M J J A	

Risks and Issues

- DNA rates high with Stress echo
- Stress Echo capacity
- Stress Echo nursing support

Key Actions

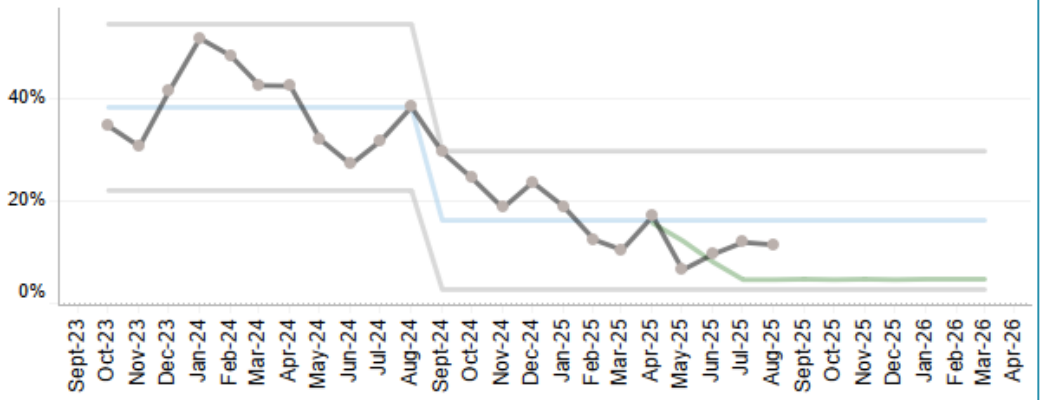
- Locum consultant covering any cancelled Stress Echo list due to consultant annual leave/COW weeks, meaning we're utilising100% of the Stress Echo capacity available.
- DNA rates for ECG remain high at 15% – Work now underway to implement text reminder service and planned to be implemented during September/October 2025
- Cardiology ACP has now completed her competencies in Stress Echo, this will now help protect the capacity and reduce the need of cancellations or reductions due the nursing A/L from September 2025.
- SDP being worked up for insourcing for Stress Echo due to capacity issues via SET agency. – Due to be submitted to DD WC 08th September 2025
- Trajectory for Stress Echo completed which reflects the gap with the capacity and demand for Stress Echo, without additional staffing or outsourcing the breaches will continue to rise month on month.

Number of diagnostic breaches reported by week

Diagnostic Description	27 Jul 25	03 Aug 25	10 Aug 25	17 Aug 25	24 Aug 25	31 Aug 25
Cardiology - echocardiography	160	231	313	253	253	187

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Diagnostics: Echo



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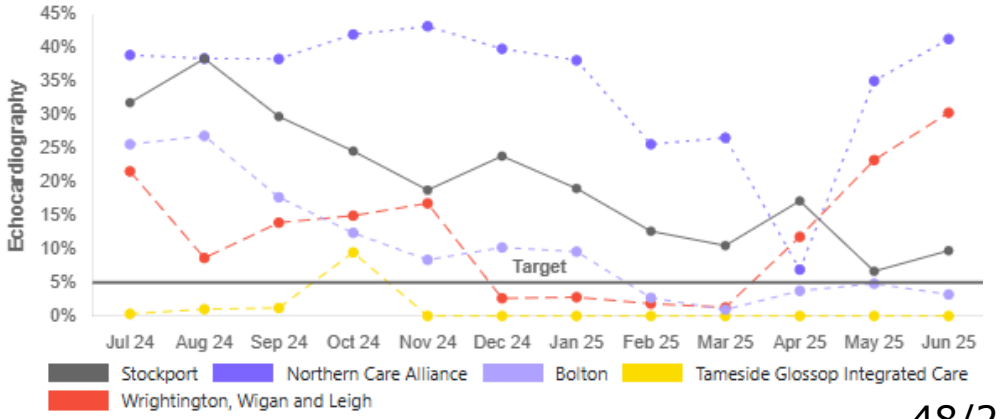
Benchmark data from Public View – June 2025



Signed off by	Ruth McNulty
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
31-day standard	The percentage of patients on a cancer pathway that have started treatment within 31 days of their diagnosis.	>= 92.2%	86.4%	↓	M A M J J A	▲

Performance Summary

- The final 62-day performance for July is 69.7 % which was below the expected trajectory target, but a significant improvement on the June position.
- The latest performance for August is 76.3% and the final position is forecast to be ahead of trajectory.
- The 31-day performance is currently below the National standard of 96% but achieved trajectory in July.

Risks and Issues.

- Urology Oncology capacity deficit remains a challenge despite some recent improvement in waiting times.
- Robotic theatre capacity is insufficient for demand. This is the key driver of the adverse 31-day and 62-day position.
- Access to the mutual aid Robotic lists at the Christie will cease at the end of September, exacerbating the capacity deficit.
- Outpatient capacity in the Lung service.

Actions and Mitigations

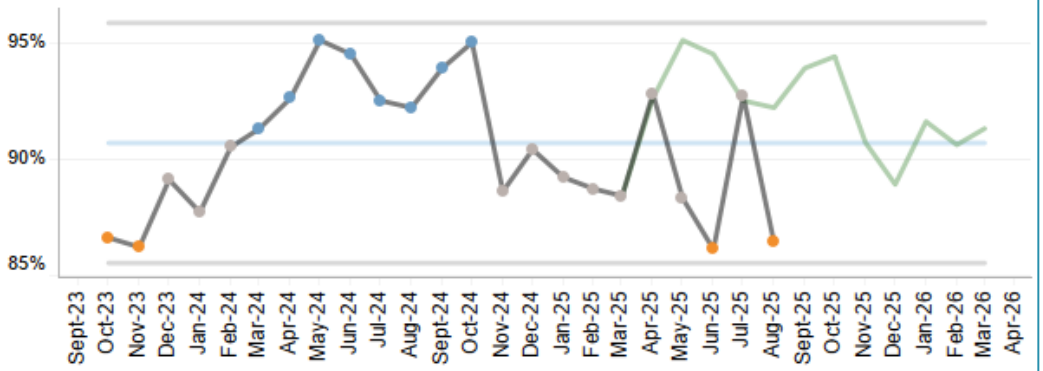
- Additional Urology Oncology clinics continue to be secured with the Christie implementing additional capacity at Macclesfield in August.
- Additional robotic theatre sessions job planned in the evenings and weekends
- SDP in development for alternative to robotic prostate surgery
- Alternative mutual aid robotic capacity being sought
- SDP in development for additional Consultants in Lung.
- Changes to Lung Outpatient templates have been agreed to facilitate additional face to face capacity.
- Lung Consultant job planning process in September will consider how to further optimise Outpatient capacity for cancer pathway patients.

Curtis,Soile 26/09/2025 14:24:03

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

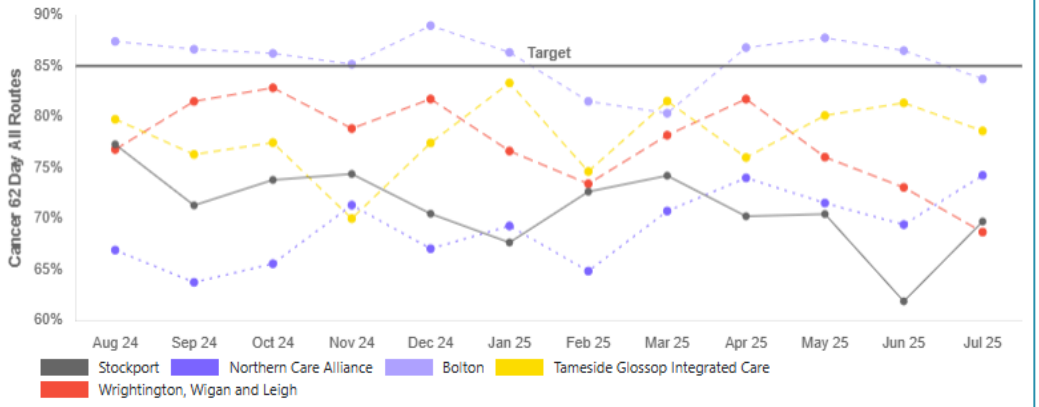
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for 31-day standard



At least 2 of the last 3 data points are in the outside thirds of the control limits. The latest data point in the lower third and could be viewed as a concern.

Benchmark data from Public View – July 2025



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
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	4	↑	M A M J J A	▲
Wait for first attendance 18-week ..	Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	>= 64.4%	63.2%	↑	M A M J J A	▲

Performance Summary

- 65-week wait performance - Reduced in month to 4 breaches (6 in Jul-25)
- Wait for first attendance 18-week% - 63.20% behind the forecast of 64.40%

Risks and Issues

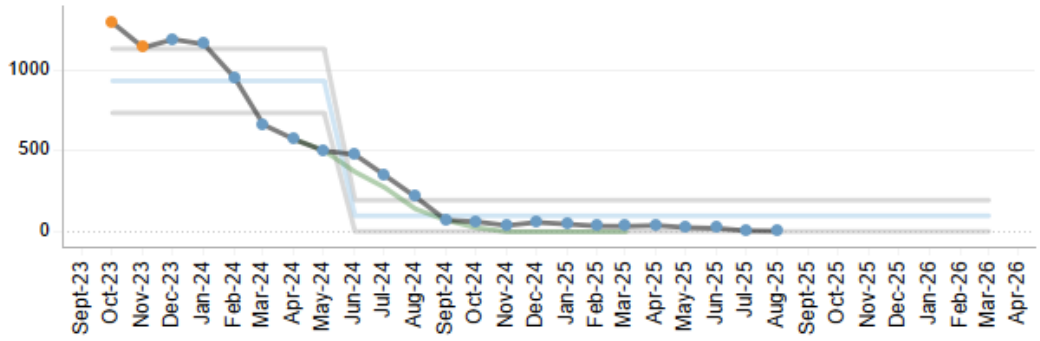
- **Long waits for external diagnostics** at MFT and Salford - primarily for PH manometry, SeHCAT scans and Bravo capsule tests (Gastro and UGI), and genetic testing (Chemical pathology).
  - ➢ Action/Mitigation: Internal and external escalation processes for diagnostic long wait delays remain in place.
- **Long wait times for 1st appointment** across several specialties.
  - ➢ Action/Mitigation: Services progressing recruitments and additional capacity plans following approval of IPT elective business case. Most recruits will be in place for Q3. Short-term additional capacity initiatives mobilised non-recurrently in the meantime.
- **Capacity constraints for complex Gynaecology procedures** listed late in pathway.
  - ➢ Action/Mitigation: New additional consultant to commence in post from September, increasing capacity. Continued use of consultant connect to triage referrals and manage demand more efficiently through offering specialist advice and guidance back to GPs.
- **Ad hoc patient choice / complexity factors** delaying treatments
  - ➢ Action/Mitigation: 3x weekly RTT performance PTLs remain in place to maintain rigor & drive performance. Robust management of DNA's/ patient cancellations in line with access policy
- **Advantis system issues** have adversely impacted RTT validation and digital dictation backlogs.
  - ➢ Action/Mitigation: Outsourcing typing project to commence in September to reduce letter backlog.

The current forecast is zero 65-week breaches by the end of September, noting potential risks on a small volume of patients related to the above issues.

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

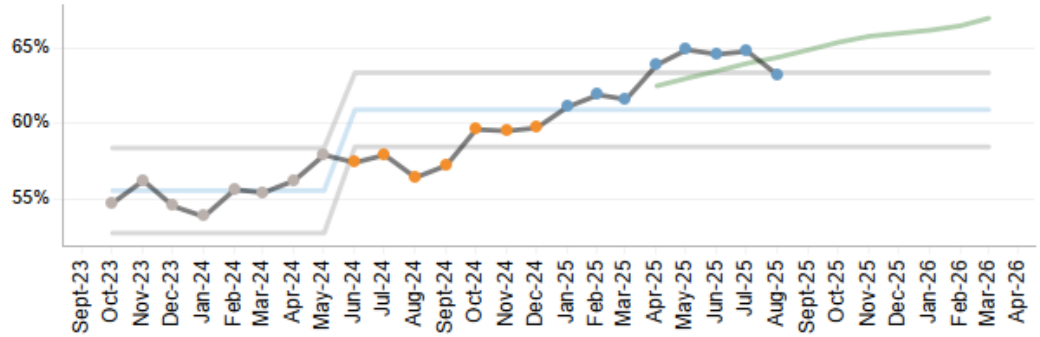
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for 65-week breaches



There have been 7 or more consecutive data points below the mean. This shift could be viewed as an improvement.

Performance for Wait for first attendance 18-week %



There have been 7 or more consecutive data points above the mean. This shift could be viewed as an improvement.

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Community** UCR

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
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%	63.9%		M A M J J	

Performance Summary

- Provisional data has been published by NHSE for July 2025 which reports the UCR 2-hour performance as 63.9%, this is currently below the national 70% target.
- The number of referrals in scope of the 2-hour standard in July was 200, which represents an increase of 38% from June 2025.
- Following a review of national guidance, the data for patients where the delivery of care within two hours is not clinically or socially appropriate, had not been identified accurately in the reporting datasets due to a coding issue on EMIS. This is now corrected and the refreshed July position, to be published next month will see an improvement in the performance.

Risk and Issues

- Currently not meeting the 70% trajectory and a deteriorating position.
- ACP vacancies; ACP workforce under review and currently Neighbourhood team offering mutual aid.
- Further education required to increase confidence and competence of UCR team re new processes – SPOA test of change.

Actions and Mitigations

- Director of Operations to conduct a service review in September 2025
- Marketing campaign commenced in month.
- Updates to Community Services Data Sets (CSDS) submissions to be implemented by BI, in line with operational processes and national guidance.
- Request for Transformation support alongside implementation of SPOA.
- Deep-dive at patient level detail to understand any other trends contributing.

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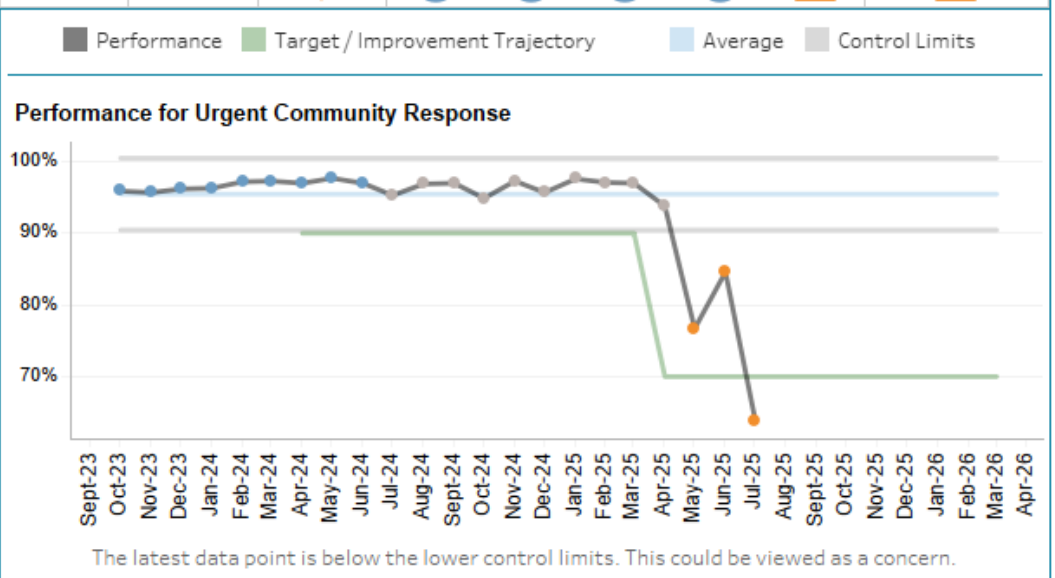

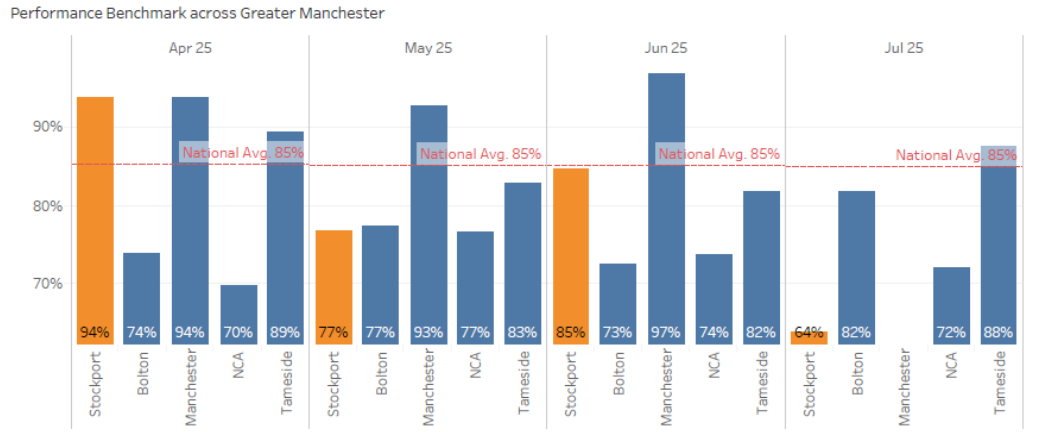

Signed off by	Liza McIlvenny
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Community** Virtual Ward

	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%	82.6%		M A M J J A	

Progress update on increasing capacity / utilisation for Virtual Ward

Revised Operational Model

- Revised operating model, prompted by attendance at NW summit.
- Evaluation of SFT VW operational and clinical processes / workforce.
- Benefit realisation session with T &G FT.
- Service development signed off will reduce run rate and deliver CIP.
- Consultation to start September 2025.

Engagement

- July 25 Virtual Ward marketing campaign commenced across primary, secondary care and OOH to promote clinical pathways and relationships.
- Review of accessibility/responsiveness of the service and engagement with users in progress
- Big Conversation with Karen James positive and optimised focus from Acute to support pathways and flow, follow up meetings ongoing.
- Met with MFT Medical Director for shared learning.

Pathway Development

- In-reach to ED/MSDEC to strengthen and optimise clinical pathways.
- Successful post natal hypertension pathway highly successful.
- Frailty pilot – Frequent attenders >7 CFS commenced - to offer direct access to VW at point of deterioration to prevent hospital attendance and admission. Await evaluation.
- Promotion of community service referrals re response to deterioration – hospital deflection into VW.
- Identification of 3 further pathways NOF, Surgery, Gen Med to compliment ongoing offer.

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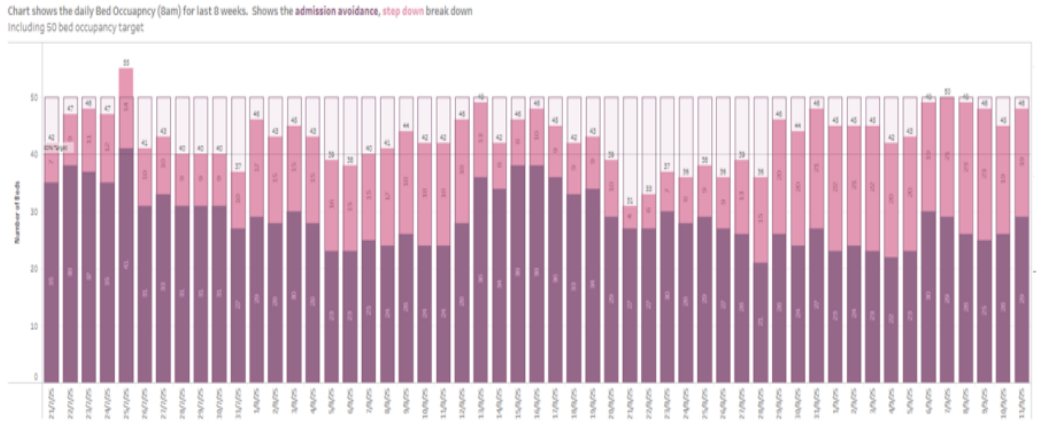
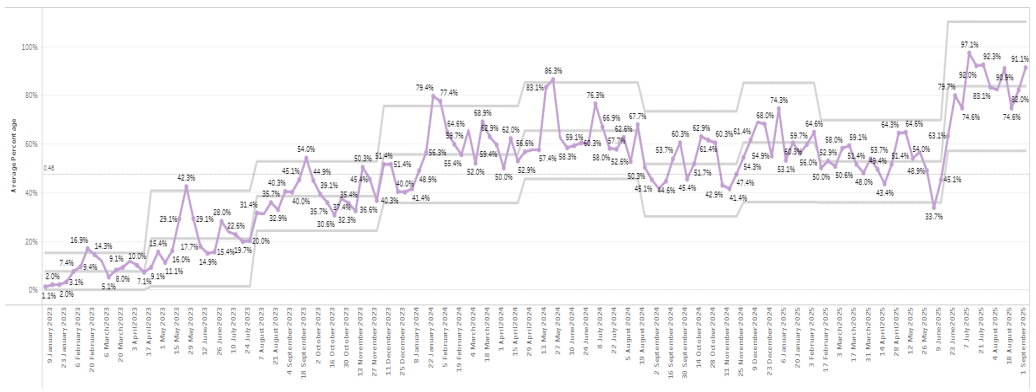
Performance | Target / Improvement Trajectory | Average | Control Limits

Daily Bed Occupancy View – last 8 weeks



Weekly Average Bed Occupancy View



Signed off by	Liza McIlvenny
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Outpatient Efficiencies** DNA

		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%	6.5%		M A M J J A	

Performance Summary

- The DNA rate for August was 6.5%, remaining below the 7% mark for the past 6 months. The Trust continues to record the lowest DNA rate in Greater Manchester (excluding The Christie).

Risks and Issues

- Fluctuation in outpatient booking centre capacity could impact DNA rates. Recruitment to turnover and increased WTE from IPT funding have been agreed.
- Ongoing relocation of outpatient services following OPD B closure has an inherent increased risk of DNA.
- Processes relating to reminder service reports and processes.

Actions and Mitigations

- T&F group work with medicine & paediatrics remains in place.
- Ongoing reminder validation, both prospective and retrospective, continues weekly.
- Work is ongoing through the GIRFT Further Faster initiative.
- Calls to high-risk patients are ongoing daily. A data review is also being undertaken by BI to improve the quality of the information.

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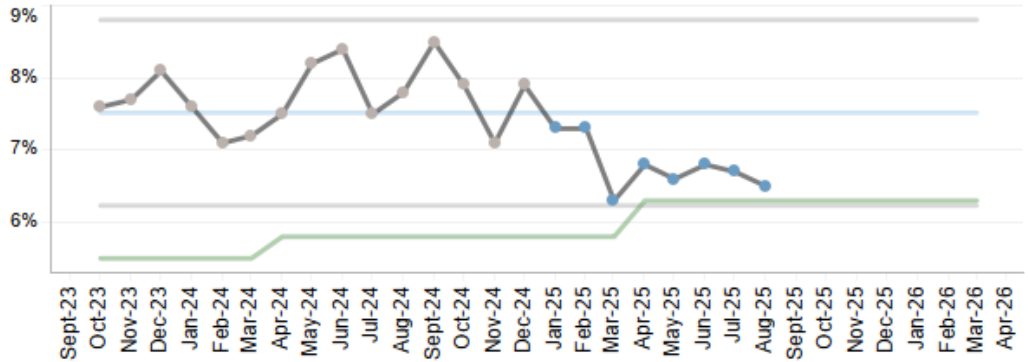
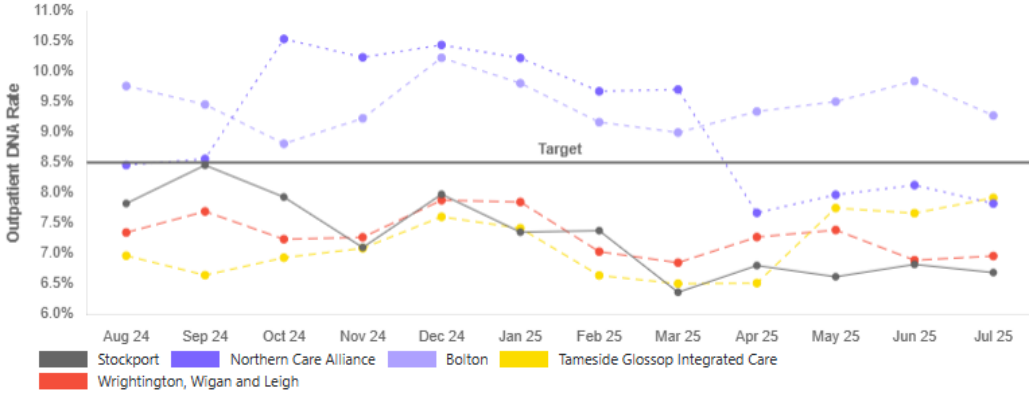
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Outpatient DNA rate



There have been 7 or more consecutive data points below the mean. This shift could be viewed as an improvement.

Benchmark data from Public View – July 2025



Signed off by	Mike Allison
Executive Lead	Jackie McShane

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.	>= 43.2%	42.4%	→	M A M J J A	▲

Performance Summary

- The percentage of appointments in August recorded as a New attendance or Outpatient Procedure was 42.4%, which is below trajectory, however it is still quite early in the month with not all validations/outcomes having yet been completed so improvement to this position can be expected.
- Year-to-date performance is 42.9% and the rolling 12-month rate is 43.3%.
- Benchmarking data from HED shows the Trust to be under the national average rate (45.4%) and placed in quartile 2.

Risks and Issues

- Disruption to outpatient services displaced following the closure of OPB has impacted on the position , evident in the benchmarking performance for dental services.
- Poor engagement by clinicians recording the procedures within the digital electronic outcome form (CLIO).
- Transcription errors by administrative staff who transcribe the data into Patient Centre.
- Missing procedure codes on the electronic outcome form CLIO.

Actions and Mitigations

- Improvements expected with the opening of the new OP building and move back on site for displaced specialties.
- Ongoing sign-off process with divisions to ensure procedures performed in clinic are listed on CLIO.
- Development to CLIO to add any additional procedures so they can be captured.
- Ongoing review of specialty procedure benchmarking to highlight areas of concern.
- Ongoing validation and engagement with administrative staff about correct recording processes on PAS.
- Continued distribution of data quality reports highlighting transcribing errors.
- Attendance at Clinical Review Groups to raise awareness and importance of data recording on CLIO.

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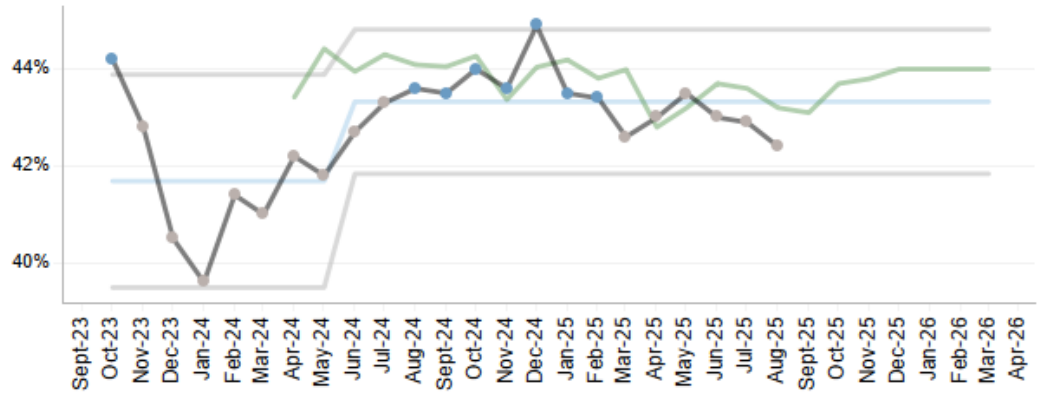
Updated provided by	Debbie Hope
Executive Lead	Jackie McShane

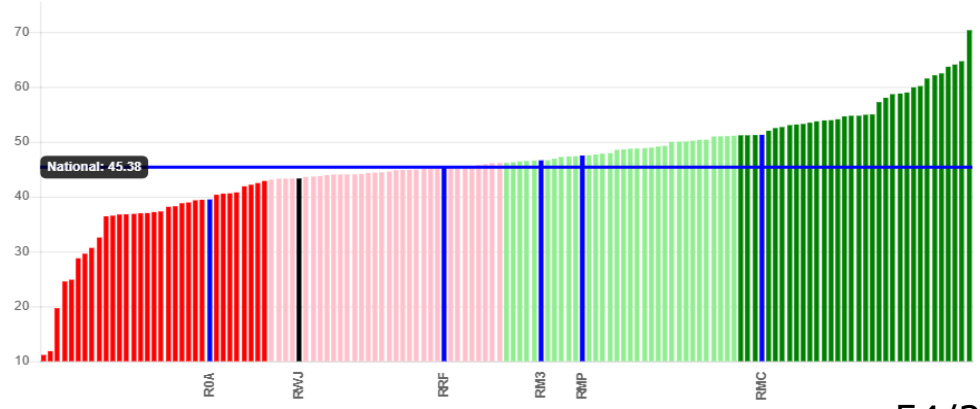
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for OP First Attend and Procedure



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Benchmark data from HED – rolling 12-mth to Jun'25 (43.3%), National rate 45.4%



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%	77.6%	↑	M A M J J A	▲

Performance Summary

- Capped utilisation in August 2025 was 77.6% (Main theatres 79.1%, Maple Suite 68.9%, Stockport Eye Centre 70.6%) A slight increase from July which was 76.8%.
- Slight increase in average late starts in August (38 mins) compared to July (33min)
- Decrease in on the day cancellation in August compared to July.
- Booking utilisation decreased to 99% from 106%.

Key Risks/Issues

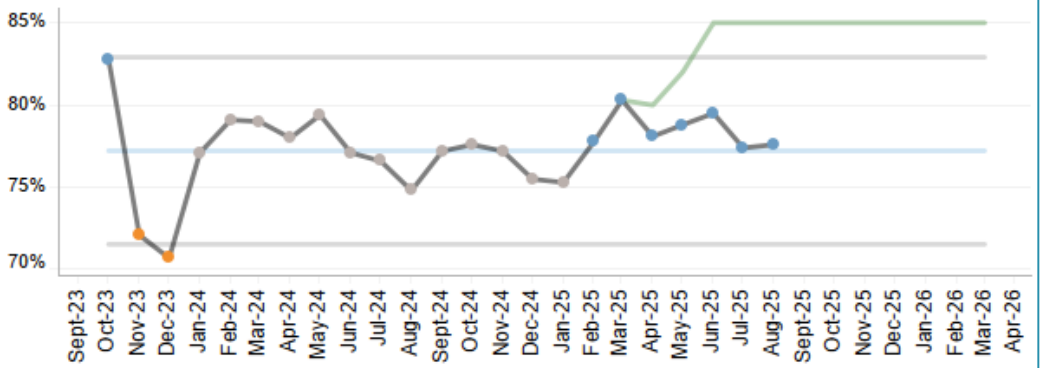
- Theatre Estates challenges remain a challenge with temperature and humidity issues in August.
- Short notice cancellations with challenge to backfill lists to maintain utilisation.

Actions and Mitigations

- Commencement of Associate Director for Theatres.
- Evening sessions now underway, progressing with job planned sessions for anaesthetists.
- Review of lists to prioritise urgent cases to mitigate the impact of theatre issues on patients.
- Strong working relationship with HSDU, including new escalation process to improve kit prioritisation.

Performance | Target / Improvement Trajectory | Average | Control Limits

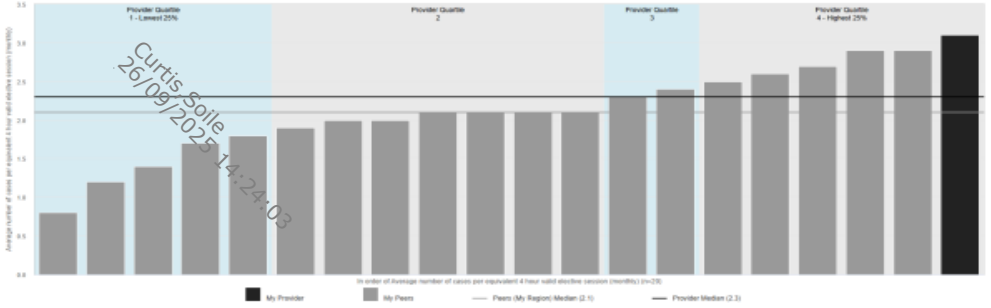
Performance for Capped Touch Time Utilisation



There have been 7 or more consectutive data points above the mean. This shift could be viewed as an improvement.

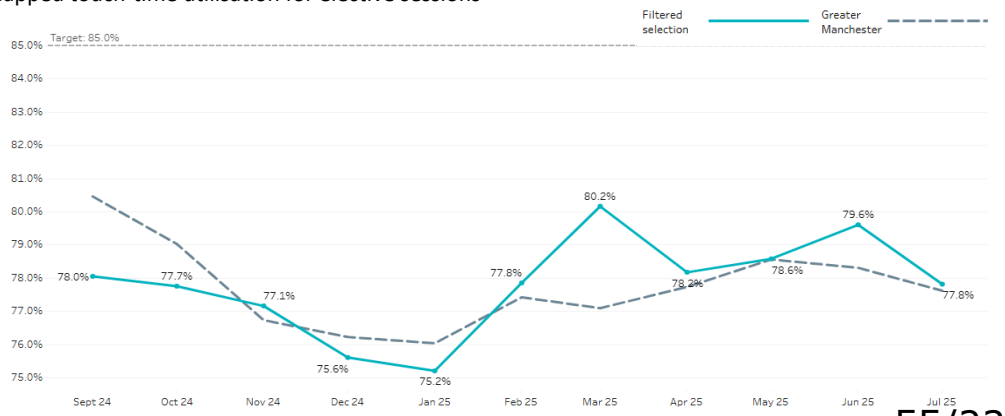
Benchmark data from Model Hospital – NW Region, July 2025

Average cases per equivalent 4-hour elective session



Benchmark data from GM Theatre Performance dashboard – July 2025

Capped touch-time utilisation for elective sessions



Updated provided by	Nnamdi Okolie
Executive Lead	Jackie McShane

Workforce **Appraisal Rate**

Target	Actual	6-month trend	Previous Performance	1-month Forecast
>= 95%	81.6%	↓	M A M J J A	▲

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.

The Trust's overall appraisal compliance for August 2025 was 81.6%, against the target of 95%. This reflects a small improvement on July's position (80.5%) but remains significantly below target and not where we expected to be at that point in the annual appraisal window that runs from 1st April to 30th September.

This year we have implemented a cascade approach to setting performance objectives and as such appraisals are completed through the tiers of the structure, from the top down. To support the transition and the delivery of high-quality appraisals, the appraisal window has been extended by one month to 31 October 2025. This is a one-off extension for this year only.

To maintain focus and provide assurance, the following actions are in place:

- Communication campaign: Updates have been cascaded through Team Brief, directly to leaders (8a and above) with clear instructions on how to get back on track, and via a targeted internal communications campaign encouraging appraisees to prepare for and book their appraisals in if they have not already.
- Monitoring and reporting: divisional leaders and managers continue to receive detailed appraisal compliance reports. HR colleagues are reinforcing this as a priority in divisional meetings and planning the approach where there are compliance issues.

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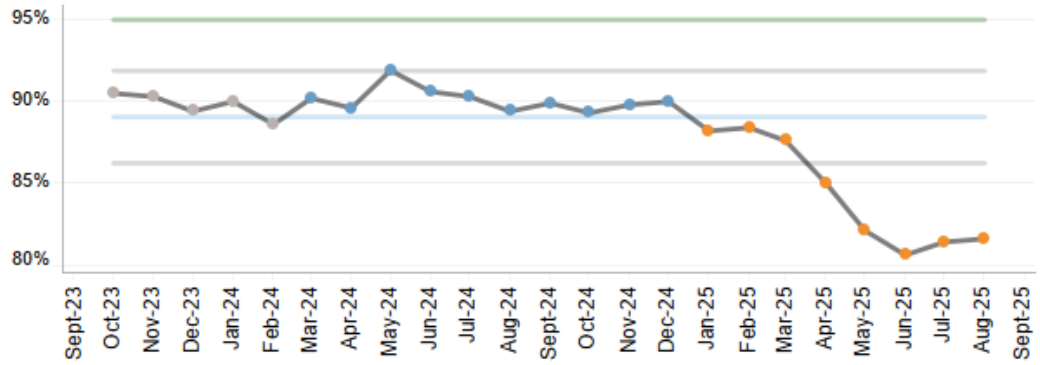
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Appraisal Rate: Overall



There have been 7 or more consecutive data points below the mean. This shift could be viewed as a concern.

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Finance **Risks**

		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%	-4.3%	→	M A M J J A	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		37.2	→	M A M J J A	
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	9.1%	↗	M A M J J A	●
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%	136.3%	↘	M A M J J A	▲

Risks

There are some key risks in the plan, which will be monitored throughout the year:

- Payments for variable activity within ICB contracts
- Achievement of the Trusts £29.2m Cost Improvement Plan (CIP)
- Inflationary pressures over and above those included in planning assumptions
- Costs of industrial action – July costs have been offset bringing forward CIP ahead of profiled plan. The cost of covering this and any further strikes is a financial pressure, alongside the impact of loss of activity.
- The requirement for enhanced care
- Although we aren't currently forecasting to require revenue support funding in 2025/26 this is subject to the assumptions above.

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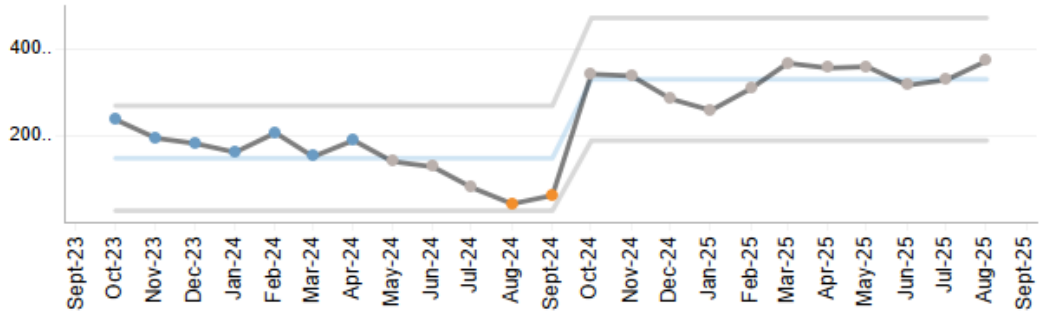
Signed off by	Kay Wiss
Executive Lead	John Graham

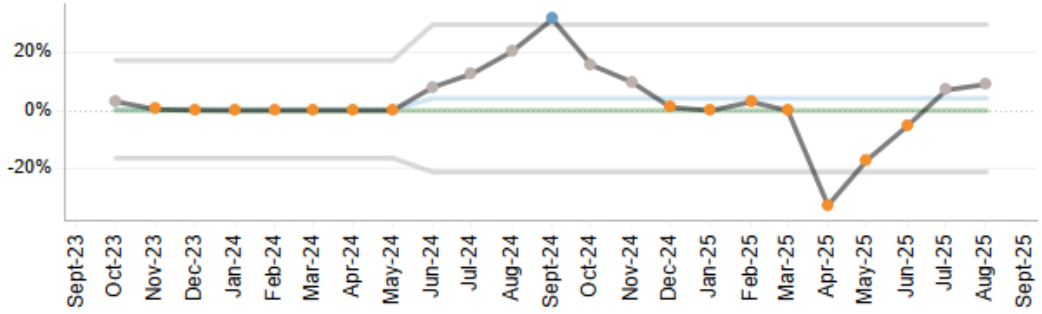
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Cash Balance



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for CIP Cumulative Achievement



The latest data point is within the control limits. This is viewed as common cause or normal variation.

NHS Stockport NHS Foundation Trust

				Agenda No.	10
Meeting date	**2nd October 2025**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Financial Position Month 5 2025/26				
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 2025/26, 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 agreed a balanced financial plan for 2025/2026 with a CIP(STEP) programme of £29.2m.

The Trust has a planned deficit of £5.7m at the end of Month 5 and the Trust was in line with this plan. A detailed finance paper was presented to the Finance & Performance Committee on the 18th September 2025 and this paper is the summarised key extracts from that paper.

From an overall plan perspective at this stage in the financial year the Trust is forecasting a balanced year-end position in a best-case scenario; however there remain elements of risk to delivery of this plan.

The Trust has delivered savings of £22.2m at Month 5 which is 76% of the full year target of £29.2m. Schemes have now been identified to deliver the full target, but this is with more high risk or technical non-cash releasing schemes offsetting the current £2.0m divisional shortfall.

Agency expenditure to Month 5 is £3.0m against a plan of £2.6m and this represents a 20% reduction on 2024/25 run rate but is less than NHSE's minimum reduction of 30%. In August there were the equivalent of 53 WTE agency staff; 26 nurses, 23 medical staff and 4 other clinical staff.

Bank costs to Month 5 are £12.5m which is below the plan of £12.9m and represents a 13% reduction which is higher than the required NHSE minimum expectation of 10%.

The Trust's cash balance at the end of August 2025 was £37.2m against a plan of £27.3m. There are outstanding creditors where there is currently on-going work to resolve including utility payments and NHS Property Services.

The Trust has spent £6.9m on capital costs to Month 5 against a plan of £9.9m, with spend to date relating to the Outpatients Modular Build and the Emergency Care Campus.

Stockport Foundation Trust

Finance Report Month 5 2025/2026

John Graham - Chief Finance Officer

Contents

Key Messages

NHS Stockport NHS Foundation Trust

Summary of Financial Position

- After 5 months of the financial year the Trust is reporting a **break-even position against plan** for system reporting purposes and a **net deficit of £5.6m**
- **STEP of £11.4m** has been delivered to date which is £1.0m ahead of the profiled plan. £22.2m (76%) of the full year £29.2m has been delivered, and £14.3m (69% of the recurrent requirement).

Key Metrics

- **Agency spend of £3.0m** is £0.4m worse than plan to date. This represents a **20% reduction** on 2024/25 run rate but is less than NHSE's minimum expectation of a 30% reduction.
- **Bank spend of £12.5m** is £0.4m better than plan and represents a **13% reduction** on 2024/25 run rate, which is better than NHSE's minimum expectation of a 10% reduction.
- The cash balance at the end of August 2025 was **£37.5m.**
- The Capital forecast for 2025/2026 is £0.4m favourable to the £37.4m plan, due to IFRS16 changes with timing of Marple Clinic's lease.
- WTE worked has reduced by 35 in July to 6,129, which is **109 below plan.**

Forecast Outturn & Key Risks

The Trust plan for 2025/2026 is break-even for system reporting purposes, including £43.2m deficit support funding. At this stage of the financial year the forecast is in line with plan in a best-case scenario; however there remain elements of risk to delivery of this plan.

The key risks can be summarised as:

- Payments for variable activity within ICB contracts
- Achievement of the final 24% of the Trust's £29.2m efficiency plan (STEP)
- Divisional positions within budget, and all pressures are contained within funding available in the plan particularly covering the winter period where there is no additional funding
- Inflationary pressures over and above those included in planning assumptions.
- Costs of industrial action – July costs have been offset bringing forward CIP ahead of profiled plan. The cost of covering this and any further strikes is a financial pressure, alongside the impact of loss of activity.
- The requirement for enhanced care.
- Although we aren't currently forecasting to require revenue support funding in 2025/2026 this is subject to the assumptions above

Overall Financial Position

Stockport NHS Foundation Trust

Income & expenditure Position	August 2025 (M05) Budget £m	August 2025 (M05) Actual £m	August 2025 (M05) Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Budget £m	Forecast Actual £m	Forecast Variance £m	Annual Plan £m
Total Income	**43.0**	**42.6**	**(0.4)**	**212.0**	**212.1**	**0.1**	**512.2**	**514.5**	**2.3**	**512.2**
Substantive Staff	(27.8)	(27.4)	0.4	(140.2)	(139.9)	0.4	(335.4)	(340.2)	(4.9)	(335.4)
Bank Staff	(2.6)	(2.4)	0.2	(12.9)	(12.5)	0.4	(30.9)	(26.7)	4.2	(30.9)
Agency Staff	(0.5)	(0.5)	0.1	(2.6)	(3.0)	(0.4)	(6.3)	(6.2)	0.1	(6.3)
Pay Costs	(30.9)	(30.2)	0.7	(155.7)	(155.3)	0.4	(372.6)	(373.1)	(0.5)	(372.6)
Drugs	(2.0)	(1.8)	0.2	(10.1)	(9.9)	0.2	(24.6)	(24.6)	0.1	(24.6)
Clinical Supplies & Services	(2.7)	(3.0)	(0.3)	(12.5)	(13.4)	(0.8)	(28.7)	(29.9)	(1.3)	(28.7)
Other Non Pay Costs	(6.4)	(6.0)	0.4	(28.7)	(28.3)	0.4	(59.7)	(58.9)	0.7	(59.7)
Below the Line	(1.7)	(2.1)	(0.4)	(10.8)	(10.7)	0.0	(26.9)	(26.9)	0.1	(26.9)
Total Expenditure	**(43.7)**	**(43.3)**	**0.4**	**(217.8)**	**(217.7)**	**0.2**	**(512.5)**	**(513.4)**	**(0.9)**	**(512.5)**
TRUST SURPLUS / (DEFICIT)	**(0.7)**	**(0.7)**	**0.0**	**(5.8)**	**(5.6)**	**0.3**	**(0.3)**	**1.1**	**1.4**	**(0.3)**
System reporting adjustments	0.0	0.0	(0.0)	0.1	(0.1)	(0.2)	0.3	(1.1)	(1.4)	0.3
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(0.7)**	**(0.7)**	**0.0**	**(5.7)**	**(5.7)**	**0.1**	**0.0**	**0.0**	**0.0**	**0.0**
Stockport Trust Efficiency Programme (STEP)	2.2	2.6	0.4	10.4	11.4	1.0	29.2	29.2	-	29.2
Efficiencies as % of expenditure	*5.1%*	*6.0%*		*4.8%*	*5.2%*		*5.7%*	*5.7%*		*5.7%*
Capital expenditure	(1.2)	(0.5)	0.7	(9.9)	(6.9)	3.1	(37.4)	(37.0)	0.4	(37.4)
Cash & equivalents				27.3	37.5	10.3	31.6	10.6	(21.0)	31.6

Run Rate Analysis

Stockport NHS Foundation Trust

Run Rate Trends - Rolling 15 months - £000s

Month	Income	Non-Pay	Pay	Total
Jun-24	36,485	(12,846)	(28,663)	(5,024)
Jul-24	36,405	(12,224)	(28,578)	(4,396)
Aug-24	36,727	(13,039)	(28,179)	(4,492)
Sep-24	62,593	(12,508)	(28,303)	21,783
Oct-24	47,219	(14,230)	(34,307)	(1,318)
Nov-24	39,094	(10,436)	(29,541)	(883)
Dec-24	40,629	(12,165)	(28,841)	(377)
Jan-25	39,868	(10,340)	(29,189)	339
Feb-25	40,154	(10,387)	(28,820)	947
Mar-25	64,303	(29,909)	(51,217)	(16,823)
Apr-25	41,342	(12,124)	(30,458)	(1,241)
May-25	41,976	(12,483)	(30,822)	(1,328)
Jun-25	42,602	(13,100)	(31,095)	(1,593)
Jul-25	43,602	(11,549)	(32,766)	(713)
Aug-25	41,614	(13,069)	(30,194)	(1,649)
FOT 2025/26	**512,381**	**(138,227)**	**(373,077)**	**1,077**

M04 Actuals	43,602	(11,549)	(32,766)	(713)
M05 Actuals	41,614	(13,069)	(30,194)	(1,649)
Movement (M05 v M04)	(1,987)	(1,521)	2,572	(937)
% Movement	-4.6%	13.2%	-7.8%	

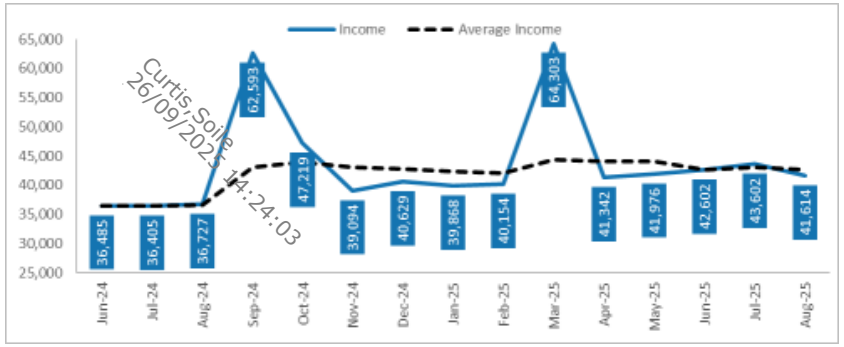
Key Movements

The graphs and tables in this slide give a rolling 15-month view of income, pay and non-pay expenditure trends.

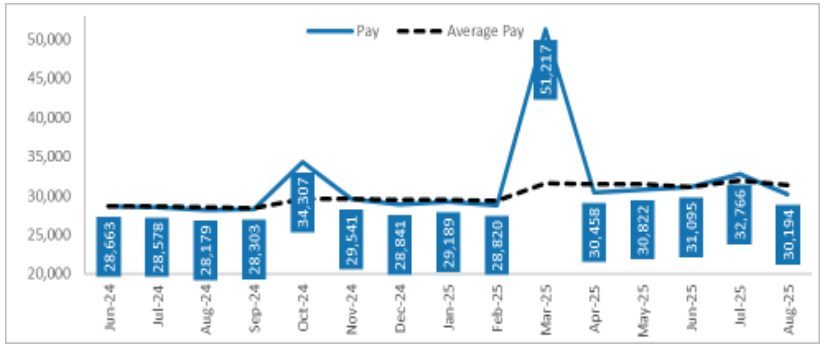
2025/26 run rate has increased for the pay award, change in national insurance rates (NI), MR service transfer (cost transfer from non-pay to pay) and phase 1 transfer of neuro rehab services to NCA.

August has seen a reduced run rate overall with pay award actuals less than estimated overall, plus lower bank and agency costs – however early indications are that this reduction will not continue into September.

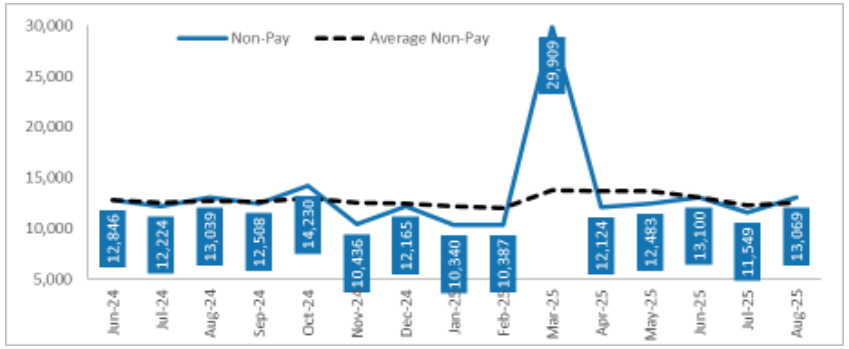
Income £000s



Pay £000s



Non-Pay £000s



NHS
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Income & Variable Activity Payments

Income Position

Income & expenditure Position	August 2025 (M05)			Year to Date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Greater Manchester ICB (Core and delegated)	31.8	31.9	0.1	162.2	162.3	0.1	387.2	387.4	0.2
Derby and Derbyshire ICB (Core and delegated)	3.2	3.2	(0.0)	16.1	16.1	0.0	38.5	38.6	0.1
Cheshire and Merseyside ICB (Core and delegated)	1.9	1.8	(0.0)	9.2	9.2	(0.1)	22.1	22.0	(0.1)
Specialised Commissioning	0.3	0.3	(0.0)	1.4	1.5	0.1	3.3	3.5	0.2
Low value activity	0.2	0.2	0.0	0.8	0.8	0.0	1.9	1.9	(0.0)
Local Authority	0.5	0.5	0.0	3.0	3.0	0.0	6.8	6.8	0.0
Injury cost recovery scheme	0.1	0.1	0.0	0.3	0.4	0.1	0.7	0.8	0.2
Other income from patient care	0.2	0.0	(0.2)	0.6	0.1	(0.4)	8.8	8.2	(0.5)
Clinical Income from Patient Care Activities	**38.2**	**38.1**	**(0.1)**	**193.5**	**193.3**	**(0.2)**	**469.3**	**469.2**	**(0.1)**

The clinical income year to date position is marginally adverse to plan by £0.2m. The Trust is forecast to be broadly in line with plan by year end. Conversations are on-going with commissioners around final contract offers for 2025/26 and how the share of income will be allocated to points of delivery. The values in the table above represent the latest confirmed values.

Activity and corresponding financial targets have been loaded into the Trust's Service Line Activity Monitoring (SLAM) system, aligned to the Annual Plan. The next slide shows the performance against the variable elements of the Trust's contracts. It should be noted that plans have only been finalised with Greater Manchester ICB and Specialist Commissioning, other commissioners are still subject to change.

Contract Performance – Variable Activity

Clinical Income	Year to Date at August 2025									
	Activity Actuals vs Activity Plan					Price Actuals vs Price Plan				
	Activity Plan	Activity Actual	Activity Variance	%	% change from July	Price Plan £m	Price Actual £m	Price Variance £m	%	% change from July
Day Case	13,380	14,394	1,014	8%	-1%	11.7	12.4	0.7	6%	-1%
Elective	2,496	2,227	(269)	-11%	-3%	10.5	9.2	(1.2)	-12%	-2%
Elective Excess Bed Days	317	337	19	6%	-4%	0.1	0.1	0.0	2%	-4%
Outpatient Procedure	17,265	19,524	2,259	13%	3%	3.7	4.2	0.5	12%	7%
Outpatient First Attendance	42,645	42,922	277	1%	-2%	9.2	9.3	0.1	1%	0%
Sub Total - Elective Plan	**76,103**	**79,404**	**3,301**			**35.1**	**35.2**	**0.1**	**0%**	**0%**
Drugs	-	-	-	0%	0%	5.6	5.5	(0.1)	-2%	-3%
Devices	-	-	-	0%	0%	0.9	1.1	0.2	27%	14%
Other Variable	907	764	(143)	-16%	6%	0.3	0.3	(0.0)	-12%	6%
Sub Total - Other Variable	**907**	**764**	**(143)**			**6.8**	**6.9**	**0.1**	**1%**	**0%**
Total - Variable	**77,009**	**80,167**	**3,158**			**42.0**	**42.1**	**0.2**	**0%**	**0%**

The elective plan is showing a small overperformance of £0.1m to the end of August. This has not been factored into the financial position due to the risk around payment from the ICB's. GMICS have notified the Trust that they are not expecting to pay for elective overperformance, and they are likely to propose activity management plans to align financial performance with agreed plans. This could result in ceiling / caps being applied to 'variable' elements of the contract. The information is based on actual activity. Derby and Derbyshire ICB have very recently agreed to pay for elective overperformance against the revised lower contract baseline; this will be monitored in line with other ICB performance going forward.

Risk relating to payment for Excluded Drugs & Devices

There is a small overperformance against plan of £0.24m for devices and underperformance on drugs of (£0.11m). In line with ICB discussions and national guidance this is being treated as pass through. Corresponding expenditure budgets have been set to cover the net increase in expenditure of £0.13m.

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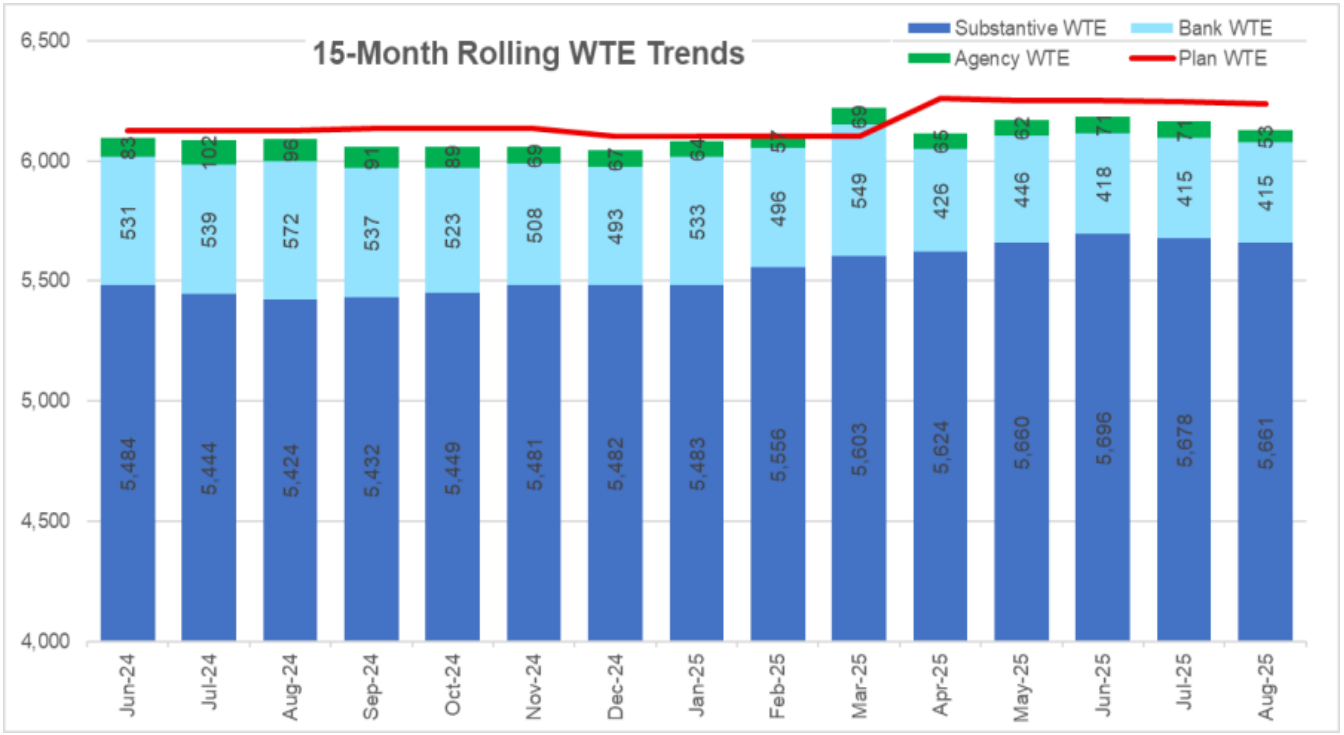
Workforce & Temporary Staffing

Staff and WTE reconciliation - WTE

Stockport NHS Foundation Trust

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	*Bank % of WTE*	*Agency % of WTE*	Plan WTE
Jun-24	5,484	531	83	6,097	*8.7%*	*1.4%*	6,126
Jul-24	5,444	539	102	6,085	*8.9%*	*1.7%*	6,127
Aug-24	5,424	572	96	6,092	*9.4%*	*1.6%*	6,127
Sep-24	5,432	537	91	6,060	*8.9%*	*1.5%*	6,134
Oct-24	5,449	523	89	6,060	*8.6%*	*1.5%*	6,134
Nov-24	5,481	508	69	6,058	*8.4%*	*1.1%*	6,136
Dec-24	5,482	493	67	6,042	*8.2%*	*1.1%*	6,103
Jan-25	5,483	533	64	6,080	*8.8%*	*1.1%*	6,103
Feb-25	5,556	496	57	6,109	*8.1%*	*0.9%*	6,103
Mar-25	5,603	549	69	6,221	*8.8%*	*1.1%*	6,103
Apr-25	5,624	426	65	6,115	*7.0%*	*1.1%*	6,258
May-25	5,660	446	62	6,168	*7.2%*	*1.0%*	6,252
Jun-25	5,696	418	71	6,185	*6.8%*	*1.2%*	6,251
Jul-25	5,678	415	71	6,164	*6.7%*	*1.1%*	6,244
Aug-25	5,661	415	53	6,129	*6.8%*	*0.9%*	6,238
Movement in month	**(18)**	**(0)**	**(18)**	**(35)**			
Movement since April	**37**	**(10)**	**(12)**	**14**			

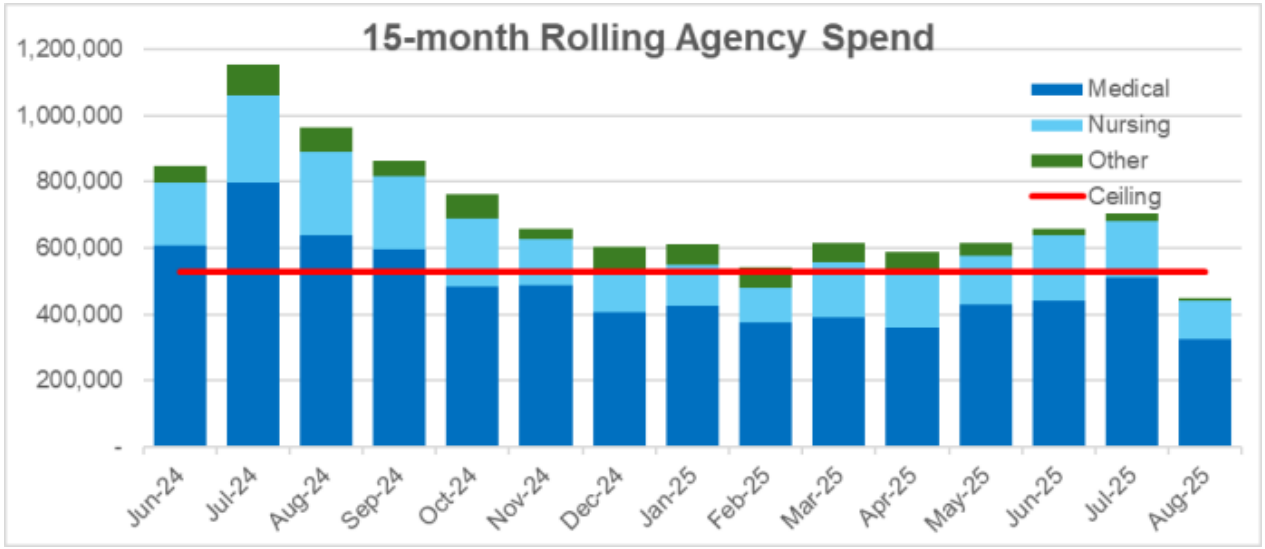


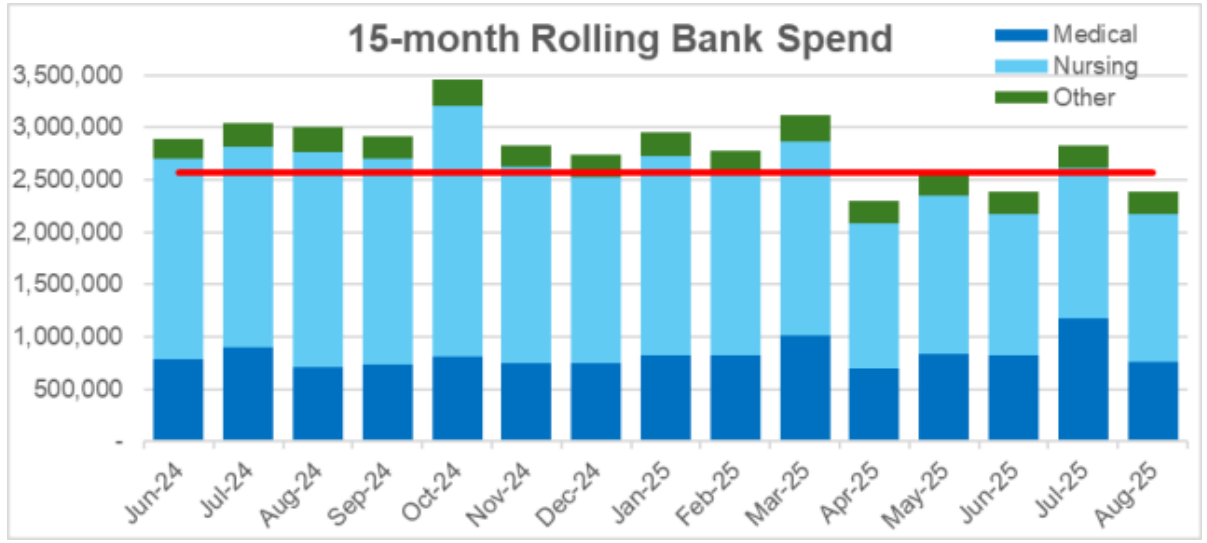
WTE Summary

Total WTE has reduced by 35 between July and August 2025, reducing the total increase to 14 since April.

Total WTE is 109 WTE below plan in August.

Staff and WTE reconciliation - £





August (M05) is a complex month for reporting staffing costs with junior doctor rotations in early August, industrial action salary deductions for those who participated in the strike, payments received for pay award including arrears, alongside centralisation of the divisional temporary staff booking team; therefore, this is being carefully analysed and the underspends may not continue into September.

August agency costs are £0.5m, which is £0.05m below the ceiling. In the five months to date there has been an average reduction of 20% compared to the 30% target – spend in 2025/26 is £3.0m compared to the £3.8m baseline from last year.

Bank costs in August are £2.4m, which is £0.2m below the ceiling. In the five months to date there has been an average reduction of 20% compared to the 10% target – spend in 2025/26 is £12.5m compared to £14.3m baseline from last year.

Trust Efficiency Programme

STEP (Stockport Trust Efficiency Programme)

NHS Stockport NHS Foundation Trust

The Trust STEP target for 2025/2026 is £29.2m, of which £20.5m (70%) is recurrent and £8.6m (30%) is non-recurrent.

In year £22.2m (76%) of the full year CIP target has been delivered, and £14.3m (69%) of the recurrent target.

Schemes have now been identified to deliver the full target, but this is with more high risk or technical non-cash releasing schemes offsetting the £2.0m divisional shortfall. The divisional shortfall is unchanged from last month.

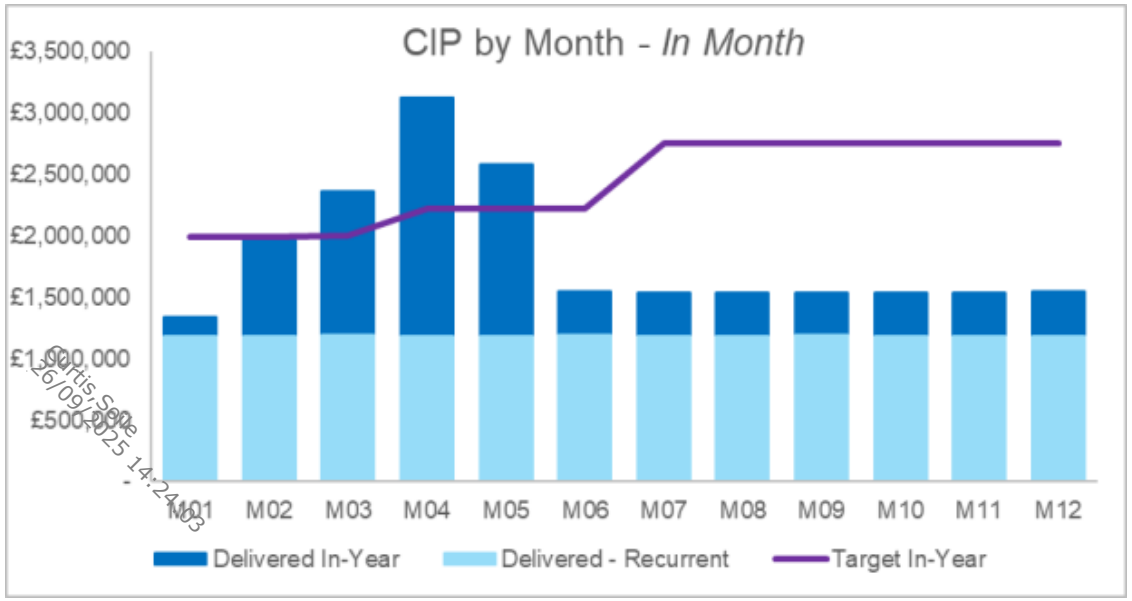
			2025/26 In Year £'000							2025/26 Recurrent £'000						
Division	Target YTD	Delivered YTD	Target - FYE	Delivered	Green	Amber	Red	Gap	% Identified	Target Recurrent	Delivered	Green	Amber	Red	GAP	% Identified
Medicine and Urgent Care	2,055	1,568	4,933	4,051	-	-	15	867	82%	3,476	3,523	135	-	78	(260)	107%
Surgery	1,620	1,620	3,889	2,417	268	30	662	512	87%	2,740	1,014	522	36	526	641	77%
Women & Children	803	1,415	2,228	2,583	11	-	-	(366)	116%	1,570	1,003	51	-	-	516	67%
Integrated Care	773	758	1,854	1,533	114	-	1	206	89%	1,307	560	128	-	1	617	53%
Clinical Support Services	794	914	2,305	1,222	806	164	414	(300)	113%	1,624	498	936	161	512	(482)	130%
Estates & Facilities	612	158	1,470	312	30	80	54	994	32%	1,036	159	2	115	105	655	37%
Corporate	678	465	1,627	1,228	188	25	136	51	97%	1,146	582	243	36	136	150	87%
Sub-total Divisions	**7,335**	**6,898**	**18,306**	**13,347**	**1,418**	**297**	**1,281**	**1,962**	**89%**	**12,899**	**7,339**	**2,017**	**348**	**1,358**	**1,837**	**86%**
General Trust	3,094	4,485	10,894	8,830	-	2,274	1,751	(1,962)	118%	7,676	6,915	-	-	1,198	(437)	106%
TOTAL	**10,429**	**11,383**	**29,200**	**22,178**	**1,418**	**2,572**	**3,032**	**(0)**		**20,575**	**14,254**	**2,017**	**348**	**2,555**	**1,400**	
TOTAL IDENTIFIED		**11,383**		**TOTAL IDENTIFIED**				**29,200**			**TOTAL IDENTIFIED**				**19,175**	
	YTD gap	*(954)*					*In Year gap*	*(0)*						*Recurrent gap*	*1,400*	
	% Identified	**109%**					***% Identified***	**100%**						***% Identified***	***93%***	

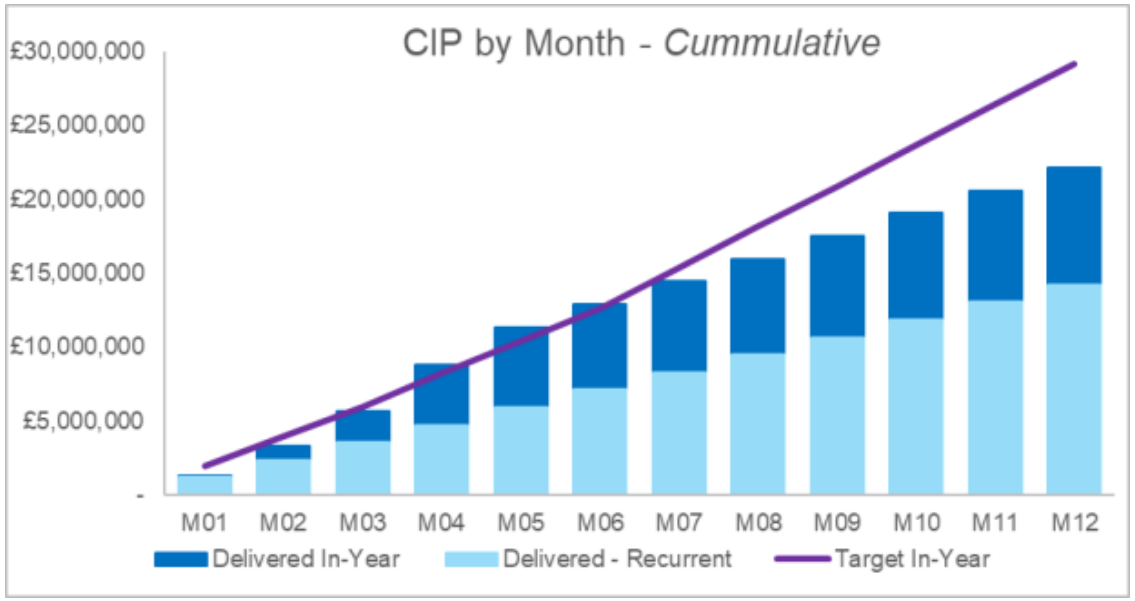
STEP (Stockport Trust Efficiency Programme)

£1.9m of CIP has been transacted during August to increase the total efficiencies delivered to £22.2m (76%) in year.

STEP of £11.4m has been delivered to date which is £1.0m ahead of the profiled plan to date. Technical non-cash schemes over delivered in previous months to offset divisional shortfalls earlier in the year, but divisions have now transacted more schemes. The divisional shortfall to date has decreased from £1.4m to £0.4m in month, which is positive.

However, the charts below show that the pressure to deliver STEP both in year and recurrently remains high and is a key risk to delivery of the Trust's plan. The Trust has declared a likely £1.4m shortfall in recurrent delivery for 2026/27 this month, which will be offset with non-recurrent schemes in year.





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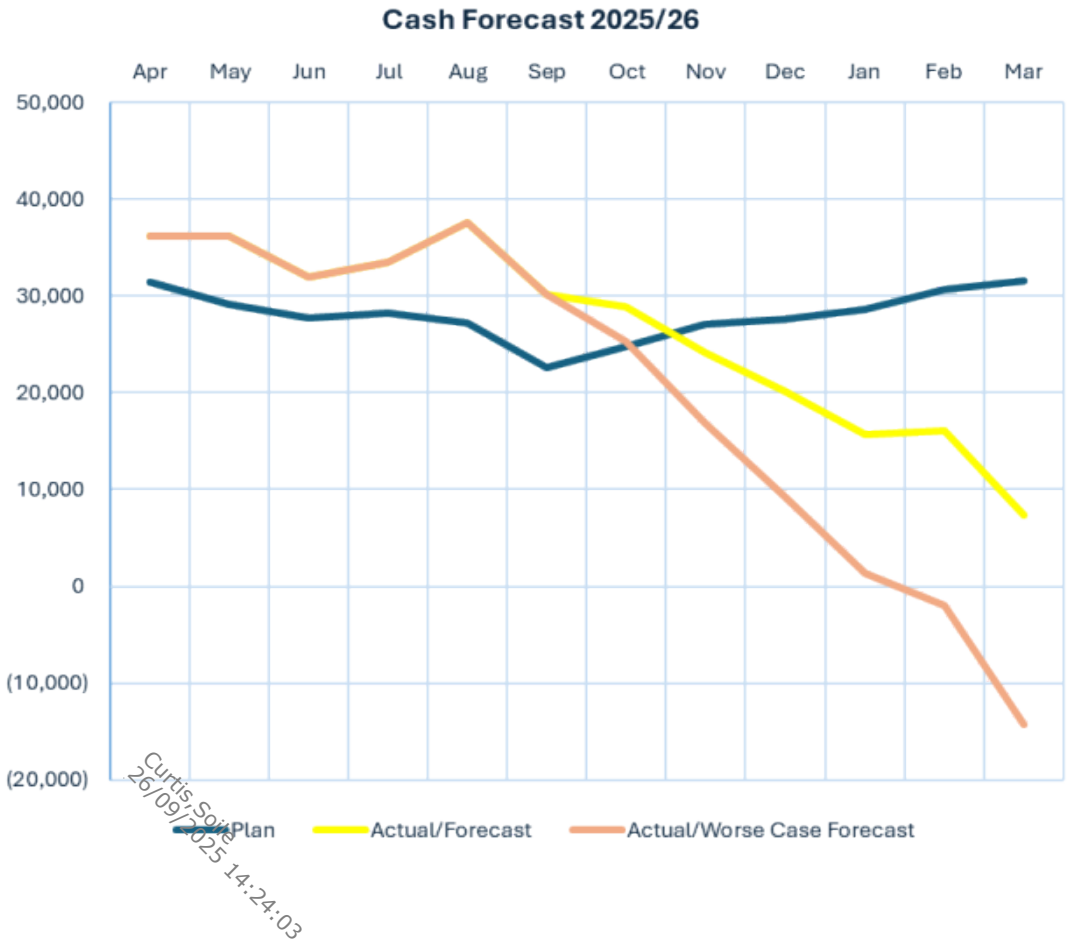
Cash, Capital & PFI

Cash



Cash balances at the end of August were £37.2m for the Trust and £0.3m for the Pharmacy Shop, an increase of £4m from July 2025. The increase is predominantly due to lower than anticipated revenue payments.

The Annual Plan for cash for August 2025 was £27.3m – therefore an improved cash balance of £10.2m compared to plan. The cash balance reflects the initial funding for the 2025/26 pay award which was paid to staff in August, with the associated arrears to HMRC and NHS Pensions being paid in September. The Trust received additional funding in August for the award.

The cash forecast has been updated based on current run rate, known cash commitments and risks, the reduction of £2.1m depreciation funding and £0.8m Neurorehab funding. It is expected that this reduction will be transacted in October. The graph shows that the Trust cash balances are forecasting a significant variance from Plan with a March 2026 outturn of £7.4m – which is a variance from Plan by £24.2m. This is an increase of £5.2m from the figure reported previously, predominantly due to an assessment of cashflows arising from revenue creditor payments, capital expenditure and an update of pay expenditure forecasts following the pay award.

Cash balances are anticipated to fall to approximately £30m by the end of September. The fall in September is mainly attributable to the half-yearly payment of PDC dividend (estimated £3.2m), and HMRC/Pension creditors arising from the pay award (estimated £1.6m) .Outstanding creditors include significant utility payments and NHS Property Services, both of which the balances owed are yet to be finalised.

The graph includes a worst case forecast which includes the risk of the removal of funding from Q3 of non-recurrent deficit funding (£21.6m). The Trust will require cash support from the end of January through to March 2026 without this funding. There are no mitigations profiled yet to offset the threat to income, however the forecasts shown do not include potential income from Derbyshire ICS (£5.4m), UEC D2A (£1.7m) and Future Funding Flows (£1.2m).

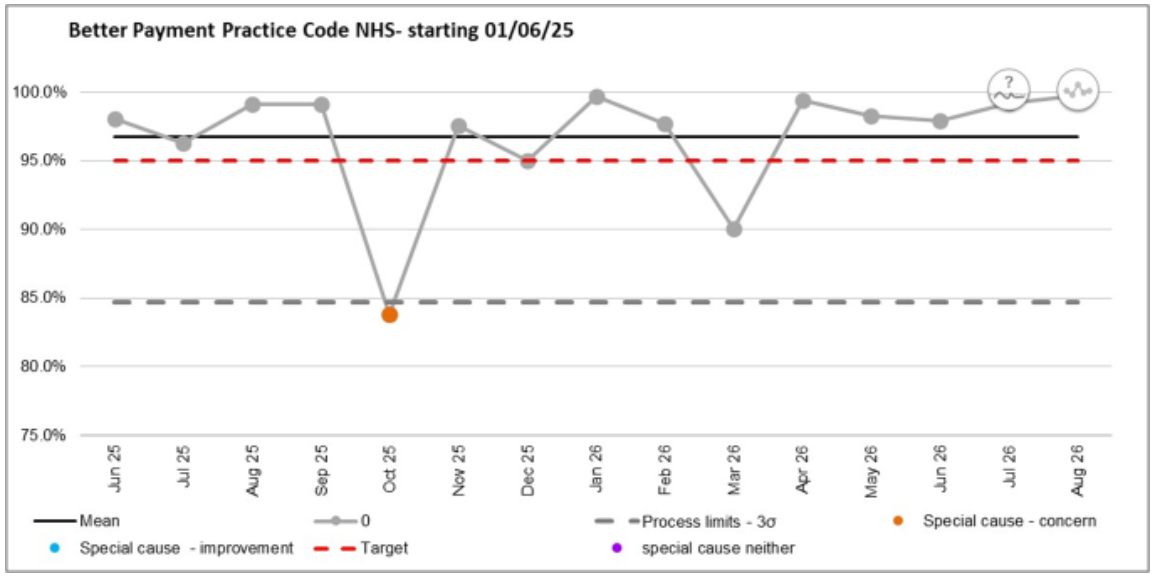
Cash

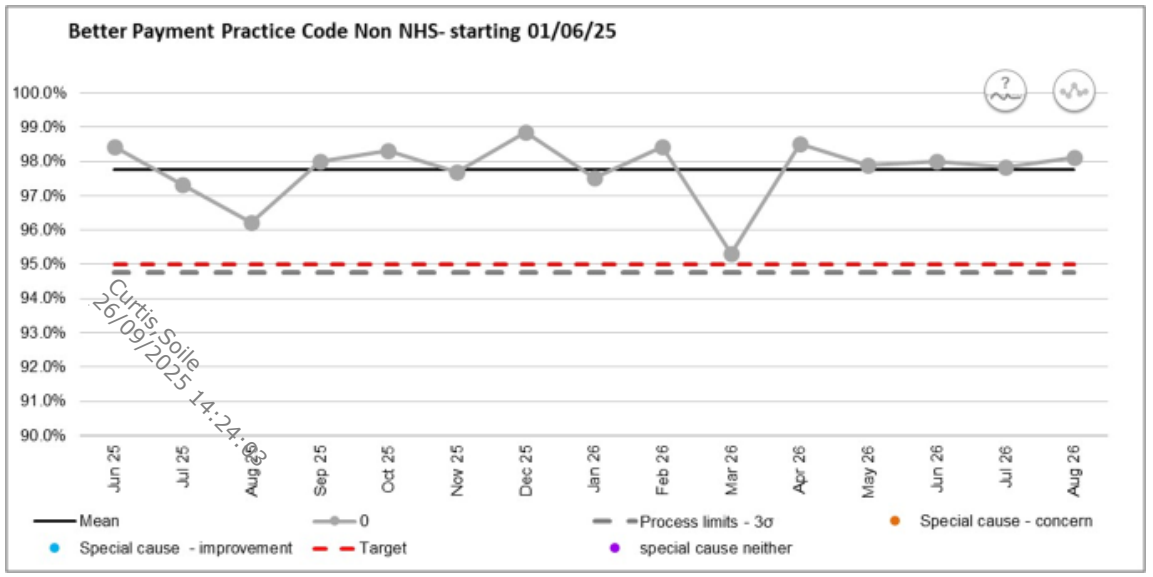
	August	September	October	November	December
Cash and cash equivalents at beginning of period		37,532	30,225	28,923	24,085
- Capital		2,456	3,592	3,881	3,658
- Revenue		35,076	26,634	25,042	20,427
In month movements					
Capital		1,136	290	(223)	2
Revenue (Excluding cash releasing efficiencies impact)					
- Income		40,069	42,375	39,288	39,801
- Pay		(33,909)	(32,388)	(32,234)	(32,373)
- Other expenditure		(16,013)	(12,802)	(12,904)	(12,639)
Cash releasing efficiency savings		1,411	1,224	1,235	1,266
Cash and cash equivalents at end of period	37,532	30,225	28,923	24,085	20,142
- Capital	2,456	3,592	3,881	3,658	3,660
- Revenue	35,076	26,634	25,042	20,427	16,482
Lowest cash balance in period		29,344	28,505	23,705	19,551

Change in Cash Forecast from previous month	5,646	8,424	7,021	6,409	

- NHSE reporting of a four-month cash forecast is now extended to December 2025.
- Actual cash at the end of August is £10.3m higher than plan and £5.6m higher than the previous month forecast.
- The improvement in forecast for August predominantly relates to forecast creditor payments which have been reprofiled into subsequent months.
- It has been assumed in the forecast that the depreciation and Neurorehab adjustment of £2.9m will be recovered with arrears from October and then monthly until the end of the financial year.
- The forecast highlights where efficiency savings materialise as cash. Planned efficiency savings for the year to December are £21.3m, of which £12m are forecast to be cash-releasing. Cash releasing efficiency savings in August were £1.8m.
- The Cash Monitoring Group will continue to closely monitor the impact of the risks outlined.

Better Payments 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 as a trend in the charts opposite and summary in the table below.

Better payment practice code	BPPC M03 Number	BPPC M03 Value £000's	BPPC M04 Number	BPPC M04 Value £000's	BPPC M05 Number	BPPC M05 Value £000's
Non NHS						
Total Bills paid in the year	3792	17,563	6144	20,976	3805	14,825
Total bills paid within target	3716	17,480	6011	20,354	3733	14,742
Percentage of bills paid within target	98%	99%	98%	97%	98%	99%
NHS						
Total Bills paid in the year	427	956	738	1,094	419	1,891
Total bills paid within target	418	618	732	1,087	418	1,890
Percentage of bills paid within target	98%	65%	99%	99%	99%	99%
Total						
Total Bills paid in the year	4219	18,519	6882	22,070	4224	16,716
Total bills paid within target	4134	18,098	6743	21,441	4151	16,633
Percentage of bills paid within target	98%	98%	98%	97%	98%	99%

Capital

NHS Stockport NHS Foundation Trust

	August 2025 (M05)			Year to Date			Forecast		
Division £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Estates	(1.2)	(0.4)	0.8	(6.5)	(5.7)	0.8	(13.4)	(13.4)	-
Equipment	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(1.1)	(1.1)	-
Digital	-	0.1	0.1	(2.5)	(1.0)	1.5	(21.0)	(21.0)	-
Sub-total	**(1.2)**	**(0.5)**	**0.7**	**(9.2)**	**(6.9)**	**2.3**	**(35.5)**	**(35.5)**	**-**
IFRS16	-	-	-	(0.8)	-	0.8	(1.8)	(1.4)	0.4
Total Capital	**(1.2)**	**(0.5)**	**0.7**	**(9.9)**	**(6.9)**	**3.1**	**(37.4)**	**(37.0)**	**0.4**

Key Points

- The Trust is forecasting a £0.4m underspend against the updated capital plan for IFRS16 following updates on the Marple Clinic lease which is now due to be undertaken in 2026/27.
- The year to date £2.3m underspend relates to rephasing of the capital plan, current forecasts will see expenditure re-align with the plan over the remainder of the year. The year-to-date IFRS16 variance relates to the Meadows transfer which has not yet been finalised and transacted; the lease is not yet in place.
- £0.2m of charitable funding has been approved to purchase equipment for the new Outpatients unit, this is not yet reflected in the NHSE return and will be included in the table above from next month.
- Capital spend to date relates to two schemes carried forward from 2024/25:
  - Emergency Care Campus £1.7m (forecast £1.4m, VAT credit of £0.3m expected in September)
  - Outpatients Modular Build £4.0m (forecast £4.2m)
- VAT credits of £0.2m were received relating to 2024/25 digital spend, resulting in a credit in M05.

Statement of Financial Position

	As at 31/03/2025 £000's	As at 31/07/2025 £000's
Total Non-current assets	**243,326**	**241,817**
Current assets and (Liabilities)		
Inventories	951	801
Trade receivables and accrued income	15,184	18,932
Assets held for sale	7,050	7,050
Cash and cash equivalents	36,725	37,217
Current liabilities	(69,480)	(77,639)
Provisions	(1,443)	(1,414)
Net Current Assets/Liabilities	**(11,012)**	**(15,052)**
Total Assets Less Current Liabilities	**232,313**	**226,766**
Non-current (Liabilities)		
Borrowings: leases	(8,040)	(8,066)
Borrowings: DHSC Capital Loans	(12,223)	(12,223)
Provisions	(2,789)	(2,789)
Total Non Current Liabilities	**(23,052)**	**(23,078)**
Total Assets Employed	**209,261**	**203,688**

- At month 5, the increase in receivables predominantly relates to prepayments increases totalling £3.0m, of which £0.8m relates to the prepayment of clinical negligence insurance to NHS Resolution (paid in ten instalments per national requirement). Other significant prepayments include CQC, Theatres Maintenance Contracts, and IT Contracts.
- The increase in 2025/26 current liabilities includes £0.9m for the repayment of depreciation funding to be repaid from October; £2.9m payroll related creditors including HMRC, Employers NI and Pension; and £2.6m of accrued PDC dividend which will be settled in September.
- The asset transfer and lease contracts for The Meadows asset held for sale are anticipated to be finalised by the end of September.

NHS Stockport NHS Foundation Trust

				Agenda No.	11
Meeting date	2 October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Quality Committee – Alert, Advise & Assure Report				
Director Lead	Louise Sell, Chair of Quality Committee	**Author**	Louise Sell, Chair of Quality Committee		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Quality Committee including matters for escalation to the Board of Directors.					

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
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
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

This 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
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
	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
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
	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	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 an Alert, Advise & Assure 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 meeting of the Quality Committee held in September 2025, noting areas of alert, advice and assurance.

NHS Stockport NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Louise Sell, Non-Executive Director
Date of Meeting	23 September 2025
Quorate	Yes

The Quality Committee draw the following key issues and matters to the Board of Directors' attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • Board Assurance Framework 2025/26: Draft Principal Risks • Winter Board Assurance Statement • Quality & Safety Integrated Performance Report • Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) Reviews • Review the impact of low compliance of mandatory training from a quality and safety perspective • Mental Health Plan - Mental Health Plan Progress Report - Draft Mental Health Plan • Patient Safety Quarterly Report • Maternity Services - Maternity Perinatal Quality Report - Ockenden / Kirkup Return - Quarterly Perinatal Mortality Review Tool (PMRT) Report • StARS Progress Report • Patient, Family & Carer Experience Strategy Progress Report • External Visits and Inspections Register Report • Standing Subgroup Alert, Advise & Assure Reports: - Patient Safety Group - Patient Experience Group - Health & Safety Joint Consultative Group • Quality Committee Work Plan & Attendance 2025/26
2.	**Alert**	Mental Health Plan Progress Report – continuing increase in rates of presentation of people with mental health conditions to Emergency Department (ED), length of stay in ED, violence and aggression, with decrease in Mental Health team visibility and lack of anticipated benefits of new build provision. Executive escalation to work collaboratively with partners. Quality & Safety Integrated Performance Report - PALS team capacity to respond to complaints volume is challenged, high rate of returned complaints noted. Plans in place to support the team and to equip leaders in the organisation with requisite communication and compassionate response skills.
3.	**Advise**	Board Assurance Framework 2025/26: Draft Principal Risks - current ratings agreed with some additions to key controls and assurances. No change to

		audiology service risk noted, though recruitment to key role has commenced and detailed update due in October 2025. Winter Board Assurance Statement – Draft submission of assurance statement agreed, subject to changes requested to reflect equality impact assessment. Draft Mental Health Plan – comprehensive plan welcomed. Next steps engagement with partners and experts by experience, development of implementation plan. Patient, Family & Carer Experience Strategy Progress Report – noted broad programmes of work to gather and respond to feedback. Patient Safety Quarterly Report - Review of impact of out-patients B identified a negative impact on patient experience and related complaints but no harm. - Review of impact of crowding in ED identified a negative impact on patient experience and related complaints but no harm in the quarter, though a recent pressure ulcer potentially related to a long wait was noted. - Patient Safety Incident Response Framework (PSIRF) embedding continues but is not aligned with approach in coronial service – actions planned to address internally and with the coroner. Quality & Safety Integrated Performance Report - Sepsis recognition remains below target and antibiotic administration improved in August, transformation project report due to come to committee in November - Infection Prevention & Control – C.Diff and MRSA below target, recent E Coli position improved. - Pressure ulcers - ongoing improvement work with community partners - Non-significant increase in moderate harm incidents remains an area of scrutiny
4.	**Assure**	Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) Reviews – schemes approved since last meeting reviewed and rationale for scoring agreed. Noted cumulative impact of schemes in preventing improvement to 4 hour performance, safety and medical out of hours provision. Review the impact of low compliance of mandatory training from a quality and safety perspective – no harm identified but action to enquire prospectively in light of related themes in after action reviews. Maternity Services – assurance of preparation for Clinical Negligence Scheme for Trusts (CNST) submission, and appropriate review and reporting of still births and actions on underperformance in 3rd and 4th degree tears. StARS Progress Report – continued improvement across standards, noting ED and medicines management. Noted resource limitations to further improvement and potential impact on morale. External Visits and Inspections Register Report – noted lack of matters for escalation.

		Quality & Safety Integrated Performance Report - Summary Hospital-Level Mortality Indicator (SHMI)f remains below target
5.	**Referral of Matters/Action to Board/Committee**	No matters referred
6.	**Report compiled by:**	Dr Louise Sell (Chair of Quality Committee / Non-Executive Director)
7.	**Minutes available from:**	Mrs Soile Curtis (Deputy Company Secretary)

NHS Stockport NHS Foundation Trust

Meeting date	02/10/2025	**Public**		**Agenda No**	**12**
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 board					

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
	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	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 IP&C 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 internal trajectory for Methicillin Sensitive Staphylococcus Aureus (MSSA).

- There was an increase in CPE screening but a decrease in CPE positivity rate.
- The Trust (Excluding ED) were below the aspirational target set for blood culture contaminants.
- The Trust exceeded the national mandatory requirement for surgical site surveillance by undertaking surveillance in two quarters.
- There was an increase of 145.3% in cases of influenza from the previous year.
- There was an increase of norovirus outbreaks from the previous year.

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

- The PLACE results for 2024 were below the national average in several areas.
- The Hospital Sterilisation and Decontamination Unit (HSDU) and Endoscopy Decontamination Unit (EDU) successfully past their accreditation by the British institute.
- IPC team collaborated with estates on the rebuild of the Emergency Department and development of the new outpatient's department.

Criterion 3: Ensure appropriate antimicrobial stewardship.

- Trust participated in a point prevalence audit looking at antibiotic use, indication and documentation. 27% of adult inpatients were prescribed antibiotics on the day and 86% of the antibiotic choice complied with our antibiotic guidance.

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.

- The Vascular Access Device (VAD) service received 282 referrals with 172 (61%) being appropriate and a line successfully inserted.

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 IPC support practitioners worked alongside new care support workers on wards

following completion of their care certificate.

- The IP&C team had another successful X campaign during December with our Elf antics.
- Increase in compliance for IP&C mandatory training.

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

- Due to the old estate, isolation facilities remain a challenge but are managed by the clinical site co-ordinators with support from IPC team.

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.

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

- The Trust saw a decrease in both COVID-19 and seasonal influenza vaccine rates for frontline staff.

INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2024- March 2025

Contents

Foreword

2024-25 remained a challenging year as we continue to work with Stockport's ageing population and condition of the estate.

Stockport NHS Foundation Trust (SNHSFT) is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. Keeping patients safe from avoidable HCAIs remains a high priority for the Trust.

I do not underestimate how hard this year has been for all our teams and so as my final IPC annual report as Director of Infection Prevention for SNHSFT, I would like to say a huge thanks for your hard work, commitment and unwavering support throughout the year. I am proud to introduce Stockport NHS Foundation Trust's (SNHSFT) Annual Infection Prevention and Control Service Report for the period 2024-25.

This report reflects the hard work, professionalism and dedication of, not just our dedicated Infection Prevention & Control Team, but our colleagues in estates and facilities who work tirelessly to maintain high standards of cleanliness across our Trust. This report shares the ever-increasing scope of infection control work in the Trust over the year and how we perform across the many areas of required reporting. 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 2025-26.

Nic Firth

Chief Nurse/DIPC

Introduction

This report provides the Trust board with an annual review of mandatory reporting and activities undertaken by the Infection Prevention & Control (IP&C) Service Team for 2024-25.

HCAI's can cause harm to patients, compromising their safety and leading to a suboptimal patient experience, increased length of stay with poorer outcomes; therefore, prevention of HCAI's remains a key priority for the Trust. The IP&C Team strives to promote and embed evidence based best practice with regards to the prevention and control of infection and maintain patient safety. The Trust recognises that infection control is everyone's responsibility and must remain a high priority for all staff, patients and visitors to ensure our patients are safe from acquiring a preventable HCAI.

Key Achievements 2024-25

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

- The Trust met the internal trajectory for Methicillin Sensitive Staphylococcus Aureus (MSSA).
- The Trust (Excluding ED) were below the threshold set for blood culture contaminants.
- The Trust exceeded the national mandatory requirement for surgical site surveillance.
- Hospital Sterilisation and Decontamination Unit (HSDU) & Endoscopy Decontamination Unit (EDU) were successful in passing their BSI and JAG accreditation.
- The Lead IV practitioner received an above and beyond award in recognition for her hard work and dedication to patient safety.

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 Services across Stockport and over 6,000 staff.

The Infection Prevention & Control Service played a key role during 2024-25 by providing staff with robust expertise, advice, and guidance to improve the safety and quality of care delivered to patients. In the period of 2024-25 the team consisted of:

DIPC	
Associate Nurse Director- IP&C	1.0 WTE
Matron – IP&C	1.0 WTE
IP&C Service Nurses	5.80 WTE
IV Nurse Practitioners	2.0 WTE
IP&C practitioner	1.0 WTE
IP&C support practitioners	4.53 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.

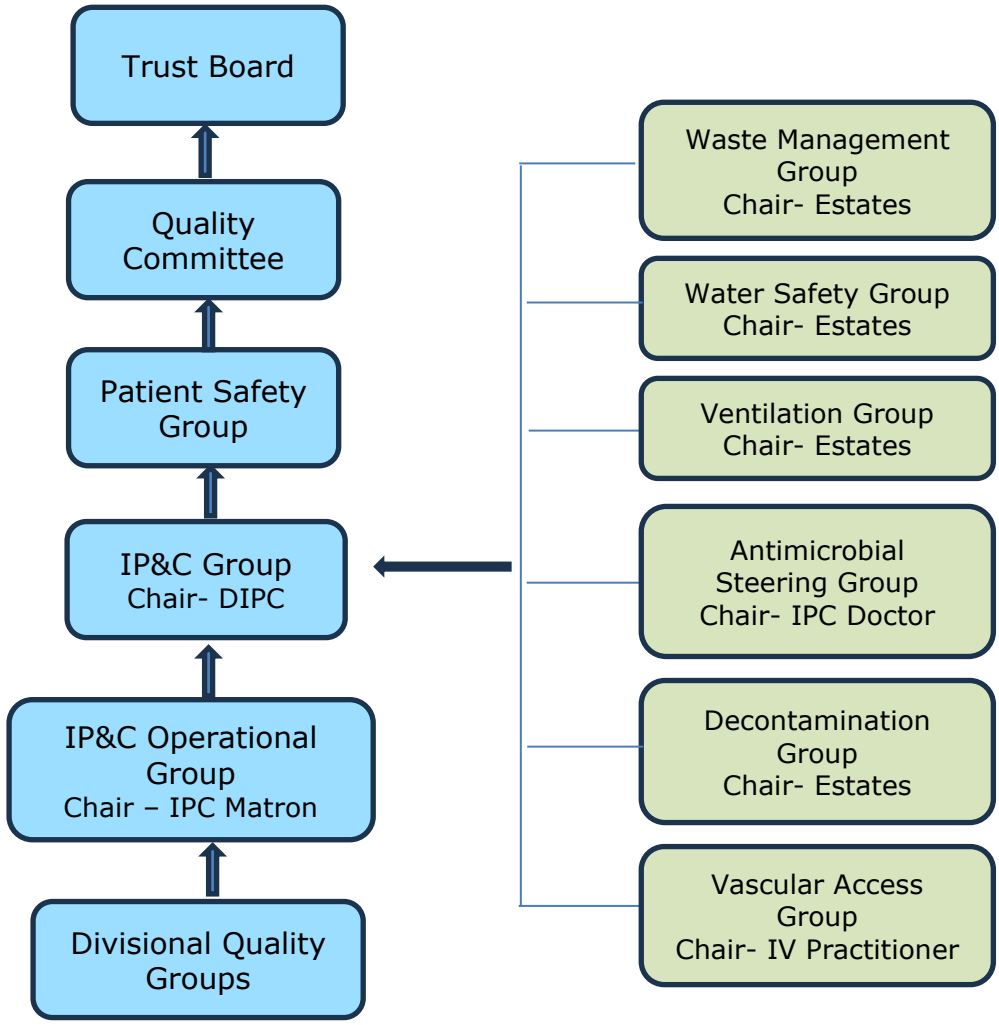
Infection Prevention and Control (IP&C) Operational Group

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:



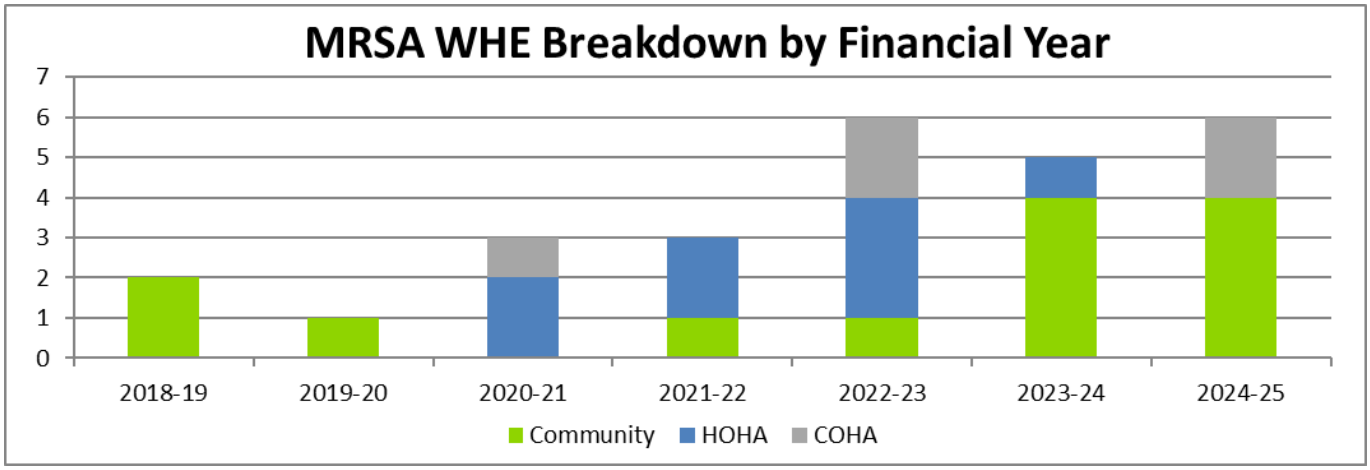
Surveillance of Alert Organisms & Mandatory Reporting

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 2024-25 are reported as a combination of Hospital-onset healthcare-associated (HOHA) and Community-onset healthcare-associated (COHA) for all isolates. From April 2024 the admission date for patients admitted through the Emergency Department changed to the decision to admit date due to increased waiting times nationally for patients in the department.

MRSA Bacteraemia

The national tolerance for MRSA bacteraemia cases continues to be zero. In 2024-25 there were 6 MRSA bacteraemia cases, 4 were attributed to the community as they were Community Onset, Community Associated (COCA) and 2 were attributed to the Trust as Community Onset, Hospital Associated (COHA) cases.



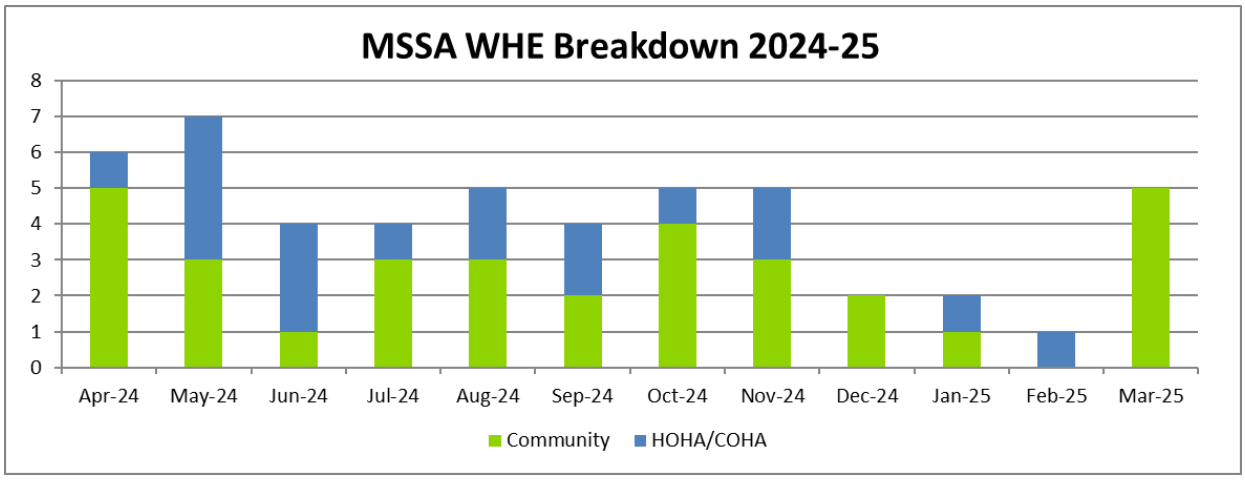
A Post Infection Review (PIR) investigation was undertaken for the COHA cases and were presented to the Trusts Health Care Associated Infections (HCAI) panel for their consideration. Both cases were complex with several comorbidities, learning from the cases has been shared with other divisions.

During 2025-26 the focus will be on MRSA screening and eradication to reduce the risk of patients developing an MRSA bacteraemia.

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. This is for HOHA cases only.

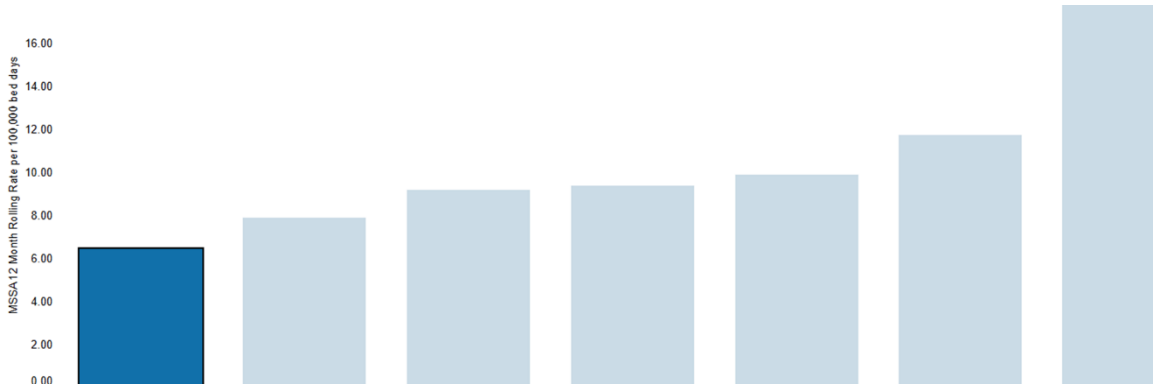
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

In 2024-25 the Trust had 14 Hospital Onset, Healthcare Associated (HOHA) cases and 4 Community Onset, Healthcare Associated (COHA) cases, totalling 18 cases. This is a decrease of 4 from the previous year.



For 2024-25 the total threshold was set at 19 cases allowing 4.75 per quarter. The Trust finished below this threshold by 1 case.

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. This is for HOHA cases only.



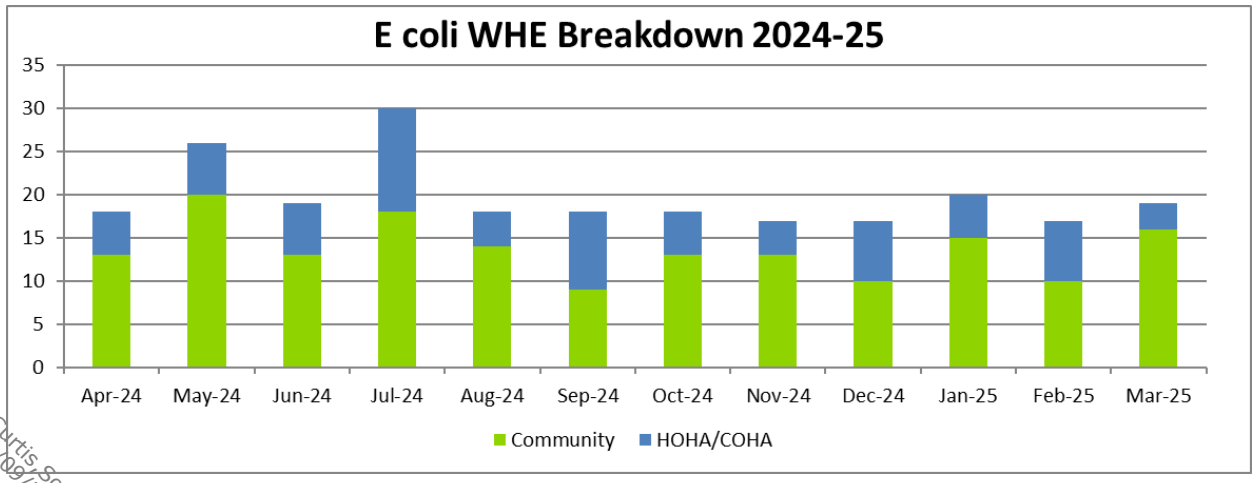
Gram negative blood stream infection (GNBSI)

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

Escherichia coli (E. coli) Bacteraemia

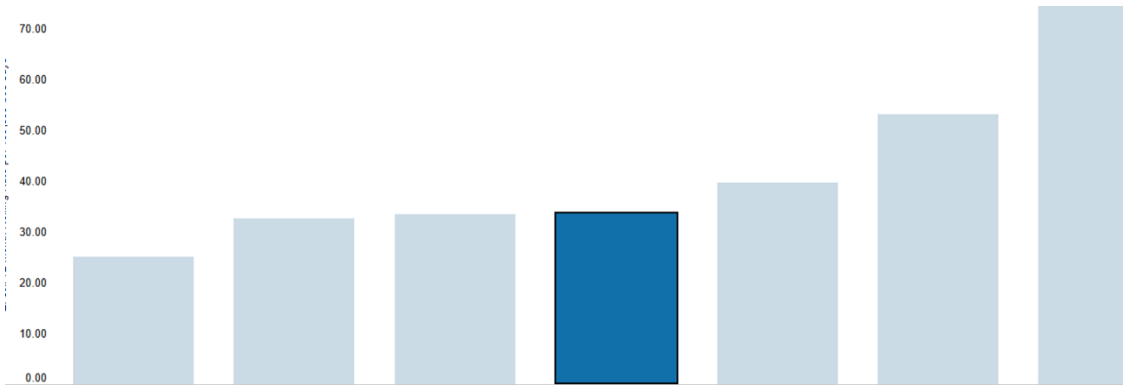
E. coli data collection continued with the predominant cases being community acquired.

In 2024-25 the Trust had 47 Hospital Onset, Healthcare Associated (HOHA) cases and 26 Community Onset, Healthcare Associated (COHA) cases, totalling 73 cases a decrease of 1 from the previous year.



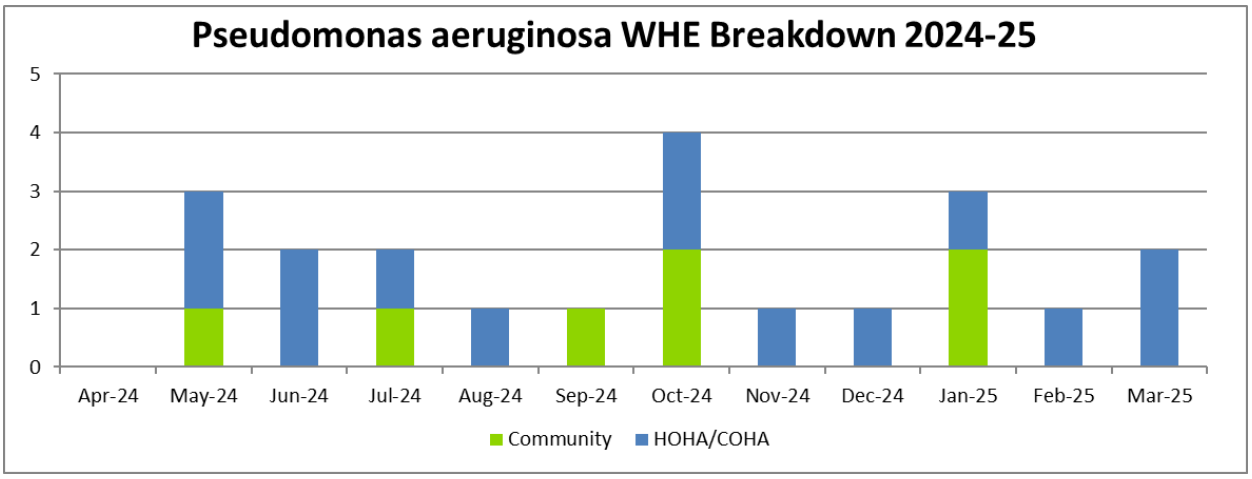
The UK Health Security Agency (UKHSA) threshold for 2024-25 was set at 70 cases allowing 17.5 per quarter. This threshold was exceeded by 3 cases.

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. This is for HOHA and COHA cases.



Pseudomonas aeruginosa

In 2024-25 the Trust had 10 Hospital Onset, Healthcare Associated (HOHA) cases and 4 Community Onset, Healthcare Associated (COHA) cases, totalling 14 cases an increase of 5 from the previous year.

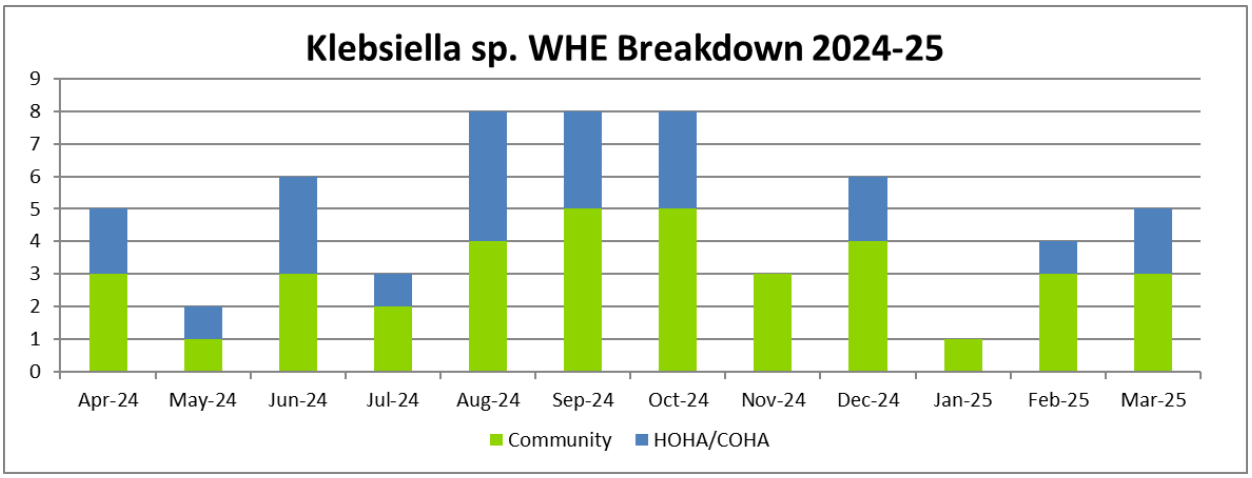


The UKHSA threshold for 2024-25 was set at 8 cases allowing 2 per quarter. This threshold was exceeded by 6 cases.

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. This is for HOHA and COHA cases.

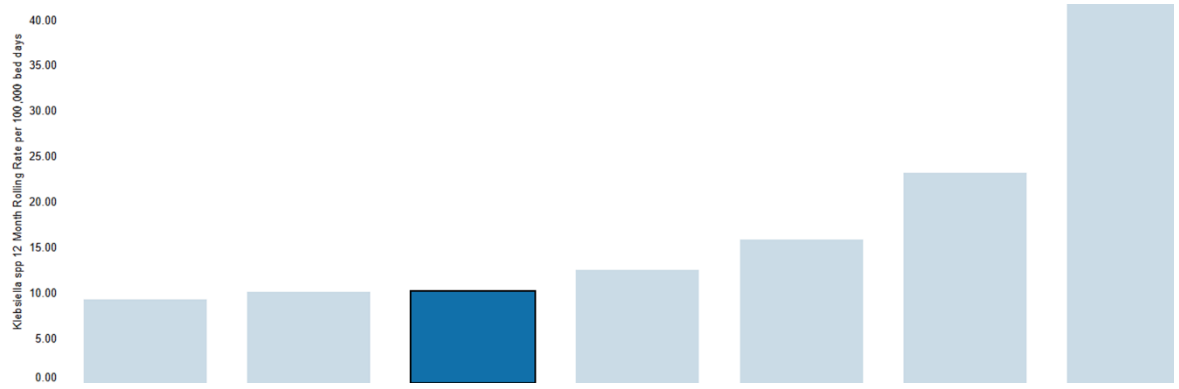
Klebsiella sp.

In 2024-25 the Trust had 10 Hospital Onset, Healthcare Associated (HOHA) cases and 12 Community Onset, Healthcare Associated (COHA) cases, totalling 22 cases an increase of 7 from the previous year.



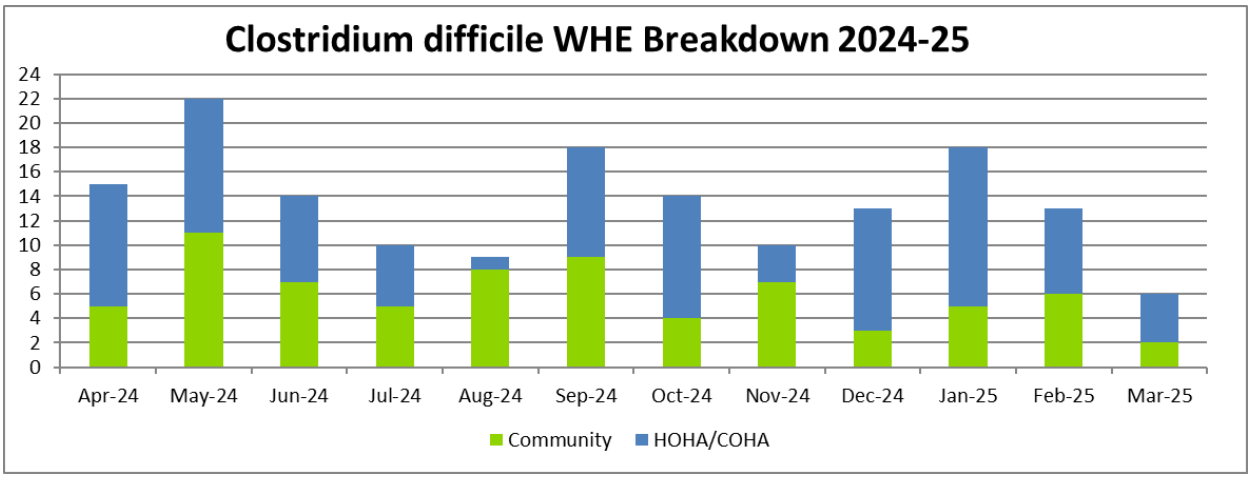
The UKHSA threshold for 2024-25 was set at 13 cases allowing 3.3 per quarter. The Trust finished over this threshold by 9 cases.

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. This is for HOHA and COHA cases.



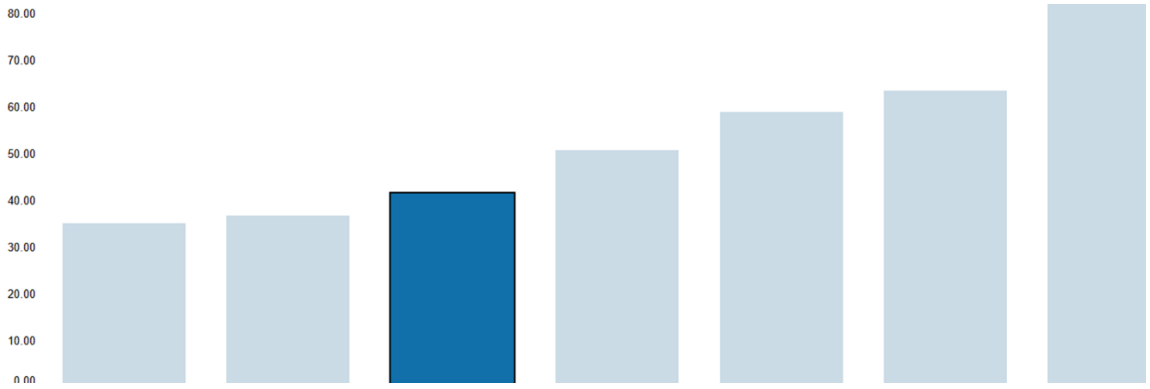
Clostridium difficile

The UKHSA threshold for 2024-2025 was set at 73 cases. In 2024-25 the Trust had 68 Hospital Onset, Healthcare Associated (HOHA) cases and 22 Community Onset, Healthcare Associated (COHA) cases. The threshold was exceeded by 17 as a total of 90 cases were recorded which is an increase of 9 cases from the previous year.



All Trust attributed cases underwent an 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.

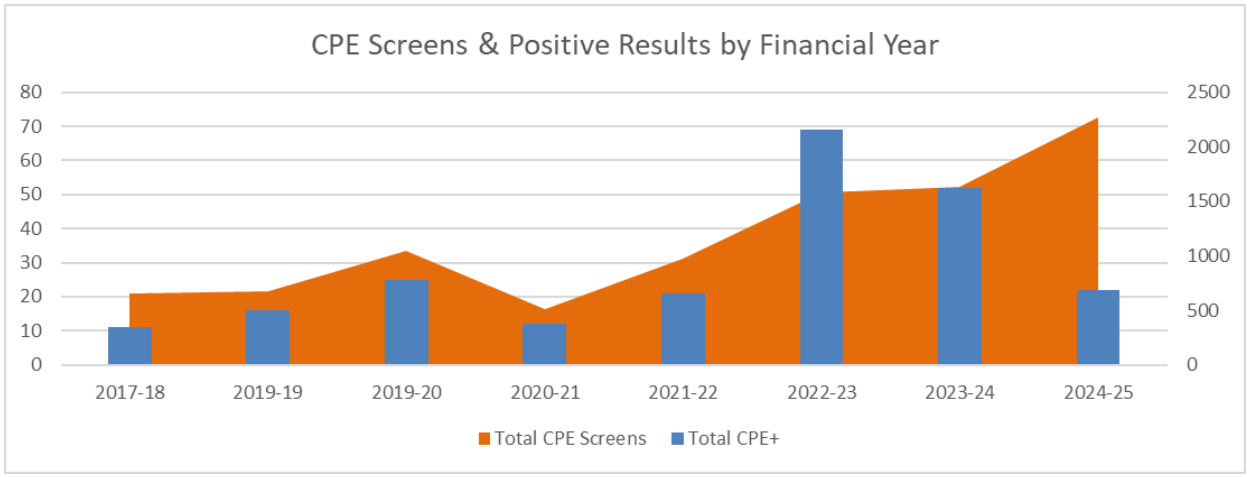
Peer Group Comparison: The Trusts monitors its performance against NHS Greater Manchester Integrated Care Board. Below illustrates the Trust in comparison with its peers for Clostridium difficile. This is for HOHA and COHA cases.



Carbapenemase Producing Enterobacteriaceae (CPE)

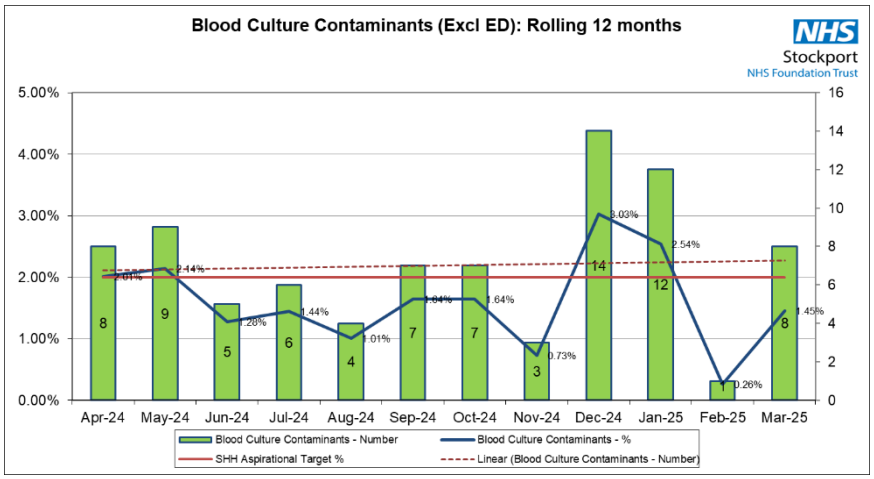
There is no mandatory surveillance or National threshold for CPE.

During 2024-25 there were 22 new CPE cases. 5 were hospital attributed and 17 were community apportioned a decrease of 30 cases on the previous year. 2265 CPE screens were processed, an increase of 38.4% in screening activity. Positive case rate was 0.97% for the financial year.

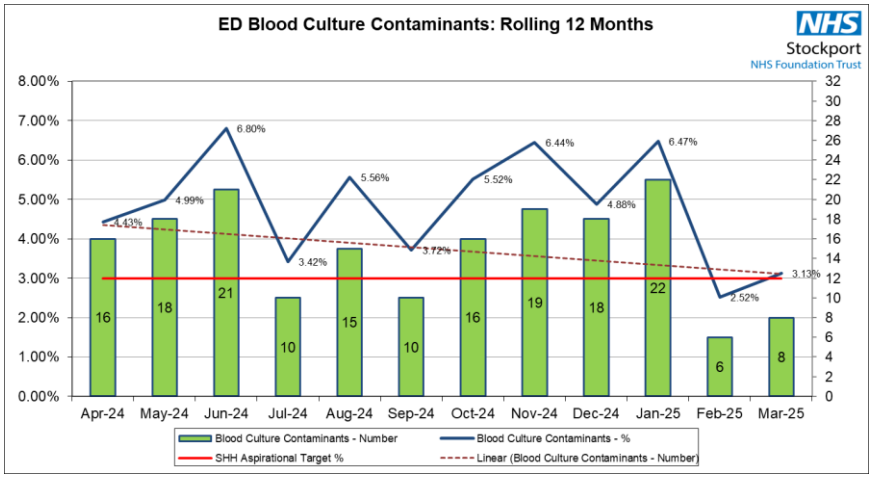


Blood Culture Contaminants

The average rate of blood culture contaminants for the Trust (Excluding ED) was 1.60% against a Trust aspirational threshold of 2% which is a decrease of 0.96% from the previous year.



The average rate of blood culture contaminants for patients within the Emergency Department (ED) was 4.82% a decrease of 0.47% from last year against our Trust aspirational threshold of 3%.



Mandatory Orthopaedic Surgical Site Surveillance Infection (SSSI)

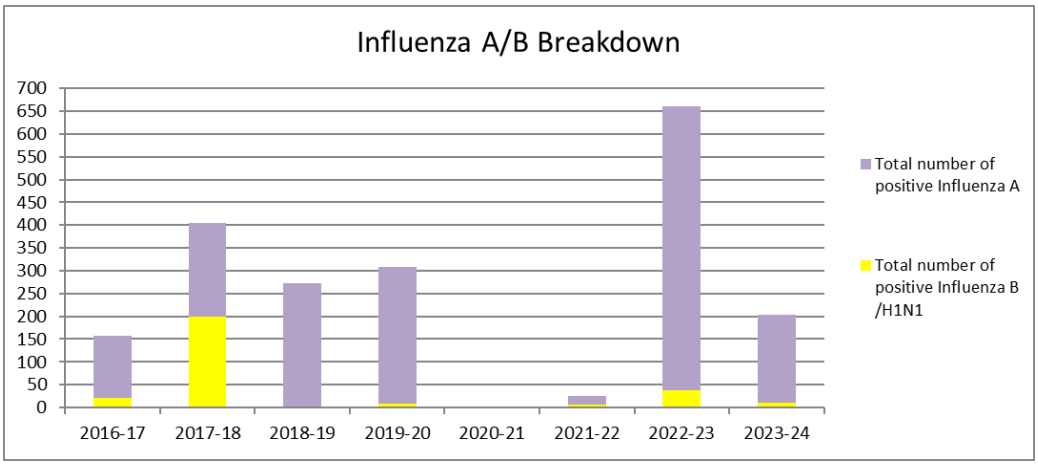
The mandatory requirement of the UKHSA is to survey one orthopaedic procedure for a period of 3 months. During 2024-25 our surveillance exceeded the mandatory requirements by undertaking surveillance in two quarters as shown in the table below.

Report Quarter	Procedure	No. of Operations	No of Surgical Site Infections	% Infection Rate
Q2: July – September 2024	Hip Replacement	91	0	0%
	Knee Replacement	53	1	1.9%
	Repair of neck of femur	116	1	0.9%
Q3: October - December 2024	Hip Replacement	109	1	0.95%
	Knee Replacement	65	1	1.5%
	Repair of neck of femur	93	2	2.2%

Outbreak reports

Influenza

During 2024-25, the Trust saw a 145.3% increase in the number of cases of the influenza virus. These cases were effectively managed within the Trust isolation framework. There were no outbreaks associated with confirmed influenza across the Trust.



COVID-19

During 2024-25 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 2024-25.

2024-25		
Positive	297	8.1%
Negative	3370	91.9%
Total Tests	**3667**	

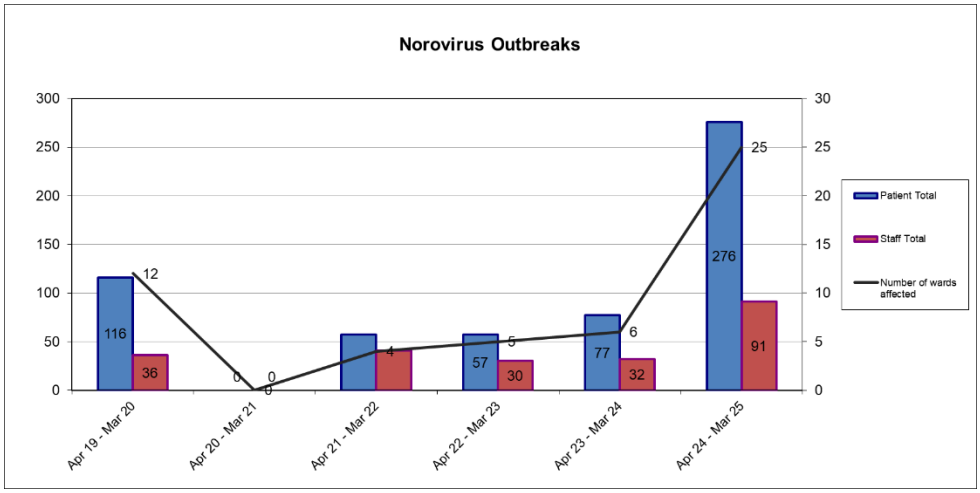
The total number of positive COVID-19 patients who were discharged or died at the end of their inpatient stay during 2024-25 is shown in the table below.

Inpatient Discharges	Inpatient Deaths
256	19

Any patient who developed a hospital acquired (nosocomial) COVID-19 infection and subsequently died with COVID-19 as part one of the death certificate were investigated to determine any learning and actions to be undertaken. During 2024-25 there were three patients with COVID-19 as part one on their death certificate. Due to the complexities of patient conditions, acquisition of COVID-19 was difficult to determine.

Norovirus

A new strain of norovirus emerged during 2024-25 which led to a significant increase in norovirus cases and outbreaks across the United Kingdom. There were 25 ward outbreaks associated with diarrhoea and vomiting across the Trust which is an increase of 19 from the previous year.



All ward outbreaks were confirmed Norovirus. Six outbreaks occurred during April, seven outbreaks during June and 6 outbreaks in March 2025, the others occurred at periods throughout the year. 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 2024-25 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 systems 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 2024-25, 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 2024-25 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 2024-25 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 2024-25 the trust decontamination services, both sterile services and Endoscopy decontamination remain committed to deliver high standards. The focus over the past 12 months has been achieving the best quality products to enable safe, effective and reliable patient care.

Both the Hospital Sterilisation and Decontamination Unit (HSDU) and Endoscopy Decontamination Unit (EDU) were successful in retaining their accreditation from the British Standards Institute, reinforcing the Trust's commitment to quality and patient safety.

The EDU also successfully achieved green status on their annual Joint Advisory Group (JAG) 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 to the Trust IPC Group.

- To continue striving for improvement and innovation, for best practice in decontamination services.

Cleaning Services

The National Standards of Healthcare Cleanliness was updated during 2024-25, the Trust reviewed the standards to ensure they continued to be adherent and displayed star ratings publicly in all areas across the Trust. All areas are monitored through audit to ensure that cleaning standards and timeframes are achieved, with auditors receiving annual 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 ensuring safe, IPC compliant practices.

Developing effective collaborative working between domestic, clinical and IPC staff continued to be the primary focus during 2024-25. The excellent teamwork produced support during outbreaks, capital cleaning projects and estate related incidents to ensure the National Standards of Healthcare Cleanliness were maintained.

Regardless of the many challenges during the past 12 months, the Domestic service team have consistently delivered cleaning services to the highest 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 appreciated the support of the Trust's Infection Prevention and Control Team, volunteer patient representatives, and other specialist matrons in conducting this year's annual PLACE inspection. 2024 marked our second year of going paperless, utilising the 'PLACE mobile' platform to complete assessments as live submissions via a tablet device.

Areas across the Trust were visited, covering all services and divisions to ensure a comprehensive assessment. Each team also conducted a food-tasting assessment taking the final tray from the meal trolley to reflect the experience of the last patient to receive a meal.

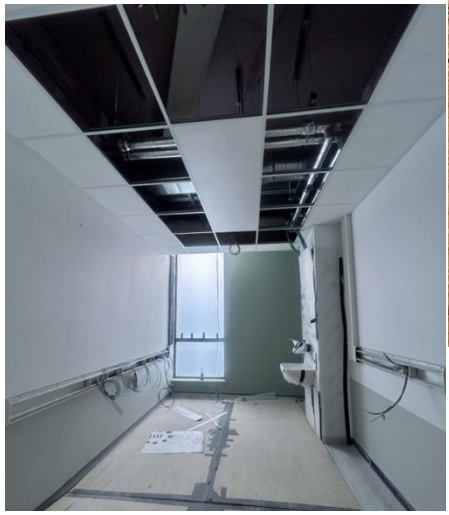
The PLACE results for 2024 were disappointing as the Trust was below the national average in several areas. The Trust has developed a comprehensive action plan and is committed to drive improvements.

Estates building work

The IPC team work collaboratively with the estates team. 2024-25 was a busy year with the phased development of our Emergency Department and the development of a new Outpatients department following the collapse of the outpatients B building in November 2023.

During the transformation of the Emergency Department the IPC team worked closely with estates and the external contractors as the department remained open throughout the work which will be completed spring 2025.

During 2024-25 the IPC team supported the trust with developments plans for the new outpatient's department, work is due to be completed during 2025-26.



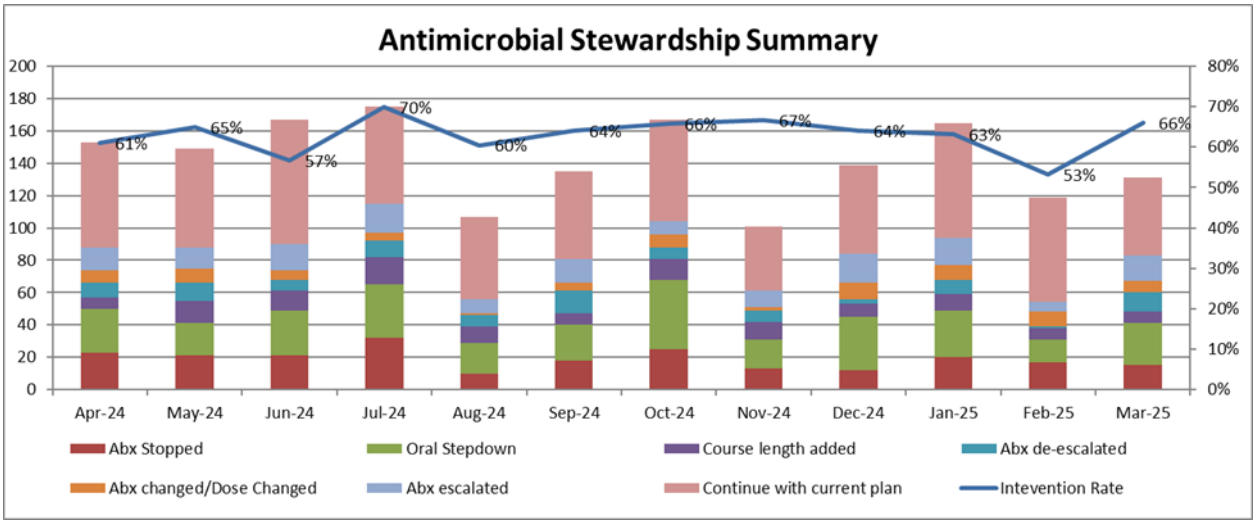
Criterion 3: Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Stewardship

During 2024-25 the antimicrobial stewardship team built on previous work to improve antimicrobial prescribing and reviews across the Trust.

During 2024-25, 193 Antimicrobial ward rounds were carried out. Data produced from these are presented to the Antimicrobial Steering Group (ASG) for discussion and recommendations for change.

The following chart below shows the breakdown of interventions made on antimicrobial ward rounds monthly.



During 2024-25, the Trust participated in a point prevalence audit looking at antibiotic use, indication and documentation. The results showed that 27% of adult inpatients were prescribed antibiotics on the day and 86% of the antibiotic choice complied with our antibiotic guidance.

During 2024-25, the antimicrobial guidance app successfully transitioned over to a new app providing the trust more flexibility for change.

During 2024-25, complex case meetings were established to enable a multidisciplinary approach for our complex patients. The co-ordinated approach enables recommendations to enable good practice in administration of antibiotics, with education and support.

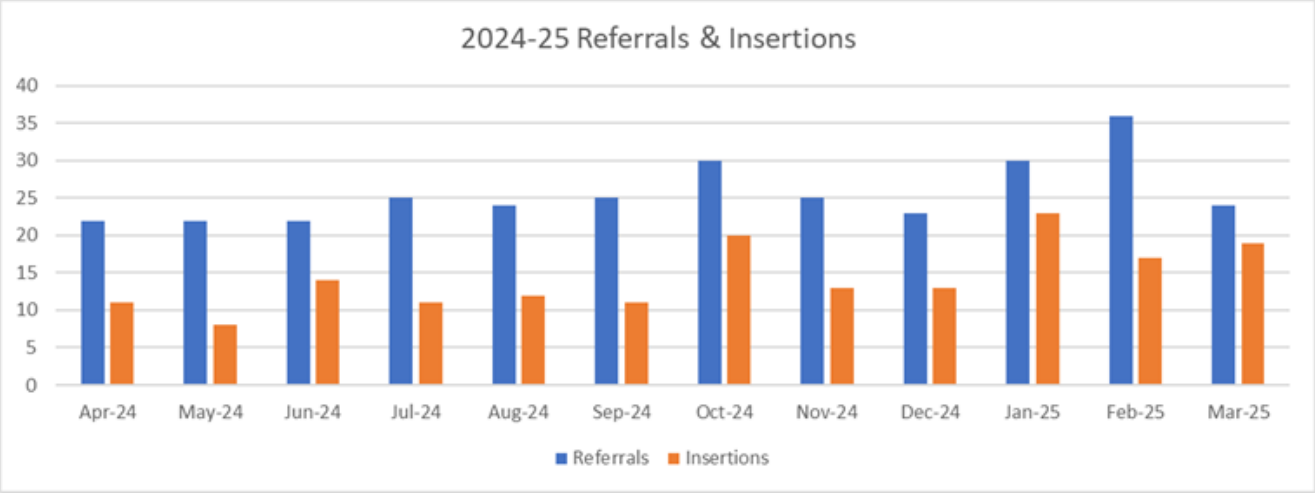
Criterion 4: provide suitable accurate information on Infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.

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

2024-25 saw increased demand on the VAD service. The service received 282 referrals with 172 (61%) being appropriate and a line successfully inserted. The service also supported and cared for a further 37 lines of patients admitted to the Trust with a line in-situ.



The VAD service team collaborated with the Nutritional MDT and the complex case meetings, supporting review of policies, developing patient information leaflets as well as providing training and education in several formats including one-to-one sessions, Toolboxes, monthly drop-in sessions and Masterclasses to upskill and educate staff in the care and management of lines.

The Lead IV practitioner received an above and beyond award in recognition for her hard work and dedication to patient safety.

Patient Safety Incident Review Framework (PSIRF)

PSIRF sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

During 2024-25 the IPC team reviewed the current HCAI investigation process against PSIRF before transitioning over. More work is required to fully understand how PSIRF align with infection prevention and control.

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 combined with mandatory infection prevention E-learning.

During 2024-25, the IPC support practitioners worked alongside new care support supporters on wards following completion of their care certificate. Providing individualised support and training enables IPC standards to be embedded into everyday practice. During 2025-26, the IPC nurses will commence individualised support and training to qualified new starters enabling IPC standards to be embedded.

The Trust training compliance for IP&C mandatory training at the end of 2024-25 was 97.47% which is an increase from the previous year. During 2024-25, due to staffing challenges within the IPC service team only 551 toolbox training sessions were provided which is a reduction from the previous year.

Link Nurses

During 2024-25, the roles and responsibilities of the infection prevention link nurses was reviewed for both the prevention of infection practitioners (PIPs) and the Associate prevention of infection practitioners (APIPs).

These PIP roles are crucial to support the IPC team in delivering latest updates quickly alongside education and training for a wider range of staff. The APIPs support the PIPs especially working with colleagues to embed IPC practice.

The PIPs attend a 3-day course and the APIPs attend a 1-day course. 2024-25 training sessions were well attended with good engagement.

During December 2024 the IP&C team took to X with our own Elf-Care-Assistant. Each day a different poem was portrayed showing what was not good practice.

Divisional groups

Surgery

One of the key actions for the 2024-2025 period was to emphasise a Multidisciplinary Team (MDT) approach in investigating and learning from Healthcare Associated Infection (HCAI) investigations. While our division has seen some improvements in this area, the action plan for 2025-2026 will continue to prioritise this approach and further engage our medical colleagues.

The division is committed to a collaborative approach to IP&C by working closely with the IP&C team. Walk rounds to provide assurance through spot checks with ward managers and matrons, and toolbox training sessions are conducted to create an optimal environment for patient care and mitigate the risk of infection.

Maintaining uniform and bare below the elbow compliance is a top priority for our division. To achieve this, we have implemented peer-to-peer challenges during safety huddles to help our staff assess compliance. Additionally, we have increased the frequency of senior nurse walk rounds to ensure we meet high standards.

For the 2025-2026 period, our division's on-going focus for improvement will be on:

- The care and management of Vascular Access Devices. During 2024-25 our senior nurses attended a master class in Vascular Access Device Management, equipping them with knowledge and skills to take ownership of improvements and sustain high-quality care.

- Maintaining a strong emphasis on Aseptic Non-Touch Technique (ANTT) compliance, with our nursing and medical teams actively sharing actions and lessons learned during our Monthly Quality Assurance Meetings. While we have made progress, further improvements are necessary and will be a focus of our efforts in the coming year.

Medicine & Urgent Care

The division continues their robust processes with estates, facilities, and IPC colleagues to closely monitor the challenges within the clinical environments. During 2024-25, the process was further enhanced with the introduction of infection prevention related questions which are asked to clinical staff ensuring that effective IPC underpins the fundamentals of our clinical practice, whilst embedding good practice in real time. The changes will provide evidence which can be shared for both our accreditation process and during CQC visits.

During 2024-25 there was an improvement in the divisional blood culture contaminates rates. This positive trend can be attributed to several key factors. First, the reinforcement of protocols for specimen collection and handling reducing the likelihood of contamination during the sampling process. Staff training sessions have emphasised the importance of aseptic techniques, ensuring that all staff are well-equipped to follow best practice.

During 2024-25, themes were highlighted from the HCAI investigations relating to areas requiring improvement for the Emergency Department (ED). The team are reviewing the themes and producing an action plan to improve compliance during 2025-26.

During 2024-25 fit testing remained a challenge ensuring adequate staff were compliant with Fit Testing due to turnover of staff.

Actions:

- To improve Fit Testing compliance with robust plans to ensure the division maintains satisfactory compliance.
- To continue with joint Infection Prevention walkaround within the clinical area
- To drive ANTT practice within ED to reduce the number of blood culture contaminants.

Women & Children

The division of Women and Children had 3 positive Clostridium difficile toxin (all for the same paediatric patient and picked up on admission), 1 MSSA and 3 E coli cases over the 12-month period. There was no MRSA bacteraemia over the past year within the division.

The division continues to focus and review any blood culture contaminants and meet with associated individuals to review and ensure appropriate action is taken and training is in place.

There is a robust plan in place and continued monitoring on the Neonatal Unit as there has been recurrent episodes of Pseudomonas detected in the visitor's bathroom sink.

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. 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 delivered on their trajectory for Clostridium difficile with 2 cases, however, did not meet trajectory for E. coli with 2 cases. The Division continues to monitor and learn from health care associated infections. will continue to strive for zero HCAI's. Work continues to embed & sustain IP&C standards, in particular PPE and commode cleanliness, as well as introducing environmental ambassador checklists for our non-clinical areas/home-visiting teams.

The teams have continued to see high standards of cleanliness, with all acute areas achieving 5-star ratings. Collaboration alongside NHS properties to have the respective reporting across our community sites.

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.

Action:

- To develop Quality metrics for adult community teams, to further support oversight/ and assurance on IPC practice.

Clinical Support Services (CSS)

Within the Division the profile of IPC has increased over the previous months secondary to the introduction of the first CSS IPC Operational Group representing the 5 directorates. The CSS IPC Operational Group meet monthly to discuss updates from within Radiology, Pathology, Pharmacy, Outpatients and Endoscopy. A report is then submitted to the Trust IPC Operational Group for consideration and escalation of key issues – a monthly meeting that CSS now attends further to the request from the Trust IPC lead. A theme coming out of the CSS IPC Operational Group is the volume of IPC related Estates jobs that have been identified as part of the process on increased IPC walkarounds – it is promising to see that work has started on the required jobs. Monthly monitoring of the Hand Hygiene and PPE audits continues with good practice noted – uniform compliance can be an issue however the newly appointed Matron in CSS is making good progress with this.

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

Isolation facilities across Stockport NHS Foundation Trust are limited due to the old estate. During 2024-25 the Trust had 150 single rooms (16.4% of inpatient beds) with 56% of these having ensuite facilities. 32 single rooms (21.3%) are in offsite facilities with 101 single rooms (67.3%) on the acute site the remaining single rooms are within delivery suite and un-usable for other patients.

Isolation facilitation is managed by the clinical site co-ordinator (CSC) team with support from IPC team.

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. On a monthly basis the senior teams within microbiology and the IPC service meet to discuss the challenges and improvements the teams can do collaboratively.

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 2024-2025 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.

Audit Activity

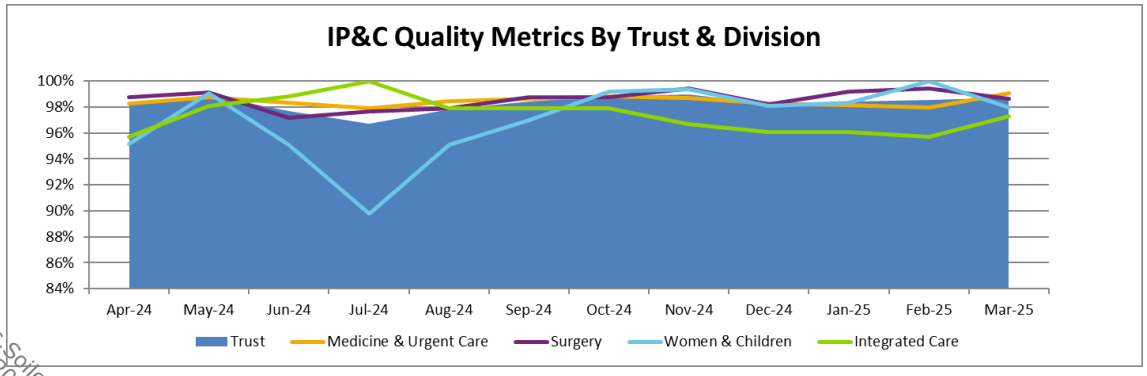
Aseptic Non-Touch Technique (ANTT)

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 2024-25 the IP&C Service team conducted 156 ANTT assessments for key assessors. These key assessors ensure within their department, staff who require ANTT compliance competency are assessed and practice safely.

IP&C Quality Metrics

Divisional Matrons undertake monthly IP&C Quality Metrics. The average compliance for the Trust during 2024-25 was 98% an increase of 1% from the previous year.



During 2024-25 Medicine & Urgent Care noted that whilst there was an overall maintenance with Hand Hygiene and Personal protection equipment (PPE) there was non-compliance at times during visits from the senior team.

IP&C Spot Audits

During 2024-25 the IP&C team undertook spot audits on Hand Hygiene, Personal Protective Equipment (PPE) Commode Cleanliness and Silver Trolley cleanliness across areas where an increase of HCAI's was noted. Below are the results:

2024-25	No. Spot Audits	Average Compliance
Hand Hygiene	277	80%
PPE	277	82%
Commode	198	79%
Silver Trolleys	31	70%
Total	**783**	**79%**

In 2024-25 the IP&C Service provided 219 bespoke tailored training sessions for new starters an increase of 71 from the previous year.

Cannula Audits

Following the development of the VAD service during 2024-25 the team developed a cannula audit to focus and monitor the care, maintenance and knowledge of vascular access devices across the Trust. The ward teams complete this audit monthly enabling them to monitor their compliance and action any education or training needs.

During 2024-25 there were 3223 audits completed, of which 211 were completed by the IPC service team for quality assurance purposes. Feedback was provided for the ward teams following audits completed by the IPC service team to ensure learning.

Sharps Audit

A sharps audit undertaken by Daniels an external company was undertaken during 2024-25. 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 2023-24	1.88%	0.00%	0.00%	1.64%	1.17%	2.58%
Percentage achieved 2024-25	1.76%	0.00%	0.00%	1.10%	1.32%	3.30%
Direction	↓	→	→	↓	↑	↑

Sustainability

During 2024-25 the IPC team supported procurement and other teams to introduce some sustainability products that were cost neutral or cost saving. These include theatre hats, gloves off and cannulas.

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 2024/25 was 21.4% for frontline staff (a decrease from the previous year 28%) with COVID-19 vaccination uptake at 8.1%. This year our flu and Covid statistics were directly reported into the NIVS national database which provides immunisation data to GP practices.

The CQUIN target set for 2025-26 is 80% for frontline staff with 100% of staff being offered the seasonal influenza vaccination.

Inoculation Injuries

The recording of inoculation incidents is undertaken with Occupational health (OH) software and the numbers for the whole year were reported to Infection Prevention & Control meetings & divisional leads.

The number of inoculation injuries to staff (including bites, scratches and splashes) was 137 which is an 31.7% increase on the previous year.

Sharps related incidents remain one of the common types of injuries to staff totalling 82. 55 injuries occurred whilst the sharp was in use, an increase of 77.4% from the previous year and 27 injuries occurred before disposal, a decrease of 3.6% from the previous year. Divisions review their statistics monthly to embed learning to reduce incidences.

Fit Testing Service

The FIT testing service has continued to be delivered throughout the year 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 was related to increases in respiratory diseases (Covid/influenza/RSV) and measles in our local community. Alternative ways of booking have been utilised to support demand such as full days for an individual area and drop-in sessions. The summer months however were underutilised and focus during 2025-26 is to maintain activity levels throughout the year.

During 2024-25, 1571 appointments were made of which 941 staff attended (60%) and of those 613 were successful (65%) for either 1 or 2 masks.

Divisional monitoring of compliance has been undertaken by the IPC operational group however focus will still be required for clinical areas to agree which staff require fit testing and to increase the number of staff successfully tested for 2 masks

During 2024-25 National competencies were recorded for all staff passes following a FFP3 fit test. The service is now paperless and supports the Trust drive towards net zero.

Action:

- 2025-26 will see the seamless transfer of fit testing to the health & safety team within risk management. Compliance monitoring being undertaken by the health & safety group.

Conclusion

2024-25 remained a challenging year with the Trust managing an ageing estate and population. The Trust is proud of its overall achievements in infection prevention and control despite not achieving the national trajectories for HCAI's.

Key Objectives for 2025-26

- Meet or end within the HCAI thresholds set internally by the Trust.
- To further develop the nurse led vascular access device service.
- To continue aligning the NHS patient safety incident response framework (PSIRF) within IP&C.
- Succession planning to ensure IPC staffing workforce fit for the future.

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

2024-25 Annual Report

Stockport NHS Foundation Trust

Innovative
Passionate
Collaborative

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

IP&C 2 Year Strategy

NHS Stockport NHS Foundation Trust

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INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2024- March 2025

Innovative
Passionate
Collaborative

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Successes

IP&C Strategy: Aim 1

- The threshold for MSSA was met
- The Trust was below the aspirational target for blood culture contaminants
- The Trust exceeded the mandatory requirement for SSI surveillance
- Increase CPE screening but no increase in positivity
- Reduction in ED blood contaminants from the previous year

IP&C Strategy: Aim 2

- IV practitioner presented with an above and beyond award
- Nutritional and complex case meetings established

IP&C Strategy Aim 3

- Gloves off campaign
- Theatre hats
- Cannula change over

IP&C Strategy: Aim 5

- IPC team away day
- IPC support practitioners working with new CSW's
- Successful PIPs and Associate PIPs course

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Stockport NHS Foundation Trust

- HSDU & EDU were successful in passing their BSI accreditation.
- Collaboration in rebuild of ED and development of new outpatients
- Transition of antibiotic app to EOLAS
- 86% of antibiotic choice complied with antibiotic guidance
- Great divisional engagement
- IP&C Elf on the shelf, interactive sessions positive feedback
- Increase in IPC E Learning compliance 97.47%

Innovative
Passionate
Collaborative

Safe practice
Engage
Responsive
Visible
Individualised support
Courage to challenge
Educate

Challenges

- Increase in influenza
- Increase in outbreaks associated with D&V
- PLACE results below national average in several areas
- Isolation facilities & old estate
- Sharps audit compliance
- The seasonal Influenza vaccine amongst frontline staff was 21.4% decrease from previous year
- Increase in inoculation injuries
- Fit testing compliance for staff

IP&C Strategy: Aim 1

- Trajectories not met
  - MRSA, E. coli, Klebsiella & Pseudomonas aeruginosa Bacteraemia's
  - Clostridium difficile
- Blood culture contaminant rate for ED remains over aspirational threshold

IP&C Strategy: Aim 2

- Increase in referrals for longlines
- Delays remain for patients requiring longlines
- Cannula audits

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Courage to challenge
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Benchmarking against GM

- 7 Trusts across GM
- Best position is 1st
- Worst position is 7th

INFECTION TYPE	END OF YEAR POSITION
Clostridium Difficile	3rd
E. coli	4th
Pseudomonas aeruginosa	6th
Klebsiella	2nd
MRSA	3rd
MSSA	2nd

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2025-26 position

- **Internal trajectories set in April 2025**
- **No Standard contract published to date**

	25-26 Trajectory	Case Numbers (Apr-Aug)	Current Position against Trajectory (Aug 25)	Trust Current Position Within GM (Jul 25)
MRSA	0	0		3rd
MSSA	15	11		1st
C difficile	81	28		3rd
E coli	69	38		4th
Klebsiella	20	14		3rd
PAE	12	7		6th

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IP&C CONTACT DETAILS:
IP&C Tel: 114669
Email: Infection.prevention@stockport.nhs.uk

FOR INFORMATION AND RESOURCES: VISIT THE IP&C MICROSITE

C	A	R	E
Compassion	**Accountability**	**Respect**	**Excellence**
We show kindness, caring and willingness to help others.	We take responsibility for our actions, behaviours, performance and decisions.	We value people's lived experience, feelings, qualities and views.	We support research, innovation, improvement and learning.

Curtis.Solle
26/09/2025 14:24:03

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NHS Stockport NHS Foundation Trust

				Agenda No.	13
Meeting date	**2 October 2025**	**Public**	✓	**Confidential**	
Meeting	Board of Directors				
Report Title	Maternity Services Perinatal Quality Report Q1				
Director Lead	Andrew Loughney, Medical Director Nicola Firth, Chief Nurse	**Author**	Sharon Hyde Divisional Director Midwifery and Nursing		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	The Board is asked to acknowledge the summary of updates for Maternity services. Quality Committee receive updates on Maternity services by way of a quarterly Perinatal Quality report in line with the Perinatal Quality Surveillance Model (PQSM) set out by NHS England. This will replace the previously titled Maternity Highlights Report to align with the GM LMNS Perinatal Quality Surveillance Model to ensure consistent and methodical oversight of the Maternity Service. This paper reports on Quarter 1 2025 position.					

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		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
	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

The Maternity service Perinatal Quality report incorporates an update to Quality Committee / the Board in line with the Perinatal Quality Surveillance Model (PQSM) set out by NHS England implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

The purpose of aligning to this model is to provide oversight of Maternity quality and safety standards to include updates on the following:

- CQC
- Maternity and Neonatal dashboard
- Perinatal Mortality review
- MNSI referrals and recommendations
- MNSI/NHSR/CQC concerns raised with the trust
- Incidents reported as moderate or above
- Coroner regulation 28 made with the trust
- Midwifery Red flags
- Midwifery, Obstetric, Neonatal nursing and Neonatal medical workforce
- Training compliance in line with the core competency framework Version2
- Service user feedback
- Progress against CNST MIS Year 7
- Staff feedback

In addition, the report will provide an update on progress against the following:

- Saving Babies Lives Care Bundle V3
- Three-year delivery plan for maternity and neonatal services (2023)
- Health Inequalities -GMEC Equity and Equality
- LMNS/ICB Assurance visit – Progress against recommendations
- Midwifery Continuity of Carer (MCoC)

Summary of updates to note for Quarter 1

The Board are asked to acknowledge the key updates for Quarter one, with reference to the CNST year 7 monitoring requirements.

- **Ongoing monitoring and compliance against CNST year 7**

  - The Maternity and Neonatal service remain on track to achieve all 10 safety actions. An area of current focus is the training compliance for the anaesthetic staff group.

  - Included in this paper are the requirements for Safety action 4. In line with CNST, compliance with the following standards should be demonstrated via audit.

  - *4.1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:*
    a. currently work in their unit on the tier 2 or 3 rota
    or
    4.2. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
    or
    4.3. hold a certificate of eligibility (CEL) to undertake short-term locums.

  - *4.4 Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?* ***(Appendix 1)***

  - *4.4. Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?*
    (Appendix 2 and 3)

- **Maternity performance**

  - Stockport are not current outliers across GM for PPH, 3rd and 4th degree tears and total Caesarean section.
  - Significant improvement in 3rd/4th degree tears since March/April data
  - QI work ongoing with Obstetric Anal Sphincter Injury (OASI) care bundle engagement with Student Midwives and Obstetric Doctors.

- **Service User feedback**

  - CQC Maternity Survey action plan coproduced with the MNVP lead remains in progress and on target for completion. This is monitored via Maternity Safety Champions Group

- **Progress against Three-year delivery plan**

  - Quarter 1 assurance meeting held with the LMNS on 24th July progress against each of the actions noted. The team continues to work towards implementing all 74 actions across the four themes.
  - Area where compliance will not be met by the set target date of March 2026 include: Implementation of new EPR – expected October 2027

- **Maternity Oversight Group**

  - Monthly meetings are in place with the LMNS/ICB in response to the service being placed on enhanced surveillance programme in 2024. Action plans monitored and progressing. Exit criteria currently in discussion.

- **Progress against Saving Babies Lives V3**

  - Quarter 1 assurance meeting held 17th June. Rating of 'significant assurance' and Implementation progress of 99% given.
  - Focus continues with element 6 and the introduction of the recent GM Diabetes guidance.
  - Quarter 2 assurance meeting planned for 16th September.

- **Staff feedback**

  - Staff Experience Improvement Plans in progress in response to the Staff survey
  - PMA group initiating 'staff voices' engagement project
  - Maternity Safety Champions Walk rounds bi-monthly
  - Moment's sessions facilitated by the culture coaches in response to the SCORE survey, culture day planned for 26th September
  - Perinatal culture and leadership programme action plan in place led by the Maternity Quadrumvirate

1. Purpose

1.1 The purpose of this paper is to provide the Trust Board with updates on the Perinatal Quality report which incorporates an update presented to Quality Committee in line with the Perinatal Quality Surveillance Model (PQSM).

1.2 The Perinatal Quality report will be presented quarterly to Patient Safety Group and Quality Committee which will, following review and discussion, provide updates to Trust Board as per CNST Year 7 criteria.

1.3 The Board is asked to acknowledge the updates for Maternity services.

1.4 The Board is asked to acknowledge and approve the evidence submissions in relation to CNST reporting requirements for Safety actions 1 – 10.

1.5 This paper reports on Quarter 1 position.

2. Introduction / Background

2.1 The Maternity service report will provide an update to the group in line with the Perinatal Quality Surveillance Model (PQSM) set out by NHS England implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

2.2 The purpose of aligning to this model is to provide oversight of Maternity quality and safety standards, and will include an update on the following:

- CQC
- Maternity and Neonatal dashboard
- Perinatal Mortality review
- MNSI referrals and recommendations
- MNSI/NHSR/CQC concerns raised with the trust
- Incidents reported as moderate or above
- Coroner regulation 28 made with the trust
- Midwifery Red flags
- Midwifery, Obstetric, Neonatal nursing and Neonatal medical workforce
- Training compliance in line with the core competency framework Version2
- Service user feedback
- Progress against CNST/MIS year 7
- Staff feedback

2.3 In addition, the report will provide an update on progress against the following:

- Saving Babies Lives Care Bundle V3
- Three-year delivery plan for maternity and neonatal services (2023)
- Health Inequalities -GMEC Equity and Equality
- LMNS/ICB Assurance visit – Progress against recommendations
- Midwifery Continuity of Carer (MCoC)

3. Care Quality Commission (CQC)

3.1 Maternity services were inspected by the CQC in September 2023. This inspection focussed on the Safe and Well led domains only. The service received a 'Requires improvement' rating for this inspection and a total of 3 'Must do' and 4 'Should do' actions were issued. These actions have been monitored via a service action plan through the divisional risk and governance meeting, Divisional quality group, Patient safety group and trust Quality committee. This action plan has now been signed off as complete at trust board.

CQC maternity ratings	Overall	Safe	Effective	Caring	Well-led	Responsive
	Requires Improvement	Requires Improvement	N/A	N/A	Requires Improvement	N/A

4. Maternity and Neonatal dashboard

4.1 The local dashboard data shows that there have been **692** bookings for maternity care at Stockport during for Quarter 1 and a total of **666** registerable births.

2025/26	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year-end total
Total bookings	245	206	241										
Total quarter bookings	692												
Total registerable births	221	240	205										
Quarter total births	666												

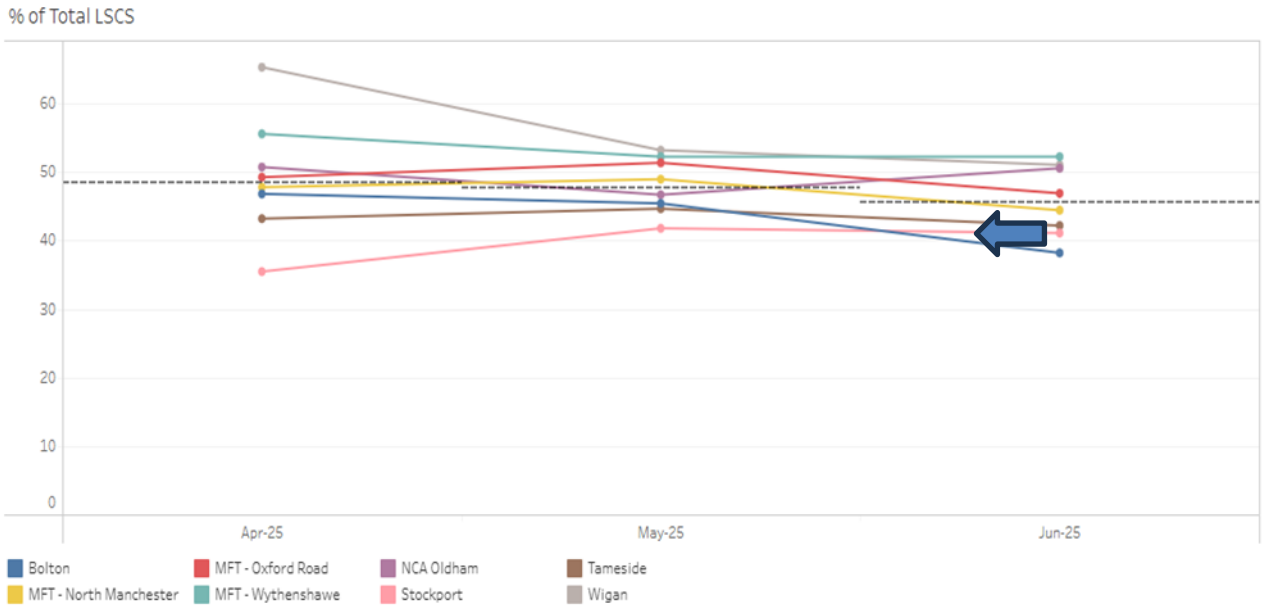
4.2 Caesarean Section

From our local dashboard data, the total caesarean section rate for Q1 equates to **254** deliveries (126 elective caesarean section, 128 emergency caesarean section) out of the total of 660 women delivered.
This is **38.5%** of all registerable births.

The GM median is **47.3**% and as can be seen from the chart below, Stockport is the lowest GM providers in quarter 1.

It is important to note the NHSE/I advised hospital trusts in 2021 to no longer use targets for total caesarean rates as a means of performance management to ensure that clinically appropriate decisions are made to maintain safety. It is important that we provide personalised care, providing the required information for pregnant people to make informed decisions regarding their care.

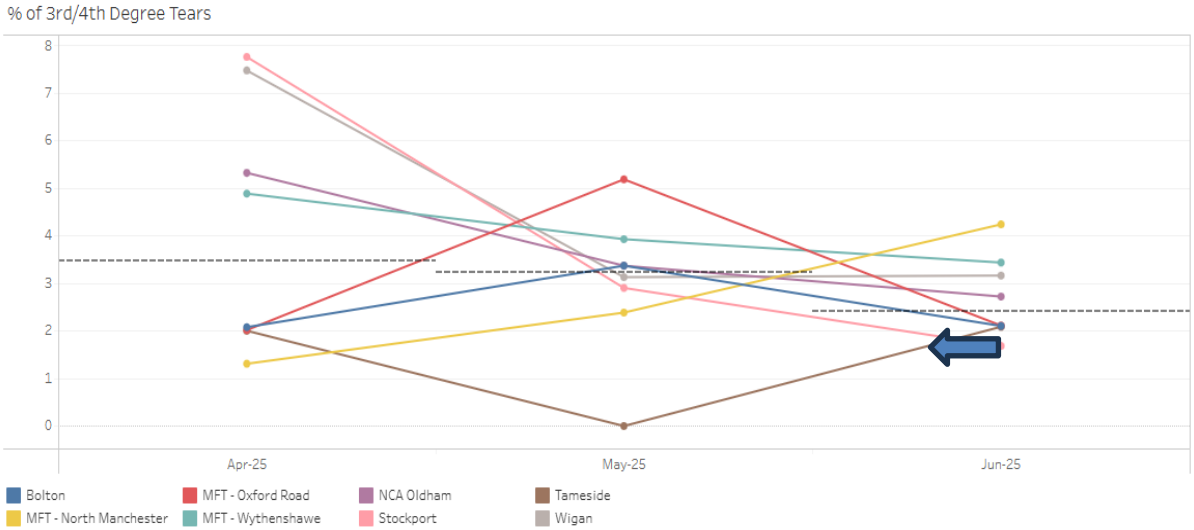
This data is submitted to GMEC SCN and reported on locally to monitor any trends.



NB: - The blue arrow indicates Stockport's position.

4.3 3rd and 4th degree tears

The 3rd and 4th degree tear rate for Quarter 1 was 4.18% (17 out of 406 vaginal births). The GM median is 3.0%.



NB: - The blue arrow indicates Stockport's position.

As can be seen from the graph above for Quarter 1 incidence of 3rd and 4th degree tears, the service has seen a notable reduction in incidence since Quarter 4. The service has a working group monthly that has been strengthened to involve the obstetric lead. A monthly deep dive of the data is discussed and any required actions addressed.

Quality improvement works this quarter has included the following initiatives: -

- Staff survey to identify any current issues
- Safety/training bus to share education on episiotomy technique through simulation
- Perineal assessment and suturing training reintroduced onto mandatory training.
- Shared learning across the wider network to explore trends, led by Leicester NHS Trust
- University education for Student midwives explored and local action taken for standardised learning on OASI care bundle for all Stockport students across 3 universities.
- OASI training will be included in the Doctors induction going forwards and the clinical lead will link with educational supervisors should further support be assessed as required
- Perineal Pelvic Health Midwife recruitment in progress

Information is shared via the Divisional Risk and Governance meeting and Labour ward forum.

4.4 Post Partum Haemorrhage

Post partum haemorrhages (PPH) account for most obstetric emergencies within maternity services, and it remains the top 10 leading cause of maternal death in the UK, accounting for 17 maternal deaths between 2019-2021

(MBRACE-UK- Saving Babies Lives, Improving Mothers Care 2023 – Main Report), hence the need to be able to routinely deal with this emergency appropriately and in a timely manner.

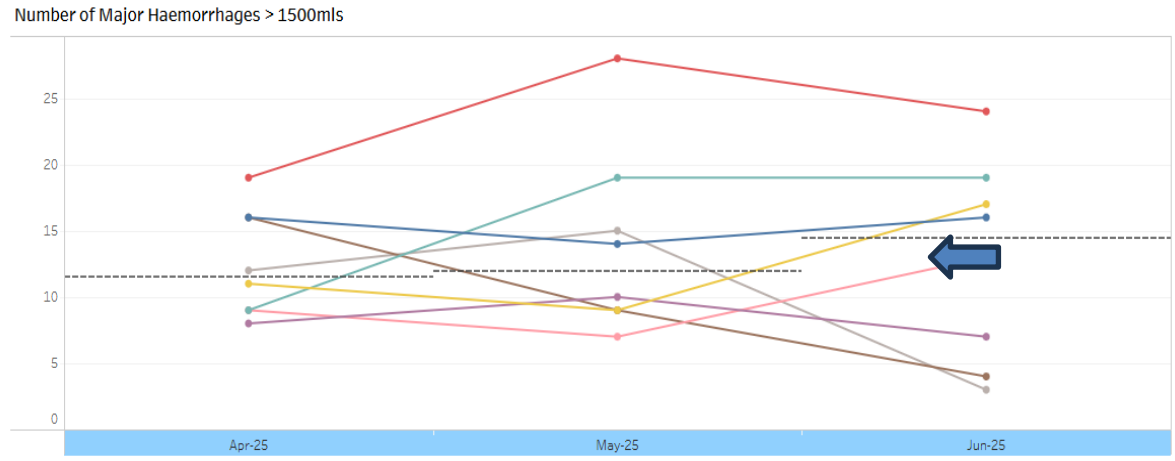
PPH is the most common form of major obstetric haemorrhage. The traditional definition of primary PPH is the loss of > 500 ml of blood within 24 hours of birth. Secondary PPH is defined as abnormal bleeding from the birth canal between 24 hours and 12 weeks postnatally.

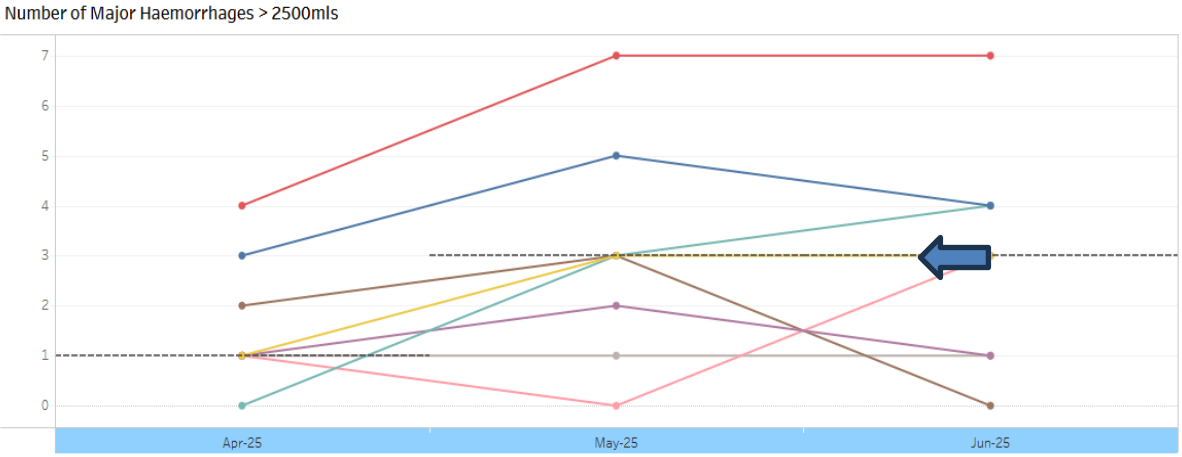
PPH is classified as follows in guidance:

Minor PPH 500 - 1000mls
Major PPH 1000 - 1499mls
Massive PPH Greater 1500mls - 2500mls
Life Threatening PPH greater than 2500mls

Data is submitted to GM for the massive and life threatening PPHs only. This is also captured on our local dashboard.

During Quarter 1, the service reported 25 incidences of PPH >1500mls (GM median 38) and 4 incidences of >2500mls (GM median 7). As can be seen below, Stockport have been consistently below the GM median this quarter.





NB: - The blue arrow indicates Stockport's position

The service facilitates weekly PPH review to maintain close oversight of incidence and management. This process has been strengthened further to introduce a monthly MDT review working group for all PPH's >1.5L. Early themes identified were

- Weighed blood loss not embedded in practice
- PPH proforma and guideline not aligned to current NICE guidance
- Team communication and timings following identification of PPH.

An action plan to address these issues has been completed this quarter and any further actions required will be monitored via the working group and shared within Labour ward forum and the Divisional Risk and Governance meeting.

4.5 Hypoxic Ischaemic Encephalopathy (HIE)

The service had 1 case of HIE reported during Quarter 1.

Datix/ Harm	Reported Date	Description	Location	Demographics/Medical history (Hx)	Immediate Learning
146759 (ATAIN) 146842 (Cooling) MI-041891 StEIS 2025-2918		Suspected HIE IOL for abnormal blood flow studies, Multiple types of analgesia in labour, acute fetal compromise – bradycardia and tachycardic baseline. EMCS 40+1 APGAR's 5, 9, 10, Resuscitation performed, Cord pH's arterial (6.95 BE -15.5) and venous (7.06 BE -13)	DS	Combined risk ratio 1.58; No abnormalities seen at birth. •Asian or Asian British: Pakistani •First language Urdu •Interpreter not required, no issues with language or literacy and no learning disabilities Deprivation Index = 3 •G2P0 •Small fibroids noted on early pregnancy scan – not significant •MH felt low at booking •Never had anaesthetic	Reported to MNSI – accepted investigation Presented at PSIRG on 16/05/25 Reported to NHSR ENS StEIS submitted as MNSI investigation, await report.

		BW 3120g Centile 27.5. Baby required NN resus, admission to NNU and subsequent cooling therapy. MRI – mild HIE, MNSI in progress.		•Hx of domestic abuse previous partner, no concerns new partner •Declined vaccinations (flu, pertussis, RSV)	

5. Perinatal Mortality Review Tool (PMRT)

5.1 A PMRT quarterly paper is submitted to Patient Safety Group and Quality Committee. The Q4 PMRT paper was presented at PSG and Quality committee in May 2025. This paper provided details on quarter 4 reportable cases.

During Quarter 1, there have been 3 cases reported to MBRRACE. These 3 cases will require an MDT review.

1. 18/04/2025- Antepartum stillbirth- 40 weeks gestation, parents declined MNSI input, reported to MNSI for information only.

2. 01/05/2025- Neonatal Death- 25+0 gestation, coroners postmortem undertaken.

3. 09/06/2025- Antepartum stillbirth- 24+2 weeks gestation, under Fetal Medicine Unit (FMU) known contracted parvovirus within this pregnancy.

5.2 In line with CNST year 7 Safety action 1

- *The MBRRACE notifications were completed within the requirement of 7 working days for all cases (100% compliance achieved).*

- *1.2 and 1.3) Surveillance was completed and PMRT review started with parent's perspectives & factual questions completed as required for all 3 cases within the 2 months. (100% compliance achieved).*

During Quarter 4, there was one case reported to MBRRACE which was eligible for PMRT. This review is yet to be completed as the Postmortem/ placental reports remain outstanding.

PMRT from December completed in May: x1 with a joint review with Birmingham Women's Hospital

Datix 137866

Antepartum fetal loss at 23+2, while mother was visiting family in Birmingham.39yr old, G5 P3+1, from Bangladeshi, BMI 27, consultant led care due to previous SGA, on scan pathway. Obstetric History – 2019 NVD at 42 weeks, 2018 Misc, 2015 IOL NVD at 42 weeks, 2013 IOL forceps del at 42 wks.

NVD following IOL, baby weighed 460g.

Care graded B/B – action for Stockport to ensure DV question is documented when asked.

6. MNSI referrals and recommendations

Cases to date	
Total referrals	24
Referrals / cases rejected	7
Total investigations to date	17
Total investigations completed	14
Current active cases	3
Exception reporting	0

There have been 3 completed MNSI cases as detailed below, with one outstanding case remaining.

MI-039621 (Datix 140236)	FDIU 39+2 (Feb 25)	Final report shared. Await action plan to PSIRG. No safety recommendations, safety prompts to consider
MI-039723 (Datix 140616)	Suspected HIE (Feb 25) MRI - Normal	Final report shared. Await action plan to PSIRG. No safety recommendations, safety prompts to consider
MI-041712 (Datix 145471)	FDIU 40+1 (May 25)	Rejected - no parental consent, no omissions await PMRT.
MI-041891 (Datix 146759 / 146842)	Suspected HIE (May 25) MRI – Mild HIE	Interviews completed

There were no new recommendations shared in Quarter 1.

7. Incidents reported as moderate or above

7.1 There have been no reported incidents as moderate harm or above during Quarter 1

8. MNSI/NHSR/CQC concerns raised with the trust

8.1 June – Datix 148761; CQC raised concerns regarding care from patient – managed through CQC enquiry

9. Coroner regulation 28 made with the trust

9.1 Nil reported Quarter 1.

10. Midwifery Red flags

10.1 Red Flags: (Maternity Manager of the Day reviews staffing during the shift and inputs to Datix accordingly). Work has commenced in the service to increase reporting on Midwifery red flags in line with NICE recommendation.

Datix Number	Description	Review / Actions
145925	Triage relocated	Escalation process followed- reviewed by ward manager
144850	M2 Batched observations	Trust/ward manager oversight
145478	In-utero decline	Maternity and NNU matrons review all cases
145277	In-utero decline	Maternity and NNU matrons review all cases
145183	Triage relocated	Escalation process followed- reviewed by ward manager
147592	M2 Delay Doctor review	Rotas being reviewed to include SHO weekend cover to aid discharges. Resident consultant every weekend to aid escalation.
147591	M2 Delay Doctor review	Rotas being reviewed to include SHO weekend cover to aid discharges. Resident consultant

		every weekend to aid escalation.
147483	DS declined in-utero transfer	Maternity & NNU matron's attend In-utero meeting to review cases and escalate to senior management prior to decision
147481	DS declined In-utero transfer	Maternity & NNU matron's attend In-utero meeting to review cases and escalate to senior management prior to decision
146363	Dr's late for ANC	Consultant oversight

There were **0** maternity diverts in Quarter 1

Shared learning

LMNS – Local Maternity and Neonatal System, (regional oversight of incidents and themes). Governance and risk lead midwife attends a monthly Safety SIG event to present local data across regional group of hospitals, identifying themes and learning across the region.

Regional themes/actions summarised for sharing

Item	Themes / Important Messages	Points to consider
1	Management of Pre-term labour with particular identification of subtle signs of labour.	• Listen to women and observe and monitor changes in subtle labour symptoms. • For non-tertiary units to consider early intra-uterine transfer alongside early optimisation. • IT systems communicate effectively so that information is shared at the appropriate time and place.

2	Several safety events related to instrumental deliveries and birth trauma to mother or baby.	• Consider station of presenting part and appropriate number of pulls on forceps blades. • Consider effective communication with obstetric and maternity staff when undertaking an instrumental delivery.

Pre-term labour and subtle signs of pre-term labour patient information leaflet is being developed by GM. This is also discussed at SBL training and there are posters to prompt staff. The information leaflet will be useful for women to identify pre-term labour and this will be translated into the 5 most common languages in GM.

11. Midwifery, Obstetric, Neonatal nursing and Neonatal medical workforce

11.1 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® midwifery staffing review (March 2023). A further Birthrate plus® workforce review will commence in September.

At the end of Quarter 1, the service has the following vacancy:

- 3.02wte clinical midwives
- 8.76wte Midwives on maternity leave
- 3.52wte MSW

Proposed plans are in discussion regarding the recruitment of Stockport's Student Midwives that are due to qualify in September to fill vacancy and support turnover.

Supernumerary status of shift coordinators 100% for Quarter 1.

Labour Ward Co-ordinator Supernumerary status	Percentage of shifts where the Labour Ward Co-ordinator is supernumerary at the start of the shift.	%	100.0%	100.0%	100.0%

One-to-one care in labour-

April - 96.5%

May - 98.6%

June - 98.4%

(This data excludes elective and emergency caesarean section deliveries. A total of 405/666 births were eligible and 396 received 1:1 care. There were 6 BBA's, 2 precipitate deliveries and 1 fully dilated on arrival)

1:1 Care in Labour	One to One Care % Delivered (Minus EL LSCS and EMCS)	%	96.5%	98.6%	98.4%

11.2 Obstetric cover

The service currently provides 24/7 obstetric cover on delivery suite. MDT ward rounds take place twice daily, 7 days per week.

- Dr Lucy Tomlinson is the Clinical Director for O&G
- Currently 15 O&G consultants providing Obstetric cover. A 16th consultant has been appointed to commence in September.
- Every weekend has a resident long day obstetric consultant on Delivery Suite
- 7/10 weekday nights have a consultant on call solely responsible for obstetrics the other 3 nights the consultant covers O&G
- Consultant lead roles for Delivery Suite, Governance, Fetal Monitoring, Pre-term birth, Maternal Medicine and SGA.
- 0.2 WTE short on Tier 2 rota due to 80% trainee and 0.4 WTE short of the tier 1 rota due to 2 80% trainees. These shifts are filled mostly with internal locums or external locums with Certificate of Eligibility.

11.3 Anaesthetic Workforce

The service has 24-hour maternity anaesthetic cover in place. A resident consultant covers 8-6pm weekdays in addition to a IACOA dedicated senior doctor 24/7. Out of hours, the consultant allocated to CEPOD covers maternity emergencies.

11.4 Neonatal workforce

Nursing workforce has a 2.45wte vacancy but remains compliant with BAPM staffing requirements.

The trust is now compliant for Tier 3 medical staffing with effect from September 2024 following the employment of two additional Paediatric Consultants.

Funding has been agreed for Tier 1 medical staffing to align to BAPM standards.

12. Training compliance in line with the core competency framework Version 2 (CCFv2)

12.1 The below table demonstrates compliance for Quarter 1 against the core competency framework in line with the Maternity Incentive Scheme Year 7 requirement. Training targets are set at 90% for all elements, with a stretch

target of 95%. The CCFv2 sets out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

The service facilitates 5 mandatory study days which cover all requirements of the CCFv2. The following tables demonstrate compliance for the 4 elements of training required for CNST year 7.

Staff group	Fetal Monitoring April 2025	Fetal Monitoring May 2025	Fetal Monitoring June 2025
MIDWIVES	97%	97%	97%
DOCTORS O&G	94%	88%	88%
OVERALL	96%	94%	94%

Staff group	NNR April 2025	NNR May 2025	NNR June 2025
MIDWIVES	98%	99%	98%
AP only	100%	100%	100%
OVERALL	97.5%	97%	96%
NEONATAL NURSES	100%	97%	82%
PAEDIATRICIANS	97%	97%	97%

Staff group	PROMPT April 2025	PROMPT May 2025	PROMPT June 2025
MIDWIVES	98%	99%	98%
DOCTORS O&G	90%	93%	93%
AP/MA	98% (Role spec)	96% (Role spec)	96% (Role spec)

OVERALL	93%	95%	95%
ANAESTHETISTS	67% (Role Spec)	80% (Role Spec)	83% (Role Spec)
OPD/ANAESTHETIC NURSES	91% (Role Spec)	91% (Role Spec)	95% (Role Spec)

Staff group	SBL V3 April 2025	SBL V3 May 2025	SBL V3 June 2025
MIDWIVES	98%	97%	97%
DOCTORS O&G	90%	95%	93%
AP/MA	98% (Role spec)	98% (Role spec)	96% (Role spec)
OVERALL	93%	94%	95%
ANAESTHETISTS	67% (Role Spec)	80% (Role Spec)	83% (Role Spec)
OPD/ANAESTHETIC NURSES	91% (Role Spec)	91% (Role Spec)	95% (Role Spec)

- PROMPT overall compliance for all staff groups has reached the stretch target of 96%
- Neonatal Resuscitation overall compliance is 97% this month.
- SBLCBv3 overall compliance 94%
- Fetal Monitoring for all Midwives and Obstetricians ST3 and over, Overall compliance = 97%
- Maternity Education 97%
- Public Health 96%

There is a current focus on the Anaesthetic staff group to ensure compliance >90% for PROMPT in line with CNST safety action 8.

13. Service user feedback

13.1 Following the CQC maternity survey results 2024, an action plan has been co-produced with the MNVP lead. This has been shared within the Trust Patient experience group and Maternity Safety Champions Group. Progress

will be monitored via the Women's and Children's Risk and Governance group.

Work is ongoing to review the systems in place to obtain patient feedback. The service have recognised that this is an area that requires further development and plan to work with the MNVP and Trust Patient experience team to explore available options to ensure that patient feedback is accessible and inclusive for all our service users.

Staff feedback

Maternity Safety Champions Walk rounds take place bi-monthly. During Quarter 1 there have been 2 walk rounds.

20th May- Maternity triage. Feedback was obtained from service users during the visit with positive feedback received regarding the timeliness of clinical assessment. However, there was a dissatisfaction with the triage area from a comfort and welcome perspective. Staff shared their vision for how the service could improve in the short and long term and further discussions are planned to explore the use of charitable funds to make some short-term changes to enhance the patient experience in the department.

23rd June- focus on maternity triage to delivery suite patient transfer. The medical director timed a walkthrough of transferring to delivery suite using an alternative lift to the dedicated emergency transfer lift. An action has been taken to implement a full emergency patient transfer drill bi-annually to be shared with the team.

The PMA group are planning to launch a staff voices engagement project to encourage a strengthened team ethos, and a culture day is planned for September in response to the SCORE survey.

Following the staff survey, a Staff Experience Improvement plan has been developed to be shared with the team. This will be monitored through risk and governance for progress.

Perinatal culture and leadership programme action plan in place led by the Maternity Quadrumvirate

14. Progress against Maternity Incentive Scheme (MIS)

14.1 The Maternity Incentive scheme data collection period runs from 2nd April-30th November. The maternity service successfully declared full compliance with the scheme for year 6.

CNST year 7 launched 2nd April 2025. The reporting periods for each safety action is between April 2025 – 30th November 2025, within each safety action there are specific requirements that need to be reported throughout this time frame. All safety actions will not be BRAG rated as complete until each standard has been met, therefore the BRAG rating will reflect progress. Any concerns with achieving compliance will be raised within the report.

B	Complete
R	Concerns in achieving compliance
A	Some challenges that need support
G	On track no action needed

Action No	Maternity Safety Action	August 2025
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	G
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	G
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	G
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	G
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	G
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	G
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	G
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training? Required Standard 90% of attendance in each relevant staff group	Y
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	G
10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	G

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

4.1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

-Audit demonstrates 100% compliance against the required criteria for action ***(appendix 1)***

4.4) Has the trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance

-Audit compliance demonstrates 100% compliance with this action ***(appendix 1)***

4.7) Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?

-Audits for September-December 2024 and January-April 2025 demonstrate 100% compliance with this action ***(appendix3&4)***

15. Saving Babies Lives Care Bundle V3 (SBLCBv3)

15.1 Progress towards full implementation of SBLCBv3 continues, with ongoing targeted QI work and Action plans in areas of each element requiring improvement.

The SBL Assurance process for CNST Y7 has been streamlined by GM LMNS with Provider progress towards full implementation of process intervention metrics reported via a modified SBL Implementation tool on NHS Futures platform. The first submission of this new implementation tool for CNST Y7 was completed by the deadline of 6th June 2025.

In line with CNST year 7, there is an ask that a minimum of three assurance discussions are held within the reporting period of 2nd April-30th November 2025. The first assurance meeting was held on 17th June and Stockport received an assurance rating of 'Significant Assurance' and an implementation progress result of 99% against the 6 elements.

Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	99%	Partially implemented	99%

Due to the fluctuating nature of performance and outcome metrics, compliance data for all interventions across the elements will be reported via a separate GM database with agreed thresholds and standards for auditing. This will facilitate ongoing monitoring of all interventions but reduce the burden of reporting where compliance is consistently achieved and allow focus on specific areas of non-compliance that require targeted improvement.

Current compliance for element 6 of 83% aligns with the introduction of the recent GM guideline, once completed this will increase trust compliance to 100%

Gaps and QI progress will be monitored through the ongoing LMNS Quarterly Assurance meetings – the next assurance meeting will be held on 16th September.

16. Three-year delivery plan for maternity and neonatal services (2023)

16.1 The Three-year delivery plan (March 2023) sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for

women, babies, and families by incorporating the findings from the Ockenden (2020/2022) and East Kent (2022) reports.

Stockport NHS Foundation trust has reported full compliance against the 7 IEA in the Ockenden report with the exception of a consultant midwife.

16.2 The Three-year delivery plan focuses on 4 themes with the implementation of all key objectives to be in place by 2026:

1. Listening to and working with women and families, with compassion
2. Growing, retaining, and supporting our workforce
3. Developing and sustaining a culture of safety, learning, and support
4. Standards and structures that underpin safer, more personalised, and more equitable care.

16.3 The Maternity Perinatal Performance Oversight Panel (MPPOP) implemented by the LMNS have reviewed quarter 1 evidence and BRAG rating, and Stockport remain on target to meet full compliance across the 4 themes.

Theme	Description	BRAG
1	Listening to and working with women and families with compassion	G
2	Growing, retaining and supporting our workforce	A
3	Developing and sustaining a culture of safety, learning and support	A
4	Standards and structure that underpin safer, more personalised and more equitable care	A

Out of 72 actions, BRAG rating position for Quarter 1 as follows;

Blue -41

Green -23

Amber -8

Red -0

An area where compliance will not be met to highlight is the Maternity EPR system that will not be in place by 2026

Work continues against the outstanding actions- Q2 assurance planned for 30th October.

17. Health Inequalities -GMEC Equity and Equality

17.1 The GM Equity and Equality action plan provide both system and provider level actions over a 5-year time frame to complete in 2027.There are a total of 68 provider level actions from 2022-2025. A number of these actions are in progress, and a working group has been developed to ensure momentum is maintained with progress.

As part of the Equity and Equality workstream within the LMNS, a Vitamin D task and finish group has been commenced and will play a vital role in shaping our local response to disparities in maternal health outcomes, particularly in relation to vitamin D supplementation during pregnancy. A representative from the Equity and Equality working group will represent Stockport at this meeting in July.

18. LMNS/ICB Assurance visit – Progress against recommendations

18.1 The Stockport NHS Foundation Trust Maternity Oversight Group (MOG) has been established following the feedback and outcomes of the assurance visit undertaken by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) on 15 October 2024.

The recommended level of oversight to be undertaken by the LMNS on behalf of the NHS GM Integrated Care Board (ICB) is Enhanced Surveillance.

The Maternity Oversight Group meet monthly and progress with the action plans for each workstream are reviewed. The workstreams under enhanced surveillance are: -

- Maternity triage
- PWR data
- Bereavement team psychological supervision
- Medical cover for triage
- Digital roadmap

The latest oversight meeting took place on 12th June with assurance that progress is being made with the action plans over the 5 areas. Exit criteria are currently in discussion.

19. Midwifery Continuity of Carer (MCoC)

19.1 NHS England is funding an enhanced midwifery continuity of care model that builds on the default continuity of care model. The default midwifery

Continuity of Carer (MCoC) model aims to deliver personalised care to women by having the same midwife or a small team of midwives provide care throughout a person's pregnancy and in the post-partum period.

Enhanced MCoC aims to provide extra support to women and their families in the most deprived areas of England. In practice, the enhanced MCoC model provides additional funding to LMNS's based on numbers of women living in the most deprived 10% of neighbourhoods. Funding has been awarded to the trust following a successful bid which was submitted through the LMNS. This funding has enabled the service to recruit two band 4 Assistant Practitioners for our MCoC teams to provide "holistic support that reduces midwives' workload and releases additional time for the midwives to care for women" (NHS 2021).

In Stockport we have seen a rise in our young parent's (YP's) pregnancy rate and a significant rate of under 16's getting pregnant, this has tripled since 2021. In 2024 the service booked 51 YP's compared to 47 in 2023.

The pilot MCoC 'Willow team' launched on 25th March prioritising continuity of care to young parents and to women from Stockport's most deprived area. Since launching, the Willow team have successfully provided full maternity continuity of care to 41% of their caseload.

Appendix 1

CNST safety action 4 evidence

Safety action 4 – Obstetric medical workforce

4.1 - NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grades) rotas;

A – Currently work in their unit on the tier 2 or 3 rota

Or

B – have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)

Or

C – Hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums

Short term O&G Locums 01/02/25-31/08/25

Name	Criteria met
AS	B
SB	A
UB	A
DP	A
DN	A
SS	A
CC	A
AT	A
JR	A

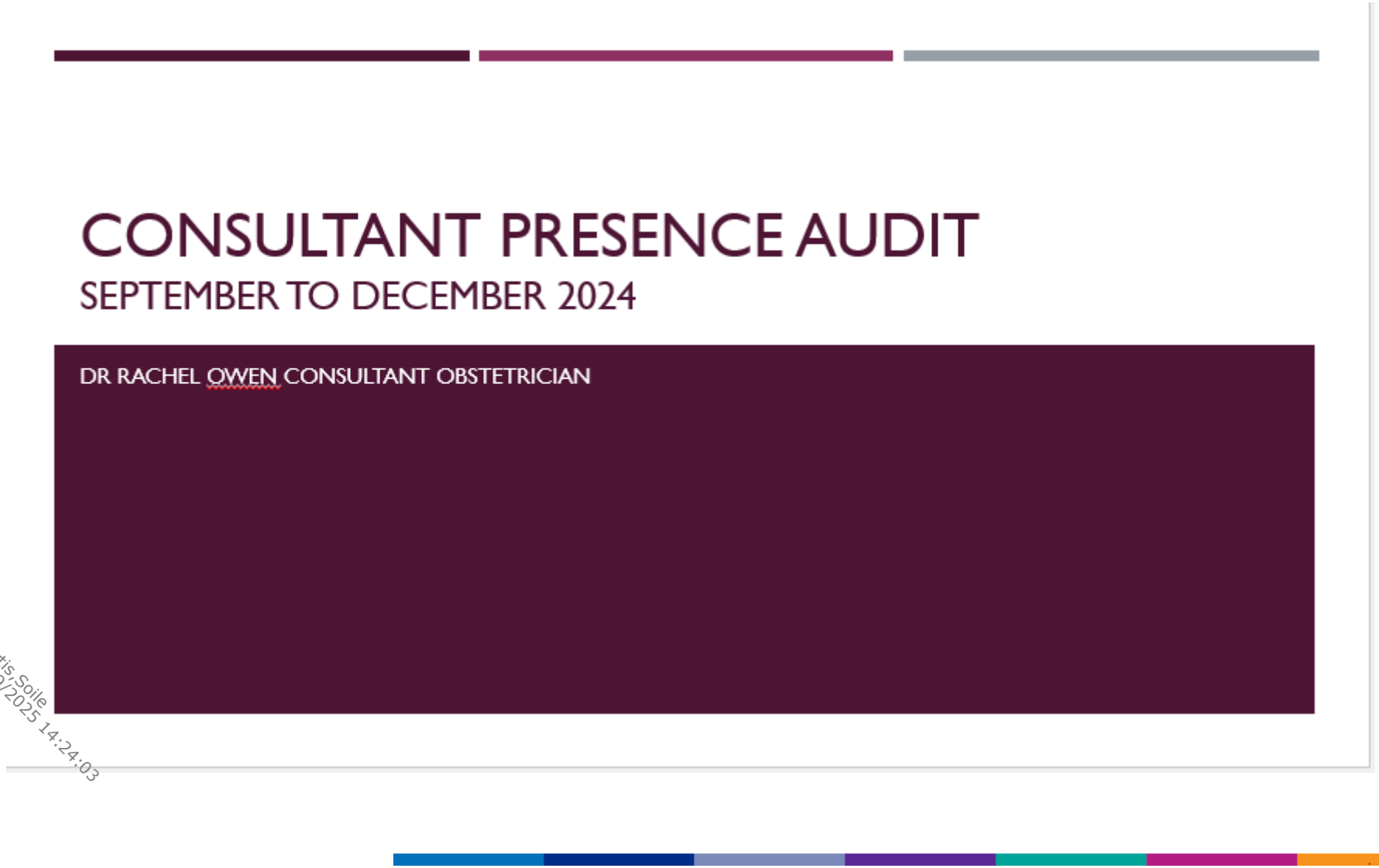
The audit demonstrates compliance has been met for Safety action 4 and does not require an action plan.

4.4 - Implemented the RCOG guidance on engagement of long term locums and provided assurance that they have evidence of compliance

Name	Criteria Met (monitoring and Effectiveness tool used)
AM	Y
TM	Y
SS	Y

Appendix 2

CNST Safety action 4.7 evidence



SUMMARY

- As per CNST standards, we are required to continue to monitor the compliance of consultant attendance for the clinical situations listed in the RCOG workforce document 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology.'

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SEPTEMBER 2024

- 4 cases identified requiring consultant presence as per RCOG guidance.
- 100% consultant attendance, consultant present for each case.
- 1 case of Caesarean section for placenta praevia, consultant did CS.
- 1 case of PPH and return to theatre following Em Cs, requiring brace suture and uterine artery ligation, consultant directly involved throughout.
- 1 case of PPH > 2litres following forceps delivery, MOH instigated, required Bakri balloon, total EBL 2.5litres. Consultant directly involved throughout.
- 1 case of intrapartum stillbirth – unplanned birth at home, woman and baby transferred via ambulance to hospital and consultant called to attend unit.

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OCTOBER 2024

- 2 cases identified requiring consultant presence as per RCOG guidance.
- Consultant present for both cases
- 1 case was a Caesarean section for a patient with a BMI >50
- 1 case was a postpartum haemorrhage of 3195mls in which the emergency buzzer was used and the consultant attended immediately with the MDT to manage the PPH including the instigation of the Massive Obstetric haemorrhage protocol.

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NOVEMBER 2024

- 4 cases identified requiring consultant presence
- Consultant present for all 4 cases
- 2 cases of PPH > 2 litres, one case required transfer to HDU for short period of observation
- 1 case of return to theatre following CS for Examination under anaesthetic and surgical evacuation of uterus due to ongoing bleeding within 24 hours of the CS
- 1 case of eclampsia requiring stabilisation and delivery by urgent Caesarean section.

DECEMBER 2024

- 5 cases identified requiring consultant presence
- Consultant present for all 5 cases.
- 1 case of complex extensions at CS and return to theatre. Consultant called and attended for CS and undertook return to theatre the following day.
- 3 cases of PPH of 2 litres or above. Consultant already present for 1 case following forceps birth and called to attend for the other 2 cases.
- 1 case of second theatre being opened at night due to Category 1 CS whilst theatre occupied with perineal repair, consultant called to attend and attended.

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SUMMARY

- Current data demonstrates 100% compliance with consultant presence according to indications listed in RCOG document.

Curtis Soile
26/09/2025 14:24:03

Appendix 3

CNST safety action 4 evidence

CONSULTANT PRESENCE AUDIT

JANUARY 2025 – APRIL 2025

DR RACHEL OWEN CONSULTANT OBSTETRICIAN

JANUARY 2025

- 4 cases identified requiring consultant presence as per RCOG guidance
- 100% consultant attendance – consultant attended for all 4 cases
- Three cases of elective Caesarean section for placenta praevia. All cases done as elective procedures with consultant present for each case.
- One case of Caesarean section for a patient with BMI >50. This was a Category 2 CS for early labour and footling breech presentation, the BMI was 55 and the consultant was present in theatre throughout the case.

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FEBRUARY 2025

- 8 cases identified requiring consultant presence as per RCOG guidance.
- 100% consultant attendance, consultant present for each case.
- 1 unexpected intrapartum stillbirth at term, admitted in early labour, prev Caesarean section, FDIU on antenatal ward, consultant present to confirm FDIU and make plan of care. MNSI case.
- 2 cases where second theatre opened due to second emergency. Consultant called to attend and attended for both cases.
- 2 cases of CS for placenta praevia, both elective cases, consultant present for both
- 1 case of ITU admission following CS, thought due to anaphylactic reaction possibly to anaesthetic drug(s), Obstetric and Anaesthetic consultants directly involved throughout. Patient recovered quickly.
- 2 cases of PPH >2 litres, both at CS, cons present for CS in both cases. 1 case also return to theatre, consultant involved directly in return to theatre.

MARCH 2025

- 2 cases identified requiring consultant presence as per RCOG guidance
- 100% consultant attendance – consultant attended for both cases
- 1 case of Caesarean section for BMI >50. Category 2 CS for malpresentation, consultant called to attend and attended
- 1 case return to theatre. Elective CS, developed small bowel obstruction on day 3 post op due to adhesions, laparotomy under General surgeons and short stay on HDU post op. Consultants directly involved throughout care
- 1 other case of possible CS for woman with BMI >50 but notes not available and not enough information on electronic notes to determine BMI at time of birth.

APRIL 2025

- 4 cases identified requiring consultant presence
- Consultant present for all 4 cases
- 2 cases of PPH – MOH activated, 2 litre loss following forceps delivery, loss due to trauma and tone, consultant present throughout case. Other case of PPH due to retained placenta, transferred to theatre and MOH activated, consultant called to attend and attended.
- 1 case of CS for placenta praevia. Category 3 CS due to recurrent APH, consultant did the CS
- 1 case of ITU admission day 2 post elective CS due to pneumonia and lung collapse. Consultants directly involved throughout care.

NHS Stockport NHS Foundation Trust

				Agenda No.	14
Meeting date	2 October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	People Performance Committee – Alert, Advise & Assure Report				
Director Lead	Beatrice Fraenkel, Chair of People Performance Committee	**Author**	Beatrice Fraenkel, Chair of People Performance Committee Soile Curtis, Deputy Company Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the People Performance Committee including matters for escalation to the Board of Directors.					

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
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

This 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
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
	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
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
	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	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 an Alert, Advise & Assure 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 meeting of the People Performance Committee held in September 2025, noting areas of alert, advice and assurance.

NHS Stockport NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	David Curtis, Non-Executive Director (Acting Committee Chair)
Date of Meeting	11 September 2025
Quorate	Yes

The People Performance Committee draw the following key issues and matters to the Board of Directors' attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • People Integrated Performance Report • Operational Plan Update • Medical Appraisal & Revalidation Report • Annual Staff Flu Vaccination Programme • Violence & Aggression Standards • Guardian of Safe Working – Q1 • GMC Annual National Trainee Survey • Resourcing & Retention Update • Advancing Levels of Attainment E-Rostering and Job Planning • Safer Care (Staffing) Report • Collaborative Working Position Update • Board Assurance Framework and Aligned Significant Risks • Alert, Advise & Assure Reports: - Joint Health & Wellbeing Group - Equality, Diversity & Inclusion Group - Educational Governance Group
2.	**Alert**	No matters from this meeting to alert to the Board of Directors.
3.	**Advise**	The Committee will continue to seek assurance in areas below trajectory including: • Appraisals – Overall appraisal compliance in July 2025 was 80.52% (reflective of the new cascade approach), which is a slight increase on the previous month of 79.77%, but an overall decrease in the 4-month position by 4.37%. Work is ongoing to address the issue. • Agency expenditure – Performance against the 1.5% agency spend as a percentage of pay bill is above target at 2.16%. Ongoing actions taken to improve the position. • Time to hire – Decreased in July 2025 to 59 days from 61 in June, and is slightly above the target of 57 days. The Committee received a report providing an update on workforce delivery against the 2025/26 Operational Plan. The Committee noted actual versus planned staffing levels, variance trends and progress on strategic workforce and Cost Improvement Programme (CIP) targets. It was noted that most planned initiatives had been delivered except for the Devonshire neuro-rehabilitation transfer which had been delayed. The Committee received a report providing an update on progress made in

		addressing violence and aggression towards staff. The Committee heard that under-reporting of incidents remained a concern and noted mitigating actions in this area, including introduction of a new checklist tool, enhanced training and promotion of anonymous reporting mechanisms. The Committee received a Safer Care (Staffing) Report, which provided 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 Committee acknowledged the improved sickness absence position. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2025/26 to Board of Directors in October 2025.
4.	**Assure**	Positive assurance received around the following People metrics: • The in-month sickness rate for July is 5.17%, which is below the target of 5.5%. • Mandatory training compliance at 95.61%, which is above target of 95%. • Turnover (adjusted) remains compliant at 10.06% and is below target of 11.5%. The Committee noted positive assurance regarding the Trust's medical appraisal and revalidation processes. The Quality Committee had referred the matter of staff vaccination rates to the People Performance Committee to enable early consideration of what could be done differently this year to increase uptake in this area. The Committee received a report on the Trust's approach to this year's staff flu vaccination campaign and heard that a programme and communications were being developed based on insight from NHS England regarding vaccine hesitancy. The Committee received a General Medical Council (GMC) Annual National Trainee Survey Report. The Committee noted a high response to the survey and heard that overall the Trust's scores were within national average. Areas of good practice were acknowledged and action plans were being developed for low-performing specialties The Committee received a report providing an overview of the Guardian of Safe Working activity between 3 March 2025 and 31 July 2025. The Committee noted relatively low exception reporting and forthcoming changes to the reporting system. It was noted that one immediate safety concern had been identified during the reporting period, which had been appropriately addressed and managed.
5.	**Referral of Matters/Action to Board/Committee**	
6.	**Report compiled by:**	**David Curtis, Non-Executive Director**

7.	**Minutes available from:**	**Soile Curtis, Deputy Company Secretary**

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				Agenda No.	15
Meeting date	2 October 2025	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Stockport NHS Foundation Trust 2024-2025 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 are asked to review the Stockport NHS Foundation Trust 2024-2025 Annual Submission to NHS England North-West: Appraisal, Revalidation and Medical Governance report, and support this being returned to NHS England North-West, as recommended by the People Performance Committee.					

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	*	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
	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)
Financial impacts if agreed/not agreed	1A (ii)
Regulatory and legal compliance	1B
Sustainability (including environmental impacts)	1A (ii)

Executive Summary

The Trust is required to submit the Stockport NHS Foundation Trust 2024-2025 Annual Submission to NHS England North-West: Appraisal, Revalidation and Medical Governance report.

The report is attached, and the purpose of this is to provide 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 the national requirements, which 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 continue to recruit additional Medical Appraisers in 2025/26 to maintain the required levels of staffing in this area, and the report highlights the plans that are in place to address this.

1. Purpose

The Board of Directors are asked to review the Stockport NHS Foundation Trust 2024-2025 Annual Submission to NHS England North-West: Appraisal, Revalidation and Medical Governance report, and support this being returned to NHS England North-West, as recommended by the People Performance Committee.

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 small 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 Sections 1-2 details the response to the specific questions from NHS England and provides assurances that these are being managed appropriately and as required.

3.2 Section 3 details the summary, including actions that need to be undertaken.

3.3 Section 4 requires signing off by the Chief Executive or Chair of the Trust.

4. Recommendations

4.1 The Board of Directors are asked to review the Stockport NHS Foundation Trust 2024-2025 Annual Submission to NHS England North-West: Appraisal, Revalidation and Medical Governance report, and support this being returned to NHS England North-West, as recommended by the People Performance Committee.

2024-2025 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 2025**.

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.

2024-2025 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?	NHS Acute Trust.

	Name	**Contact Information**
Responsible Officer (RO)	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 Responsible Officer Report to the Board:
Action from last 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, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

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

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however 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 provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of Stockport NHS Foundation Trust can confirm that:

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

Y/N	Yes.
Action from last year:	1. Continue with the current status.
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:	1. The current RO is leaving the Trust on the 30.09.2025. The Chief Executive Officer / Trust will ensure the appointment of an RO to ensure the duties and responsibilities are fulfilled.

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

Y/N	Yes.
Action from last year:	To continue with the current status, 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.
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, providing a service noting point 3 above. 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. ➢ 33 Appraisers (0.25 programmed activity allowance) conducting eight appraisals per year. A central funding pot for appraiser PAs has now been made operational and is available for all newly recruited appraisers with effect from April 2025, fully addressing points 1 and 2 above.
Action for next year:	To continue with the above, and to note the following actions: 1. Recruit to all appraisal slots using the central funding pot with a target for the achievement of this being set for December 2025.

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

Y/N	Yes.
Action from last year:	1. To continue with the above, but noting the following action: 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 2025/26. 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.
Comments:	The records are held on GMC connect, and in the automated Appraisal & Revalidation System, currently the Premier IT System. We are engaging with colleagues at Tameside and Glossop Integrated Care NHS Trust to review and explore whether a joint solution is the best approach for our future model.
Action for next year:	1. To complete the above review and potential alignment of software solutions with Tameside and Glossop Integrated Care NHS Trust.

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

Y/N	Yes.
Action from last year:	1. To continue with the current status.
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	1. To continue with the above.

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

Y/N	Yes.
Action from last year:	1. To continue our collaboration with East Cheshire NHS Trust and The Christie NHS Foundation Trust.
Comments:	Collaboration with East Cheshire NHS Trust and The Christie NHS Foundation Trust continues. Appraiser refresher events are taking place, with 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 2025/26.

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.

Y/N	Yes.
Action from last year:	1. To continue with the current status.
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 on behalf of the Trust Medical Appraisal Lead. They offer an opportunity to discuss Good Medical Practice, 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	1. 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 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.

Y/N	Yes.
Action from last year:	1. Continue with the current status.
Comments:	The average Trust annual compliance rate in the 2024/25 year was 92.45%. All doctors due to appraise in 2024/25 completed their appraisal, or had a formal postponement approved (due to long-term sickness absence or maternity leave) or left the Trust. 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:	1. To 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.

Y/N	Yes.
Action from last year:	1. Continue the current process.
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:	1. To continue with the above.

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).

Y/N	Yes.
Action from last year:	1. Continue with the current process.
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:	1. Continue with the above.

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

Y/N	Yes.
Action from last 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.
Comments:	Despite this rise in the number of doctors employed, the Trust has ensured that all eligible doctors were able to appraise in 2024/25. Currently, there are 485 doctors requiring an appraisal. Following further recruitment in 2024/25, the Trust currently has 44 trained appraisers providing 410 appraisal slots.

	This means that in 2025/26 the Trust faced a shortage of appraisal slots. The issue was escalated to the Responsible Officer, Medical Appraisal Lead, and the Trust Medical Workforce Group. A 'central funding pot' for funding Medical Appraisers (currently funded from divisional budgets) has now been created so that funds are readily accessible for the appointment of Medical Appraisers, as required.
Action for next year:	1. Continue with regular recruitment rounds to appoint new appraisers, as required, with the next one being scheduled for Autumn 2025.

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).

Y/N	Yes.
Action from last year:	1. To improve the frequency of Appraisal Support Group meetings. 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.
Comments:	In the 2024/25 period, two Appraisal Support Group meetings have taken place on the 23/09/2024 and 09/03/2025. The next ASG meeting is scheduled to take place on 14/10/2025. 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 with 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. 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.

Y/N	Yes.
Action from last year:	1. The Trust plans to undertake a new Quality Assurance exercise in 2024/25.
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 2025 Quality Assurance exercise is currently underway with results due to be reported at the next ASG in October 2025.
Action for next year:	1. To undertake another quality assurance exercise in 2026.

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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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. There is currently one doctor who started with the Trust whilst under open investigation by the GMC in 2024/25 that highlighted any fitness to practice concerns. No patient or staff safety concerns were at play in that case, with no restrictions imposed by the GMC.
Action for next year:	1. Continue with current status.

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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. Continue with current status.

1D – Medical governance

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

Y/N	Yes.
Action from last year:	1. Continue with current status.
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. There have been no exceptions in this process in the last year.
Action for next year:	1. Continue with the above.

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

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. Continue with the above.

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

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. 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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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 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.
Action for next year:	1. Continue 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.

Y/N	Yes / partial (just to note required action)
Action from last year:	1. Continue with current status.
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. All doctors undergoing a disciplinary process are also brought to the attention of a lead non-executive director.
Action for next year:	1. Consider how best to record and report information ascertaining to the protected characteristics of the doctors and country of primary medical qualifications.

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.

Y/N	Yes
Action from last year:	1. Continue with current status.
Comments:	The systems and processes for responding to concerns are now well established, including the transfer of information between organisations and RO's. This communication is now effective, and evidence is available to demonstrate that this is completed in a timely manner.
Action for next year:	1. To review the recruitment process with regards to the transferring of information during the recruitment process.

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 (Ref GMC governance handbook).

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. Continue with the above

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

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. 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 (Ref Messenger review).

Action from last year:	1. Continue with current status.
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:	1. Continue with the above. 2. The Physician Associates are now also being brought into the Trust appraisal system with the Medical Director appointed as the Lead Executive. The Medical Director is reviewing the findings of the Leng enquiry and presenting a plan for its implementation in September 2025.

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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
Comments:	Qualifications and experience are assessed at the interview stage and also through the application form and/or CV. All pre-employment checks are carried out within the Recruitment Department. 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:	1. 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.

Y/N	Yes.
Action from last year:	1. To continue with status.
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:	1. 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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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 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:	1. Continue with the 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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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. 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:	1. 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).

Y/N	Yes.
Action from last year:	1. Continue with current status.
Comments:	The Trust is proactive at inductions and appraisals whereby employees are reminded that if they have any concerns these can be raised in 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 these 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:	1. Continue with the 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.

Y/N	Yes.
Action from last year:	1. To continue with current status.
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:	1. Continue as 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.

Y/N	Yes.
Action from last year:	1. Continue with current status.
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:	1. Continue as above.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	475
Total number of appraisals completed	446
Total number of appraisals approved missed	10
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	108
Total number of late recommendations	4
Total number of positive recommendations	94
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	25
Total number of trained case managers	2
Total number of concerns received by the Responsible Officer[1]	0
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	14 months extended due to sickness and resignations.
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0

[1] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	116
Total number of new employment checks completed before commencement of employment	All were in line with NHS Employment Check Standards.
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[2]	0

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.
Actions still outstanding
1a (ii) The Trust does still need to continue to recruit additional appraisers to help ensure that all appraisees have an appraiser in 2025/26.
Current issues
A high priority for the Trust remains to recruit additional appraisers so that each appraisee has an assigned appraiser. To assist with the above, the Trust has now implemented 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 and is exploring if this can be done in partnership with Tameside and Glossop Integrated Care NHS Foundation Trust to maximise efficiencies.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1A (i) The current RO is leaving the Trust on the 30.09.2025. The Chief Executive Officer / Trust will ensure the appointment of an RO to ensure the duties and responsibilities are fulfilled. 1A (ii) Ensure that Trust has recruited additional appraisers so that each appraisee has an assigned appraiser. 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.

[2] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

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 2026. 1D (ix) The Physician Associates are now also being brought into the Trust appraisal system with the Medical Director appointed as the Lead Executive. The Medical Director is reviewing the findings of the Leng enquiry and presenting a plan for its implementation in September 2025.
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 doctors due to appraise in 2024/25 completed their appraisal, or had a formal postponement approved (due to long-term sickness absence or maternity leave). This is a great achievement, and the Trust will look to enhance the services in 2025/2026 through recruiting further appraisers and looking to secure the best available appraisal and revalidation system.

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:	Stockport NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

NHS Stockport NHS Foundation Trust

				Agenda No.	16
Meeting date	2 October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Audit Committee – Alert, Advise & Assure Report				
Director Lead	David Hopewell, Chair of Audit Committee	**Author**	Lisa Byers, Assistant Director of Finance		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Audit Committee including matters for escalation to the Board of Directors.					

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

This 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	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 an Alert, Advise & Assure 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 Audit Committee meeting held in September 2025, noting areas of alert, advice and assurance.

NHS
Stockport
NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell
Date of Meeting	16th September 2025
Quorate	Yes

The Audit Committee draw the following key issues and matters to the Board of Director's attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • Risk Management Committee Key Issues Report – September 2025 • Feedback from Board Committees • Internal Audit Progress Report • Internal Audit Follow Up Report September 2025 • Anti-Fraud Progress Report September 2025 • Failure to Prevent Fraud Update • External Audit Progress Report • Arrangements by which staff can raise concerns
2.	**Alert**	The Committee discussed IT risks within the Trust both within discussions on the Risk Management Report and the Internal Audit Follow Up Report. The Committee will continue to seek further assurance in this area. More generally, where dates to Follow Up actions have been changed, it was agreed that future changes will need to be agreed with the Executive Lead and include in future reports to the Audit Committee where dates have slipped.
3.	**Advise**	MIAA provided a further update to the Committee on the new Failure to Prevent Fraud legislation on the steps to be taken in quarters two and three to prepare the organisation. MIAA are offering briefing webinars for Boards & Senior Leaders - Preparing for the New Corporate Criminal Offence on the Tuesday 30th September and Friday 10th October. The Committee received a report providing feedback on the Counter Fraud Functional Standard Return was submitted in May 2025. The Committee received a report on arrangements in place by which staff can raise concerns. It was advised of a multiple routes and mechanisms for staff to raise concerns and further work ongoing to reinforce a culture where staff feel safe to do so. The People Performance Committee will be asked to maintain oversight of this area. MIAA will also be conducting a Freedom to Speak Up audit in 2026/27.
4.	**Assure**	The Committee were assured on progress of the Internal Audit Plan for 2025/26 Performance indicators all rated green. The Committee received the following final audit reports: • Quality Spot Check – Moderate Assurance • Fit and Proper Person - Substantial Assurance

		The Committee received assurance that the recommendations found in five ward areas within the report are being addressed Trust wide. The Clinical Effectiveness Group are reviewing the actions to report to the Quality Committee. The Audit Committee will receive a further update after the MIAA report has been followed up at Quality Committee. The Committee received the Anti-Fraud Report for September 2025 and an update on the status of current investigations.
5.	**Referral of Matters/Action to Board/Committee**	The People Performance Committee were referred the Arrangements for Staff to Raise Concerns paper for oversight. The Clinical Effectiveness Group/Quality Committee were referred the Quality Spots Check report to respond to the follow up actions.
6.	**Report compiled by:**	David Hopewell, Chair of Audit Committee (Non-Executive Director)
7.	**Minutes available from:**	Soile Curtis, Deputy Company Secretary

NHS
Stockport
NHS Foundation Trust

				Agenda No.	17
Meeting date	2nd October 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Q2 Board Assurance Framework 2025/26				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary Executive Directors		

Paper For:	**Information**		**Assurance**	X	**Decision**	X
Recommendation:	**The Board of Directors is asked to:** - **Review and approve the Q2 Board Assurance Framework 2025/26** - **Confirm the Trust's current significant risk profile ensuring alignment between operational and principal 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

All

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 Trust maintains a Board Assurance Framework (BAF) as a key tool to identify and manage the principal risks that may threaten the achievement of the corporate objectives agreed by the Board.

Principal risks for the Q2 BAF 2025/26 (Appendix 1) have been considered via the Lead Director and/or the relevant Board Committees at meetings held in September 2025. Revision to risks is highlighted in blue text.

There has been one reduction in risk score, with Principal Risk 4.1 - Failure to recruit and retain the optimal number of staff, reduced from 12 (C3 x L4) to 9 (C3 x L3) based on an improved recruitment position, lowest vacancy rate in 12 months and better than plan turnover position.

Principal risks to achievement of the Corporate Objectives are prioritised as follows at end Q2 2025/26:

Risk No.	Risk Summary	Risk Score
7.2	Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient and staff experience.	20
1.3	Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	16
6.1	Failure to deliver annual revenue (including cash) and capital financial plans which may lead to increased regulatory intervention.	16
6.2	Failure to achieve financial sustainability through improved productivity & efficiency and system effectiveness, which may lead to suboptimal use of resources and increased regulatory intervention.	16
7.4	Failure to identify 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.	15
1.1	Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	12
1.4	Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	12
3.1	Failure to recognise and manage the impacts of health inequalities on service provision, at a Trust, Locality and Greater Manchester (GM) System, which may lead to unwarranted variation of services and inequality in health outcomes for the populations served.	12
7.1	Failure to maintain and develop a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	12
7.3	Failure to deliver the Green Plan / Net Zero targets and prepare for the impacts of climate change which may lead to worsening population health.	12

1.2	Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.	9
2.1	Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, higher turnover and sickness absence.	9
2.2	Failure to actively participate in and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes	9
3.2	Failure to deliver on the collaborative working opportunities that exist between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts.	9
4.1	Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of care.	12
4.2	Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	9
5.1	Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources.	9
5.2	Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities.	9

In addition, the Trust's significant risks from the corporate risk register (as presented and approved at Risk Management Group in September 2025), are provided at Appendix 2 to ensure triangulation between operational and principal risks. The significant risks relate to the following areas: environment, IT systems, capacity and demand, compliance with regulatory/clinical standards and infection prevention & control.

Stockport NHS Foundation Trust

Board Assurance Framework

2025/26

Corporate Objectives 2025/26

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.

Board Assurance Framework Key

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**

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 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**	

Summary: Board Assurance Framework 2025/26

Heat Map Q1

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate			1.2, 2.1, 2.2, 3.1, 4.2, 5.1	3.2, 4.1, 7.3	7.4
4 - Major			1.1, 1.4, 7.1	1.3, 6.1, 6.2	
5 - Catastrophic				7.2	

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	
Gap score 1 - 5	1.1, 1.2, 1.4, 2.1, 2.2, 3.1, 4.1, 4.2, 5.1, 6.1, 6.2, 7.1, 7.3
Gap score 6 - 9	1.3, 3.2, 7.4
Gap score 10	7.2
Gap score > 10	

Summary: Board Assurance Framework

Risk Ref	Risk Description	Q4 24/25 (IxL)	Q1 25/26 (IxL)	Q2 25/26 (IxL)	Q3 25/26 (IxL)	Q4 25/26 (IxL)	Target Score (IxL)	Lead Committee	Risk Appetite	Risk Gap
Objective 1. Deliver personalised, safe and caring services.										
1.1	Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	15 (5x3)	12 (4x3)	12 (4x3)			8 (4x2)	Quality Committee	Moderate	4
1.2	Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.	NEW	9 (3x3)	9 (3x3)			6 (3x2)	Quality Committee	Moderate	4
1.3	Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	16 (4x4)	16 (4x4)	16 (4x4)			8 (4x2)	Finance and Performance Committee	Moderate	8
1.4	Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	12 (4x3)	12 (4x3)	12 (4x3)			8 (4x2)	Finance and Performance Committee	Moderate	4
Objective 2. Support the health and wellbeing needs of our community and colleagues.										
2.1	Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, higher turnover and sickness absence.	9 (3x3)	9 (3x3)	9 (3x3)			6 (3x2)	People Performance Committee	High	3
2.2	Failure to actively participate in and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes	9 (3x3)	9 (3x3)	9 (3x3)			6 (3x2)	Board of Directors	Moderate	3
Objective 3. Develop effective partnerships to address health and wellbeing inequalities.										
3.1	Failure to deliver on the collaborative working opportunities that exist between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts.	9 (3x3)	9 (3x3	9 (3x3			6 (3x2)	Board of Directors	Significant	3
3.2	Failure to recognise and manage the impacts of health inequalities on service provision, at a Trust, Locality and Greater Manchester (GM) System, which may lead to unwarranted variation of services and inequality in health outcomes for the populations served.	NEW	12 (4x3)	12 (4x3)			4 (2x2)	Quality Committee	Moderate	8
Objective 4. Develop a diverse, talented and motivated workforce to meet future service and user needs.										
4.1	Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of care.	12 (3x4)	12 (3x4)	9 (3x3)			9 (3x3)	People Performance Committee	High	0
4.2	Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	9 (3x3)	9 (3x3)	9 (3x3)			6 (3x2)	People Performance Committee	High	3
Objective 5. Drive service improvement through high quality research, innovation and transformation.										
5.1	Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources.	NEW	9 (3x3)	9 (3x3)			6 (3x2)	Quality Committee	Moderate	3
5.2	Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities.	6 (3x2)	9 (3x3)	9 (3x3)			6 (3x2)	Quality Committee	Significant	3
Objective 6. Use our resources efficiently and effectively										
6.1	Failure to deliver annual revenue (including cash) and capital financial plans which may lead to increased regulatory intervention.	12 (4x3)	16 (4x4)	16 (4x4)			12 (4x3)	Finance and Performance Committee	High	4
6.2	Failure to achieve financial sustainability through improved productivity & efficiency and system effectiveness, which may lead to suboptimal use of resources and increased regulatory intervention.	16 (4x4)	16 (4x4)	16 (4x4)			12 (4x3)	Finance and Performance Committee	High	4

Objective 7. Develop our Estate and Digital infrastructure to meet service and user needs.										
7.1	Failure to maintain and develop a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	12 (4x3)	12 (4x3)	12 (4x3)			8 (4x2)	Finance and Performance Committee	Moderate	4
7.2	Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient and staff experience.	20 (5x4)	20 (5x4)	20 (5x4)			10 (5x2)	Quality / Finance and Performance Committee	Moderate	10
7.3	Failure to deliver the Green Plan / Net Zero targets and prepare for the impacts of climate change which may lead to worsening population health.	12 (3x4)	12 (3x4)	12 (3x4)			9 (3x3)	Finance & Performance Committee	Moderate	3
7.4	Failure to identify 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.	20 (4x5)	15 (3x5)	15 (3x5)			9 (3x3)	Finance & Performance Committee	Moderate	6

Board Assurance Framework 2025/26

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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1		**Risk Appetite: Moderate**																
Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	Quality Committee	SFT Quality Strategy: Outcome Measures 2025/26 Board established Quality Committee with responsibility for patient safety & approved Quality Committee Terms of Reference & Work Plan. Quality Committee Subgroups established including Safety & Quality Assurance / Patient Safety, Health & Safety, Safeguarding & approved Terms of Reference & Work Plans. Patient Safety Work Streams – Nutrition and Hydration, Deteriorating Patient, Resuscitation, Transfusion, Tissue Viability, Falls, Venous Thromboembolism (VTE), Sepsis, Acute Kidney Injuries (AKI) Patient Safety Incident Response Framework Policy & Patient Safety Incident Response Plan Established process for managing and learning from: - Incidents - Duty of Candour - Complaints - Legal Claims Learning from deaths process established including: - Learning from Deaths Review Process - Medical Examiner Team Safe staffing process established including: - Defined Nurse Establishments - Defined Medical Establishments - Healthcare Scientist Establishments - Medical Job Planning process - Medical Appraisal & Revalidation process in place including quality assessment - Medical & Nursing Rostering in place Established Accreditation Programme (StARS) – Inpatients, Community, Theatres, Outpatients Maternity Improvement Plan in place including completed action plan in response to CQC Maternity Inspection and LMNS.	Indirect harm from operational pressures challenging to identify & quantify Full implementation of CQC/Maternity Action Plan Increasing mental health presentation at ED, with decreased mental health team visibility Expired SFT Quality Strategy	**Level 1 - Management:** Divisional Governance: Quality Dashboards (Monthly) Mortality Steering Group Incident Response Group (IRG) Patient Safety Incident Response Group (PSIRG) Learning from Deaths Newsletter Quality Committee Subgroups: Patient Safety Group Health & Safety Subgroup Safeguarding Subgroup **Level 2 – Corporate** Quality Committee: - Quality & Safety Dashboard - CQC Report including CQC Action Plan Update, CQC Preparation (Biannually) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Intermittent Review – Long Waits in ED Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all Improvement/Action Plans - Learning from Deaths Report (Quarterly) - Management of External Visits, Inspections & Accreditations Report (Biannually) - Alert, Advise, Assure Reports: o Safety & Quality o Health & Safety o Safeguarding People Performance Committee: - Guardian of Safe Working / Freedom to Speak Up Report to Board (Quarterly) Board of Directors: - Integrated Performance Report (Quality & Safety Metrics) - Safe Care Report (Quarterly) and Bi-Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Annually / Bi-annually) - Learning from Deaths (Annual) Annual Quality Accounts	 Single source of assurance: Learning from Deaths	Interrogation & triangulation of data relating to incidents due to operational pressures (Development of Patient Safety Report) Development of Joint Quality Strategy (SFT and T&G) ~~Full implementation of CQC & LMNS Action Plan~~	September 2025 October 2025 ~~Q1 2025/26~~	4	3	12	15	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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Executive & Non-Executive Maternity Safety Champions in place with Visits & Meetings schedule. External Visits & Accreditations Policy & Register Freedom to Speak Up process established. Guardian of Safe Working process established Established Quality Impact Assessment (QIA) in place for Trust Efficiency Programme & Business Cases		Clinical Audit Forward Programme – Local & National Audit **Level 3 - Independent** MIAA Internal Audits - Quality Spot Checks 2024-25 (Limited) - PSIRF 2025-26 (Substantial) LMNS & Region Visits & Report GM ICB Enhanced Monitoring Programme CNST Submission – Year 6 Emergency Department Visit from GM ICB (Dec 2024) & Report. GM Clinical Quality & Effectiveness Group													
Principal Risk Number: PR1.2		**Risk Appetite: Moderate**																
Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.	Quality Committee	Patient Experience Strategy 2025-2026 Board established Quality Committee with responsibility for patient experience & approved Quality Committee Terms of Reference & Work Plan. Quality Committee Subgroup established including Patient Experience with approved Terms of Reference & Work Plan. Subgroup of Patient Experience Group: Membership includes representation from: Divisions, Health Watch. Patient Experience Team with accountability and responsibility for: Patient Experience, Personalised Care, Patient and User Involvement, Communication between Services Users and Board. Processes in place to gather patient experience: - Family & Friends - Carers Opinion - Patient Stories - Site Visits - Senior Nurse Walkarounds Trust End of Life Care Committee & Stockport End of Life Care Group. Electronically assisted sharing of Care Plans across multiple organisations at Locality. Mental Health Partnership Board established with Pennine Care NHS Foundation Trust including Service User Representation	Evidence of continued hospitalisation and investigation at end of life care (EoL) out with expressed preferences. Emergent themes from Complaint Analysis / Surveys PALS/Complaints Team staffing challenges. Potential missed opportunities for improvement due to inability to invest in StARS.	**Level 1 - Management:** Divisional Governance: Quality Dashboards (Monthly) Patient Experience Subgroup (Monthly) **Level 2 - Corporate:** Quality Committee: - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Maternity Services Report – Maternity Safety Champion Walk Rounds & Maternity Voices Partnership - Patient Experience Report (Biannual) - Annual Complaints Report - Alert, Advise, Assure Report: ○ Patient Experience Board of Directors: - Patient Story - Integrated Performance Report (Quality & Safety Metrics) Council of Governors: - Quarterly Formal Meetings - Quarterly Informal Governor & Joint Chair, Non-Executive Director, Chief Executive Meetings **Level 3 - Independent** Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey		Trust EoL Committee deep dive of cause of continued EoL hospitalisation out with preference & solutions. Implementation of Action Plans from National Surveys & Complaints Learning	December 2025 Ongoing (Action Plan includes actions spanning the year with differing dates for completion)	3	3	9	NEW RISK	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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Complaints Policy & established process for managing and learning from Complaints & PALS Established Accreditation Programme (StARS) includes Personalised Care assessment. Council of Governors (CoG) established, including public, staff and appointed governor from HealthWatch & attendance from Executive Directors.		- Emergency Department Survey - Maternity Survey PLACE Assessment														
Principal Risk Number: PR1.3		**Risk Appetite: Moderate**																
Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	Finance & Performance Committee	Board approved Operational Plan 2025/26, Corporate Objectives & Outcome Measures including Activity Standards & Trajectories. Board established Finance & Performance Committee with responsibility for operational performance. Approved Finance & Performance Committee Terms of Reference & Work Plan. Established models of emergency and urgent care in place in line with national standards. Rapid ambulance handover process in place. Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Virtual Ward established. Deep dive undertaken and actions implemented to achieve 80% daily occupancy. Bed modelling undertaken to assess capacity gaps. Urgent & Emergency Care GIRFT Programme – Chaired by Medical Director Workforce models in place – Flexible to adapt to surges. Locality wide Urgent & Emergency Care (UEC) Delivery Board in place - Oversight of patient flow management plans.	Increased demand for urgent & emergency care. Patient flow management due to: - Constraints in domiciliary & bed-based care impacting patients with NCTR - Financial constraints resulting in lack of 24/7 medical & surgical specialties to support discharge of non-elective patients. Locality Plan relating to intermediate care capacity not agreed with Trust – Reduction in capacity for ~~Pathway 1 and~~ Pathway 2. ~~Financial constraints resulting in suboptimal staffing levels in Emergency Department~~	**Level 1 – Management:** Divisional Governance: Performance Weekly Performance Meetings (Urgent Care) 4 Hour Clinical Standard Improvement Group (Weekly) Urgent & Emergency Care GIRFT Meeting **Level 2 – Corporate** Joint Executive Team: Performance Report (Weekly) Trust Performance Meetings (Monthly) & Divisional Performance Reviews (Quarterly) Finance & Performance Committee - Operational Performance Report – Urgent & Emergency Care Metrics (Monthly) Board of Directors: - Integrated Performance Report (Operational Performance) (Bimonthly) Locality: - Urgent & Emergency Care Delivery Board - Locality Board **Level 3 – Independent** NHS England – Activity Returns NHS GM: - Urgent & Emergency Care Oversight Meeting (Trust & Locality) - Contract Monitoring Meeting - Provider Oversight Meeting ECIST Review & Discharge Mapping		Urgent Care Delivery Board to agree priority metrics to support improvement to 4 hour standard. ~~Virtual Ward Deep Dive with best performing Trust – Action Plan to be developed to maximise utilisation.~~ Urgent Care Delivery Board undertaking deep dive into approach to frailty with view to reducing attendances & admissions. Agree & Test Locality Winter Resilience Plan. NHSE Follow Up – Agree further support from ECIST to support 4 hour standard. Escalation to ICB Commissioners via Monthly Contract Meeting & Provider Oversight Meeting	~~July 2025~~ Q3 2025/26 ~~Q2 2025/26~~ Q3 2025/26 Q3 2025/26 Q4 2025/26 Ongoing	4	4	16	16	16	16			4	2	8
Principal Risk Number: PR1.4																		

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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	Finance & Performance Committee	Board approved Operational Plan 2025/26, Corporate Objectives & Outcome Measures including Activity Standards & Trajectories. Board established Finance & Performance Committee with responsibility for operational performance. Approved Finance & Performance Committee Terms of Reference & Work Plan. GIRFT Programmes in place for all Surgical & Medical Specialties. Escalation Process in place with Performance Team: 65+ week wait patients and any P2/cancer patients that are not dated. Booking & Scheduling centralisation Board approved Expanding Elective Care Business Case 2024/25	Agreed Trust sustainability plan for MR Agreed GM sustainability plan for Paediatric Audiology Ability of GM partners to provide mutual aid and fulfil service SLAs Increased demand for elective care, including from out of area. ~~Loss of Outpatients B Department~~.	**Level 1 – Management** Divisional Governance: Performance Performance Meetings (Elective, Cancer & Diagnostics) (Weekly) Divisional Access Meetings (Weekly) GIRFT Meetings (Specialty Level) Joint Executive Team: Performance Report (Weekly)		Agree plan to increase forecast demand in MR capacity utilising CDC Implementation of AI Tool to validate elective waiting list (following delay due to Advantis issues)	Q3 2025/26 Q3 2025/26	4	3	12	12	12	12			4	2	8
				Level 2 – Corporate Trust Performance Meetings (Monthly) & Divisional Performance Review Finance & Performance Committee: Operational Performance Report - Elective, Cancer, Diagnostics Board of Directors - Integrated Performance Report (Operational Performance)		Agree with GM ICB plan to commission additional IQUIPS accredited capacity for Paediatric Audiology Review investment to right size elective care including non-recurrent investment. Refresh capacity & demand models for all specialties.as part of Medium Term Operational Planning ~~Mobilisation of new Outpatients Department.~~	~~Q2~~ Q3 2025/26 Q3 2025/26 Q3 2025/26 ~~Q3 2025/26~~									
				Level 3 – Independent NHSE – Activity Returns GM & NHS England Productivity Benchmarking NHS GM: - Contract Monitoring Meeting - Provider Oversight Meeting														

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 2024/25	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**																
Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, sickness absence and higher turnover.	People Performance Committee	Trust Health and Wellbeing (HWB) Plan and Strategy in place which presents delivery against ambitions / trajectories set by NHS England – Approved by Workforce / People Performance Committee and Board of Directors. Board established People Performance Committee with responsibility for staff wellbeing & approved Workforce / People Performance Committee Terms of Reference & Work Plan. People Performance Committee Subgroup established: Joint Health & Wellbeing Group. Approved Terms of Reference & Work Plan Approved people policies, procedures, guidelines in place including: - Organisational Development - Flexible Working - Appraisal - Sickness Absence - Relationships at Work Policy - National Parent Support (Paternity) Policy - National Sexual Safety Policy Sexual harassment in the workplace training in place. Regular sickness absence deep dive - Led by Deputy Director of People Collaborative Occupational Health Service with SFT & T&G – Including Staff Counselling Service & Physio Fast Track Service. Staff Vaccination Programme - Pertussis Influenza, Covid and MMR Board level Well Being Guardian (Non-Executive Director). FTSU Guardian and FTSU Champions Guardian of Safe Working Appraisal Process includes Wellbeing Discussion Big Conversation Programme Staff Side Partnerships established Health & Safety Mandatory Training Reasonable Adjustments Training	Impact of continuing operational & external/internal financial pressures Impact of ageing estate/quality of environment.	**Level 1 – Management** Joint Health and Wellbeing Group (Bimonthly) Staff Side Partnership Meetings Industrial Action Planning Group **Level 2 – Corporate** Divisional Performance Review / Divisional Meetings: Workforce standards, Establishments, Recruitment, Absence, Turnover & Recovery/Mitigation Actions NHS People Plan Self-Assessment People Performance Committee: - Workforce Dashboard: Sickness Absence, Turnover (Bimonthly) - Sickness Absence Report (Biannually) - Freedom to Speak-up Report (Quarterly) - Guardian of Safe Working Report (Bi-annually) Board of Directors: - Staff Story - Integrated Performance Report: Workforce (Bimonthly) - Freedom to Speak Up (Bi-annually) - National Staff Survey **Level 3 - Independent** NHS National Staff Survey MIAA Staff Wellbeing Review, February 2024 – Substantial Assurance.		~~Commission further training sessions for sexual harassment in the workplace~~ Health & Wellbeing Environmental Audit	~~June 2025~~ Nov 2025	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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
		Staff Survey Action Plans – Themed: Health and Well Being, Equality Diversity and Inclusion and Safety Culture Award & Recognition Programme including Staff Awards, Long Service Awards Established partnerships with Locality & GM System e.g. Resilience Hub																
Principal Risk Number: PR2.2		**Risk Appetite: Moderate**																
Failure to actively participate and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes.	Board of Directors	Stockport: The One Health & Care Plan 2024-2029 Board of Directors – Place Collaboration Reporting in place. Neighbourhood profiles produced by Local Authority. Executive Director representation in established Locality Structures (strategic & operational) including: - Health & Wellbeing & Locality Board Review of implication of 10 Year Plan on development of new Joint Organisational Strategy	Unfunded growth in demand for community services. Capacity & demand modelling for community services to support appropriate deployment of resources. Implications arising from the Planning Guidance 2025/26, Neighbourhood Health Guidelines and 10 Year Plan re. neighbourhood working. GM Community Service Review	**Level 1 – Management** Divisional Quality & Operations Group (Monthly) Performance Management Report Area Leadership Team (Monthly) Health and Care Collaborative – Delivery Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board Adult and Children: - Joint Safeguarding Board	Community Services Dashboard			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)		Plans to be put in place to respond to neighbourhood health guidelines arising from Planning Guidance 2026/27 ~~Review of 10 Year Plan~~ Outcome of GM community services review led by GM ICB	~~Sept 2025~~ Q3 2025-26 ~~Sept 2025~~ Q3 2025-26											
				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 2024/25	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**																
Failure to deliver on the collaborative working opportunities that exist between Stockport NHS Foundation Trust & T&G Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts	Board of Directors	Board of Directors – SFT and T&G Collaboration Reporting in place Clinical Service Partnership Group in place between both Trusts with Case for Change for clinical services for Radiology & Gastroenterology Updated Divisional Plans in place Corporate services collaborative working in place. Joint Executive Director and Senior Manager roles in place, with single Joint Executive Team. Joint Chair in post. Programme Group established to support delivery of joint governance arrangements Joint Board Development Sessions & Board of Directors – Review of each phase of joint governance arrangements. High Level Road Map established.	Failure to gain key support from staff and agreement on the resulting service by service Case for Change. No current revenue or capital or recurrent funding identified to support future service changes.	**Level 1 – Management** Clinical Service Partnerships Group **Level 2 – Corporate** Executive Team - Oversight of Key Issues Board of Directors SFT and T&G Collaboration Report **Level 3 – Independent**		Develop case for change for clinical services for Pathology and Pharmacy Development of Joint Clinical Strategy, based on learning from case for change and development of divisional plans. Commission legal opinion to support development of joint governance models New Joint Organisational Strategy	Q3 2025/26 Q3 2025/26 October 2025 Q4 2025/26	3	3	9	9	9	9			2	2	6
Principal Risk Number: PR3.2		**Risk Appetite: Significant**																
Failure to manage service provision in a way that reduces health inequalities at Trust, Locality and Greater Manchester (GM) level, which may lead to inequities in outcomes for the populations served.	Quality Committee	Greater Manchester (GM) Integrated Care Partnership (ICP) Strategy, GM Sustainability Plan & GM Annual Plan 2025/26 ONE Stockport One Future Plan and ONE Stockport Health and Care Plan. Executive Director representation in established GM & Locality Structures (Strategic & Operational) including: - Health & Wellbeing & Locality Board - Provider Partnership - Locality System Quality Group - GM Trust Provider Collaborative - GM Health Inequalities Group - GM Medical Directors Group Locality Provider Partnership chaired by CEO. Identified workstreams based on population health metrics. Executive Director led Health Inequalities Forum. Established programmes: Alcohol Harm, Health Literacy.	Factors that are the primary responsibility of partner organisations (Education, Social Housing, etc.) where the Trust has less interface with the factors affecting health No Trust employed medical public health expertise & alcohol care team	**Level 1 – Management** Provider Partnership Workstream Meetings SFT Health Inequalities Forum **Level 2 – Corporate** **Quality Committee** - Health Inequalities Report (Quarterly) - Annual Mortality Report - Annual Complaints Report - Annual Patient Experience Report - Annual Safeguarding Inspections and Report **Board of Directors** - Locality/Place Report **Locality Meetings** - Stockport Provider Partnership **Level 3 – Independent** **GM Meetings** - Trust Provider Collaborative (TPC) - Relevant Directors part of GM TPC System Boards (Cancer, Elective, Urgent & Emergency	Lack of data provision for disadvantaged groups: - Access to services - Outcomes of treatments	BI development underway to improve data provision as part of Health Inequalities Group key workstream	December 2025	3	4	12	NEW RISK	12	12			3	2	6

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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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
		Core20PLUS Ambassadors established. Trust employed Public Health Nurse (0.8 WTE) NHS Providers Health Inequalities Self-Assessment Report & Action Plan Executive (Medical Director) & Non-Executive Director Lead for Health Inequalities Patient Experience Strategy 2025-2026: Including workstreams to support health inequalities. Mental Health Partnership Board established with Pennine Care NHS Foundation Trust. Partnership and involvement with community & third sector.		Care, Diagnostics, Mental Health and Sustainable Services) - GM Medical Directors **Locality Meetings** - One Stockport Health & Care Locality Board														

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 2024/25	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**																	
Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of 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. Board established People Performance Committee & approved Workforce / People Performance Committee Terms of Reference & Work Plan. Board approved Operational Plan 2025/26 including Workforce Plan. Model Hospital / NHS Productivity & Efficiency Benchmarking - Workforce Defined Medical and Nurse Staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. E-rostering and Job Planning in place to support staff deployment. E-Rostering Workforce Group established. Weekly Staffing Approval Group (SAG) Temporary staffing and approval processes with defined authorisation levels Workforce Strategy & Divisional Workforce Plans Joint NHS England Stat Mand Programme Implementation Group established Range of leadership and management development training sessions. Local/ Regional/National Education Partnerships - Widening Participation Programme in place - Degree Apprenticeships, Medical Support Workers, Cadet Programmes. E.g. roles identified as national shortage occupations Board approved Trust Values Appraisal Process Established partnerships with Locality / GM. Director of People & OD part of GM HR Directors Forum	National workforce shortages particularly for some medical posts exist (e.g. Radiologists, Acute/Stroke Physicians) Escalation areas remaining open – staffing additional areas required. Mandatory training compliance.	**Level 1 - Management** Divisional Governance: Divisional reports on workforce standards, establishments, recruitment, and retention, absence, and turnover and recovery/mitigation action plan Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Staff Side Partnership Meetings Industrial Action Planning Group **Level 2 – Corporate** People Performance Committee - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Training Compliance Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Bimonthly) - Biannual Nursing & Midwifery Establishments - Annual Medical Job Planning - Annual Medical Revalidation Report Staffing Approval Group (Weekly) Workforce Efficiency Group Board of Directors: - Integrated Performance Report (People Metrics) (Bimonthly) - Safer Care (Staffing) Report (Bimonthly) - Nursing & Midwifery Establishments (Biannual) - People & Organisational Development Plan Progress Report (Biannual) **Level 3 - Independent** NHS National Staff Survey GMC Survey & NETS Survey Health Education Visits & Deanery Assurance Reports/Visits		~~Joint NHS England Stat Mand Programme Implementation Group – Deliver the changes for both statutory & mandatory and role essential training programmes~~ ~~Work programme focus on persistent non-compliance with mandatory training to improve participation & performance.~~ Joint NHS England Stat Mand Programme review completed and revised programme refresher period to be implemented Non-compliance escalation framework agreed and will be implemented from October	~~September 2025~~ ~~October 2025~~ October 2025 October 2025	3	~~4~~ 3	12	12	12	9			3	3	9

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 2024/25	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: PR4.2	**Risk Appetite: High**																	
Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Organisational Development (OD) Talent Management & Succession Planning Equality, Diversity & Inclusion Strategy & Implementation Plan. Board established Workforce / People Performance Committee with responsibility for equality, diversity & inclusion (EDI) & approved Workforce / People Performance Committee Terms of Reference & Work Plan. Workforce / People Performance Committee established Subgroup: - Joint EDI Group Established cross-divisional WRES/WDES Group Staff Networks (BAME / Disability / Carer/ LGBTQ+ and Neurodiversity) established with Board level sponsors. EDI Mandatory Training requirement. Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics. Hate Crime Reduction Policy in place (Red/Yellow Card) Accessible Scheme Civility Saves Lives Programme established. Peer Review of Disciplinary Cases SFT & T&G	Career development programmes for staff with protected characteristics Formal recruitment/ disciplinary processes operating as barriers to achieving greater diversity	**Level 1 - Management** WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan 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 **Level 2 – Corporate** People Performance Committee - EDI Report (Biannually) - WRES and WDES Annual Report - Gender Pay Gap - NHS Staff Survey & Action Plans - Freedom to Speak Up Report (Quarterly) Board of Directors - Annual EDI Report - NHS Staff Survey - Freedom to Speak Up Report (Biannually) **Level 3 - Independent** NHS National Staff Survey	EDI metrics to be built into People Analytics Dashboard.	EDI Action Plan Implementation Launch Joint Equality, Diversity & inclusion (EDI) Strategy Inclusion of the wider EDI metrics in People Analytics Dashboard	Ongoing (Action Plan includes actions spanning the year with differing dates for completion) January 2026 Q3 2025-26	3	3	9	9	9	9			3	3	9

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 2024/25	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**																
Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources	Quality Committee	SFT Quality Strategy: Outcome Measures 2025/26 Board established Quality Committee with responsibility for clinical effectiveness. Approved Quality Committee Terms of Reference & Work Plan Quality Committee Subgroup established including Clinical Effectiveness Group Annual Clinical Audit Programme: Including national and locally prioritised audit based on risk assessment Assurance Programme for audit and assess their implementation of NatSSIPs and LocSSIPs NICE Guidance Compliance Review Process established Clinical Benchmarking & GIRFT Review Programme established (All Trust specialties) Attendance at National GIRFT Reviews for relevant Trust specialties. Divisional Clinical Accreditation Programmes and Royal College Audit Programmes Introduction of internal Professional Standards & Dispositions for ED escalation Clinical effectiveness interface with mental health and GP Partners in Locality via established Joint Forums	Some elements of clinical effectiveness out with Trust control where interface with other organisations / professional groups	**Level 1 - Management:** Divisional Governance: Quality Dashboards (Monthly) Incident Response Group (IRG) Patient Safety Incident Response Group (PSIRG) Clinical Effectiveness Subgroup (Monthly) Clinical Audit, NICE Compliance, NatSSIPs & LocSSIPs, Results Governance, Transfusion, GIRFT				3	3	9	NEW RISK	9	9			3	2	6
				Level 2 - Corporate: Quality Committee: - External Visits & Inspections Register Report (Biannual) - Clinical Audit Forward Programme Report (Biannual) - Annual Clinical Audit Report - Annual Quality Account - Alert, Advise, Assure Report: ○ Clinical Effectiveness Board of Directors: - Integrated Performance Report (Quality & Safety Metrics)		Annual Review of Clinical Audit Forward Programme	July 2025										
				Level 3 - Independent National Clinical Audit														
Principal Risk Number: PR5.2		**Risk Appetite: Significant**																
Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities	Quality Committee	T&G / 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. Annual Joint RD&I Celebration Event: Shared Learning RD&I – 5 year financial stability projection.	Recurrent staffing shortages impacting activity Majority of staff funded from research income therefore dependent on external funding	**Level 1 – Management** Joint SFT & T&G RD&I Governance Group Clinical Effectiveness Subgroup - Research & Innovation Progress Report - Annual Research & Innovation Report				3	3	9	6	9	9			3	2	6
				Level 2 – Corporate Quality Committee: - Annual Research & Innovation Report - Alert, Advise, Assure Report: Clinical Effectiveness Board of Directors:	Revised Board level reporting for the purpose of assurance	Full joint RD&I function (in line with Strategy), specifically establishment of Joint Research Office. Full integration to follow	Q3 2025/26										

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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
				- Annual RD&I Report														
				Level 3 - Independent DHSC KPIs for Research NIHR North West CRN 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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: PR6.1		**Risk Appetite: High**																
Failure to deliver annual revenue and capital financial plans which may lead to increased regulatory intervention.	Finance & Performance Committee	Financial planning processes and central Finance Team for coordination of delivery. Board approved Financial (Revenue & Capital) Plan 2025/26. Agreed as part of Greater Manchester Integrated Care System (GM ICS) Board approved Opening Budgets based on submitted Financial Plan. Established Trust Efficiency Programme (CIP) and oversight process Cash Management Plan & Forecast procedures, including sensitivity and scenario planning. Board approval of cash support applications Joint T&G & SFT Finance Improvement Group established, chaired by Chief Executive. Board established Finance & Performance Committee with responsibility for financial performance. Approved Finance & Performance Committee Terms of Reference & Work Plan. Key financial policies including: ○ Standing Financial Instructions ○ Scheme of Delegation ○ Budgetary systems and procedures ○ Procurement Policy ○ Fraud management process ○ Treasury management policy Delivery of budget holder training workshops and enhancements to financial reporting. Internal Audit Programme – Key Financial Controls Authorisation processes for recruitment and agency spend in place via Staffing Approval Group. Workforce Efficiency Group – Oversight of temporary staffing spend. NHS Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency. Submission of National Cost Collection exercise (PLICS).	Assumptions in Financial Plan including: - Income from commissioners - Pay award funding - CDEL cover - Non-elective care demand - Inflation costs Identification & implementation of recurrent CIP Plan System deficit funding withdrawn if Operational Plans not achieved - Quarterly Review by NHS Regional Condition of estate and unavailability of equipment due to failure, resulting in impact to service delivery, productivity and revenue. Stockport System finance deficit potentially impacting on SFT position e.g. reduction on spot purchase beds.	**Level 1 – Management** Divisional Governance - Finance Metrics/CIP/Forecast Finance Training Group Cash Monitoring Group (Monthly) Operational Board (Monthly) – Review of business cases, emerging and new pressures and developments.				4	4	16	12	16	16			4	3	12
				Level 2 – Corporate Trust Efficiency Programme Group: Delivery against Plans and Milestones, Recovery Actions and Forecast. Staffing Approval Group (Weekly) Capital Planning and Monitoring Group (Monthly): Scheme level monitoring to support capital programme Divisional Performance Review (Monthly) - Financial Position, CIP, Forecast, Recovery Actions. Joint T&G & SFT Finance Improvement Group: Reports on I&E, Run Rate, TEP, Cash and Capital. Finance & Performance Committee: - Finance Report (Monthly) - CPMG – Capital Position (Monthly) - Productivity (including national productivity benchmarking) & TEP (Quarterly) Board of Directors: - Financial Position Report (Bimonthly) - Financial Plan – Review of Key Risks Stockport System Financial Recovery Group (Monthly)		Board of Directors - Review of Difficult Decisions	October 2025									
				Level 3 - Independent Independent assurance on 2025/26 Financial Plan by Seagry under instruction of NHS England. Internal Audit Reports - Key Financial Systems (Substantial) - HFMA Financial Sustainability Review: Confirmation of Self-Assessment. - Data Quality (High/Substantial)		Escalation of Commissioning/Contracting Issues & Planning Assumptions via GM Provider Oversight Meeting (POM) Conclusion by GM ICB of Future Funding Flows (FFF) work and reconciliation of funding required.	Monthly October 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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
		Divisional Performance Review Process including Finance Review . Stockport System Finance Recovery Group established (Monthly) including Trust representation. GM System Efficiency Group established including Trust representation. GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE). GM Trust Provider Collaborative (TPC) established, chaired by SFT & T&G CEO.		**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** 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. NHS Oversight Framework – SFT: Segment 3		Independent assurance on 2025/26 Key Financial Systems & Controls	Q4 2025/26									
Principal Risk Number: PR6.2		**Risk Appetite: High**																
Failure to improve productivity & efficiency and system effectiveness, which may lead to lack of organisational financial sustainability and increased regulatory intervention.	Finance & Performance Committee	Board established Finance & Performance Committee with responsibility for financial performance. Approved Finance & Performance Committee Terms of Reference & Work Plan. GM ICS and Locality Financial Planning & Oversight processes in place including GM, Local Authority & Trust representation. GM ICS commissioned Drivers of Deficit Review. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency GM business case assessment process in place. GM System Efficiency Group established including Trust representation. GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE). GM Trust Provider Collaborative (TPC) established, chaired by SFT & T&G CEO.	Underlying financial deficit driven by structural drivers. Realignment of deficit funding from 2025/26 Delivery / Implementation Plan to support GM Sustainability Plan.	**Level 1 - Management** Divisional Governance - Finance Metrics/CIP/Forecast				4	4	16	**16**	16	16			4	3	12
				Level 2 – Corporate Trust Efficiency Programme Group: Delivery against Plans and Milestones, Recovery Actions and Forecast. Finance & Performance Committee - Finance Report (Monthly) - Productivity & CIP (Quarterly) - Financial Sustainability (Biannual) Joint T&G & SFT Finance Improvement Group: Productivity & Efficiency Stockport System Financial Recovery Group (Monthly)		Escalation of Commissioning/Contracting Issues & Planning Assumptions via GM Provider Oversight Meeting (POM) Locality review of contracts with particular focus on community services. SFT Drivers of Deficit Review - Development of Action Plant to be incorporated in Medium Term Operational Planning	Monthly October 2025 ~~October~~ December 2025									
				Level 3 - Independent **Internal Audit** CIP Process (Substantial Assurance) **GM ICS** Provider Director of Finance GM Meeting 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**														

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 2024/25	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 NHS Oversight Framework – SFT: Segment 3														

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 2024/25	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**																	
Failure to maintain and develop 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	SFT Digital Strategy 2021-2026 Capital Programme in place to support funding of Digital Strategy Board established Finance & Performance Committee with responsibility for digital strategy oversight. Approved Finance & Performance Committee Terms of Reference & Work Plan. Finance & Performance Committee established Subgroups including Digital & Informatics Group. Approved Terms of Reference & Work Plan Digital Team established dedicated delivery of the Digital Strategy, with project management infrastructure in place. Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy Information Governance mandatory training. Change control process in place. Major incident & business continuity plans in place. Annual penetration testing by independent organisation Anti-virus & spam and malware update programme in place Process in place to respond to Care Cert notifications ~~DSPT~~ – Cyber Assessment Framework Submission, auditing and reporting. Action Plan submitted to NHS England	Insufficient capital investment to support the replacement of all ageing and/or unsupported hardware & software, and cyber-security resource, resulting in assets beyond 'end of life'. Dependencies on supplier to complete remedial actions. Recording of medical devices introduced on the corporate network	**Level 1 – Management** Digital Team Governance: Monitoring of data/incidents. Medical Equipment Group Cyber Meetings – CareCert. SFT Digital & Informatics Group **Level 2 – Corporate** Finance & Performance Committee: - Digital Strategy Progress Report (Biannual) - Capital Programmes Management Group – Including digital capital (Monthly) - Alert, Advise, Assure Report o Digital & Informatics Group Board of Directors: - Digital Strategy Progress Report (~~Biannual~~ Annual) **Level 3 - Independent** Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification DCB 1596 Secure Email Standard Accreditation ~~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.~~ MIAA Internal Audit Report 2024 25- Cyber Assessment Framework-Aligned Data Security and Protection Toolkit - 'Medium Assurance' (8 Outcomes Achieved, 4 Outcomes Not Meeting Standards). Overall assessment 'high risk'. Action Plan Submitted - Status 'Approaching Standards'.		External bids for capital funding. Actions from Medical Devices Management Internal Audit Information Commissioners Office Audit Action Plan ~~Implement action plan for Data Protection & Security Toolkit Assessment 2024/25 and develop Action Plan in response to DSPT 2025/26~~ Implement action plan for MIAA Internal Audit Report 2024 25 Cyber Assessment Framework-Aligned Data Security and Protection Toolkit.	Ongoing On-going (Action Plan includes actions spanning the year with differing dates for completion) As above Ongoing (Action Plan includes actions spanning the year with differing dates for completion)	4	3	12	12	12	12			4	2	8
Principal Risk Number: PR7.2	**Risk Appetite: Moderate**																	

NHS Stockport NHS Foundation Trust

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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient and staff experience.	Finance & Performance Committee	Board established Finance & Performance Committee with responsibility for estates & facilities oversight and Quality Committee for health & safety. Approved Terms of Reference & Work Plan. Finance & Performance Committee established Subgroup: Estates Strategy Group. Approved Terms of Reference & Work Plan Quality Committee established Subgroup: Health & Safety. Approved Terms of Reference & Work Plan Estates and Facilities Risk Forum established, including clinical and non-clinical representation. Approved Capital Programme in place including backlog maintenance. Six-Facet Survey Process. Additional structural surveys completed for Category D and poor condition property assets by Structural Engineers, in line with Six Facet Survey. Premises Assurance Model (PAM) Process & Action Plan. HTM Compliance Assurance Groups established. Appointment of Authorising Engineers in accordance with the requirements of HTM00. Project Board and Senior Responsible Officer identified for major capital developments. Training and Continuing Professional Development of Estates Technical and Operational staff.	Inability to deliver required levels of estates backlog maintenance due to lack of funding. Inability to deliver required upgrades due to access limitations related to clinical activity pressures Delivery/Transition Plan to address highest risk capital stock and decompression of site.	**Level 1 – Management** Capital Programme Management Group: - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Group - Compliance with regulatory standards - Health & Safety Incidents Estates Strategy Group - Site Development Strategy Progress		Operational review of backlog maintenance funding (SFT & T&G)	Q3 2025/26	5	4	20	20	20	20			5	2	10
				Level 2 – Corporate Quality Committee - Annual Health & Safety Report - Alert, Advise & Assure Report ○ Health & Safety Group Finance & Performance Committee - Estates & Facilities Assurance Report - Site Development Strategy Progress Report - Alert, Advise & Assure Reports: ○ Capital Programme Management Group ○ Estates Strategy Group Board of Directors - Site Development Strategy Progress Report		Procurement of master planning exercise for SFT & T&G to support development of estates strategy	Q3 2025/26											
				Level 3 - Independent Estates Return Information Collection (ERIC) Six Facet Survey PLACE Assessment														
Principal Risk Number: PR7.3		**Risk Appetite: Moderate**																
Failure to deliver the Green Plan / Net zero targets and prepare for the impacts of climate change which may lead to	Finance & Performance Committee	~~Approved Green Plan in place.~~ New Joint Green Plan for T&G and SFT approved by Board, August 2025. Joint SFT & T&G Green Plan Delivery Group established, meeting bimonthly. Joint appointment of Sustainability Manager and Sustainability Officer between SFT and T&G	Inability to deliver required levels of environmental and sustainability improvements due to lack of funding and awareness / ownership across all departments Climate Change Adaptation Plan	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Joint Green Plan Delivery Group - Monitoring of Green Plan delivery - Development of sustainability opportunities				3	4	12	12	12	12			3	3	9

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 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
worsening population health.		Six Facet Survey Process ~~Funding secured for a full~~ Heat Decarbonisation Plan and Heat Network Readiness Report in place. Mechanisms in place to explore and develop sustainability approach across Locality. Engagement with GM Sustainability Group Nitrous Oxide manifold system capped to reduce gas wastage and associated emissions	~~Decarbonisation Plan and Heat Network Readiness Report - Awaiting approval~~	**Level 2 – Corporate** Finance & Performance Committee: - Green Plan (Sustainability) Progress Report (Biannual) Board of Directors - Annual Green Plan Report Annual Report including Sustainability Report		Work with Carbon Energy Fund (CEF) to assess the viability of decarbonising the Stepping Hill Hospital site and connecting to the Stockport Heat Network ~~Decarbonisation Plan & Heat Network Readiness Report~~ ~~Develop new joint Green Plan SFT & T&G~~ Development of a Climate Change Adaptation Plan	Q3 2025/26 ~~Q2 2025/26~~ ~~Q2 2025/26~~ Q4 2025/26										
				Level 3 - Independent Estates Return Information Collection (ERIC) ICB Contacting Requirement Annual Check													
Principal Risk Number: PR7.4		**Risk Appetite: Moderate**																
Failure to identify 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, and New Hospital Building Programme Expression of Interest produced. Site Development Strategy to support and inform immediate site development and maintenance aspirations 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.	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel.	**Level 1 - Management**				3	5	15	20	15	15			3	3	9
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board. **Finance & Performance Committee** Site Development Strategy Progress Report (Biannual) **Board of Directors** Site Development Strategy Report (Biannually)		Review of funding approach with partners.	Ongoing										
				Level 3 - Independent														

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at September 2025)

Risk ID	Division/Corporate Service	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since July 25
3074	Operations (Cancer performance)	Risk of delayed or missed cancer diagnosis or recurrence due to deficiencies in follow-up processes.	4	4	16	8	NEW
2765	Estates & Facilities	There is a risk that limitations in capital resource will impact on ability to repair, replace and retain a fully functioning site	4	5	20	4	↔
586	Estates & Facilities	There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	4	5	20	8	↔
2908	Corporate - IT	There is a risk that the Trust could lose all access to the PAS system due to the age of the hardware	4	5	20	8	↔
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	5	4	20	8	↔
2650	Surgery	Risk of harm to paediatric patients if the audiology service does not comply with best practice recommendations	4	5	20	3	↔
2682	Estates and Facilities	There is a risk of service disruption impacting on care delivery due to standard of estate (blocks 30/31 & 52 Pathology)	4	4	16	4	↔
2949	Corporate – IT	There is a risk to the organisations Cyber security from the large number of unsupported and end of life end user devices.	4	4	16	9	↔
2969	Surgery	There is a risk of harm to patients, staff and operational flow due to failure of lifts 22 and 23	4	4	16	4	↔
2452	Clinical Support Services	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔
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	↔
2971	Corporate – Learning &	There is risk of Health and Safety to staff and visitors from water leaks in	5	3	15	6	↔

	Education	Pinewood House					
2304	Medicine & Urgent Care	There Is a risk of harm if patients cannot be transferred from ambulances to ED then there are delays in treatment	4	4	16	8	↔
2713	Medicine & Urgent Care	There is a risk of patient harm due to capacity not meeting demand resulting in overcrowding in ED	4	4	16	8	↔
3018	Surgery	There is a risk to patients in the Stockport locality due to the pause of the paediatric audiology service	4	5↑	20	8	↑