SFT Public Board Meeting - February 2026

Thu 05 February 2026, 09:30 - 12:30

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Welcome & Apologies for Absence

09:30 - 09:30
0 min

2. Declaration of Interests

09:30 - 09:40
10 min

3. Staff Story

Amanda Bromley

09:40 - 09:45
5 min

4. Minutes of Previous Meeting - held on 4 December 2025

Decision *David Wakefield*

04 - Public Board Minutes - 4 December 2025.pdf (12 pages)

09:45 - 09:45
0 min

5. Matters Arising

09:45 - 09:45
0 min

6. Action Log

Information *David Wakefield*

06 - Public Board Action Log - February 2026.pdf (1 pages)

09:45 - 09:55
10 min

7. Joint Chair's Report

Discussion *David Wakefield*

07 - Joint Chair Report - February 2026.pdf (3 pages)

09:55 - 10:05
10 min

8. Chief Executive's Report

Discussion *John Graham*

08 - Chief Executive's Report - February 2026.pdf (4 pages)

STRATEGY & PLANNING

10:05 - 10:20
15 min

9. Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust Collaboration

Discussion *Paul Buckley*

09 - SFT and TGICFT Collaboration.pdf (8 pages)

10:20 - 10:35
15 min

10. Joint Corporate Governance Model: Go / No Go Criteria Assessment

Decision *Paul Buckley / Rebecca McCarthy*

- 10 - Joint Corporate Governance - Go-No Go Assessment.pdf (8 pages)

FINANCE & PERFORMANCE

10:35 - 10:45
10 min

11. Finance & Performance Committee Alert, Advise & Assure Report

Discussion *Anthony Bell*

- 11a - Finance & Performance Committee AAA Report - Front Sheet.pdf (2 pages)
- 11b - Finance & Performance Committee AAA Report - Jan 2026.pdf (3 pages)

10:45 - 11:10
25 min

12. Integrated Performance Report - Month 9

Discussion *Executive Directors*

- 12a - Integrated Performance Report - Front Sheet.pdf (2 pages)
- 12b - Integrated Performance Report - Jan26.pdf (24 pages)

11:10 - 11:20
10 min

13. Finance Report - Month 9

Discussion *John Graham*

- 13a - Financial Position Report Month 9 2025-26 front sheet.pdf (3 pages)
- 13b - Financial position 2025-26 M09.pdf (21 pages)

11:20 - 11:30
10 min

BREAK

11:30 - 11:40
10 min

14. Quality Committee Alert, Advise & Assure Report

Discussion *Louise Sell*

- 14a - Quality Committee AAA Report - Front Sheet.pdf (2 pages)
- 14b - Quality Committee AAA Report - January 2026.pdf (3 pages)

11:40 - 11:50
10 min

15. Maternity Services: Annual CNST Board Declaration

Decision *Nicola Firth / Maternity Team*

- 15a - Board of Directors CNST YR 7 Sumbission - Front Sheet.pdf (8 pages)
- 15b - Appendix A Safety action 5 Action plan- One to one care in labour MIS year 7 v4.pdf (3 pages)
- 15c - Appendix B Safety action 8.5 8.7 8.12 Action plan 2025 v5 signed off.pdf (4 pages)
- 15d - Appendix C Action plan Safety action 8.1 8.3 2025 V4.pdf (3 pages)
- 15e - Appendix D Safety Action 7 Escalation Stockport October 2025.pdf (3 pages)
- 15f - Appendix E - CNST Y7 Overall action plan and evidence final.pdf (5 pages)
- 15g - Appendix F MIS - Year -7 Board-Declaration -Form.pdf (23 pages)
- 15h - Trust CEO Letter for Sign off by ICB MIS Year 7.pdf (1 pages)

PEOPLE

11:50 - 12:00
10 min

16. People Performance Committee Alert, Advise & Assure Report

Discussion *David Curtis*

- 16a - People Performance Committee AAA Report - Front Sheet.pdf (2 pages)
- 16b - People Performance Committee AAA Report - Jan 2026.pdf (2 pages)

12:00 - 12:15
15 min

17. People & Organisational Development Plan Progress Report

Discussion *Amanda Bromley*

17 - People OD Plan Progress Report - Jan26 v4.pdf (10 pages)

GOVERNANCE

12:15 - 12:25
10 min

18. Board Assurance Framework Q3 2025/26 & Significant Risks

Decision *John Graham*

18a - Front Sheet - Board Assurance Framework Q3 2025-26.pdf (3 pages)
18b - Appendix 1 - SFT Board Assurance Framework Q3 2025-26.pdf (25 pages)
18c - Appendix 2 - Signficant Risks - Corporate Risk Register.pdf (2 pages)

CLOSING MATTERS

12:25 - 12:30
5 min

19. Any Other Business

DATE & TIME OF NEXT MEETING

12:30 - 12:30
0 min

20. Thursday 26 March 2026, 9.30am

This meeting will be held in common with Tameside & Glossop Integrated Care NHS Foundation Trust

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 4 December 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 David Curtis	Non-Executive Director
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Mrs Jackie McShane	Director of Operations
Dr Louise Sell	Non-Executive Director
Mr Dilraj Sandher	Chief Medical Officer

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary
Mrs Kay Wiss	Director of Finance
Ms Hannah Silcock	Assistant Director of Transformation (for item 132/25)
Mr Paul Buckley	Director of Strategy & Partnerships (for items 133/25-135/25)

Apologies:

Mr John Graham	Chief Finance Officer / Deputy Chief Executive

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

REF No/Yr.	ITEM	ACTION OWNER
124/25	**Apologies for Absence** The Joint Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
125/25	**Declarations of Interest** There were no declarations of interest.	
126/25	**Patient Story** The Board watched a video highlighting end of life care and support that had been provided by the palliative care team, district nursing service and multiple other agencies to a patient and his family. The patient's wife praised the support provided by the teams during a difficult time, highlighting in particular good communication, seamless multi-disciplinary team working and continuity of care. Dr Louise Sell, Non-Executive Director, welcomed the qualitative impact of end of life care outlined by the story, noting that it triangulated with the end of life metrics reviewed by the Quality Committee.	

	Mrs Beatrice Fraenkel, Non-Executive Director, noted that the story emphasised the importance of helping the community understand what good end of life care can look like, recognising the fear often associated with conversations about dying. Mr David Curtis, Non-Executive Director, commented that the story demonstrated strong practice in areas that can often cause problems when things go wrong, including communication, collaboration between services and effective involvement of the family. The Joint Chair noted that in this case, multiple services had coordinated seamlessly to enable the patient to remain at home as per his wishes, and support was offered early and care teams were responsive to the family's needs. On behalf of the Board, he expressed appreciation to the teams and services that had contributed to the patient's care. **The Board of Directors received and noted the Patient Story.**	
127/25	**Minutes of Previous Meeting** The minutes of the previous meeting held on 2 October 2025 were agreed as a true and accurate record.	
128/25	**Matters Arising** There were no matters arising.	
129/25	**Action Log** The action log was reviewed and annotated accordingly.	
130/25	**Joint Chair's Report** The Joint Chair presented a report providing an update on national, regional and Trust developments, including: - Tameside & Glossop Integrated Care NHS Foundation Trust (T&G) and Stockport NHS Foundation Trust (SFT) Collaboration - Secretary of State Address to NHS Providers Conference - NHS England (NHSE) Advanced Foundation Trust (AFT) Programme - NHSE Strategic Commissioning Framework - Board of Directors Changes - Key Meetings & Trust Visits While acknowledging the significant financial challenges, Mr Anthony Bell, Non-Executive Director, welcomed the move to longer-term planning which would provide a framework to plan for 3-5 years ahead. Mr David Hopewell, Non-Executive Director, also welcomed the longer-term planning model, however noted challenges around the phasing of deficit funding. Mrs Beatrice Fraenkel, Non-Executive Director, expressed concern regarding	

	lack of system-wide modelling for financial and capacity risks and impact of transition costs without an overall strategic plan, and highlighted the need for strategic approach to manage risk collectively. **The Board of Directors received and noted the Joint Chair's Report.**	
131/25	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: - Medium Term Planning Framework for the NHS in England - Industrial Action - Trust Operational Pressures - Key Successes & Celebrations The Chief Executive highlighted the Trust's improvement in the NHSE Performance Ratings, from 86 out of 134 in Q1 to 62 out of 134 in Q2, acknowledging the work of the teams in this area. The Board of Directors thanked operational and clinical teams for managing the safety of services during the industrial action. **The Board of Directors received and noted the Chief Executive's Report.**	
132/25	**Transformation & Continuous Improvement Strategy Mid-Year Review** The Assistant Director of Transformation presented a report providing a mid-term review of the Continuous Improvement Strategy, which was 18 months into a three-year plan. She highlighted progress made to date, noting focus on the development of training packages. The Chief Executive commented that the full benefits and impact of programmes will be better evidenced in the end of year report to be presented to the Board of Directors in June. In response to a question from the Joint Chair querying if there were any issues the Transformation Team were facing that the Board could help with, the Assistant Director of Transformation noted the main challenge of reprioritisation due to national changes in direction, however stated that no specific support was required at this stage and delivery of the strategy remained on track. Mrs Beatrice Fraenkel, Non-Executive Director, queried how decisions were made about reprioritisation, given ongoing changes. The Assistant Director of Transformation advised that prioritisation aligned with organisational, not system, priorities and confirmed that decisions were made collectively with the Executive Team to ensure focus remained appropriate and consistent. In response to a question from Mr Anthony Bell, Non-Executive Director, querying if investing more resources would improve delivery and accelerate benefits, the Assistant Director of Transformation stated that evidence	

	suggests that investment can shorten delivery times and produce earlier savings, noting that this would be further covered in the annual report. In response to a question from Mr Anthony Bell, Non-Executive Director, querying if Key Performance Indicators (KPIs) had been agreed for the schemes and if they were being tracked effectively, the Assistant Director of Transformation confirmed that KPIs were agreed for each programme at the outset, and these were monitored regularly. Furthermore, she advised that the finance team was involved from the start of the process to assess monetary impact alongside performance measures. The Director of Operations welcomed the support from the Transformation Team which had led to many operational improvements in year. In response to a request from the Joint Chair, the Assistant Director of Transformation agreed to include further detail in the end of year report on how the Transformation Team will support major upcoming priorities such as the Electronic Patient Record (EPR). **The Board of Directors received and noted the Transformation & Continuous Improvement Strategy Mid-Year Review.**	
133/25	**Corporate Objectives & Outcome Measures 2025/26 – Mid-Year Review** The Director of Strategy & Partnerships presented a report providing an overview of progress made against the 2025/26 corporate objectives and key outcome measures during the first six months of the year. He briefed the Board on the content of the report, noting overall positive progress made towards the corporate objectives, and highlighted mitigating actions to improve performance against red and amber rated objectives. In response to a question from the Joint Chair querying the status of a Joint Clinical Strategy, the Director of Strategy & Partnerships noted ongoing engagement with clinical divisions across both organisations and advised that a draft Joint Clinical Strategy was anticipated by the end of Q4 2025/26. In response to a question from the Joint Chair querying a Plan B for Pathology, the Chief Executive stated that any approach would require a hot lab on site, noting a requirement for capital support. The Director of Operations confirmed that an outline business case was in place and business continuity plans had been fully reviewed and tested. In response to a question from Dr Samira Anane, Non-Executive Director, querying alignment of pathology outsourcing with community diagnostics and long-term sustainability, the Chief Executive advised that any outsourcing would be provided by NHS organisations within the network, and noted that community diagnostic expansion remained aligned to medium-term planning frameworks. Mrs Beatrice Fraenkel, Non-Executive Director, queried how the long-term plans aligned with operational and clinical strategies, and what were the timescales. The Director of Strategy & Partnerships stated that specialist healthcare planners and architects had been engaged in the process, noting	

	that broader alignment of strategies was expected to take at least 12 months. In response to a question from Dr Louise Sell, Non-Executive Director, seeking assurance on delivery of the 30% agency reduction target, the Director of People & Organisational Development (OD) commented that while improvements had been made with bank and agency usage, the 30% reduction target remained challenging. She highlighted contributory factors for the position and confirmed that the continued reduction was being actively managed. In response to a question from Mr David Hopewell, Non-Executive Director, querying if lack of IT standardisation was delaying integration of corporate functions between SFT and T&G, the Chief Executive advised that the delays related mainly to external, Greater Manchester (GM) level programmes such as EPR procurement and the GM financial ledger roll out, not local collaboration between the two Trusts. The Joint Chair noted longer-term plans to align systems and processes across both Trusts, however recognising that progress was dependent on external timelines. **The Board of Directors received and noted the Corporate Objectives & Outcome Measures 2025/26 – Mid-Year Review.**	
134/25	**Collaboration Report: GM Acute Provider and Place** The Director of Strategy & Partnerships presented a report providing an overview of the changes within NHS GM relating to the emerging operating model in response to the NHS reforms, and Place partnerships within Stockport. He highlighted the Integrated Care Boards' (ICBs) strengthened role in strategic commissioning and the Board heard that work was ongoing to develop a formal Place Partnership Agreement for Stockport. In response to a question from the Joint Chair regarding the business plan referred to in s3.2 of the report, the Director of Strategy & Partnerships confirmed this related to a Place-level partnership agreement, not a Trust-specific plan, which would set out shared commitments, ambitions and plans across the locality. The Chief Executive noted that the Trust was one partner within a broader system aimed at improving population health. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying risk sharing across the partners, the Chief Executive acknowledged that further work was required to strengthen cross-organisational risk management, alignment of governance frameworks and clarifying roles and responsibilities. Dr Louise Sell, Non-Executive Director, stressed the importance for the Board to be sighted on KPIs and outcomes for GM and Place transformation schemes. The Chief Executive acknowledged the comment, noting that transformational KPIs and measurable outcomes were still being developed. Dr Samira Anane, Non-Executive Director, noted the need to take learning from other GM Trusts on partnership agreements and shared understanding of risk. **The Board of Directors received and noted the Collaboration Report: GM Acute Provider and Place.**	

135/25	**Joint Corporate Governance Model** The Director of Strategy & Partnerships presented a report setting out proposals for implementing a Joint Corporate Governance Model between T&G and SFT, effective from 1 April 2026. He advised that the model aimed to strengthen collaboration, streamline decision-making, and enhance assurance across both organisations while maintaining statutory accountability. The Board acknowledged that the report incorporated outcomes from Joint Board Development Sessions and legal review. **The Board of Directors received and noted the report and, with effect from 1 April 2026, agreed to:** • **Establish a Joint Committee with Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) to be known as the Joint Board, with maximum delegation from each statutory Board; supporting documentation (Terms of Reference, Trust Constitution Scheme of Reservation & Delegation) to be approved in March 2026.** • **Establish Joint Committees with TG ICFT for Quality, People and Finance & Performance; supporting documentation (Terms of Reference and Work Plans) to be approved in March 2026.** • **Align Remuneration Committee and Charitable Funds Committee to operate in common with TG ICFT equivalents; supporting information (Terms of Reference and Work Plans) to be approved in March 2026.** • **Develop a Collaboration Agreement, to be approved in March 2026.** • **Note the outcome of the board composition review to support transition to the joint governance model, which will be presented to the Board in February 2026, noting it is the Council of Governors responsibility to appoint Non-Executive Directors.** • **Note a pooled budgets assessment will be presented at the joint SFT and TG ICFT board development session in February 2026.** • **The Go / No Go Criteria framework, with implementation of the above recommendations subject to 'Go' conditions being met.**	
136/25	**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 in October and November 2025. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered, highlighting the alert section of the report. **The Board of Directors reviewed and confirmed the Finance & Performance Committee AAA Report, including actions taken.**	
137/25	**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 Chief Medical Officer presented the quality section of the IPR and highlighted challenges and mitigating actions regarding sepsis,	

	Infection Prevention & Control (IPC), hospital and community pressure ulcers, complaints, incidents and maternity due to under-achievement in month. The Joint Chair congratulated the Tissue Viability Team for the 50% year-on-year reduction in pressure ulcers, and the Audiology Team for ongoing progress made. The Joint Chair queried how the Trust had managed relatively good IPC performance in the context of high bed occupancy. The Chief Nurse provided an overview of ongoing actions to manage transmission risk, noting a clear escalation programme in place. **Operations** The Chief Executive 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), outpatient efficiency, outpatient procedures and theatre efficiency metrics due to under-achievement in month. In response to a question from Dr Louise Sell, Non-Executive Director, querying effectiveness of escalation to the locality group regarding delays in placing patients in community beds, the Director of Operations stated that this was still work in progress. She briefed the Board on discussions with local health partners and highlighted challenges regarding the care home provision. In response to a question from the Joint Chair querying the impact of high bed occupancy and winter pressures on length of stay, the Director of Operations advised that the Trust benchmarked favourably against peers in this area, noting the positive impact of the ongoing programme of flow. It was noted that the position continued to be reported through the Finance & Performance Committee. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying if telemedicine contributed to a reduction in bed occupancy or ED demand, the Director of Operations advised that a GM evaluation of Hospital at Home programme had confirmed good value for money and noted that virtual ward utilisation had increased at the Trust, albeit overall bed occupancy had not decreased due to higher demand. In response to a question from the Joint Chair, the Director of Operations briefed the Board on ongoing preparations for the forthcoming industrial action, highlighting a focus on safety and maintaining elective activity. **People** The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted challenges and mitigating actions regarding sickness absence and appraisal rates due to under-achievement in month.	

	In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding staff flu vaccination uptake, the Director of People & OD confirmed that while the Trust had achieved the target to increase the staff flu vaccination rate by 5%, work continued to promote the vaccination. **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.**	
138/25	**Finance Report** The Director of Finance presented a report providing an update on the financial performance for Month 7 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 the Trust had a planned deficit of £6.6m at the end of Month 7, and the Trust was reporting a favourable variance of £0.2m against plan. It was noted that at this stage in the financial year the Trust was forecasting a balanced year-end position in a best-case scenario, however notable risks remained in this area. The Director of Finance advised that the Trust had delivered the full year savings target of £29.2m, however £16.6m of the £20.5 recurrent requirement had been delivered to date. The Director of Finance advised that agency expenditure in Month 7 continued to be above the target ceiling, representing a 26% reduction compared to the 30% target. It was noted that bank costs to Month 7 represented a 15% reduction, which was higher than the NHSE minimum expectation of 10%. The Board heard that the Trust's cash balance at the end of October 2025 was £35.1m against a plan of £24.8m. The Director of Finance confirmed that the Trust had received deficit support funding for months 7 and 8. The Director of Finance advised that the Trust had spent £8.5m on capital costs to Month 7 against a plan of £14.7m, with spend to date relating to the Outpatients modular build and the Urgent & Emergency Care Campus. It was noted that the forecast was to deliver plan for the year. In response to a question from the Joint Chair querying if the ICB had requested Trusts to maintain the current forecasts until after Christmas, the Director of Finance confirmed that the position would be reviewed post-Christmas based on actual performance and the impact of industrial action costs.	

	In response to a question from Mr Anthony Bell, Non-Executive Director, the Director of Finance acknowledged that risks remained regarding the availability of deficit funding, which continued to be contingent on GM system performance. She stated that the cash risk was included on the Trust's Significant Risk Register. **The Board of Directors received and noted the Finance Report.**	
139/25	**Board Resolution 2025/26** The Director of Finance presented a report asking the Board to ratify a Board Resolution for cash support to enable flexibility to access additional funding if Deficit Support Funding was unavailable. In response to a question from the Joint Chair, the Director of Finance clarified that £15m was the maximum amount of Public Dividend Capital (PDC) revenue support the Trust could draw, although the actual drawdown may be lower. In response to a question from Mr Anthony Bell, Non-Executive Director, the Director of Finance acknowledged that lessons learned from Bolton's experience should inform the Trust's approach. The Joint Chair noted that while surplus cash from other GM Trusts could be distributed in theory, inequity of cash remained within the GM. **The Board of Directors received and noted the report and ratified the Board Resolution (included in Appendix A of the report) that multiple requests for PDC revenue support could be taken in Q4 2025/26 if required, up to a maximum value of £15,000,000.**	
140/25	**Quality Committee Alert, Assure & Advise (AAA) Report** The Chair of Quality Committee (Dr Louise Sell, Non-Executive Director) presented the AAA reports from the Quality Committee meetings held in October and November 2025, noting that the November meeting had not been quorate. 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.**	
141/25	**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 in November 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.	
142/25	**Freedom to Speak Up Report** The Director of People & OD presented a report providing an overview of the Freedom to Speak Up (FTSU) Guardian's activities over the past 6 months. The Board noted continued focus on refining the Trust's approach to FTSU and heard that the Reflection & Planning Tool would be reviewed in early 2026, in alignment with the NHS Staff Survey results. In response to a question from the Joint Chair regarding the low FTSU case numbers, the Director of People & OD noted that under-reporting was likely during the FTSU Guardian's absence. She briefed the Board on mitigations in place during the FTSU Guardian's absence, including signposting queries to FTSU Champions and the Director of People & OD, however the adverse impact on FTSU visibility and proactive engagement was acknowledged. In response to a comment from Mrs Beatrice Fraenkel, Non-Executive Director, the Board of Directors sent their best wishes to the FTSU Guardian and recognised the need to review the strategic approach to FTSU, complaints handling and support for the Guardian role. **The Board of Directors received and noted the Freedom to Speak Up Report.**	
143/25	**Joint Equality, Diversity & Inclusion Strategy** The Director of People & OD presented a report seeking approval of a single Joint Equality, Diversity & Inclusion (EDI) Strategy 2026-29 between Stockport NHS Foundation Trust (SFT) and Tameside & Glossop Integrated Care NHS Foundation Trust (T&G). She briefed the Board on the consultation process conducted with staff and key stakeholders in both organisations, including staff networks and Council of Governors, noting that the feedback received had informed the draft EDI priorities. It was noted that the People Performance Committee had reviewed the draft strategy and recommended it to the Board of Directors for approval, acknowledging that work continued on the divisional objectives. The Board heard that the detailed Divisional EDI Action Plan would be submitted to the People Performance Committee in January 2026. The Director of People & OD advised that progress against the strategy would be monitored bi-monthly by the Combined EDI Steering Group, six-monthly by the People Performance Committee and annually by the Board. In response to questions from Mr Anthony Bell and Mr David Curtis, Non-Executive Directors, the Director of People & OD highlighted how the new strategy would address BAME underrepresentation at senior levels, gender inclusivity and widening participation. Dr Louise Sell, Non-Executive Director, suggested that reverse mentoring for Board members should be re-explored as part of the implementation of the Joint EDI Strategy. **The Board of Directors received and noted the report and approved the**	

	Joint Equality, Diversity & Inclusion Strategy, acknowledging pending divisional actions.	
144/25	**Improving Resident Doctors Working Lives** The Chief Medical Officer presented a report providing an update on progress being made against NHSE's 10 Point Plan to improve working conditions for resident doctors, following the NHSE letter "Getting the basics right for resident doctors" received in August 2025. The Board heard that the letter had highlighted ongoing issues for resident doctors and required Trusts to take action within a 12-week timescale, with longer term milestones extending into 2026. The Chief Medical Officer advised that a multi-disciplinary Task and Finish Group had been established to coordinate the Trust's response, noting that resident doctors were being consulted directly for feedback. He advised that the Trust was on track to deliver the NHSE 10 Point Plan, with clear governance, engagement and monitoring mechanisms in place. In response to comments from Dr Samira Anane, Non-Executive Director, expressing concern regarding the longstanding issues highlighted in the plan, the Chief Medical Officer stressed the importance on focusing on improvement actions that were within the Trust's gift. **The Board of Directors received and noted the Improving Resident Doctors Working Lives Report and progress being made against the 10 Point Plan.**	
145/25	**Audit Committee Alert, Assure & Advise (AAA) Report** The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the AAA report from the Audit Committee meeting held in November 2025, detailing key issues and risks considered. **The Board of Directors reviewed and confirmed the Audit Committee AAA Report, including actions taken.**	
146/25	**Annual Emergency Preparedness, Resilience and Response (EPRR) Report – Core Standards and Statement of Compliance** The Chief Executive presented the Annual EPRR Report, providing an overview of the Trust's EPRR related activities in 2025/26. The Board noted the declaration of 'Partially Compliant' against the 2025/26 EPRR Core Standards. The Board heard that an assurance meeting had taken place on 21 October 2025, during which representatives from NHS GM EPRR Team had reviewed the Trust's submission and associated evidence, and had confirmed the Partially Compliant rating. It was noted that gaps remained against criteria within Domain 5 (Training & Exercising) and Domain 9 (Business Continuity). The Board heard that progress was being made on non-compliant areas and the Chief Executive advised that EPRR resource would be reviewed once the EPRR Manager was back in work. In response to a question from Mr Anthony Bell, Non-Executive Director, querying how the Trust compared with GM in this area, the Chief Executive	

	noted that the Trust had not been an outlier in previous years, however more recent GM comparisons would be explored. In response to a question from the Joint Chair regarding the partial compliance position, the Chief Executive noted reasonable assurance in this area, noting that any deviations would be escalated as exceptions through the relevant Committees. **The Board of Directors approved the Annual EPRR Report, including compliance position with the core standards.**	
147/25	**Any Other Business** The Joint Chair noted that this would be the last Board meeting attended by Mrs Beatrice Fraenkel, Non-Executive Director. He thanked Mrs Fraenkel for her contribution to the Board of Directors during her three-year tenure and wished her the very best for the future.	
148/25	**Date and Time of Next Meeting** Thursday 5 February 2026, 9.30am, Pinewood House Education Centre.	
149/25	**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
				No open actions.		

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.	7
Meeting date	5th February 2026	**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
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

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:

- Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) Collaboration
- National Provider Leadership Update
- Key Meetings & Trust Visits

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

Following the discussions and approvals provided by both Trust Boards in November and December 2025, we continue to make steady progress toward implementing our new joint corporate governance arrangements. This includes the establishment of a Joint Board and Joint Board Committees, designed to strengthen assurance processes and support more effective decision-making across both organisations.

I want to acknowledge that transitioning to new governance structures is never straightforward and thank all colleagues who have contributed to the extensive discussions that have enabled us to reach this stage.

Formal communication from myself and Karen has been issued to the NHS England Regional Director and the Greater Manchester Integrated Care System. No concerns have been raised in response.

In line with our timeline, we will be considering specific matters as part of our programme later in the meeting.

2. National Provider Leadership Update

On 16 January 2026, NHS Providers and the NHS Confederation confirmed the appointment of Sir Ciarán Devane as the inaugural Chief Executive of their newly merged national membership body, which will formally launch in April 2026. The merger creates a single voice for provider organisations and systems across the UK, with the aim of streamlining advocacy, sharpening policy influence, and enhancing support for Boards during a period of significant reform.

3. Trust Activities

As we continue through the winter period, I would like to thank colleagues across all services for their continued professionalism, resilience and commitment. This remains an exceptionally demanding time operationally, and I am grateful for the care and compassion shown every day.

Since the last Board meeting, I have attended several engagements at local, regional and national level. These included the NHS Confederation and NHS Providers Quarterly Shared Leadership Forum, which brought together Chairs and system leaders from across the country with discussions focused on national reform, provider leadership, and the implications of ongoing structural and policy changes for Boards. I also attended the Greater Manchester (GM) Trusts Chairs' meeting with discussion focused on opportunities and challenges we face as a system.

Alongside these engagements, I have continued my programme of visits across the Trust to engage with staff and see services first-hand. Recent visits have included Endoscopy, Pre Op Assessment, Oncology, A&E, Acute Frailty Unit and Audiology. As always, these visits have provided valuable insight into operational pressures and the exceptional commitment shown by colleagues.

Stockport
NHS Foundation Trust

				Agenda No.	8
Meeting date	5th February 2026	**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
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

This report provides an update on matters of interest, which have arisen since the last Board meeting held in November 2025 including:

- Medium Term Planning Framework for the NHS in England
- National Guidance: Sexual Safety, Misconduct Prevention and Chaperoning
- North West Neonatal Services Review
- Trust Operational Pressures
- Success & Celebrations

1. Medium Term Planning Framework for the NHS in England

Following Board approval in November 2025, the draft plans were submitted in December 2025, covering activity, workforce, and finance. These draft submissions highlighted several significant challenges in meeting the full set of national expectations across the planning period, particularly in areas where demand, productivity, or financial constraints remain acute.

Work is now underway to prepare the final submission due in early February 2026. This next stage includes:

- Incorporating feedback received from NHS England and the Integrated Care Board
- Refining underlying assumptions and addressing gaps in activity, workforce, productivity and financial trajectories
- Developing the narrative plan and associated Board Assurance Statements
- Finalising the supporting divisional plans and producing 2026/27 Plans-on-a-Page
- Ensuring alignment with wider system planning requirements and the ICB's commissioning intentions.

Work is being coordinated through the Strategy Team with active involvement from the Executive Team and Divisional Triumvirates. The Trust Board will discuss this matter in further detail later in the meeting.

2. National Guidance: Sexual Safety, Misconduct Prevention and Chaperoning

NHS England has issued new national guidance setting out strengthened expectations to prevent sexual misconduct in the NHS. These include:

- Updated actions to prevent sexual misconduct, requiring organisations to strengthen policy, training and assurance arrangements.
- New national principles for chaperoning practice, setting out clear expectations for how chaperones should be offered, trained and used to safeguard patients and staff.
- A self-assurance checklist for primary care providers to support implementation of the NHS Sexual Safety Charter, to be completed by March 2026.

For the Trust, this means ensuring our existing policies and practices on sexual safety, misconduct prevention and chaperoning remain aligned with national standards. To this end, we are reviewing relevant policies, ensuring staff are aware of updated expectations, and working with the ICB to support system-wide compliance in both Trust and primary care settings.

3. North West Neonatal Services Review

NHS England has commenced formal staff engagement as part of the North West Safe and Sustainable Specialised Health Services for Babies and Children Transformation Programme, which includes a review of neonatal critical care services.

Engagement with neonatal staff across provider organisations will run from late January through February 2026 and will involve opportunities to attend virtual briefing events and to provide feedback on the published Case for Change via an online questionnaire. The engagement process will inform the development of a short-listed set of options for future service configuration later in 2026, ahead of further financial, equality and assurance processes. The Trust will support local neonatal teams to

participate in the engagement activity and will continue to work with system partners as the programme progresses.

4. Trust Operational Pressures

Our operational performance continues to reflect the pressures facing both the Trust and the wider NHS. Whilst improvement is being sustained particularly around elective and cancer care, urgent and emergency care continues to be a challenge and perform below the national target. Poor patient flow is a significant driver of this position and emphasises the importance of system-wide collaboration to support continuous improvement.

Despite these pressures, colleagues across the organisation continue to demonstrate considerable resilience and commitment to delivering safe, high-quality care, and I would like to acknowledge their continued efforts during this sustained period of winter demand.

5. Successes & Celebrations

5.1 Work Experience Gold Standard

Stockport has achieved the Gold standard in support and training for work experience applicants. NHS England's review showed that the learning and development team together with colleagues across the organisation offered excellent support for people undergoing work experience across the Trust, with high standards of assessment, and high-quality learner packs providing accessible information. They were also judged to give those on work experience a friendly environment in which to discuss their options, and a good range of opportunities to develop transferable skills.

				SFT Paper	9
Meeting date	**5 February 2026**	**Joint Paper**	**X**	**TGICFT Paper**	
Meeting	Board of Directors				
Report Title	Corporate and Clinical Services Collaboration				
Director Lead	Paul Buckley, Director of Strategy and Partnerships	**Author**	Angela Dawber, Associate Deputy Director of Strategy & Partnerships		

Paper For:	**Information**	**X**	**Assurance**		**Decision**	
Recommendation:	The Board is asked to consider the update on the corporate and clinical collaboration work.					

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	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 paper provides an update on the corporate and clinical services collaborative work between Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust.

Corporate and Clinical Services Collaboration

1. Introduction

1.1 This paper provides an update on the collaborative working that is taking place between Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust (trusts), covering both corporate and clinical services collaboration.

1.2 As NHS organisations we have a duty to collaborate as outlined in the Health and Care Act (2022). The statutory guidance published in response and the requirements included within the NHS England Well Led framework informs the approach to exploring greater collaboration opportunities to improve our effectiveness and the health and wellbeing of both populations.

1.3 The approach to collaboration between both trusts is also being taken forward with other secondary care, primary care and locality partners across Greater Manchester.

2. Corporate Services Collaboration

2.1 Each Executive Director/Director has continued to review and progress opportunities to collaborate by reviewing the corporate support services that fall within their respective portfolios. This work is overseen through the Joint Executive Team.

2.2 A summary of the areas progressed to date and other areas of opportunity are set out in **Appendix 1.**

3. Clinical Services Collaboration

3.1 The initial clinical workstreams continue to develop, overseen by a new Tameside and Stockport Clinical Collaboration (TASCC) steering group. As a clinically driven programme of work, clinical leads present regular updates on progress as part of the highlight reports.

Gastroenterology

3.2 The Gastroenterology steering group has been focusing greater alignment to support joint working. Moving forward, they have identified four priorities for collaboration:

- **Endoscopic Retrograde Cholangio Pancreatography (ERCP):** nationally, there is a shortage of ERCP professionals and GM's ICB is looking to decommission ERCPs at low volume units, putting both services at risk. The first priority for collaboration across the two Gastro teams will be to implement a joint list, enabling both Trusts to meet JAG requirements for ERCP competencies.
- **Hepatology**: The Trusts are seeing an increase of low-risk Metabolic Associated Steatotic Liver Disease (MASLD) referrals into secondary care. The second priority for the teams will be to develop an aligned pathway that ensures low level cases are effectively managed in primary care.
- **IBD:** Both Trusts have growing demand for IBD services and issues with lack of staffing. The third priority will be to develop an aligned pathway, drawing from best practice at both sites, aligned to national standards. This will consider optimal use of appointments to reduce waiting times and a skill mix to ensure patients are seen by the most appropriate professional to manage their needs and reduce the backlogs in consultant clinics.

Emergency GI Bleed Rota: Emergency GI bleeds out-of-hours are currently transferred to Stockport on a treat and transfer pathway. The sub-group have considered revised options, and the service will remain as currently provided.

Radiology

3.3 The radiology teams have been working closely together for some time now, sharing best practice and providing cross-cover. Moving forward, four key priorities have been identified:

- **MR capacity:** the teams have undertaken a capacity and demand review to map growth in MR scans, identify when additional scanners will be required and where they would be best placed between the two Trust sites and the Community Diagnostics Centre to improve patient flow and reduce waiting times.
- **Procurement Opportunities**: The Trusts have already delivered over £300k savings through joint procurement of reporting capacity. Teams continue to collaborate to identify further opportunities to make savings in procurement of equipment and outsourcing services.
- **Sub-specialism Review:** The teams are working together to review options for joint appointments in areas where activity levels are too low to warrant a full-time lead on each site. The ambition is to jointly offer a full range of services for local people and a wider range of opportunities for staff to sub-specialise, improving recruitment, retention and career development for our teams.
- **Benchmarking:** Work continues to learn from each other through benchmarking of capacity and performance.

Pharmacy

3.4 Both Trusts provide a full pharmacy service, including managing medication stocks for the hospitals, preparing sterile aseptic products, quality control, and dispensing medication for inpatients and outpatients.

3.5 The pharmacy teams have been working closely together to share learning and identify opportunities to share resources, reduce duplication, offer staff wider opportunities for development, and increase our spending power through joint procurements.

3.6 To date, the pharmacy teams have created a joint role for procurement and distribution. Plans are underway to develop centralised medicine stores and options for outpatient pharmacy.

Pathology

3.7 Pathology services are under increasing pressure, with demand growing by around 10% a year. Across the country there is a shortage of pathology professionals, linked to the growth in demand, impacting on resilience. Stockport and Tameside's pathology teams have come together to develop a baseline of service offers and case for change.

3.8 Initial progress has been made in Microbiology, where joint recruitment was undertaken to attract new consultants to a wider team across the two Trusts and fill vacancies created by recent retirements. The new Clinical Lead for Microbiology is working with teams to develop a single service model for medical microbiology to ensure that the service is sustainable long into the future.

3.9 The Trusts have also recently appointed a joint operational lead across the two services, with the aim of creating single management and leadership structures for the departments that facilitate improvements in quality and efficiency.

3.10 Future work will include a review of histopathology sustainability, alignment of point of care testing, joint procurements for improved value, and joint capital bids to upgrade lab facilities.

3.11 Progressing our work with these initial four areas has helped inform some further learning and expand on that previously described.

- Dedicated capacity will be required to progress the work within clinical, operational and corporate teams.
- A more structured approach will be beneficial in moving forward.
- A benefits tracker is in place and initial benefits identified will need further review to ensure they define specific outcomes (**Appendix 2**)
- There is a clear desire from corporate and clinical teams to take this work forward, evidenced by teams sharing their intent to explore opportunities.
- Regular communication so that the purpose is clear to all colleagues is clear.

4. Joint Clinical Strategy

4.1 Good progress has been made through the engagement with Divisional triumvirates to support the development of our joint Clinical Strategy, which a working draft was shared at the last TASCC steering group. Comments on the first draft were requested by the end of February to enable a final version to be presented to the meeting in March and the Joint Executive Team thereafter.

4.2 Continued engagement with Divisional Triumvirates to systematically assess the most appropriate model of care for each service delivered by the two Trusts is ongoing. This will form part of the delivery plan and a road map for greater alignment of clinical services for the future that will be reviewed by the TASCC steering group.

4.3 This work sits within a revised strategic framework that is developing in response to the joint working between Trusts, which will see the development of a joint Quality Strategy and a joint Organisational Strategy.

5. Conclusion and Next Steps

5.1 The Board of Directors are asked to consider the update on the corporate and clinical collaboration work.

Appendix 1 – Areas of Corporate Collaboration

Area	Progress	Next Steps
Finance	Recurrent benefits of the sharing of executive posts across the two Trusts Shared learning between finance teams Consistent approach and combined annual planning processes	Review of financial ledger systems Continued sharing of best practice and opportunities for training with wider teams e.g. HFMA Operating Game
Medical	Trainees have the ability to be provided with training across larger base Good practice shared across both sites Medical leadership training and appraisal process standardisation and assuring quality Joint Research, Development and Innovation strategy	Scoping joint working for clinical teams Explore combined SAS leadership and CESR delivery
Nursing	Alignment of Professional standards (Nursing, Midwifery & AHP and IPC) Alignment of assurance processes (Accreditation) with both Trusts using ARS format Corporate Benchmarking e.g. Governance & Corporate nursing teams completed and as opportunities arise, and will be repeated Collaborative working for delivery of national ambitions e.g. PSIRF which is in place and plans to review and align in place Shared learning - TV, IP, Safeguarding, Pt Exp – Deputy Chief Nurses and teams collaborating and further review to align to take place	Joint Chief Nurse from 1 April 2026, Joint Chief AHP April 2026, Joint Dep Dir Quality Governance April 2026 Collaborative Workforce planning with all corporate roles reviewed as they come up. Leadership structures reviewed to align, SNCT & safer staffing tools used as per national guidelines Systems review shared with governance paper & business case developed for one risk management system going forward, which is currently under review Build shared Quality Improvement capacity Shared professional standards, pathways and working to established national standards Review opportunity for shared bank is being progressed
Estates & Facilities	Increasing opportunities for joint working between teams. Continuation of peer reviews. Development of common EFM systems (MiCAD) Amalgamation of primary management vehicles (e.g. E&F SMT) Alignment of core operational practices (car parking, governance). Strategy development including joint Sustainability Manager	Further development of joint working leading to potential single structure

Area	Progress	Next Steps
Digital	Laboratory Information Management System (LIMS) joint procurement and skills sharing. Joint Electronic Patient Record (EPR) business case, with joint programme team. A joint Clinical Coding structure in place, with cross-organisation working in place. Collaboration between business intelligence functions to deliver joint committee reporting.	EPR implementation plan developed. The plan shows how digital teams will be brought together during the project, so that they are shared at project end (or before when appropriate). Shared teams for training, systems, software development, and medical records.
Strategy & Partnerships	Strategy & Partnerships Team work across both trusts Annual planning processes reviewed and improved Shared learning from respective locality Provider Partnership developments. Reduced duplication of attendance at GM / external meetings and consistency across Trusts Ability to respond jointly to new initiatives Dedicated capacity for driving clinical collaboration in place Single operational/annual plan process Development of joint Quality Strategy	Completion of joint Clinical Strategy Completion of joint Organisational Strategy.
Operations	Good in depth knowledge of each others services Good level of collaboration regarding clinical services Common performance report and metrics develop with alignment of performance data collection to aid benchmarking & continuous improvement. Cross cover at GM forums to reduce duplication/release time.	Continue sharing best practice and benchmark services. Further scope to collaborate on clinical services.
People	A number of joint services and joint working already in place. EDI & H&WB meetings have been combined across the two Trusts as have the Staff Networks. Trial of a joint recruitment service was trialed in 25/26 – evaluation completed likely to be made permanent. Operating model for Workforce Information team currently in draft proposing a joint WI team across the two Trusts. Joint Senior Leadership Team meetings and joint wider leadership team meetings in place along with Joint Team Brief meetings from Jan 26.	Structure proposals for Employee Relations /Business Partnering team discussed at Joint Execs during 2025 – updated paper to be take 26/1/26 Proposal will include a Joint Medical Staffing lead with a view to aligning processes and systems going forward; plans for a joint ET&D service also included.

Benefits Tracker

	Gastroenterology	Radiology	Pharmacy	Pathology
	Delivered Benefits	**Delivered Benefits**	**Delivered Benefits**	**Delivered Benefits**
	• SFT providing ERCP training for TGICFT clinicians • 2 new Gastroenterologists recruited at TGICFT • Models of care agreed	• Additional diagnostic capacity • Access to DEXA in Tameside • MDT support for Urology at TGICFT • Joint contract for reporting at reduced cost	• Draft case for change • Draft WOS paper • Aseptics paper approved • Joint procurement & distribution role in place	• Draft case for change • Joint operational lead in place • Joint recruitment for microbiology consultants undertaken • Single rota for OOH microbiology
	Anticipated Benefits	**Anticipated Benefits**	**Anticipated Benefits**	**Anticipated Benefits**
	• Consistent delivery of RTT standards • Consistent delivery of cancer standards	• Consistent delivery of 95% DM01 • Reduction in DNAs for DEXA	• Reduction in delayed discharges	• Consistent delivery of turnaround times • Reduction in delayed discharges
	• Reduction in vacancy rate • Improved staff satisfaction • Improved opportunities for sub-specialisation	• Reduction in vacancy rate • Improved staff satisfaction	• Reduction in vacancy rate • Improved staff satisfaction • Improved opportunities for sub-specialisation	• Reduction in vacancy rate • Improved staff satisfaction • Improved opportunities for sub-specialisation
	• Robust 24/7 GI bleed rota • Expansion of local service offer Improved patient satisfaction • Positive CQC rating • Cross-cover for IBD nursing	• Expansion of local service offer • Improved patient satisfaction • Positive CQC rating • Increased use of AI	• Expansion of local service offer • Improved patient satisfaction • Full accreditation	• Expansion of local service offer • Improved patient satisfaction • Full accreditation
	• Reduction in bank / agency spend	• Reduction in bank / agency spend • Reduction in outsourcing costs	• Maximise income generation • Reduction in bank / agency spend	• Reduction in bank / agency spend

NHS Stockport NHS Foundation Trust

				Agenda No.	10
Meeting date	5th February 2026	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Joint Corporate Governance Model: Go / No Go Criteria Assessment				
Director Lead	Paul Buckley, Director of Strategy & Partnerships	**Author**	Paul Buckley, Director of Strategy & Partnerships Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	**The Board of Directors is asked to:** • **Approve the implementation of joint corporate governance arrangements with Stockport NHS Foundation Trust from 1 April 2026.**					

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

In November and December 2025, the Boards of Directors of Tameside and Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) approved the move to joint corporate governance arrangements from 1 April 2026.

This decision included creating:

- a Joint Committee (the Joint Board) with the maximum delegation from both Boards
- Joint Committees for Quality, People, and Finance & Performance
- aligned Remuneration and Charitable Funds Committees that will operate in common across both organisations
- Audit Committees will remain separate during 2026/27 to meet statutory requirements, but their work plans will be aligned.

The Boards also agreed to develop a formal Collaboration Agreement. This will set out how the partnership will work, the expectations for governance, and the operational framework that supports it. An assessment would also be carried out to explore future pooled budget arrangements to support transformation, integration, and efficiency.

As this is a significant and complex change, a detailed Go / No Go Criteria framework was created and approved by the Trust Board's to test readiness. The criteria covered statutory and legal requirements, and the operational arrangements needed for the Boards and Committees to function safely and effectively from day one. This ensures all regulatory obligations are met.

An assessment against the criteria has been completed and confirms the programme is on track. Several key documents were planned for approval by 31 March 2026, with final drafts due for Board review in March. Based on current drafts, there are no issues to escalate to the Board.

Final versions of the documents are being reviewed and will be uploaded to the Reading Room on AdminControl during the week beginning 9 February. A summary of key changes will also be provided. This gives Board members early sight of the materials ahead of the joint board development session on 5 March and the decision to be taken at the Board meeting on 26 March. Members may provide comments beforehand.

At the development session on 5 March, the Board will also discuss how the committees will work in practice. This will include expectations for reporting, the role of committee chairs, and ensuring that, under the new joint governance model, committees focus on the right level of detail and provide meaningful insight for both organisations.

Given the progress made and the positive assessment against all Go / No Go Criteria (Appendix 1), the Trust Board is asked to support a 'Go' decision to implement joint corporate governance arrangements from 1 April 2026. This recommendation will also be presented to the SFT Trust Board on 5 February 2026.

Appendix 1: Go / No Go Criteria

Criteria (Go)	Criteria (No go)	Assessment
In line with the legal advice received, establish a joint committee of the two Trust Boards, with maximum delegation, and a single term of reference, and revise the governance documents of each Trust to reflect its establishment		
Legal advice has confirmed the proposed structure, delegation, and terms of reference are compliant with statutory requirements and the NHS England Statutory Guidance on delegation and joint working.	Legal advice identifies that the proposed committee structure, delegation or terms of reference are non-compliant with statutory requirements or the NHS England Statutory Guidance on delegation and joint working, creating for the Trusts a risk of challenge or regulatory intervention.	**Go:** Legal advice note obtained confirming the proposed arrangements provide a sound legal basis on which to proceed. Statutory Boards will meet annually to undertake matters that cannot be delegated. Additional statutory Board meetings only if required. **Dates/Evidence:** Joint SFT & TGICFT board development session 6th November 2025 - Legal Advice Note & Presentation from Legal Advisors.
The joint committee's terms of reference are finalised, clearly detailing its delegated functions, scope, and decision-making process, and are approved by both Trust Boards.	The terms of reference are not finalised, are vague on the delegated functions, or they include functions which should not be exercised jointly and are vague on the decision-making process. The terms of reference are not approved by both Trust Boards.	**Go**: Draft Joint Board Terms of Reference, informed by legal advice, in place. Delegated Authority reflects maximum delegation from each statutory Board. To be presented to the SFT & TGICFT Boards on 26th March 2026 for approval. **Dates/Evidence:** Draft Terms of Reference & Work Plan available in Reading Room following Trust Board(s).
All necessary constitutional amendments have been made in accordance with the process for amendments set out in each Trust's Constitution and aligned Schemes of Reservation and Delegation (SORDs) for both SFT and TGICFT to delegate agreed functions to the joint committee have been drafted and approved by their respective Boards.	One or both Trusts' Constitutions and/or SORDs have not been updated or aligned to clearly reflect the establishment of the joint committee and delegate functions to it, or amendments are incomplete/not yet approved.	**Go**: Draft Trust Constitutions, informed by legal advice, in place, reflecting all required amendments. Standardised with exception of Composition of Council of Governors. Draft Schemes of Reservation and Delegation (SORDs) under review by Finance Teams. Standardised with exception of Divisional/Role Titles as needed. Standardised delegated approval limits Joint Finance & Performance Committee / Joint Board. Legal opinion following internal review. To be presented to the SFT & TGICFT Boards on 26th March 2026 for approval. **Dates/Evidence**: Draft Trust Constitutions available in Reading Room following Trust Board(s). Draft Schemes of Reservation and Delegation (SORDs) to be made available in Reading Room by 20th February 2026.

Criteria (Go)	Criteria (No go)	Assessment
Include all Executives and Non-Executive Directors on both Boards as members of joint committee		
The Boards have reached agreement on the total number of joint posts across the two Boards and on whether to retain non-joint Non-Executive Directors (NEDs), balancing the desire for closer integration with the need for independent scrutiny.	There is ongoing unresolved debate or disagreement between the Boards regarding the total number of joint posts and the optimal long-term composition of non-executive leadership and how to manage the potential for conflicts in any future statutory transaction.	**Go**: Agreement reached on the number of the joint posts for Executive and Non-Executive Directors, with Remuneration Committees and Nominations Committees/Councils of Governors respectively. All NED roles will be joint, and legal advice has confirmed that this approach is compliant and legally sound. Outcome of board composition review to be presented to Trust Boards in Jan/Feb 2026. **Dates/Evidence**: SFT & TG ICFT Remuneration Committee in Common - 27th November 2025 SFT & TG ICFT Nominations Committee in Common - 7th November and 18th December 2025 SFT & TGICFT CoG - 21st January 2027 TGICFT Board of Directors - 29th January 2026 SFT Board of Directors - 5th February 2026
The Boards have reached agreement on Executive Director posts, ensuring that the Executive Director members of the Trust Boards meet statutory requirements and have the skills, knowledge and experience to ensure the Trusts comply with their statutory responsibilities as well-led organisations.	There is ongoing unresolved debate or disagreement between the Boards regarding Executive Director posts and/or the Executive Director members of the Trust Boards do not meet statutory requirements or have the skills, knowledge and experience to ensure the Trusts comply with their statutory responsibilities as well-led organisations.	**Go**: Agreement reached on the number of Executive Director posts by Remuneration Committees. Outcome of board composition review to be presented to Trust Boards in Jan/Feb 2026. **Dates/Evidence**: SFT & TG ICFT Remuneration Committee in Common – 27th November 2026 TGICFT Board of Directors - 29th January 2026 SFT Board of Directors - 5th February 2026
The Councils of Governors have reached agreement on Non-Executive Director posts, ensuring that the Non-Executive Director members of the Trust Boards have the skills, knowledge and experience to ensure the Trusts comply with their statutory responsibilities as well-led organisations.	There is ongoing unresolved debate or disagreement between the Councils of Governors regarding Non-Executive Director posts and/or the Non-Executive Director members of the Trust Boards do not have the skills, knowledge and experience to ensure the Trusts comply with their statutory responsibilities as well-led organisations.	**Go**: Agreement reached on the number of joint NEDs with Nominations Committees. Outcome of board composition review to be presented to Trust Boards in Jan/Feb 2026. Recruitment for new joint appointments underway. **Dates/Evidence**: SFT & TG ICFT Nominations Committee in Common – 18th December 2025

Criteria (Go)	Criteria (No go)	Assessment
		SFT & TGICFT CoG - 21st January 2026
The above agreements are appropriately documented in Board and/or Council of Governor resolutions.	The Boards and/or Council of Governors have not agreed one or more of the above and therefore agreements are not documented in Board / Council of Governor resolutions.	**Go**: Decisions documented in Minutes of all meetings referenced above. **Dates/Evidence**: Minutes of all meetings referenced above.
Each Trust Board to delegate as many of the Boards' functions to the joint committee as is permitted, in line with the NHS England Statutory Guidance on the delegation and joint exercise of functions, to realise its potential for efficiency and joint decision-making in line with the agreed joint Organisational Strategy **To decide whether to delegate all such functions on day one of the joint committee's operation or gradually over a period of time**		
The Boards have agreed the remit of the joint committee and the functions that will be delegated to it from day one, and the joint committee's terms of reference and each Trust's SORD has been finalised/amended to reflect those delegations. The Boards have agreed that the proposed operation of the joint committee is in line with the developing joint Organisational Strategy.	There is ongoing unresolved debate or disagreement between the Boards regarding the remit of the joint committee and the functions that will be delegated to it and/or the joint committee's terms of reference and each Trust's SORD have not been finalised / amended to reflect agreed delegations and/or the proposed operation of the joint committee is not deemed to be in line with the developing joint Organisational Strategy.	**Go**: SFT and TGICFT Boards agreed to establish a Joint Committee with maximum delegation from each statutory Board to support the Trusts strategic ambitions. As above regarding Joint Board Terms of Reference and SoRD. **Dates/Evidence**: TGICFT Board of Directors - 27th November 2025 SFT Board of Directors - 5th December 2025
The Boards have considered the establishment of a pooled fund concurrent with the establishment of the joint committee and if confirmed they are to be implemented to enable the joint committee to implement its decisions swiftly and efficiently		
The pooled fund arrangements are agreed and clearly documented in the collaboration agreement or otherwise, with all necessary detail as recommended by legal advice and as advised by Trust finance teams.	The pooled fund arrangements are not agreed and/or are not clearly documented leading to delays and bureaucracy once the joint committee begins making decisions which require financial input.	**Go**: Legal advice provided on the scope of pooled budgets. An initial assessment is underway, and a proposal is to be considered at the joint board development session on 5th March, as previously agreed with the Trust Board(s). It is anticipated that pooled budgets will not be confirmed from the outset of the new joint governance arrangements, however development will continue during 2026/27. **Dates/Evidence**: Discussion at joint board development session 5th March 2026.
Retain separate Audit, Charity, and Remuneration Committees to meet statutory requirements and comply with NHS England guidance on functions excluded from joint exercise but hold meetings "in common" with aligned agendas, where this is determined as appropriate		

Criteria (Go)	Criteria (No go)	Assessment
The separate statutory committees (Audit, Remuneration, Charity) have made decision to remain separate or operate 'in common'. Where meeting 'in common' aligned terms of reference are in place to ensure a collaborative approach to their sovereign responsibilities has been agreed. Where remaining separate, work plans have been standardised.	The statutory committees are not aligned on their processes, with no 'meetings in common', suggesting a lack of operational integration needed for the overall joint governance model to function efficiently and effectively.	**Go**: SFT and TGICFT Boards agreed to Remuneration Committee and Charitable Funds Committee operating in common. Audit Committees to operate separately, with aligned workplans for 2026/27, proposed to move to in common in 2027/28. Draft Terms of Reference, informed by legal advice, in place. Each Committee will report to the Joint Board. To be presented to the SFT & TGICFT Boards on 26th March 2026 for approval. **Dates/Evidence**: TGICFT Board of Directors - 27th November 2025 SFT Board of Directors - 5th December 2025 Draft Terms of Reference & Work Plans available in Reading Room following Trust Board(s).
Consider structure and operation of other Board committees and whether joint committees or meetings "in common"		
Each Trust Board has agreed the structure and operation of other Board committees. The committee's terms of reference are finalised, clearly detailing its delegated functions, scope, and decision-making process, and are approved by both Trust Boards, along with work plans.	There is disagreement as to the structure and operation of other Board committees and the respective committees of each Trust are not aligned on their processes or have not committed to a joint committee or 'meetings in common'.	**Go**: SFT and TGICFT Boards agreed to establish Joint People; Quality and Finance & Performance Committees. Draft Terms of Reference, informed by legal advice, in place. Each Committee will report to the Joint Board. To be presented to the SFT & TGICFT Boards on 26th March 2026 for approval. **Dates/Evidence**: TGICFT Board of Directors - 27th November 2025 SFT Board of Directors - 5th December 2025 Draft Terms of Reference & Work Plans available in Reading Room following Trust Board(s).
Draft and execute a formal collaboration agreement between SFT and TGICFT		
A collaboration agreement is approved and entered into by both Trusts, setting out matters such as collaborative principles and behaviours, the role of each Trust and governance arrangements, in line with legal advice.	The Trusts do not have an agreed, finalised collaboration agreement, or the drafted agreement fails to include necessary detail recommended by legal advice.	**Go**: A draft collaboration agreement, informed by legal advice, is in place. It will outline the Partnering Principles, Reporting Requirements & Records & include a series of Schedules, including opportunity to develop plans for future corporate and clinical collaboration. To be presented to the SFT & TGICFT Boards on 26th March 2026 for approval. **Dates/Evidence**:

Criteria (Go)	Criteria (No go)	Assessment
		Draft Collaboration Agreement available in Reading Room following Trust Board(s).
Establish a reporting framework		
A consistent reporting template has been agreed and implemented across both Trusts. Training delivered to all relevant staff on reporting expectations and template use. Reporting cycle aligned with joint governance calendar and escalation routes clearly defined. Agendas and papers produced in consistent style, with confidence papers can be distributed within agreed timescales.	A consistent reporting template has not been agreed across both Trusts and relevant staff are unclear on reporting expectations. Reporting timelines unclear or misaligned with governance schedules	**Go**: A new draft report template in place. 'Effective Report Writing' training delivered by Good Governance Institute (GGI) in early March for 80+ senior leaders. Commissioned to ensure reports are clear, concise and truly focussed on escalation and improvement action and focussed on appropriate escalation and improvement actions for Board/Board Committee level. Future reports will take the form of: • Joint Report - This report provides an integrated overview across both Trusts. • Joint Summary with separate Trust Report - The summary highlight's key matters for both Trusts, followed by a report for each Trust. • Separate Trust Report - This report focuses on [Trust Name]. New joint corporate calendar has been drafted considering the requirements for timely distribution of papers. **Dates/Evidence**: New Reporting Template & Draft Corporate Calendar available in Reading Room following Trust Board(s).
Establish information sharing & document management procedures		
Shared document management system implemented and tested for storing and sharing papers Board/Board Committee level papers. Information-sharing protocols agreed and embedded in governance processes.	No common system for document storage/sharing. Protocols not agreed or tested.	**Go**: Shared document management system (SharePoint) in place for internal storing of Board/Board Committee papers. A single AdminControl portal will be made available to all Board members for dissemination and access of papers. Archive access to separate SFT and TGICFT AdminControl will remain. **Dates/Evidence**: N/A
Engage with and report on above activity to Councils of Governors.		
The respective Councils of Governors have been engaged throughout, have shared views	There has been minimal engagement with the Councils of Governors and explicit support is	**Go**: Both Trusts Council of Governors have been engaged on the proposed changes and confirmed support for the decision,

Criteria (Go)	Criteria (No go)	Assessment
and provided support for the proposed changes.	absent.	by both SFT and TG ICFT Boards, to implement joint governance arrangements from 1 April 2026, including the establishment of a Joint Board with maximum delegation from each statutory Board. **Dates/Evidence**: SFT Council of Governors - 10th December 2025 TGICFT Council of Governors - 11th December 2025

NHS
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				Agenda No.	11
Meeting date	5 February 2026	**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 January 2026, 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	Anthony Bell, Non-Executive Director
Date of Meeting	15 January 2026
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 Planning 2026/27 • Finance Report • Productivity and Efficiency Update • Operational Performance Report • Contracts for Approval • Expanding Robotic Assisted Surgery Business Case • IT Reviews – Update on Outstanding Follow Up Actions • Electronic Patient Record Update • Board Assurance Framework and Aligned Significant Risks • Winter Resilience Planning • Standing Committees Alert, Advise & Assure Reports: - Digital & Informatics Group - Estates Strategy Steering Group - Capital Programme Management Group
2.	**Alert**	The Committee considered an Operational Planning 2026/27 update, and agreed to alert the Board to the following risks: • Deliverability of 82% Emergency Department (ED) trajectory by year-end 2026/27 • Diagnostics and Cancer 62-day performance trajectory, noting that delivery was dependent on investment, including robotics and diagnostic capacity • Impact of No Criteria to Reside (NCTR) on capacity and quality • Growth in non-elective admissions while the bed base remained static due to lack of funding • Workforce growth versus financial expectations • Scale and recurrent nature of Cost Improvement Programme (CIP) requirement • Gap to control total and potential adverse impact of deconstructing block contract • Contract uncertainty, particularly with Derbyshire. Concerns regarding the delivery of the 78% Emergency Department (ED) 4-hour trajectory by year-end 2025/26, given historical performance in this area and the need for system flow improvement, as stated in the Trust's Operational Plan submission. Concerns regarding 12-hour waits and impact on patient experience, albeit acknowledging that no harm had been identified to date.

		Concerns regarding reduction in discharge to assess beds impacting on ED performance and flow, with continued risk to winter performance acknowledged. Concerns regarding paediatric audiology and consequent adverse impact on children, the diagnostic target and future sustainability of the service. While the Committee noted that recovery was underway with a provider commissioned by the Greater Manchester Integrated Care Board (GM ICB), it was acknowledged that the impact of external support would take time to embed. Concerns regarding the risk of non-achievement of the Financial Plan given significant associated risks, including risks relating to income and cash.
3.	**Advise**	The Committee received the Finance Report for Month 9 and noted: • At Month 9, the Trust was reporting breakeven against plan for system reporting purposes and a net deficit of £7.4m. 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 Stockport Trust Efficiency Plan (STEP) for 2025/26 was £29.2m and had been delivered in full in year. • The Trust has maintained sufficient cash to operate during the month, however key risks were noted in this area. • The Capital forecast for 2025/26 was £28.8m in line with plan. The Committee received a report providing an update on a productivity & efficiency pack published by NHS England. The associated opportunities were acknowledged. The Committee received the Operational Performance Report for Month 9, 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 received an update on winter resilience performance and heard that Opel 4 escalation had been declared for a 48-hour period in December 2025. It was noted that elective activity had been maintained during the escalation. The Committee received an update on the Electronic Patient Record Programme, noting ongoing activities in this area. The Committee reviewed the following contracts and recommended them to the Board of Directors for approval: • Water contract • Pathology LIMS The Committee recommended the Expanding Robotic Assisted Surgery Business Case to the Board of Directors for approval, subject to strengthened benefits, cost clarity and governance detail. Following referral from the Audit Committee, the Finance & Performance Committee received an update on outstanding high risk follow up actions relating to IT reviews.

		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 February 2026.
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. The Committee acknowledged positive assurance regarding STEP delivery, which had been delivered full in year.
5.	**Referral of Matters/Action to Board/Committee**	The Committee recommended the following contracts to the Board of Directors for approval: • Water contract • Pathology LIMS The Committee recommended the Expanding Robotic Assisted Surgery Business Case to the Board of Directors for approval, subject to strengthened benefits, cost clarity and governance detail.
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.	12
Meeting date	5th February 2026	**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

December 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

14 of 25 quality metrics are now achieving their performance targets.

Exception reports included this month relate to performance against Sepsis, E. Coli and MRSA Infections, Hospital and Community Pressure Ulcers, Complaints, Incidents, and Maternity.

- Sepsis performance measure for timely recognition continue to report above the 90% threshold. Although antibiotic administration performance has shown some improvement in recent months, there are no significant changes, and the reported rate is still below the target threshold.
- The number E. coli infections continues to be high, and rates have increased each month consecutively since September 2025. No further MRSA infections have been reported since September 2025, but rates will now continue to be above the planned improvement trajectory for the rest of the financial year.
- The rate of Hospital-acquired pressure ulcers continues to drop month on month. Although the fall in overall numbers is positive, the number reported due to lapses in care have not fallen at the same rate, which has led to an increase in the report percentage due to lapses in care. This affects both Hospital and Community-acquired pressures ulcers.
- The rate of informal complaints has seen a significant increase across November and December 2025, whilst the rate of formal complaints continues at the higher rate reported since September 2025. The timely response to complaints has dropped over the same period.
- Rates of patient safety incidents causing moderate and above harm have not changed significantly, varying between 2.6 and 3 incidents for every 10000 bed days.
- Most Maternity metrics are performing well, but 3rd and 4th degree tears continue to report above the 2% national target.

Operations Highlight

17 of 26 operational metrics now achieving their performance targets, including all ED and Cancer metrics.

Exception reports included this month relate to performance against Patient Flow, Diagnostics, RTT, Virtual Ward, DNA rates, Outpatient Procedures, and Theatres.

- Performance against most patient flow metrics continues to be challenging, with 3 of 4 metrics reporting above their target threshold or planned improvement trajectories.
- Diagnostic performance is showing improvement and continues to be below the planned performance trajectory. Patients over 6-weeks are now decreasing in Endoscopy, and Echo is now reporting below the target, but performance in Audiology has been challenged due to available service capacity in December.
- 4 out 5 RTT metrics are achieving their performance targets in December. Performance against the wait for first attendance does show improvement but is below the improvement threshold. We now report 0 patients waiting over 65-weeks for treatment.
- Virtual Ward has seen some strong improvements in recent months but has dropped below the 80% target in November and December 2025.
- 2 of the 3 metrics for Outpatient Efficiencies are achieving their performance targets in December. DNA rates have been increasing since October 2025, with seasonality and industrial action identified as potential drivers.
- Performance in theatre capped touch time utilisation has not seen any significant changes and remains challenging. Action plans are in place to support improvement by end of March 2026.

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

4 of 6 workforce metrics are now achieving their performance targets.

Exception reports included this month relate to performance against Sickness Absence and Appraisal rates.

- Monthly sickness absence rates have continued to increase month to month since June 2025. This increase is expected during winter periods and is consistent with rates from December 2024.
- Appraisal rates continue to show strong improvement around 90% for the last 3 months, reflecting the continued organisational focus on completion and recording.

Finance Highlight

2 of 4 finance metrics are now achieving their performance targets.

After 9 months of the financial year the Trust is reporting a breakeven position against plan for system reporting purposes and a net deficit of £7.4m.

- The forecast at month 9 is that the Trust will achieve the annual plan.
- STEP of £30.2m has been transacted, delivering 104% of the in-year target. To date £23.2m has been delivered which is £2.2m ahead of the profiled plan. The recurrent target has also been over-delivered, following review of non-recurrent delivery during 2026/27 planning.
- The Trust has maintained sufficient cash to operate during December. Cash balances at the end of December were £35.9m - £35.6m for the Trust and £0.3m for the Pharmacy Shop, an increase of £4m from November. The Trust did not receive its non-recurrent deficit support funding for November (£3.6m). However, this was paid in December, along with the deficit support for December.
- The capital programme of £28.8m is made up of £17.1m internal funding and £11.7m PDC. The is based on NHSE forecasts for 25/26. Internally however forecasts at present total £25.9m, leaving a gap of £2.9m to plan.
- There have been schemes identified as a risk of not progressing to a total of £2.2m, which could further increase the gap to £5.1m. The Capital Programme Management Group (CPMG) have bi-weekly meetings in place to manage the position, and plans are being developed to close this gap and deliver 25/26 capital in full.

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	Oct-24 to Sep-25	≤ 100		↑	88	●	●
Sepsis: Timely recognition	Jan-25 to Dec-25	≥ 90%		↓	95.7%	●	●
Sepsis: Antibiotic administration	Jan-25 to Dec-25	≥ 90%		↗	75.7%	▲	▲
C.diff infection rate	Jan-25 to Dec-25	≤ 38.25		↑	29.76	●	●
MRSA infection rate	Jan-25 to Dec-25	≤ 0.92		↓	1.37	▲	▲
E. coli infection rate	Jan-25 to Dec-25	≤ 32.17		↘	37.54	▲	▲
Hospital-Acquired Pressure Ulcers	Dec-25	≤ 74	30	↑	6	●	●
Rate of HAPU - Overall	Jan-25 to Dec-25	≤ 3.45		↑	2.24	●	●
Rate of HAPU due to Lapses in Care	Oct-25	≤ 30%	45.5%	→	33.3%	▲	●
Community-Acquired Pressure Ulcers	Dec-25	≤ 175	156	↓	23	▲	▲
Rate of CAPU due to Lapses in Care	Oct-25	≤ 5%	6.5%	→	0%	●	●
Written Complaints Rate	Dec-25	≤ 9.3	10.23	↘	10.13	▲	▲
PALs and Informal Enquiry Rate	Dec-25	≤ 86.8	78.45	↓	118.08	▲	▲
Timely Response to Complaints	Dec-25	≥ 95%	91.3%	↓	80%	▲	▲
Rate of Re-opened Complaints	Dec-25	≤ 10%	13.8%	↗	6.9%	●	●
Parliamentary & Health Service Ombudsman ..	Dec-25	≤ 0	17	→	0	●	●
Incident Rate - Moderate+ Harm	Jul-25 to Dec-25	≤ 2.7		→	3.47	▲	▲
Patient Safety Alert Breaches	Dec-25	≤ 0	0	→	0	●	●
Duty of Candour Breaches	Dec-25	≤ 0	4	→	1	▲	●
Never Event Incidence	Dec-25	≤ 0	1	→	0	●	●
Rate of Registrable Stillbirths	Dec-25	≤ 0	4	↗	0	●	●
Smoking at Time of Delivery (SOTD)	Dec-25	≤ 5%	3.1%	→	2.3%	●	●
3rd or 4th degree tears	Oct-25 to Dec-25	≤ 2%		→	4%	▲	▲
Postpartum Haemorrhage	Dec-25	≤ 2.5%	3.7%	↗	2.1%	●	●
Avoiding Term Admissions	Dec-25	≤ 5%		→	3%	●	●

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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

	Reporting Period	Latest Target	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
4hr Standard	Dec-25	≥ 65.9%	68.7%	→	69%	●	●
Patients in department over 12hrs	Dec-25	≤ 14.5%	11.6%	↘	12.7%	●	●
Ambulance handover time	Dec-25	≤ 39.19		↘	26.17	●	●
No criteria to reside (NCTR)	Dec-25	≤ 45	701	→	81	▲	▲
Adult G&A Bed Occupancy	Dec-25	≤ 92%	95.6%	→	94.9%	▲	▲
Timely discharge	Dec-25	≤ 78.4%	81.1%	↗	81.2%	▲	▲
Average discharge delay	Dec-25	≤ 6.9		→	4.9	●	●
Length of stay: Elective	May-25 to Oct-25			↑	2.03		
Length of stay: Non-elective	May-25 to Oct-25			↑	9.82		
Diagnostics: 6-week Standard	Dec-25	≤ 14.7%	21.1%	↑	16.1%	▲	▲
62-day standard	Dec-25	≥ 72.3%	73.4%	↗	79.6%	●	●
31-day standard	Dec-25	≥ 88.9%	89.3%	→	89%	●	●
28-day standard (FDS)	Dec-25	≥ 79%	81.6%	↑	82.1%	●	●
14-day standard (2WW)	Dec-25	≥ 93%	97.3%	↗	99%	●	●
Incomplete pathways 18-week %	Dec-25	≥ 58.2%		↗	58.4%	●	●
52-week breaches	Dec-25	≤ 674		↑	599	●	●
65-week breaches	Dec-25	≤ 0		↑	0	●	●
52-week breach %	Dec-25	≤ 2.2%		↑	1.7%	●	●
Wait for first attendance 18-week %	Dec-25	≥ 66%	64.3%	↗	65.3%	▲	▲
Virtual Ward Utilisation	Dec-25	≥ 80%	75%	↗	75.4%	▲	▲
Urgent Community Response	Nov-25	≥ 70%		↗	84%	●	●
Outpatient DNA rate	Dec-25	≤ 6.3%	6.8%	↘	7.5%	▲	▲
Outpatient clinic utilisation	Dec-25	≥ 90%	94.3%	↓	91%	●	●
Patient initiated follow up (PIFU)	Dec-25	≥ 5%	6%	↘	5.9%	●	●
OP First Attend and Procedure	Dec-25	≥ 44%	43.2%	↘	42.2%	▲	▲
Capped Touch Time Utilisation	Dec-25	≥ 85%	78%	→	76.4%	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Dec-25	≥ 90%	95.4%	→	96%	●	●
Sickness Absence: Monthly Rate	Dec-25	≤ 5.5%	5.6%	↓	6.7%	▲	▲
Workforce Turnover	Dec-25	≤ 12.7%	11.2%	↗	11%	●	●
Appraisal Rate: Overall	Dec-25	≥ 95%	85.1%	↑	90.4%	▲	▲
Mandatory Training	Dec-25	≥ 95%	95.6%	↑	96.6%	●	●
Agency Costs %	Dec-25	≤ 3.2%	1.7%	↑	1.4%	●	●
Finance Scorecard							
Capital Expenditure	Dec-25	≤ 10%		↑	32.6%	▲	▲
Cash Balance	Dec-25			→	35.6		
CIP Cumulative Achievement	Dec-25	≥ 0%		→	10.8%	●	●
Financial Controls: I&E Position	Dec-25	≤ 0%		↓	84%	▲	▲

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%	95.7%	↓	J A S O N D	●
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%	75.7%	↗	J A S O N D	▲

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.

Antibiotic Administration

- The compliance rate for antibiotic administration in December stands at 40%, a significant drop in compliance from 90% in November
- 12 month rolling period for timely recognition is 75.7%, which shows a drop from 80.6% in the month of November.
- Out of the 5 patients screened for sepsis, 2 received antibiotics in strict adherence to Trust guidelines which were both high risk

Key Events/Ongoing Issues

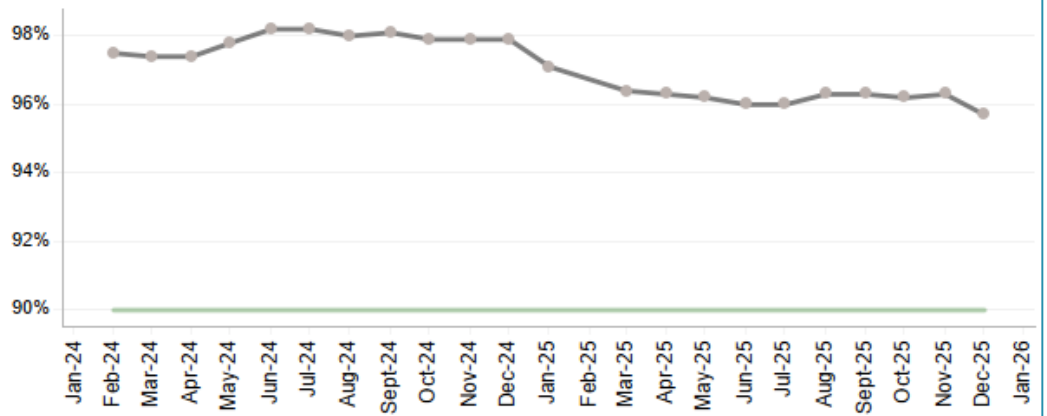
- 55.56% of suspected high risk sepsis during OOH did not utilised 2222
- The majority of delays are happening during OOH with the longest delay identified during 07:30-09:00 gap period, when e-task was unavailable
- AMAT Audit pilot: ongoing support to pilot ward areas, with continued data collection and feedback
- Wards that achieved 100% for both timely recognition and antibiotic administration in December: B2 and M4
- New NICE guidance released November 2025: NG253 for adults (16+) not pregnant, NG254 for under 16's, NG255 for pregnant/recently pregnant people
- Sepsis link nurse meeting scheduled this coming 28th Jan.
- Patientrack sepsis update has been stood down, with an anticipated go-live by first quarter of 2026.

Curtis.Soile 30/01/2026 12:41:34

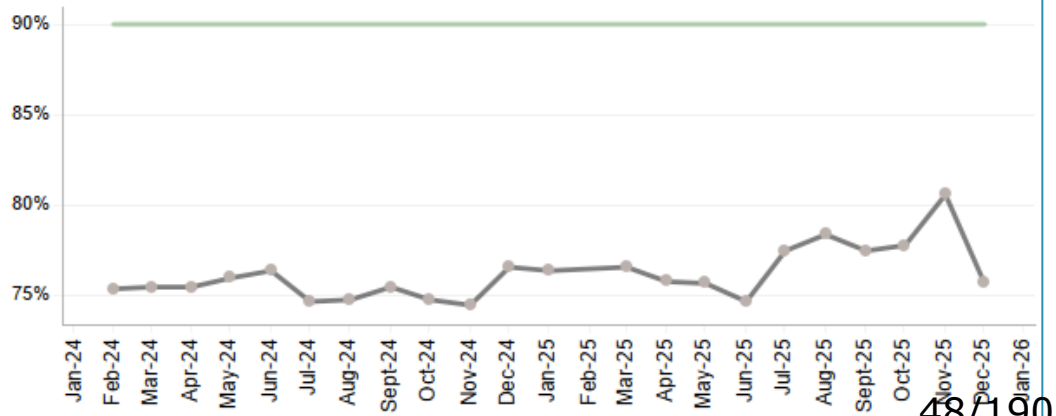
Update provided by	Christe Bolanio
Executive Lead	Dilraj Sandher

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Sepsis: Timely recognition (12-month rolling)



Performance for Sepsis: Antibiotic administration (12-month rolling)



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.	<= 32.17	37.54	↘	J A S O N D	▲

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.

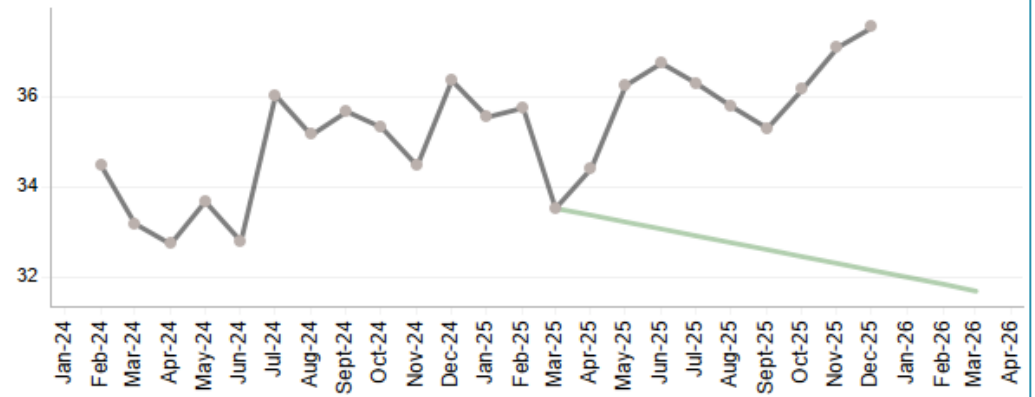
There were 6 HOHA and 2 COHA cases in December totalling 67 YTD. The Trust is over the projected threshold of 51.75 for the end of December.

The latest National figures (Oct 2025) rank Stockport fourth out of the seven GM Trusts which is a 1 place worse position than the previous month.

The E. coli deep dive paper was presented to PSG in November where it was acknowledged the work being taken forward by the team and that the data provided good assurance, identified themes, areas of focus and expectations for improvement.

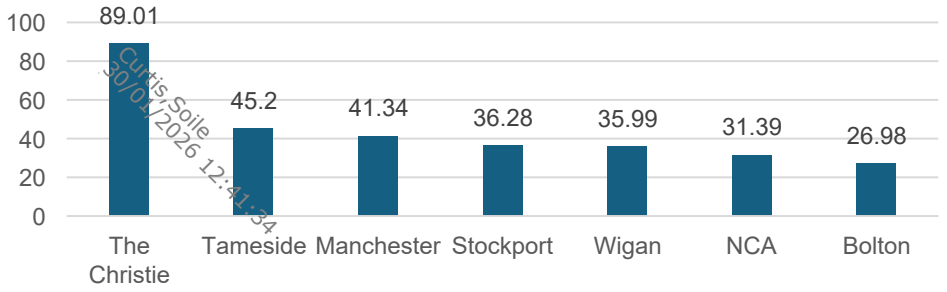
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for E. coli infection rate

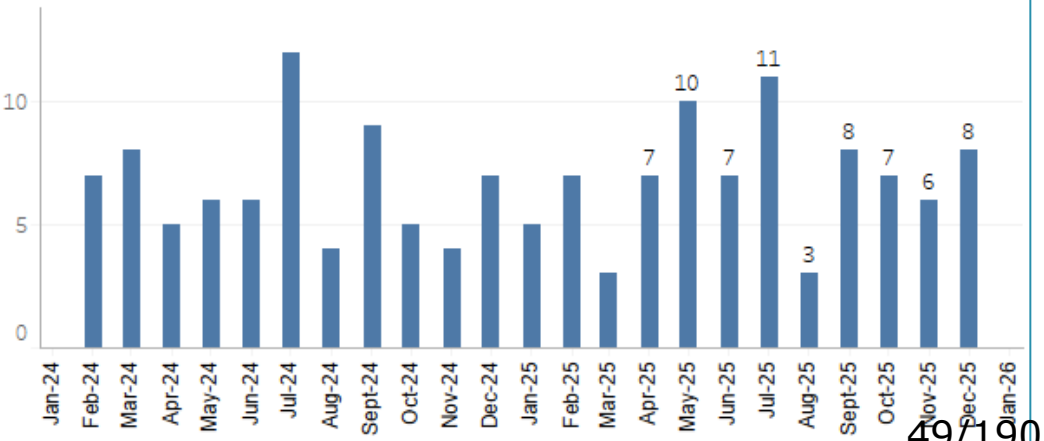


The latest data point is within the control limits. This is viewed as common cause or normal variation.

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



Performance for E.Coli Infection Count



Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

Quality **Infection Prevention** MRSA

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0.92	1.37	↓	J A S O N D	▲

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.

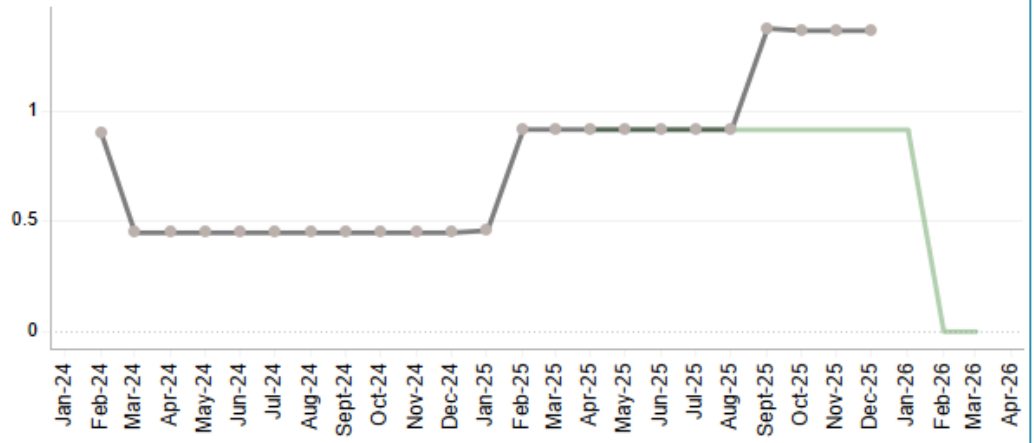
The Trust had no cases of MRSA Bacteraemia in December. The Trust now has 1 case in 2025-26 against a zero-tolerance threshold.

The latest National figures (Oct 2025) rates show Stockport is ranked third out of the seven GM Trusts which is the same as the previous month.

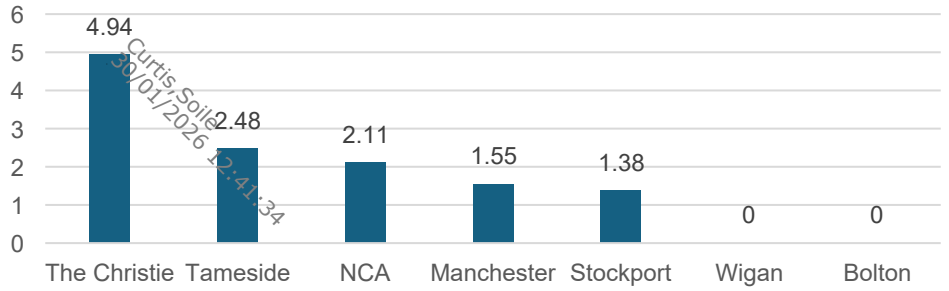
The thematic review action plan was presented to the Vascular Access Group in November for monitoring of progress. Moving forward, it is a monthly agenda item to provide assurance of the progress made.

Performance | Target / Improvement Trajectory | Average | Control Limits

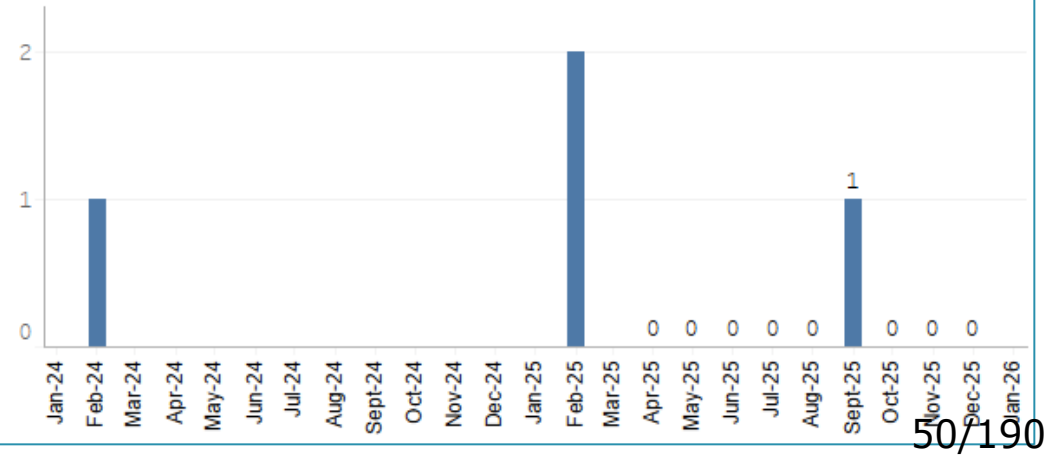
Performance for MRSA infection rate



Benchmark data for MRSA infections from NHSE – October 2025



Performance for MRSA Infection Count



Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

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BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Quality **Pressure Ulcers** Hospital

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Hospital-Acquired Pressure Ulcers	Total number of pressure ulcers acquired in a hospital setting.	<= 6	6	↑	J A S O N D	●
Rate of HAPU - Overall	The number of hospital-acquired pressure ulcers, calculated as a rate per 10,000 bed days. Reported as a rolling 12-month average.	<= 3.45	2.24	↑	J A S O N D	●
Rate of HAPU due to Lapses in Care	Hospital-acquired pressure ulcers determined to be as a result of lapses in care, as a percentage of all hospital-acquired pressure ulcers.	<= 30%	33.3%	→	J A S O	●

HAPU Rate performance is based on data from a rolling 12-month period.

The Trust has set a target to reduce the number of hospital-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 (December), there have been 6 pressure ulcer incidents, which is the highest month reported so far this year. There have been 3 category 2 pressure ulcer, 2 category 3 and one category 4
- The category 4 PU reported found no lapses in care which contributed to it developing, however both category 3 pressure ulcers did find lapses in care, these incidents were attributed to ED and may be reflective of the increased pressures in ED.

Strategies

- Learning from incidents remains essential to strengthening our practices so we can consistently prevent pressure ulcers, even during periods of increased pressure. As we move into Quarter 4, our focus will be on continuing to share and embed the effective practices that contributed to the significant reduction in pressure ulcer incidents seen prior to December.

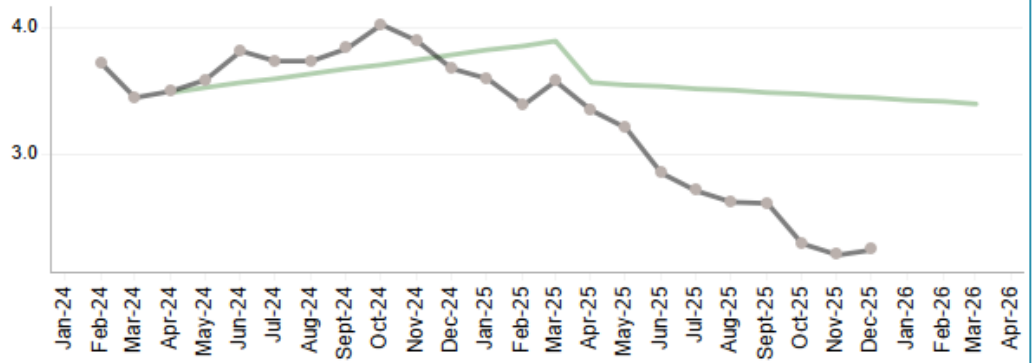
Please note: Rates due to Lapses in Care are reported 2 months in arrears to allow investigations to take place. Numbers are correct at the time of reporting but will be subject to change dependant on the number of pressure ulcers still awaiting investigation.

Pressure Ulcers Awaiting Investigation | by month of incident reporting

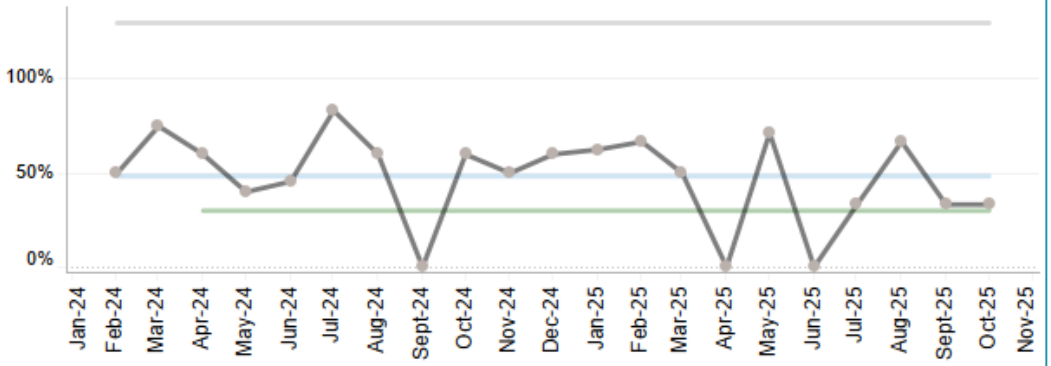
	Total	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025
Hospital acquired	3	1	0	0	1	1

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Rate of HAPU - Overall



Performance for Rate of HAPU due to Lapses in Care



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

Update provided by	Lisa Gough
Executive Lead	Nic Firth

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	23	↓	J A S O N D	▲
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%	→	J A S O	●

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

Performance

- This month (December), 18 Category 2, 4 Category 3 and 1 Category 4 pressure ulcers were reported.
- The spike in figures in November has continued in December, with higher numbers of pressure ulcers reported. For Quarter 3 we have only had one lapse in care identified, however the higher number of incidents has created a build-up of investigation outcomes and currently 67% of those reported are without an outcome.

Strategies

- Effective targeted action plans rely on having completed investigations and clear narratives to inform meaningful quality improvement. While community teams provide assurance that lapses in care remain uncommon, the continued high number of reported incidents highlights the need to strengthen community practices further. Our ongoing focus is on identifying opportunities to enhance care delivery, while empowering patients and carers through improved education and support.

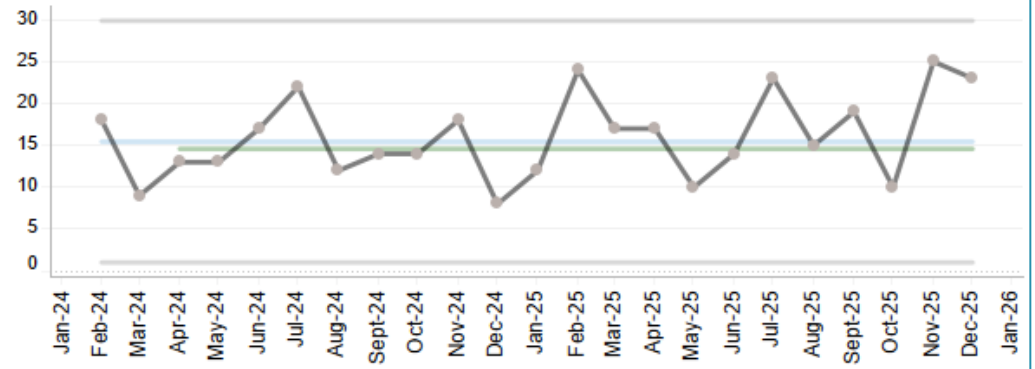
Please note: Rates due to Lapses in Care are reported 2 months in arrears to allow investigations to take place. Numbers are correct at the time of reporting but will be subject to change dependant on the number of pressure ulcers still awaiting investigation.

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	Sept 2025	Oct 2025	Nov 2025	Dec 2025
Community acquired	49	3	1	0	4	0	0	0	0	0	0	2	6	16	17

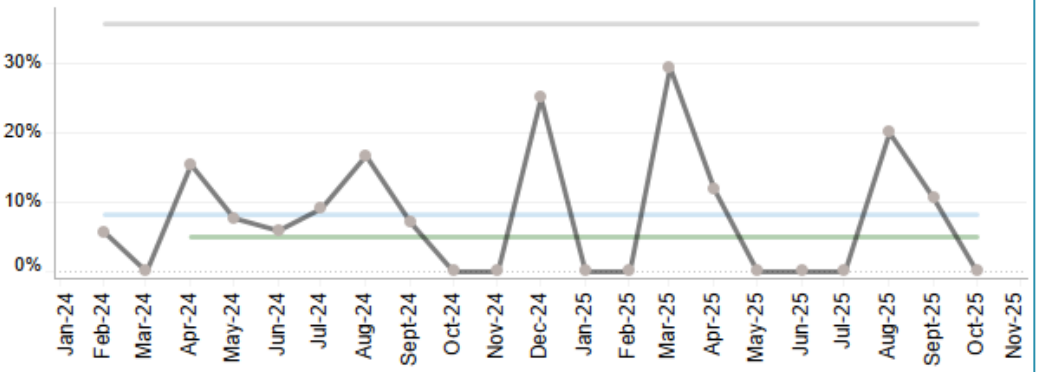
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Community-Acquired Pressure Ulcers



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

Performance for Rate of CAPU due to Lapses in Care



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

Update provided by	Lisa Gough
Executive Lead	Nic Firth

Quality **Complaints** Rates

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 9.3	10.13	↘	J A S O N D	▲
PALs and Informal Enquiry Rate	The number of PALS and informal enquiries received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 86.8	118.08	↓	J A S O N D	▲

Note: In lieu of national targets, local target thresholds based on average rates from previous financial year

Written Complaints Rate

- There were 58 formal complaints received in December 2025 - Clinical Support Services = 1, Medicine & UC =30, Surgery = 12, Women, Children and Integrated Community Services = 13, Corporate = 1, Estates & Facilities = 1.
- Top five themes for formal complaints in December 2025 was as follows:
  1. Communication
  2. Clinical Treatment
  3. Patient Care
  4. Staff values and behaviours
  5. Admissions and discharges

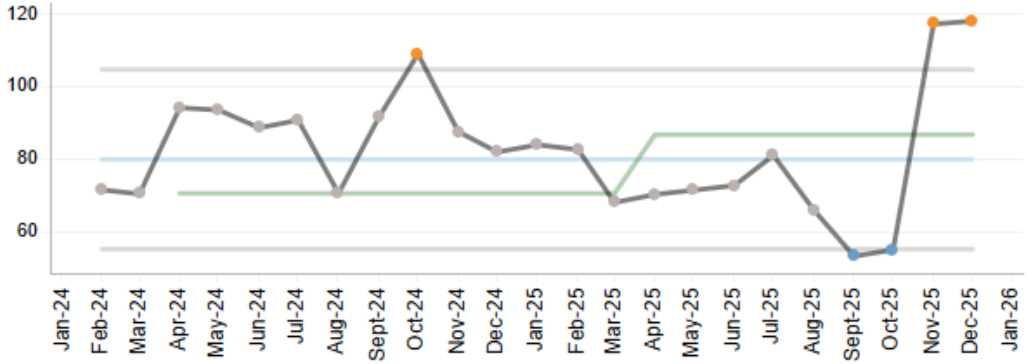
PALs and Informal Enquiry Rate

- The PALS & Complaints team receive communication in person, on the phone, via emails, in writing and via the Trust website, 24 hours a day.
- The team are currently being supported by an NHSP staff member and a new full time staff member will be in post shortly. The backlog is being reduced by approximately 100 contacts a week and should be cleared by the end of the financial year. All contacts with the team are being triaged, as much as possible, with anything urgent being dealt with immediately, and the team continue to focus on resolving concerns via early resolution, where appropriate, with the hope to reduce the number of formal complaints.
- Top five themes for informal/early resolution concerns in December 2025 were as follows:
  1. Appointments
  2. Communication
  3. Waiting time
  4. Clinical treatment
  5. Other

Signed off by	Waseem Munir
Executive Lead	Nic Firth

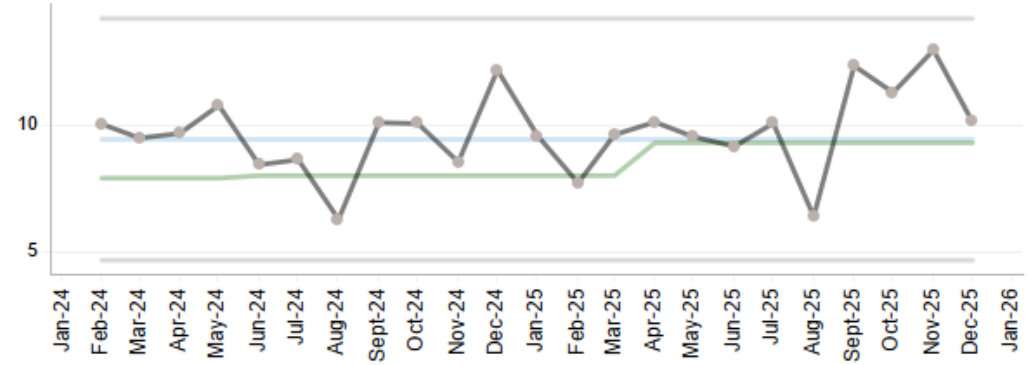
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for PALs and Informal Enquiry Rate



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

Performance for Written Complaints Rate



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

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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%	80%	↓	J A S O N D	▲
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%	6.9%	↗	J A S O N D	●
Parliamentary & Health Service Ombudsman Cases	The total number of open Ombudsman cases.	<= 0	0	→	J A S O N D	●

Timely Response to Complaints

- The reduced response rate is multifactorial, reflecting increased complaint volumes, delays in receiving information from divisions, staffing pressures within the complaints team and the necessary governance and approval processes. In addition, periods of significant operational pressure across the Trust, including times of OPEL 4 and Industrial Action can impact the ability of divisions to provide timely responses; this was a contributing factor during December.
- Despite ongoing staffing challenges, robust arrangements are in place to manage and mitigate delays. The complaints team actively monitors response times and engages early with divisions where delays are identified. Matters are escalated to the triumvirate where required to understand the cause of delay, ensure appropriate support is provided to staff and agree actions to expedite responses.
- Clear and regular communication is maintained with complainants throughout the process and revised timescales are agreed where necessary. While the NHS Complaints Procedure does not mandate fixed response times, the Trust continues to aim to issue responses within 60 days and maintains oversight to ensure delays are appropriately managed and minimised.

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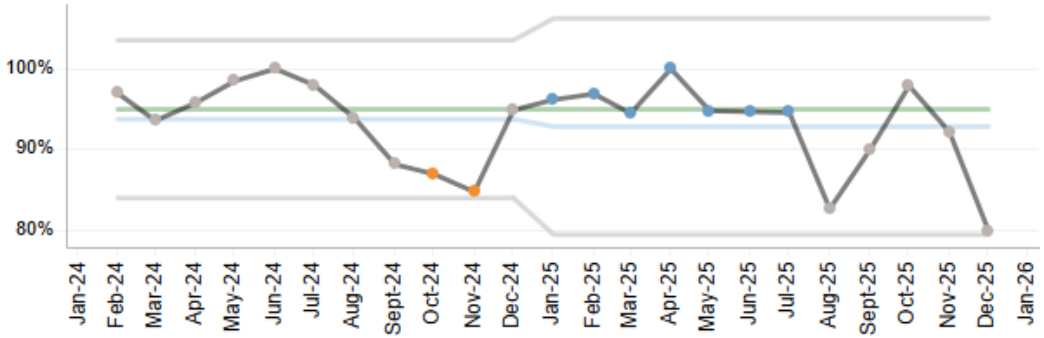
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Timely Response to Complaints



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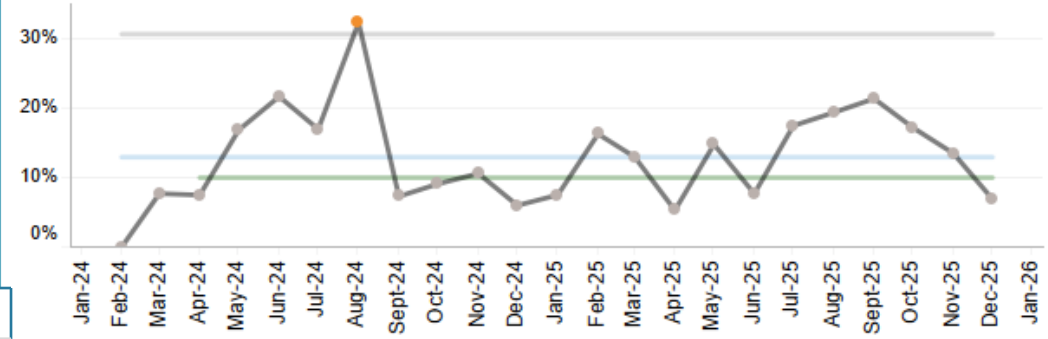
Performance for Rate of Re-opened Complaints



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	3.47	→	J A S O N D	▲
Patient Safety Alert Breaches	The number of national patient safety alerts not completed to deadline.	<= 0	0	→	J A S O N D	●
Duty of Candour Breaches	Total number of duty of candour breaches of regulation in month.	<= 0	1	→	J A S ▲ N D	●
Never Event Incidence	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur.	<= 0	0	→	J A S O ▲ D	●

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.

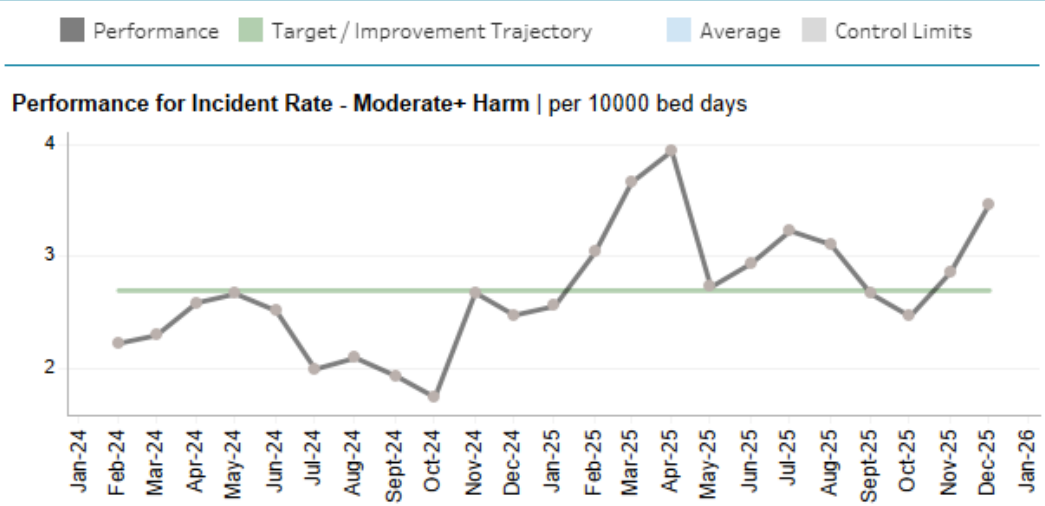
Patient Safety Incident Rate

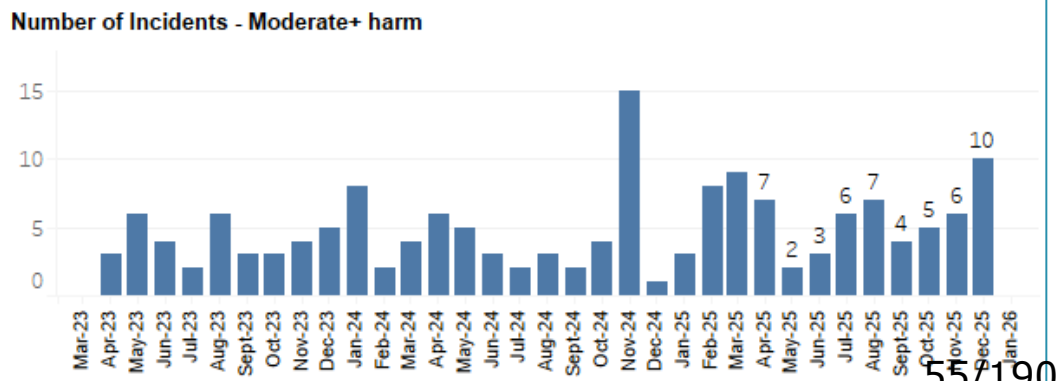
- In December there has been a decrease in the overall number of patient incidents reported, but still within normal variance. However, there has been an increase in the number of moderate or above harm patient incidents reported (note: the harm level for some is yet to be confirmed).
- Ten have been reported:
  - A patient fell and fractured their left wrist. The case has been presented at Harm Free Care (HFC) panel.
  - A patient fell and fractured their right neck of femur. The case has been presented at HFC.
  - A patient fell and fractured their spine. The case is scheduled to be presented at HFC.
  - Four cases relate to the management of patients with diabetes. Two of these incidents relate to previous months and were identified during an audit.
  - One case was identified from audiology lookback.
  - One case was a patient complaining the wrong cyst was removed from him penis . The case was presented at Patient Safety Incident Response Group; it was agreed this is not a Never Event and will proceed as a formal complaint response.
  - A child with a chest infection deteriorated without physiotherapy intervention while on Treehouse and was subsequently transferred to the Paediatric Intensive Care Unit at Royal Manchester Children's Hospital.
- 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.

Duty of Candour Breaches

- There were 4 incidents where letters opening Duty of Candour were due to be sent in December 2025.
- At the end of December there was one incident that breached its due date, due to the incident requiring a review at the Harm Free Care Panel first, before DoC could be initiated.

Signed off by	Waseem Munir
Executive Lead	Nic Firth





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%	4%	→	J A S O N D	▲
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%	2.1%	↗	J A S O N D	●

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

3rd/4th degree tears

- Local Euroking data shows 3 deliveries with a 3rd degree tear in December 2025:
  - X1 Forceps delivery, 4th degree tear
  - X1 Forceps/failed ventouse delivery, 3b tear, episiotomy
  - X1 NVD, 3a tear (No mention of episiotomy performed on Euroking documentation)
- This represents 4% of all singleton vaginal deliveries for the month (excluding below 37 weeks gestation and breech deliveries). This is above national target of 2%.

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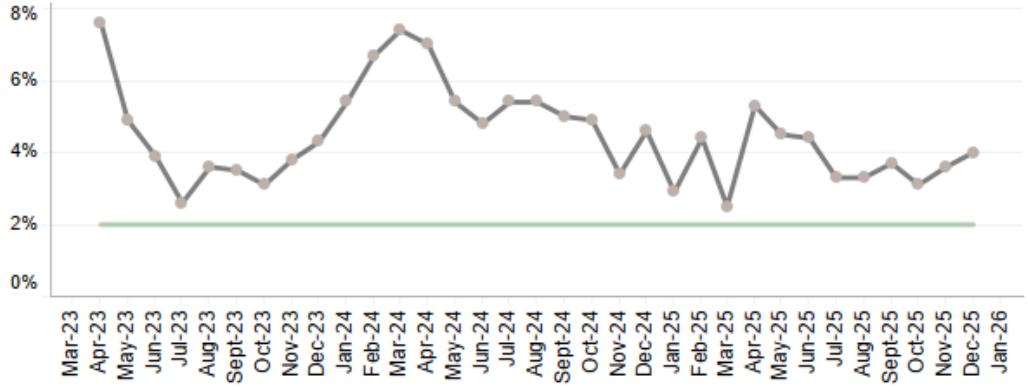
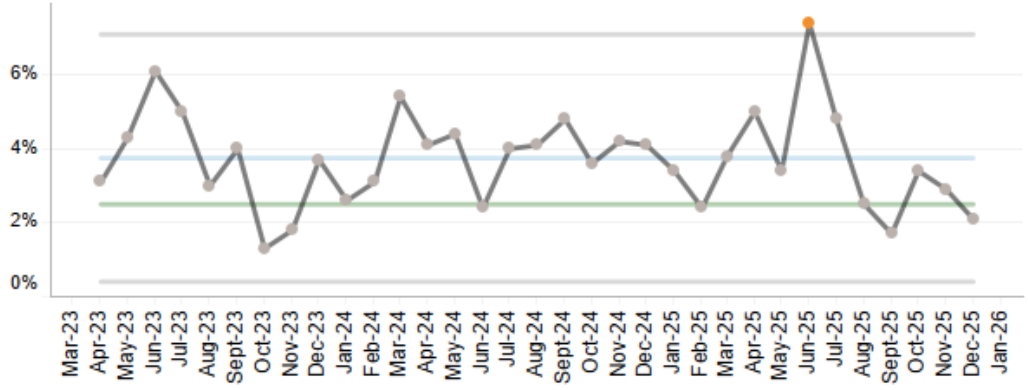
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for 3rd or 4th degree tears



Performance for Postpartum Haemorrhage



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

Signed off by	Sharon Hyde
Executive Lead	Nic Firth

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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	81	→	J	A	S	O	N	D	▲
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%	94.9%	→	J	A	S	O	N	D	▲
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.	<= 78.4%	81.2%	↗	J	A	S	O	N	D	▲

Performance Summary

- The average number of patients with a No Criteria to Reside was 81 in December. With the exceptions of September and November, we have seen a month-on-month increase in numbers since March this year, with numbers now at the same level as January. For comparison, the number reported in December 2024 was 69.
- Adult G&A bed occupancy for December was 94.9% but has not changed significantly since January 2025.
- The percentage of discharges made on the Discharge Ready Date for December is 81.2% and has been above the monthly trajectory since April 2025.

Risks and Issues

- Ongoing reduction in community capacity for Pathways 2 - 3 for Stockport has resulted in a significant increase in unmet need placements since the 1st September 2025
- Community capacity in Pathways 1 - 3, for Derbyshire, East Cheshire and other areas.
- New process in Derbyshire for fast tracks and Pathway 3 patients – extending length of stay whilst awaiting ASC to complete a financial review.
- Ambulance availability for patients who cannot return to the community any other way.
- HCRs completed too late in the patient's stay, impacting medication availability and earlier discharges.
- Delays in Saffron process re; referral and acceptance.
- Increased LoS in Devonshire, delays in acceptance process.

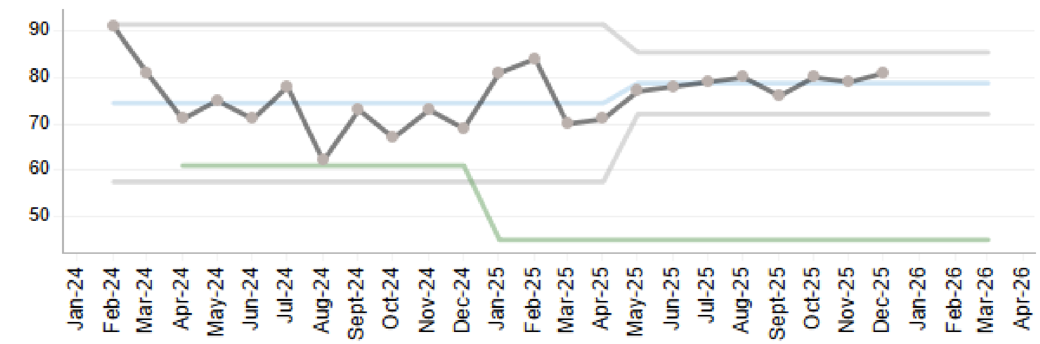
Actions and Mitigations

- System partner agreement for pathway 3 identified referrals to be discharged via Spot purchase. Supported by nurse and therapy input to facilitate complex discharge planning .
- Continue twice weekly system meetings in place to review Stockport Pathway 2/3 delays over 48 hours.
- Review of escalation processes.
- 3x weekly meetings with ReACH to ensure continual flow via pathway 1, patients leaving D2A bed bases.
- Continued Programme of Flow on stroke wards to support earlier conversations with stroke patients and their families re discharge planning and ongoing therapy support.
- Pilot ongoing to use trust minibus for pathway 1 Stockport discharges and D2a bed-bases to support earlier discharges.
- New referral form for ward to complete for saffron to support flow commenced December 2025. PDSA ongoing. Plan to have weekly Sitrep from Saffron to understand flow.

Updated provided by	Liza McIlvenny
Executive Lead	Jackie McShane

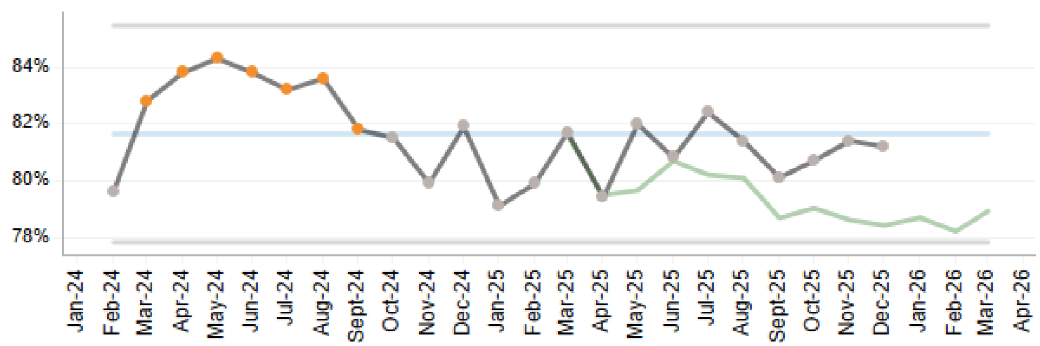
Performance · Target / Improvement Trajectory · Average · Control Limits

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.	<= 54.3%	85.7%		J A S O N D	

Performance Summary

- Continued improvement in performance now that we have additional capacity available, provided by Health Harmonie.
- December reported an increase in 6ww breaches due to reduced weekend activity delivered by Health Harmonie.

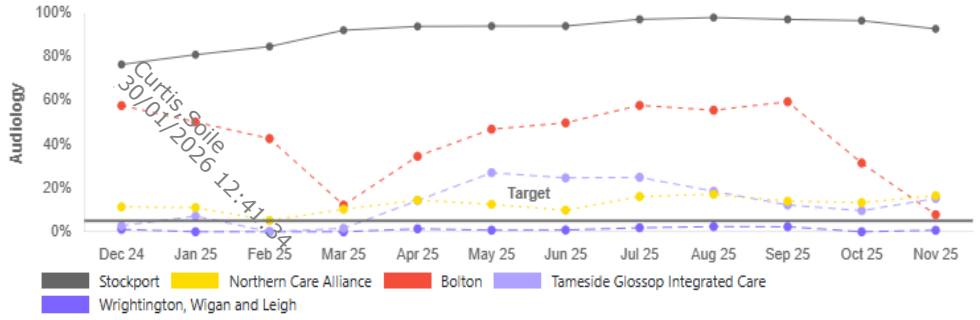
Risks and Issues

- Paediatric (5yrs and under) service remains paused
- Look back ongoing since November 2024
- Fragile workforce

Key Actions

- Approval given to recruit a Service Lead (Band 8b) – Recruited, due to commence in post 16.2.26
- 140 patients have been seen in HH clinics for the month of December
- Continual Monitoring of long waits , booking longest waits in order
- HH plan to open clinics at Woodley for under 5's (7 days per week) – date to be confirmed
- Ongoing Strategy Meetings with ICB, Executive Team and Division

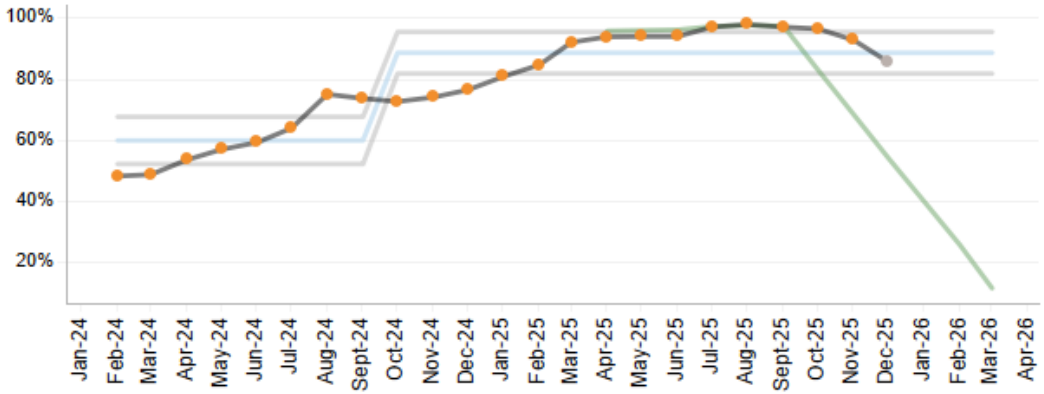
Benchmark data from Public View – November 2025



Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Diagnostics: Audiology



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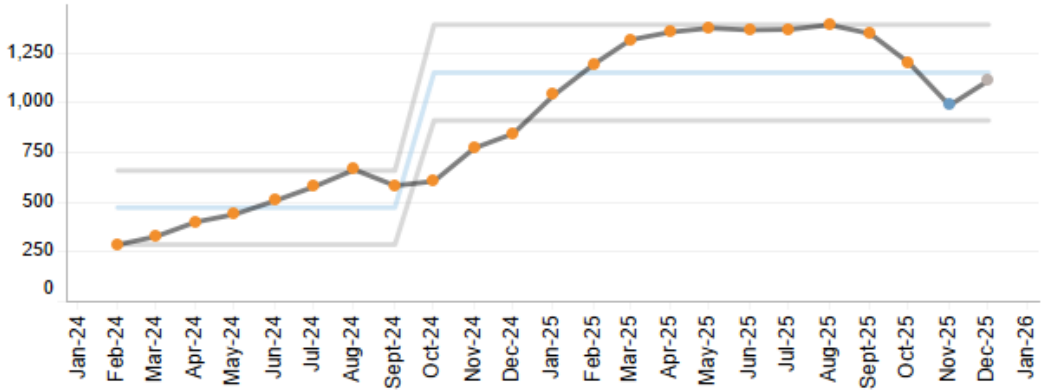
Performance for Diagnostics: Audiology Breaches



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NHS Stockport NHS Foundation Trust

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.	<= 8.2%	10.8%		J A S O N D	

Performance Summary

- Total waiting list size reduced and DM01 position improving week-on-week.
- Additional activity supported through WLIs to enable DM01 recovery.
- DNA rates remain the lowest in Greater Manchester.

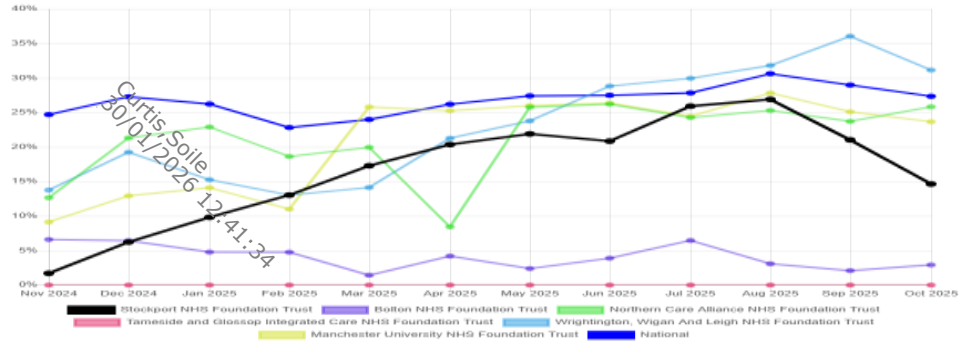
Risks and Issues

- Demand has remained at a historically high level.
- Locum Endoscopist fixed term contract has ended. Activity gap is being filled with WLI sessions in the short term.

Key Actions

- SDP to be completed for Locum Endoscopist.
- Continue call reminder service.
- Continue to maximise booking utilisation, monitored through new BI dashboards.

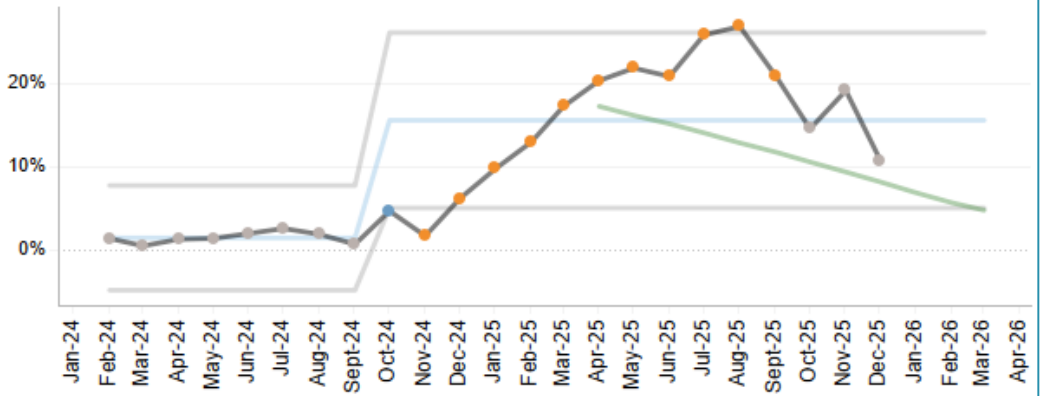
Benchmark data from HED – October 2025



Signed off by	Mike Allison
Executive Lead	Jackie McShane

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Diagnostics: Endoscopy



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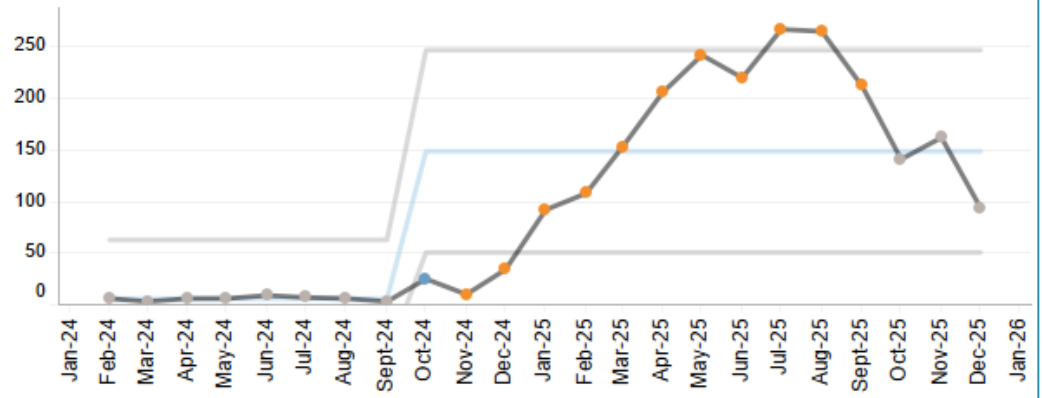
Performance for Diagnostics: Endoscopy breaches



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Integrated Performance Report
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BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Referral to Treatment (RTT)**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Wait for first attendance 18-week .. Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	>= 66%	65.3%		J A S O N D	

Performance Summary

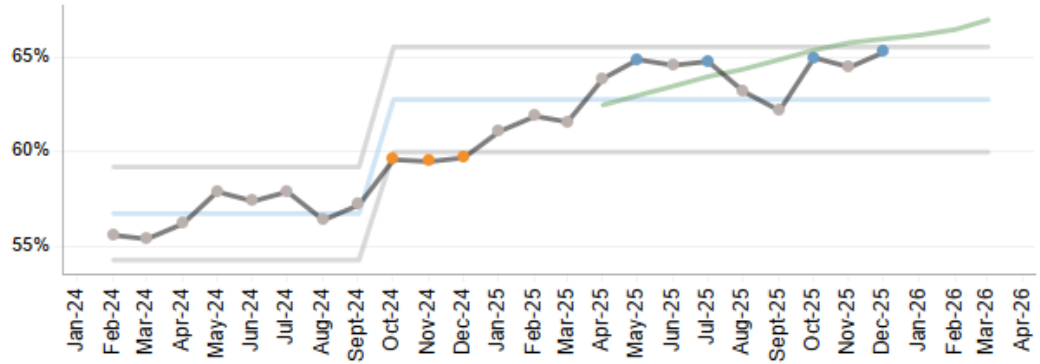
- 65-week wait performance – Zero breaches
- 52-week wait performance – 599 which is a reduction and ahead of plan (674)
- 18-week wait performance –58.4%, on plan (58.2%)
- Wait for first attendance 18-week% - 65.30%, behind plan of 66.0% (0.8% improvement on last month)

Risks and Issues

- **Long wait times for 1st appointment** across several specialties
  - Action/Mitigation: Activity plan profiled higher in Q4. Further additional capacity plans being mobilised using slippage on IPT funding and regional transformation funding GM allocation
- **Ophthalmology Squint service backlog**
  - Action/Mitigation: Communications with MFT regarding future of the service, request for mutual aid at GM ICB level & started outsourcing patients to CHEC
- **Long waits for external diagnostics** for PH manometry, SeHCAT scans, 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
- **Orthopaedic knee elective backlog**
  - Action/Mitigation: Outsourcing to IS ongoing, new knee consultant commences Jan-26, 4-joint theatre list improvement project to commence Jan-26
- **Chemical pathology outpatient waits**
  - Action/Mitigation: Additional WLI clinics / triage sessions Q3-4 & mutual aid support from Tameside
- **Outpatient booking team workforce pressures** creating delays in registering all RTT referrals. This is an issue for wait for 1st attendance 18w% as there is a backlog of referrals not on the system (and hence in the denominator) in time for the WLMDS data extract on the last Sunday of each month which is used for this metric.
  - Action/Mitigation: Additional overtime hours being worked in the Outpatient central booking team

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Wait for first attendance 18-week %



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Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Integrated Performance Report
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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%	75.4%		J A S O N D	

Performance Summary

- Whilst we've seen much improved utilisation of hospital at home this year, performance in December dipped to below the 80% target at 75.4%.
- There were 16 days in month below the 40 bed/80% occupancy target, with 10 of these across the Christmas period.
- Admissions to the ward remain high with 209 admissions in December, 86% were admission avoidance and 14% admitted on a step-down pathway.

Risks and Issues

- Recruitment underway, however workforce gaps predicted until end of February
- Available equipment whilst transition is taking place, old kit is out of warranty
- Ongoing engagement / buy in with partners / stakeholders

Actions and Mitigations

- VW Escalation Plan developed, reported into 3 x daily bed meetings to share capacity/support patients back into community
- One Stockport SPOA "go live"
- VW returned to SFT and Digital platform separation from T&G
- Adastra bookable appointments to "go live"
- SFT VW workforce - successful recruitment for Senior ACPs/nurses in VW
- Digital equipment transition process commenced to new system Lusci
- One Stockport SPOA care coordination "go live" – 14.02.26
- Ongoing comms campaign across locality, knowledge of SPOA and VW. Rebrand "Hospital @ Home"
- Ongoing VW offer direct in-reach to Acute
- Ongoing pathway development, discussion commenced with Pennine re; support to Saffron

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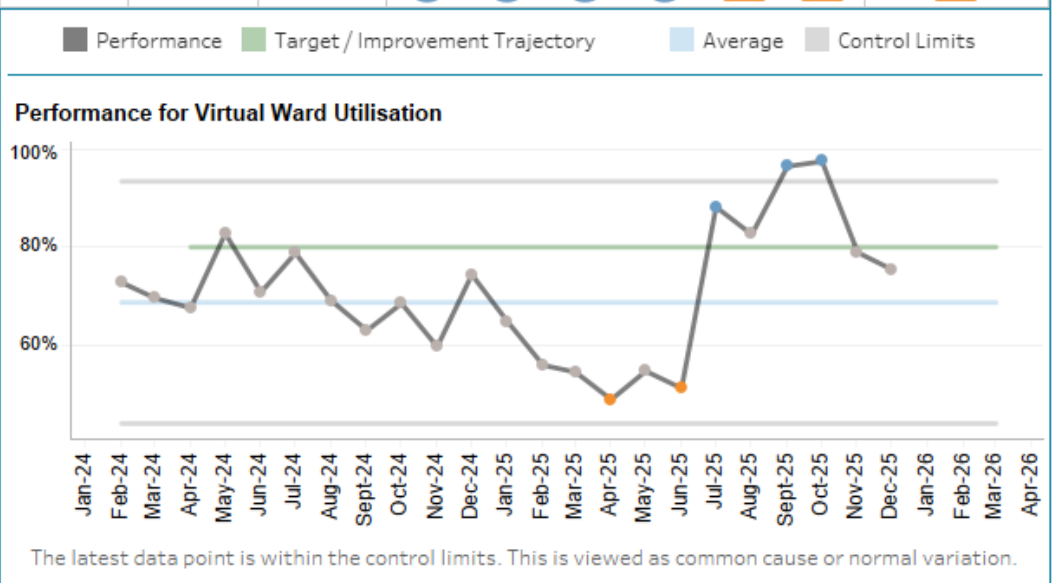

Updated provided by	Liza McIlvenny
Executive Lead	Jackie McShane

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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%	7.5%		J A S O N D	

Performance Summary

- The DNA rate for December has increased to 7.52% from under 7% where it has been maintained in the previous 8 months
- Seasonality & IA may have an impact on the overall performance.

Risks and Issues

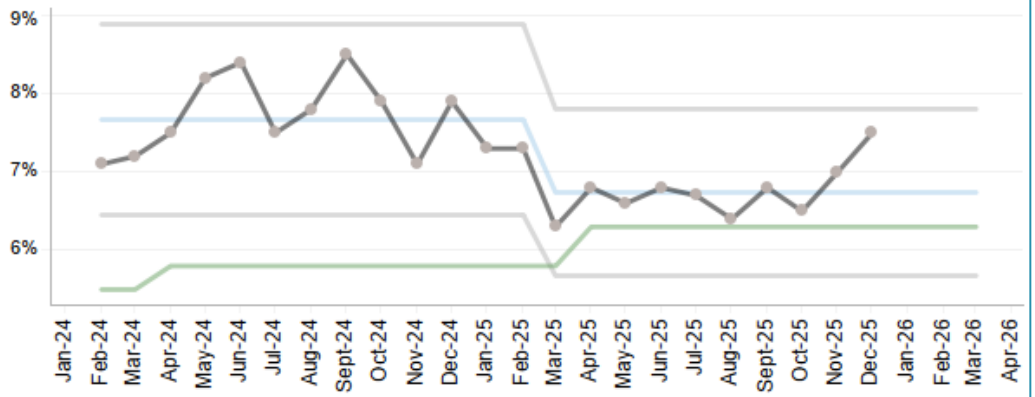
- Fluctuation in outpatient booking centre capacity could impact DNA rates. Recruitment to turnover and increased WTE from IPT funding are in place.
- Processes relating to reminder service

Actions and Mitigations

- DNA rate deep dive to be completed
- Review of booking processes
- Further work with operational divisions and specialities identified from the deep dive
- Validation of reminders and IP with upcoming OP appointments will continue
- Calls to high-risk patients are ongoing daily with a review of options to increase these

Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Outpatient DNA rate



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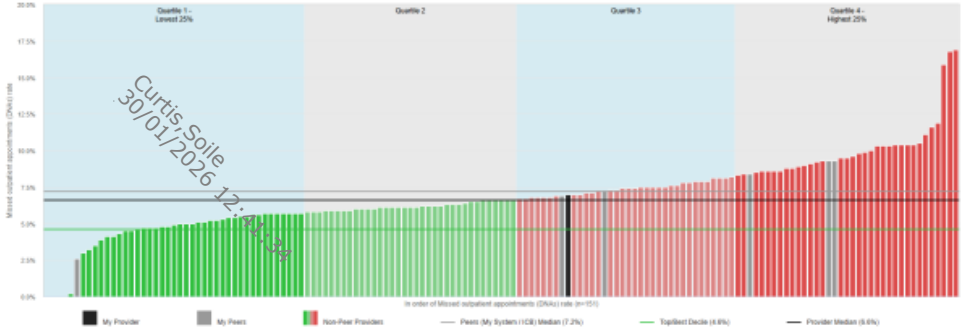
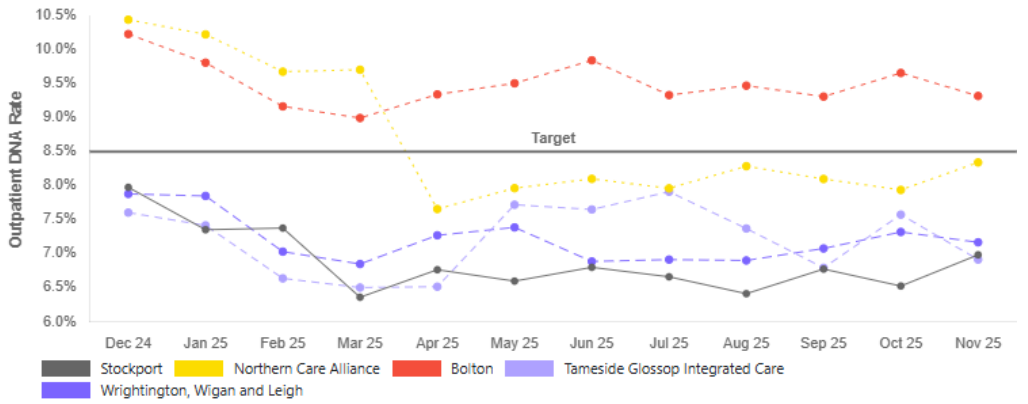
Outpatient DNAs rate – Benchmark data from Model Hospital – Nov25



Benchmark data from Public View – November 2025



Signed off by	Mike Allison
Executive Lead	Jackie McShane

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.	>= 44%	42.2%	↘	J A S O N D	▲

Performance Summary

- The percentage of appointments in December recorded as a New attendance or Outpatient Procedure was 42.2%, this is likely to improve once all appointments for the month have been coded.
- Year-to-date performance is 43%.
- Benchmarking data from HED shows the Trust to be below the national average rate (46.27%) and placed in quartile 2.
- Performance is driven a large proportion of follow up activity being undertaken.

Risks and Issues

- Disruption to outpatient services displaced following the closure of OPB has impacted on the position, evident in the benchmarking performance of procedures for dental services.
- Poor engagement by clinicians recording 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

- Ongoing review with divisions to ensure procedures performed in clinics 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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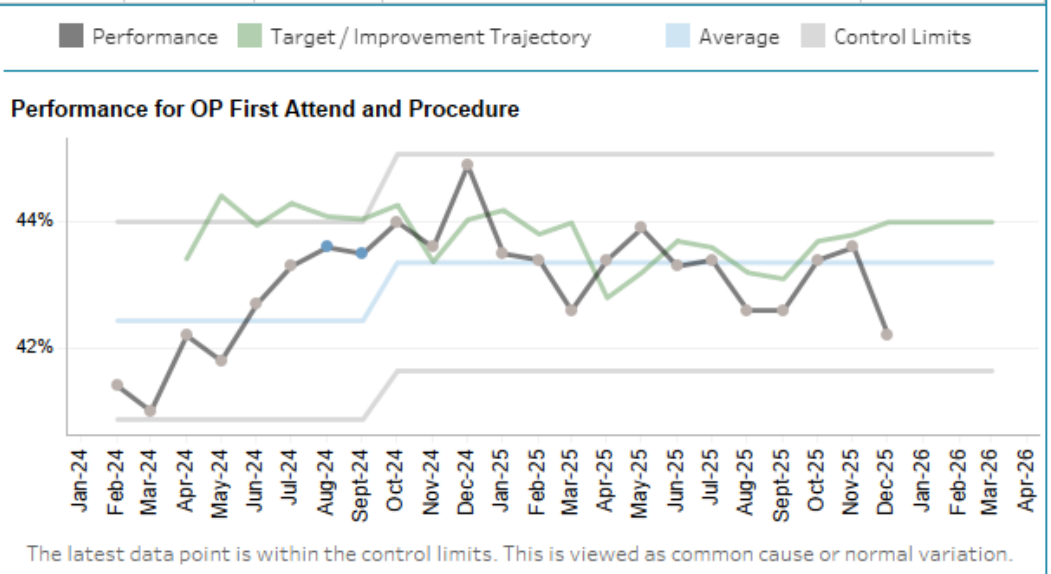

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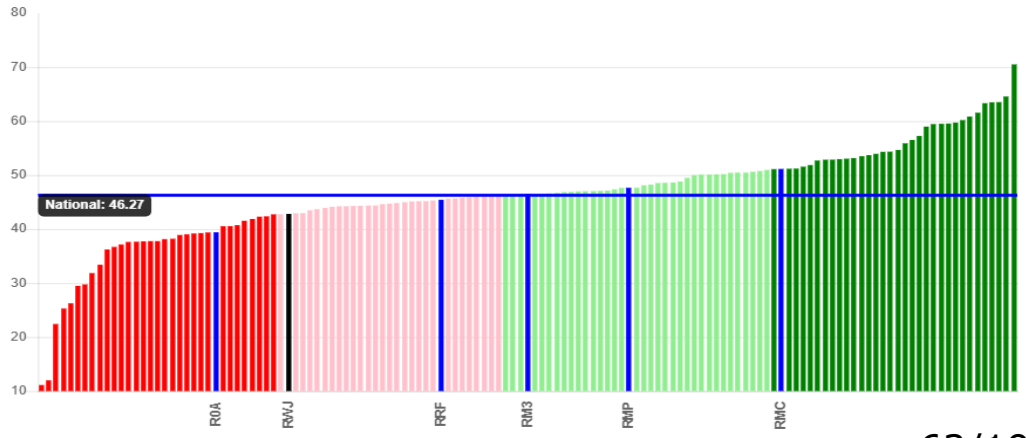
Benchmarking from HED – rolling 12-mth to Oct'25 (42.82%), National rate 46.27%



Updated provided by	Debbie Hope
Executive Lead	Jackie McShane

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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%	76.4%	→	J A S O N D	▲

Performance Summary

- Capped touch-time utilisation performance was 78.1 % for w/c 15th December 2025. (Maple suite at 57.8% and the Eye Centre is at 55.6%)
- Action plan in place to ensure 85% capped utilisation is achieved by end March 26. Plan updated monthly by surgical specialities. First update due 26th January 2026
- Late starts are improving . Model Hospital data reports the Trust at 11mins. Regional median is at 17mins.
- December 2025 saw the lowest reportable cancellations for the past 3 years
- The Trust ACPL is 2.7 . Regionally ACPL is at 2.0

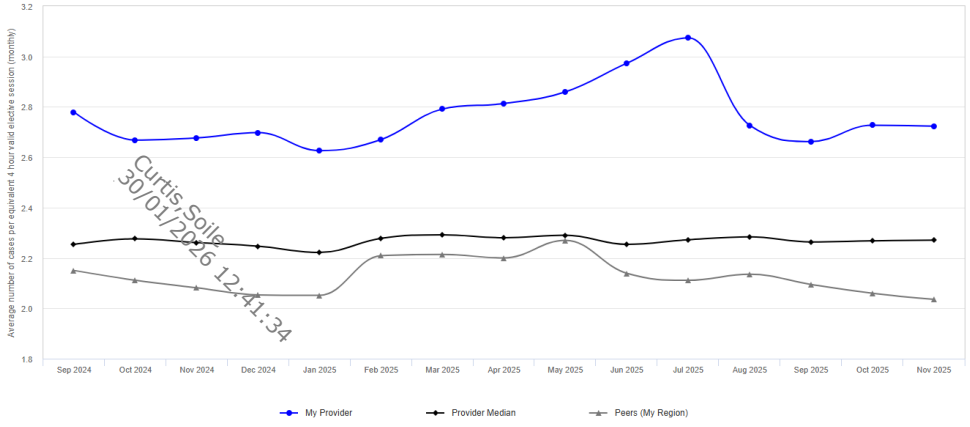
Key Risks/Issues

- Although improved, HSDU and general equipment related issues remained a challenge in December.
- HDU bed availability led to an increase in cancellations.

Actions and Mitigations

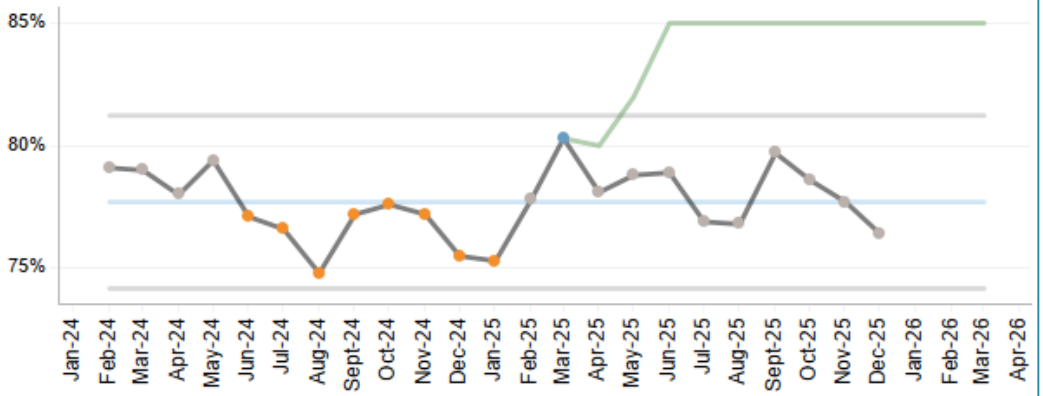
- 642-1 now is undertaking a two week forward look as opposed to one. This will further increase in March to three weeks to aid better planning
- Proposal been written to formalise an extended recovery pathway to mitigate cancellations
- 4 joint TKR lists commence in January 2026
- Increased pre-op assessment capacity to enable booking of standby patients across specialties

Averages cases per session - Benchmark data from Model Hospital – Nov25



Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Capped Touch Time Utilisation



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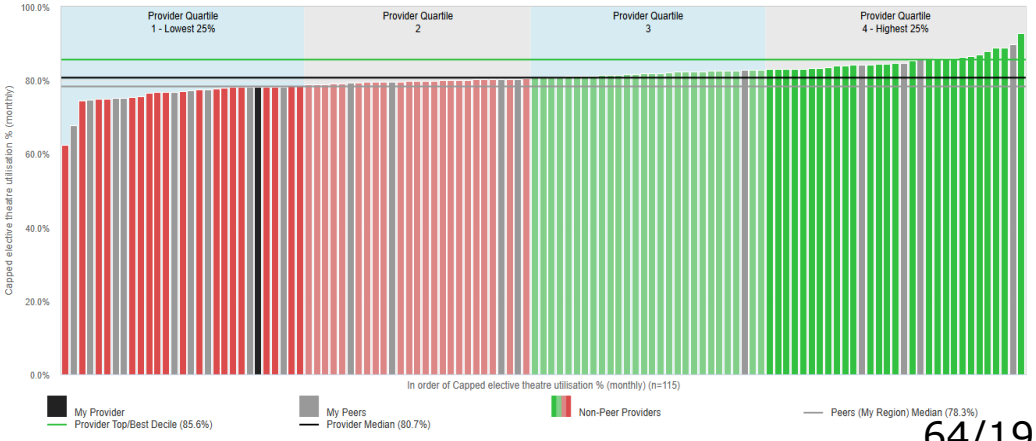
Capped touch time utilisation - Benchmark data from Model Hospital – Nov25



Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Workforce **Sickness Absence**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate — The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 5.5%	6.7%	↓	J A S O N D	▲

The sickness rate in December 2025 increased by 0.34%, rising to 6.74%, which is 1.24% above the Trust target of 5.5%. This increase is consistent with the seasonal rise in sickness levels typically seen during winter, when respiratory infections, Gastro, Flu, and other winter illnesses are more prevalent.

For comparison, the rate for the same period in 2024 was 6.24%, representing an increase of 0.5%. Stress-related absences have seen an increase and is reflective of increased complexities in home and work situations. We have a wealth of support available for staff experiencing mental health issues and we are continuing to communicate these on a person-centred approach.

All divisions have seen an increase in sickness rates, with the exception of Estates & Facilities, which reported a decrease of 0.79%. Corporate remains the only division with sickness levels below the Trust target of 5.5%.

In response, the Trust continues to promote the Winter Wellbeing Campaign, including reminders to staff about the importance of flu vaccinations and winter health guidance. Thirty managers are booked onto Supporting Wellbeing and Managing Attendance training in January. Divisions continue to manage attendance through their HR Management Teams and Hotspot Meetings. As of 09/01/25 there are 35 individuals who have triggered final supporting attendance meetings.

Flu vaccination uptake: As of 16/01/26, 43.5% of all staff and 42.4% of frontline staff have received their flu vaccination, against the GMICB target of 41.6%. Continued promotion of winter vaccination remains a priority to help mitigate seasonal sickness pressures.

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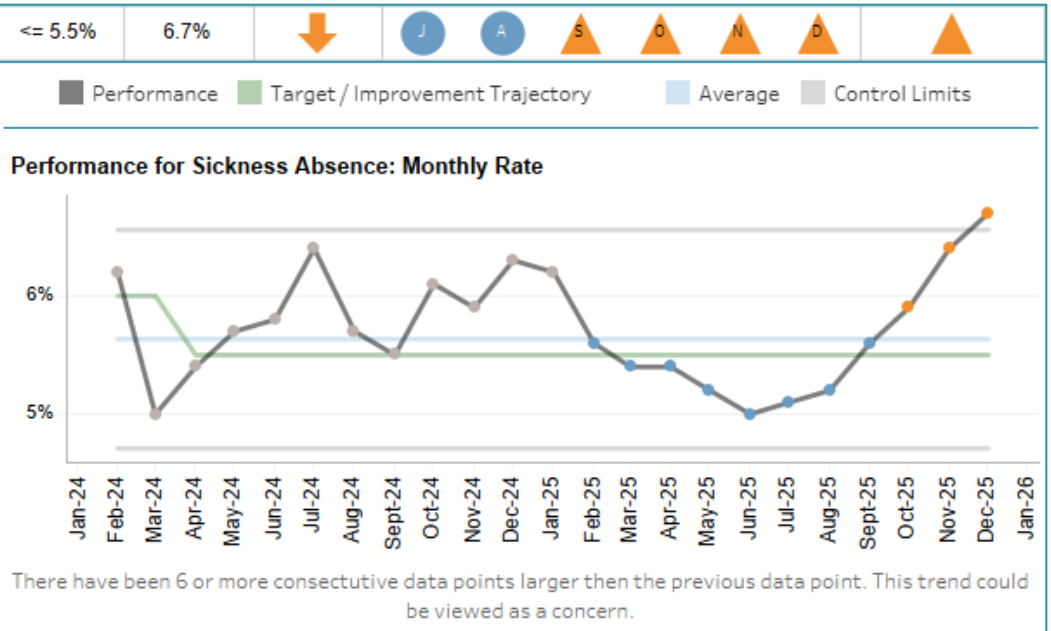

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Workforce **Appraisal Rate**

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.	Target	Actual	6-month trend	Previous Performance	1-month Forecast
		>= 95%	90.4%	↑	J A S O N D	▲

At the end of December 2025, Let's Talk appraisal compliance stood at 90.41%, remaining below the 95% target but reflecting continued organisational focus on appraisal completion and recording. Exception reports were issued to divisions and directorates during December, and leadership teams prioritised both the completion of outstanding appraisals and the accurate logging of outcomes on ESR. This resulted in a known increase in the number of appraisal conversations taking place across the Trusts.

While compliance has not increased in the December position, this reflects recording factors rather than a lack of activity. Further work is underway with divisions to ensure all outstanding 2025 appraisals are prioritised and completed, and that appraisal activity is planned and scheduled earlier in 2026 in line with the cascade approach. This includes reinforcing expectations around appraisal timing, supporting managers to plan ahead, and improving oversight at divisional level.

In parallel, People and Organisational Development teams are reviewing appraisal recording and reporting processes in January, in preparation for the 2026 Let's Talk appraisal cascade.

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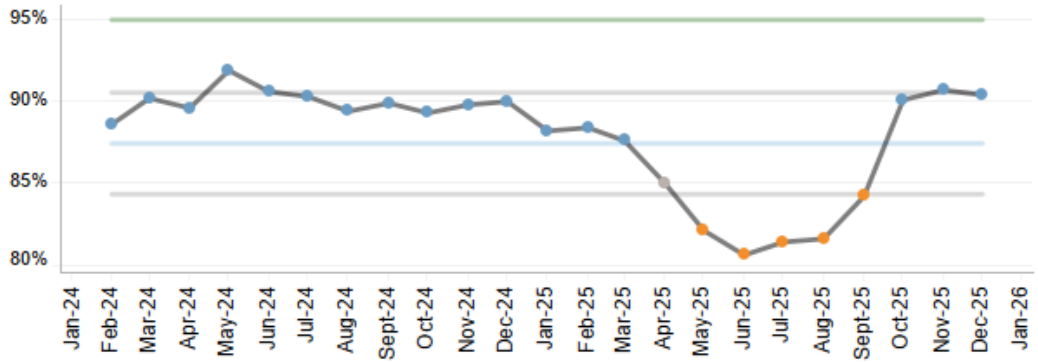
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Appraisal Rate: Overall



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Signed off by	Emma Cain
Executive Lead	Amanda Bromley

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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%	84%	↓	J A S O N D	▲
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		35.6	→	J A S O N D	
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	10.8%	→	J A S O N D	●
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%	32.6%	↑	J A S O N D	▲

Risks

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

- Payments for variable activity within ICB contracts which have been formally rejected and will not be paid in 2025/26.
- Costs of industrial action – mitigations for the July £0.6m cover costs were identified, and NHSE have indicated that costs for November and December's strike will be forthcoming and £0.5m has been assumed in the M09 position.
- The requirement for enhanced care.
- Risk to clawback of deficit support funding due to overall GM financial position at year end. Q4 DSF has been confirmed subject to this condition.
- Although we aren't currently forecasting to require revenue support funding in 2025/2026 this is subject to the assumptions above.

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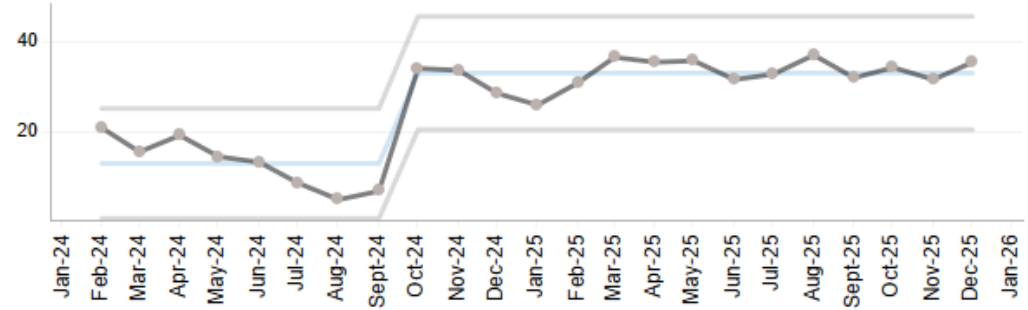
Performance | Target / Improvement Trajectory | Average | Control Limits

Performance for Cash Balance



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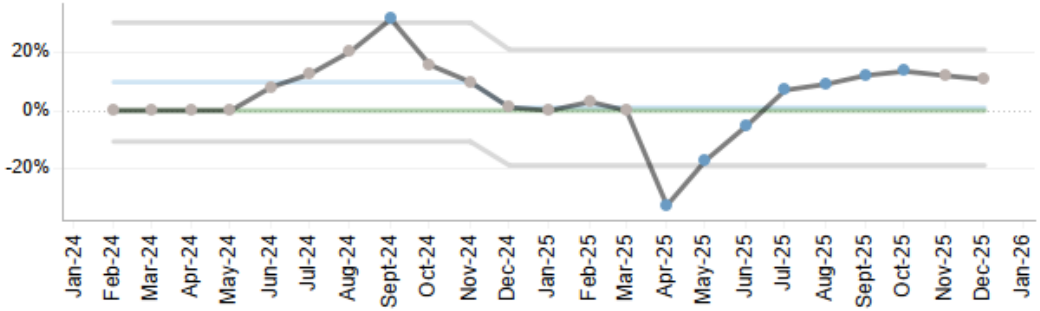
Performance for CIP Cumulative Achievement



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

Signed off by	Kay Wiss
Executive Lead	John Graham

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				Agenda No.	13
Meeting date	**5th February 2026**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Financial Position Month 9 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 9 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 £7.4m at the end of Month 9 which is in line with the financial plan. A detailed finance paper was presented to the Finance & Performance Committee on the 15th January 2026 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

where there is a range between a deficit of £5.9m and £7.6m. National funding for elements of the industrial action has been notified and this has improved the forecast in month as previously this was an adverse variance to plan.

The Trust has transacted its full year savings target of £29.2m and at Month 9 £23.2m has been delivered which is £2.2m ahead of the profiled plan. £17.2m (83%) of the recurrent requirement has been delivered. A further clarification on recurrent savings will increase this achievement in Q4.

Agency expenditure to Month 9 is £4.7m against a plan of £4.8m. In December there were the equivalent of 41 WTE agency staff; 20 nurses, 17 medical staff and 4 other clinical staff. Bank costs to Month 9 are £22.2m which is below the plan of £23.2m. There has been an increase in month associated with industrial action.

The Trust's cash balance at the end of December 2025 was £35.6m against a plan of £27.6m. Deficit Support Funding has been received in December for the delayed November payment and December.

The Trust has spent £9.6m on capital costs to Month 9 against a plan of £18.2m, with spend to date relating to the Outpatients Modular Build and the Emergency Care Campus. The forecast is to deliver plan for the year and enhanced focus continues to ensure delivery of the plan.

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Stockport Foundation Trust
Finance Report Month 9
2025/2026

John Graham - Chief Finance Officer

Contents

Key Messages

NHS Stockport NHS Foundation Trust

Summary of Financial Position

- After 9 months of the financial year the Trust is reporting a **breakeven position against plan** for system reporting purposes and a **net deficit of £7.4m**.
- Costs of £0.5m have been incurred to cover December's **industrial action**. In line with the national steer the Trust has assumed income to cover this cost.
- **STEP of £30.2m** has been transacted, delivering **104% of the in-year target**. To date £23.2m has been delivered which is £2.2m ahead of the profiled plan. The recurrent target has also been over-delivered, following review of non-recurrent delivery during 2026/27 planning.

Key Metrics

- **Agency spend of £4.7m** is again below plan in month, bringing the year to date position in line with plan. This means that the **30% reduction** on 2024/25 run rate has been achieved to date.
- **Bank spend of £22.2m** is £0.9m better than plan. This represents a **14% reduction** on 2024/25 run rate, which is better than NHSE's minimum expectation of a 10% reduction. As the majority of industrial action cover costs are incurred by bank staff, the reduction excluding this additional unplanned cost would have been higher.
- The cash balance at the end of December 2025 was **£35.9m.**
- The Capital forecast for 2025/2026 is in line with the £28.8m plan, however there is an underspend risk of £5.1m.
- WTE worked decreased by 10 in December to 6,170, which is **12 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 (DSF). The forecast is in line with plan for external reporting purposes.

The Trust's likely year end forecast position is £5.9m adverse to plan, based on the key risks below:

- Payments for variable activity within ICB contracts which have now been formally rejected and will not be paid in 2025/26 including :
  - £5.4m income assumption from Derbyshire ICB
  - £1.2m income assumption from GM ICB to start to realign contractual payments and activity
- Divisional positions remain within budget, and all pressures are contained within funding available including winter and acuity pressures.
- Inflationary pressures over and above those included in planning assumptions.
- Costs of industrial action – mitigations for the July £0.6m cover costs were identified, and NHSE have indicated that costs for November and December's strike will be forthcoming and £0.5m has been assumed in the M09 position.
- The requirement for enhanced care.
- Risk to clawback of deficit support funding due to overall GM financial position at year end. Q4 DSF has been confirmed subject to this condition.
- 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	December 2025 (M09) Budget £m	Actual £m	Variance £m	Year to Date Budget £m	Actual £m	Variance £m	Forecast Budget £m	Actual £m	Variance £m
Total Income	**44.2**	**44.7**	**0.5**	**383.8**	**384.6**	**0.9**	**517.3**	**519.8**	**2.6**
Substantive Staff	(28.2)	(28.3)	(0.1)	(252.9)	(251.9)	1.0	(336.8)	(337.7)	(0.8)
Bank Staff	(2.6)	(2.6)	(0.0)	(23.2)	(22.2)	0.9	(30.9)	(28.2)	2.7
Agency Staff	(0.5)	(0.4)	0.1	(4.8)	(4.7)	0.0	(6.3)	(5.8)	0.5
Pay Costs	(31.3)	(31.3)	0.0	(280.8)	(278.9)	1.9	(374.0)	(371.7)	2.4
Drugs	(2.5)	(2.4)	0.2	(19.0)	(18.9)	0.1	(25.2)	(25.3)	(0.1)
Clinical Supplies & Services	(2.4)	(3.2)	(0.7)	(21.9)	(24.5)	(2.6)	(28.6)	(32.5)	(3.8)
Other Non Pay Costs	(6.0)	(6.3)	(0.3)	(50.0)	(49.8)	0.2	(63.0)	(62.6)	0.4
Below the Line	(2.3)	(2.3)	0.0	(19.7)	(26.6)	(6.9)	(26.7)	(33.6)	(6.9)
Total Expenditure	**(44.5)**	**(45.3)**	**(0.8)**	**(391.4)**	**(398.6)**	**(7.2)**	**(517.6)**	**(525.6)**	**(8.1)**
TRUST SURPLUS / (DEFICIT)	**(0.4)**	**(0.7)**	**(0.3)**	**(7.6)**	**(14.0)**	**(6.4)**	**(0.3)**	**(5.8)**	**(5.5)**
System reporting adjustments	0.0	0.3	0.3	0.2	6.6	6.4	0.3	5.8	5.5
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(0.3)**	**(0.3)**	**0.0**	**(7.4)**	**(7.4)**	**0.0**	**0.0**	**0.0**	**0.0**
Stockport Trust Efficiency Programme (STEP)	2.2	2.6	0.4	15.4	17.5	2.1	29.2	29.2	-
Efficiencies as % of expenditure	*5.0%*	*5.7%*		*3.9%*	*4.4%*		*5.6%*	*5.6%*	
Capital expenditure	(3.0)	(0.7)	2.3	(18.2)	(9.6)	8.6	(28.8)	(28.8)	-
Cash & equivalents				27.6	35.9	8.3	31.6	23.9	(7.7)

Run Rate Analysis

Stockport NHS Foundation Trust

Run Rate Trends - Rolling 15 months - £000s

Month	Income	Non-Pay	Pay	Total
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)
Sep-25	42,578	(12,881)	(30,761)	(1,064)
Oct-25	42,387	(19,047)	(30,218)	(6,878)
Nov-25	43,885	(11,428)	(31,311)	1,146
Dec-25	44,655	(14,033)	(31,299)	(677)
FOT 2025/26	**517,753**	**(151,878)**	**(371,653)**	**(5,777)**

Previous Month Actuals	43,885	(11,428)	(31,311)	1,146
M09 Actuals	44,655	(14,033)	(31,299)	(677)
Movement (M09 v M08)	770	(2,604)	11	(1,823)
% Movement	1.8%	22.8%	0.0%	

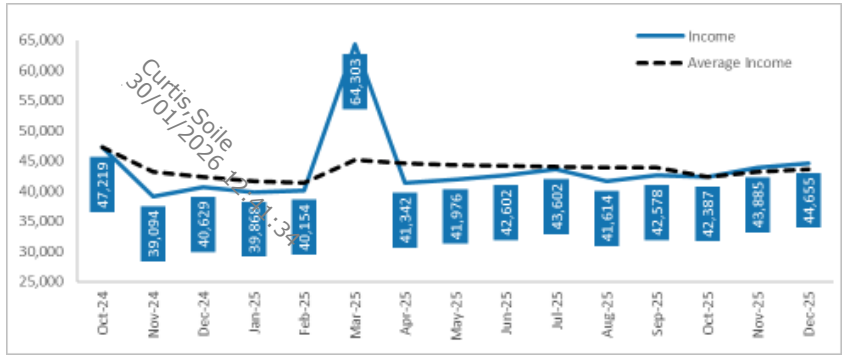
Key Movements

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

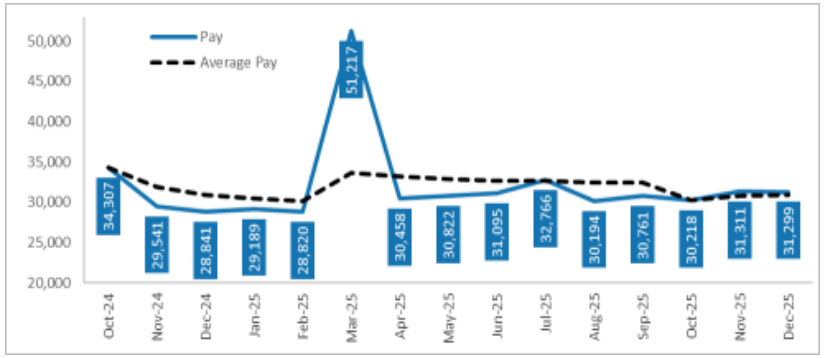
Non-pay costs were high in month due to the costs of supporting increased ED throughput and OPEL 4, as well as increased theatre consumables (as covered on slide 12) and one-off revenue costs associated with the pathology LIMS system. The £7.1m asset transfer of the Meadows took place in October, as previously reported.

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. Phase 2 of the transfer should take place before 31st March 2026. Industrial action cover costs are also included in July, November and December, as per the previous slide.

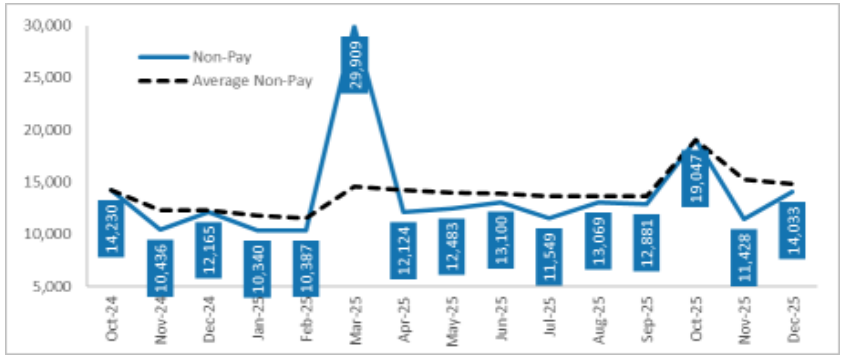
Income £000s



Pay £000s



Non-Pay £000s



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Income & Variable Activity Payments

Income Position

Income & expenditure Position	December 2025 (M09)			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)	33.8	34.0	0.1	294.6	294.6	0.1	392.4	392.8	0.4
Derby and Derbyshire ICB (Core and delegated)	3.3	3.3	(0.0)	29.0	29.0	0.0	38.6	38.7	0.0
Cheshire and Merseyside ICB (Core and delegated)	1.9	2.0	0.1	16.6	16.6	(0.1)	22.1	22.1	(0.0)
Specialised Commissioning	0.3	0.4	0.1	2.6	2.8	0.3	3.4	3.7	0.4
Low value activity	0.2	0.2	(0.0)	1.4	1.4	0.0	1.9	1.9	0.0
Local Authority	0.5	0.5	(0.0)	5.1	5.1	(0.0)	6.8	6.8	0.1
Injury cost recovery scheme	0.1	0.0	(0.0)	0.5	0.7	0.2	0.7	1.0	0.3
Other income from patient care	0.0	0.0	0.0	0.2	0.2	(0.0)	0.3	0.3	(0.0)
Clinical Income from Patient Care Activities	**40.1**	**40.4**	**0.4**	**350.0**	**350.5**	**0.5**	**466.2**	**467.4**	**1.1**

The clinical income year-to-date position is favourable to plan by £0.5m. The Trust year end forecast is £1.1m favourable to plan for year end. Conversations are on-going with commissioners around final contract agreement for 2025/26; the values in the table above represent the latest confirmed values.

The main variances to the year-to-date plan are:

- Specialised Commissioning (NHSE) drugs over performance £0.4m
- GM ICB overperformance on drugs and devices £0.3m
- Cheshire ICB and Derby ICB overperformance on drugs £0.2m
- Income offset to fund divisional drug overspend (£0.4m)
- An increase in RTA claims £0.2m

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. At this stage no under / over performance is included in the Trust position as it is unclear what level of overpayment / claw back is likely.

Contract Performance – Variable Activity

Clinical Income	Year to Date at December 2025									
	Activity Actuals vs Activity Plan					Price Actuals vs Price Plan				
	Activity Plan	Activity Actual	Activity Variance	%	% change from Nov	Price Plan £m	Price Actual £m	Price Variance £m	%	% change from Nov
Day Case	24,429	26,510	2,081	9%	-1%	21.4	23.2	1.7	8%	-1%
Elective	4,581	4,148	(433)	-9%	0%	19.3	17.0	(2.3)	-12%	0%
Elective Excess Bed Days	649	550	(99)	-15%	3%	0.2	0.2	(0.0)	-17%	3%
Outpatient Procedure	32,402	36,898	4,496	14%	-3%	7.0	7.8	0.8	11%	-2%
Outpatient First Attendance	79,038	77,488	(1,550)	-2%	-1%	17.1	17.0	(0.2)	-1%	-1%
Sub Total - Elective Plan	**141,099**	**145,594**	**4,495**			**65.1**	**65.1**	**(0.1)**	**0%**	**-1%**
Drugs	-	-	-	0%	0%	10.1	10.8	0.7	7%	1%
Devices	-	-	-	0%	0%	1.4	2.3	0.9	66%	7%
Other Variable	1,632	1,371	(261)	-16%	2%	0.6	0.5	(0.1)	-12%	2%
Sub Total - Other Variable	**1,632**	**1,371**	**(261)**			**12.1**	**13.6**	**1.5**	**13%**	**2%**
Total - Variable	**142,732**	**146,965**	**4,234**			**77.2**	**78.7**	**1.5**	**2%**	**0%**

The latest elective plan estimate is showing a small underperformance of £0.05m to the end of December. This has not been factored into the financial position as agreement with commissioners around payment for over/under performance are yet to be finalised. GMICS have notified the Trust that they are not expecting to pay for elective overperformance, and they are likely to propose activity management plans instead. This could result in ceiling / caps being applied to 'variable' elements of the contract.

Key areas of underperformance are elective inpatients for trauma and orthopaedics and urology. In earlier months this was offset by day case overperformance in endoscopy, general surgery and gynaecology.

There is an overperformance against plan of £0.90m for devices and overperformance on drugs of £0.72m. In line with ICB discussions and national guidance these costs are being treated as pass through. Corresponding expenditure budgets have been set to cover the net increase in expenditure of £0.36m in December.

Contract Performance – Variable Activity Forecast Scenarios

Clinical Income - Elective Plan	ICB Annual Contract Plan	Forecast Variance		
		Scenario 1	Scenario 2	Scenario 3
	£m	£m	£m	£m
NHS Greater Manchester ICB	66.0	(0.3)	(0.0)	0.3
NHS Derby & Derbyshire ICB	9.4	1.1	1.1	1.2
NHS Cheshire & Merseyside ICB	5.8	(0.1)	(0.1)	(0.0)
Spec Comm / Other NHSE	5.0	(0.1)	(0.3)	(0.3)
Other	0.9	-	-	-
Total - Elective Plan	**87.1**	**0.6**	**0.7**	**1.2**

As previously stated, elective activity under / over performance is not currently factored into the Trust financial position due to the lack of clarity around ICB payment for variable elements of the contract.

Forecast scenarios have been produced, which show potential over performance ranging from £0.6m to £1.2m.

- Scenario 1 is based on months 1-9 run rates, adjusted for the impact of industrial action and Derby/Cheshire proposed activity outsourcing.
- Scenario 2 is based on the planned activity profile for the remaining months of the year, adjusted for the impact of industrial action and Derby/Cheshire proposed activity outsourcing.
- Scenario 3 is based on the average daily income over last 3-months for the remaining 2025/26 working days, adjusted for Derby/Cheshire proposed activity outsourcing.

Whilst the figures suggest the risk of underperformance, and therefore claw back, is low, there is a risk that the Trust will not be paid for all of the £1.2m of activity, if current activity performance continues. Derby have been invoiced for their overperformance in line with agreement at the start of the financial year which if paid mitigates part of this.

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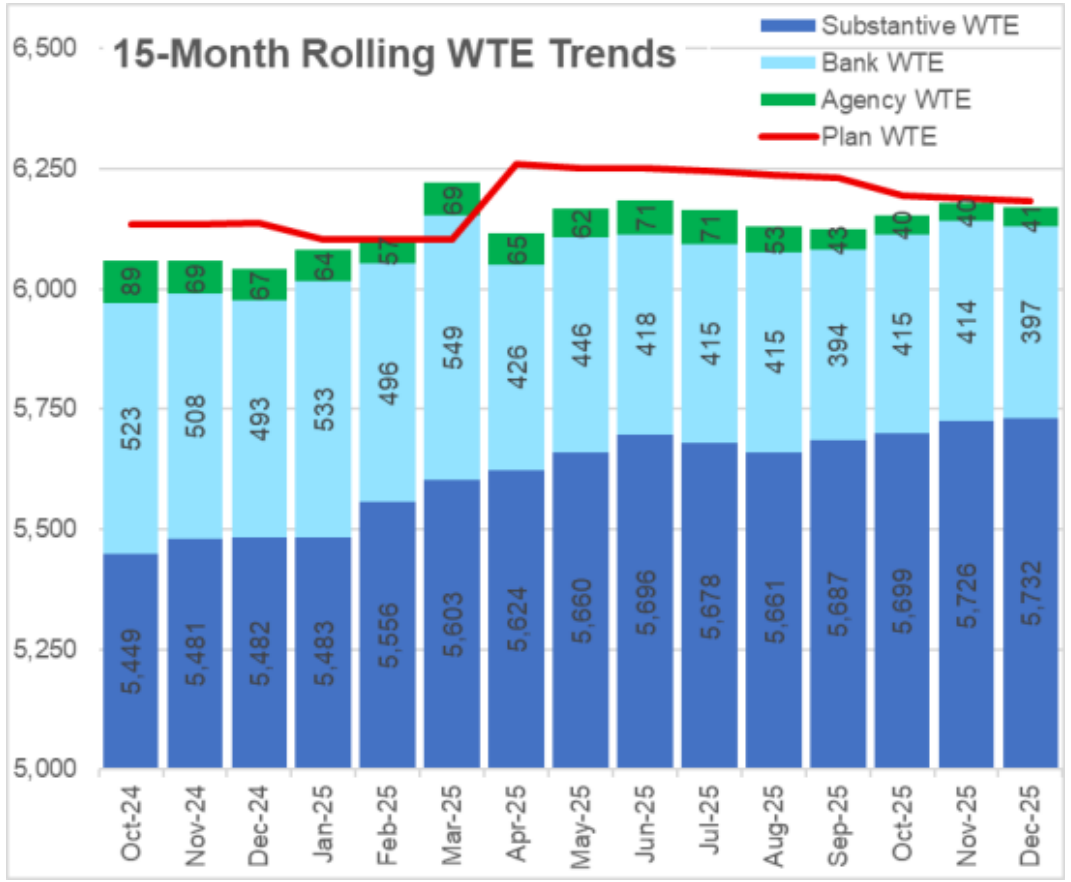
Workforce & Temporary Staffing

Staff and WTE reconciliation - WTE

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	*Bank % of WTE*	*Agency % of WTE*	Plan WTE	Variance to Plan
Oct-24	5,449	523	89	6,060	*8.6%*	*1.5%*	6,134	(74)
Nov-24	5,481	508	69	6,058	*8.4%*	*1.1%*	6,134	(76)
Dec-24	5,482	493	67	6,042	*8.2%*	*1.1%*	6,136	(94)
Jan-25	5,483	533	64	6,080	*8.8%*	*1.1%*	6,103	(23)
Feb-25	5,556	496	57	6,109	*8.1%*	*0.9%*	6,103	6
Mar-25	5,603	549	69	6,221	*8.8%*	*1.1%*	6,103	118
Apr-25	5,624	426	65	6,115	*7.0%*	*1.1%*	6,258	(144)
May-25	5,660	446	62	6,168	*7.2%*	*1.0%*	6,252	(84)
Jun-25	5,696	418	71	6,185	*6.8%*	*1.2%*	6,251	(66)
Jul-25	5,678	415	71	6,164	*6.7%*	*1.1%*	6,244	(80)
Aug-25	5,661	415	53	6,129	*6.8%*	*0.9%*	6,238	(109)
Sep-25	5,687	394	43	6,124	*6.4%*	*0.7%*	6,232	(108)
Oct-25	5,699	415	40	6,154	*6.7%*	*0.6%*	6,195	(41)
Nov-25	5,726	414	40	6,180	*6.7%*	*0.6%*	6,188	(8)
Dec-25	5,732	397	41	6,170	*6.4%*	*0.7%*	6,181	(12)
Movement in month	**6**	**(17)**	**1**	**(10)**	***-0.3%***	***0.0%***	**(6)**	**(4)**
Movement since April	**108**	**(28)**	**(24)**	**55**	***-0.5%***	***-0.4%***	**(77)**	**132**

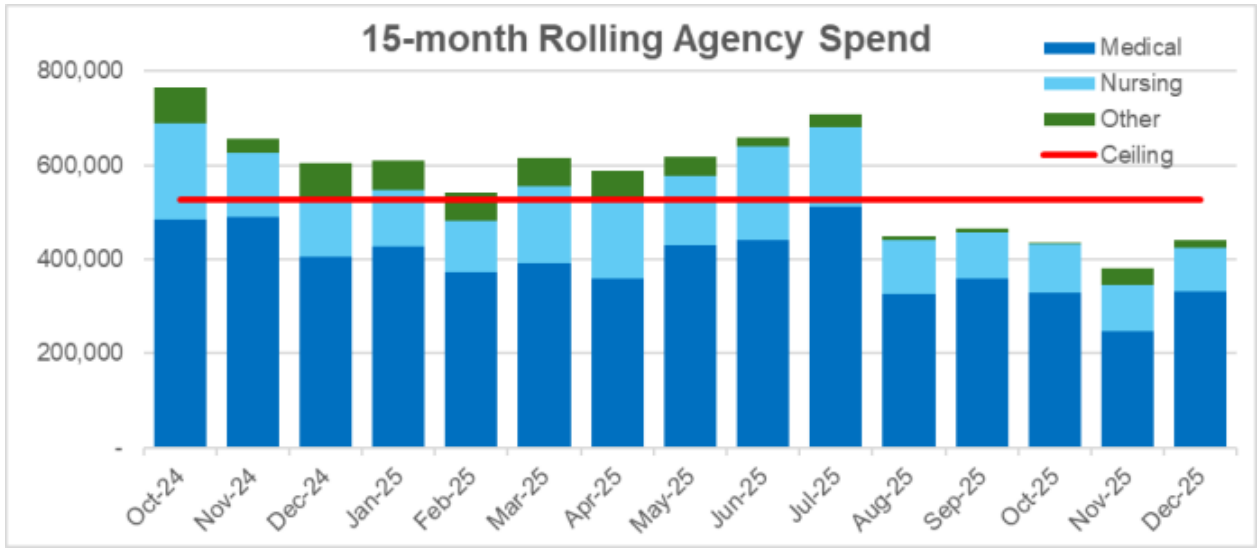


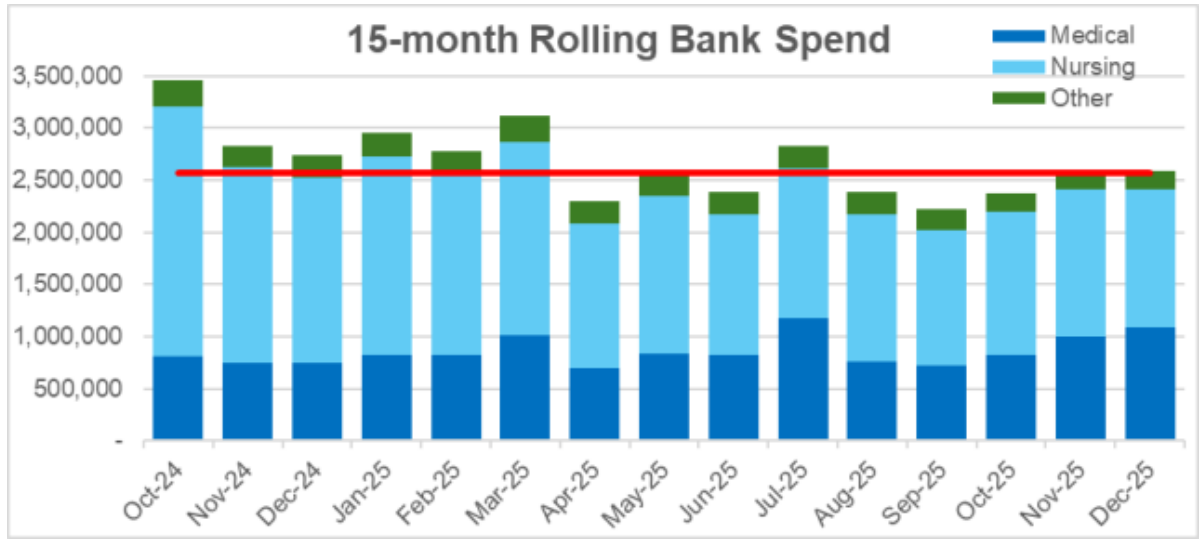
WTE Summary

Total WTE has decreased by 10 between November and December 2025, a total increase of 55 since April. Total WTE is 12 WTE below plan in December.

The WTE plan reduced significantly in the second half of the year, linked to anticipated CIP schemes. This impact, alongside the increases in substantive WTEs explains the reduction in monthly variance to plan.

Staff and WTE reconciliation - £





The Trust submitted a compliant annual plan for 2025/2026 which included a 30% reduction in bank and a 10% reduction in agency, based on 2024/2025 M08 forecast out-turn. The Trust's annual expenditure limits are therefore £30.9m for bank and £6.3m for agency. The above charts show the target reduction level as a flat line, though this is not being directly monitored in the Trust's monthly Provider Finance Return (PFR).

December agency costs are £0.4m, which is £0.1m below the ceiling – agency spend has been below the ceiling for the 5th consecutive month. Year to date the 30% target reduction has now been delivered.

Bank costs in December are £2.6m, which is in line with the ceiling. Industrial action cover costs are mainly incurred as bank spend, so the 14% reduction delivered compared to the 10% target would be improved further if these costs were excluded.

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Trust Efficiency Programme

STEP (Stockport Trust Efficiency Programme)

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 the target has been delivered and exceeded.

For external reporting purposes STEP is reported in line with plan (as shown in the table below); however, divisions are encouraged to keep transacting in year schemes to support identification of non-recurrent underspends being removed from individual cost centre positions in year and prompt recurrent review.

As part of the annual plan review for 2026/27 with NHSE NW £4.9m of non-recurrent vacancy factor has been made recurrent, which represents c.80% forecast NRVF in 2025/26. This split of this by division has not yet been finalised and will be discussed at the Trust STEP meeting in January. This recurrent vacancy factor is required in addition to the 5% savings target of £26.8m in 2026/27.

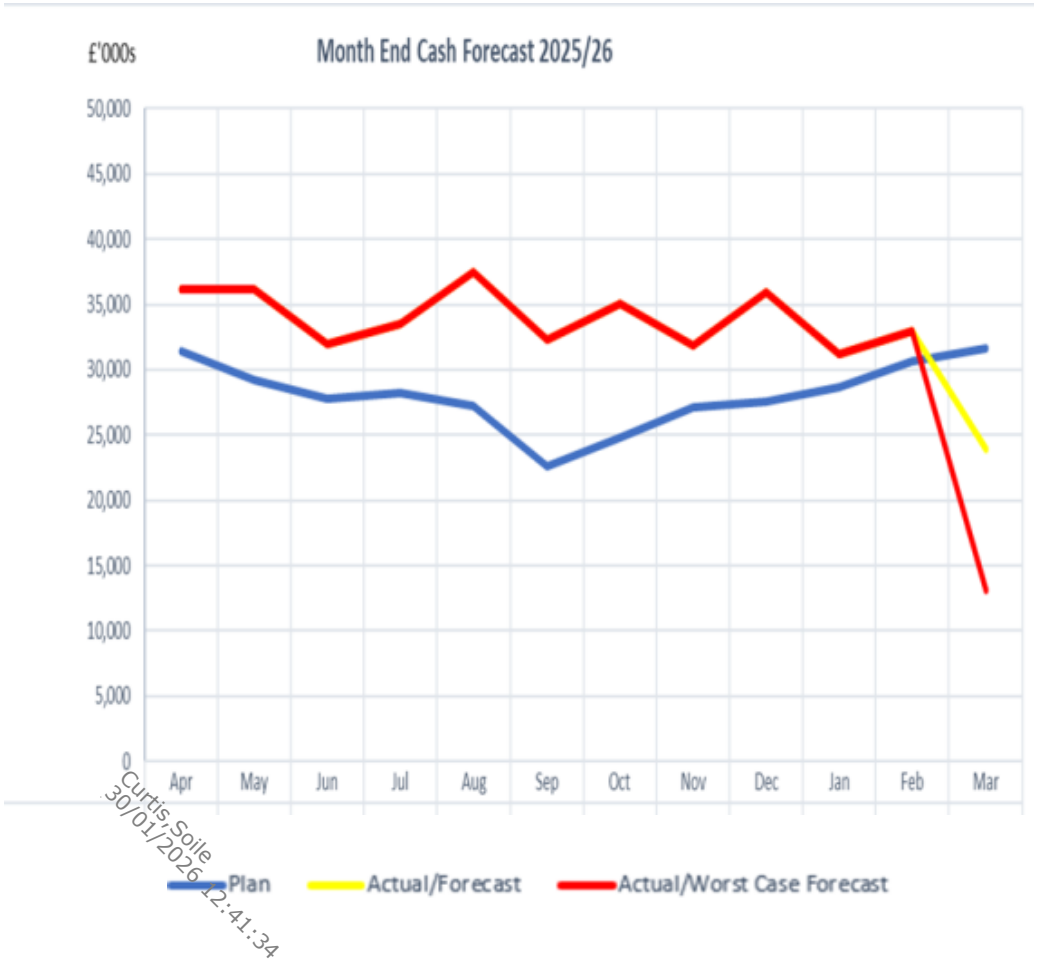
Including the above, recurrent STEP delivery is £22.959m against the £20.575m target, so has also over delivered.

			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	3,700	3,544	4,933	4,933	-	-	-	(0)	100%	3,476	3,523	1,188	-	-	(1,234)	136%
Surgery	2,916	2,916	3,889	3,702	20	65	528	(426)	111%	2,740	1,309	1,477	-	-	(46)	102%
Women & Children	1,596	2,321	2,228	3,177	-	-	-	(949)	143%	1,570	1,333	1,600	-	-	(1,363)	187%
Integrated Care	1,391	1,801	1,854	2,291	-	-	-	(437)	124%	1,307	1,188	31	-	-	87	93%
Clinical Support Services	1,630	2,265	2,305	2,712	-	-	-	(407)	118%	1,624	910	1,002	-	-	(288)	118%
Estates & Facilities	1,103	577	1,470	729	5	15	2	720	51%	1,036	253	214	-	-	569	45%
Corporate	1,220	1,226	1,627	1,658	0	-	-	(32)	102%	1,146	839	282	-	-	26	98%
Sub-total Divisions	**13,556**	**14,652**	**18,306**	**19,203**	**25**	**80**	**529**	**(1,532)**	**108%**	**12,899**	**9,355**	**5,793**	**-**	**-**	**(2,249)**	**117%**
General Trust	7,371	8,546	10,894	11,032	(1,708)	-	-	1,570	86%	7,676	7,811	-	-	-	(135)	102%
TOTAL	**20,927**	**23,197**	**29,200**	**30,235**	**(1,683)**	**80**	**529**	**38**		**20,575**	**17,166**	**5,793**	**-**	**-**	**(2,384)**	
TOTAL IDENTIFIED		**23,197**		**TOTAL IDENTIFIED**				**29,162**			**TOTAL IDENTIFIED**				**22,959**	
	YTD gap	*(2,270)*				*In Year gap*		*38*					*Recurrent gap*		*(2,384)*	
	% Identified	**111%**				***% Identified***		**100%**					***% Identified***		***112%***	

NHS
Stockport
NHS Foundation Trust

Cash, Capital & PFI

Cash



Cash balances at the end of December were £35.9m - £35.6m for the Trust and £0.3m for the Pharmacy Shop, an increase of £4m from November. The Trust received November and December's non-recurrent deficit support funding for in December – total £7.2m.

The Annual Plan for cash for December 2025 was £27.6m, giving an improved cash balance of £8.3m compared to plan.

The cash forecast has been updated based on current run rate, known cash commitments and risks, and the reduction of £2.1m depreciation funding (based on the full year effect now assumed to be transacted from February) . The graph shows that the Trust cash balances are forecasting a variance from Plan by £7.7m, with a March 2026 balance of £23.9m. This year end forecast balance is an increase of £6m from the figure reported previously. This improvement is mainly due to a comprehensive review of all cashflows, with the primary factor being a £6.5 million reduction in year-end capital expenditure, which is now expected to occur early in 2026/27. As a result, year-end capital creditors are projected to be £12.5 million, including expenditure from existing forecasts and any spending relating to the £5.1 million capital gap identified elsewhere in this report. Any commitments from this gap are likely to result in cash outflows during the 2026/27 financial year.

The Trust has now received confirmation of payment of Q4 Deficit Support Funding (DSF). It is important to note that the approval of DSF is still subject to clawback in the event the system fails to deliver the 2025/26 financial plan, and the graph includes a worst case forecast which shows the risk of clawback for quarter 4 (£10.8m) in March which would leave year end cash balances at approximately £13.1m.

Cash

	December	January	February	March
Cash and cash equivalents at beginning of period		35,898	31,181	32,975
- Capital		7,058	8,582	16,305
- Revenue		28,840	22,598	16,671
In month movements				
Capital		1,524	7,723	(2,708)
Revenue (Excluding cash releasing efficiencies impact)				
- Income excluding Deficit Support Funding		36,503	37,243	37,499
- Deficit Support Funding - included in forecast and expected to be received		3,600	3,600	3,600
- Deficit Support Funding - included in forecast but not likely to receive				
- Pay		(32,444)	(32,518)	(32,755)
- Other expenditure		(15,364)	(15,664)	(16,639)
Cash releasing efficiency savings		1,463	1,410	1,923
Cash and cash equivalents at end of period	35,898	31,181	32,975	23,894
- Capital	7,058	8,582	16,305	13,596
- Revenue	28,840	22,598	16,671	10,298
Lowest cash balance in period	35,865	31,177	31,177	23,806

Change in Cash Forecast from previous month	3,199	3,166	1,527	6,017

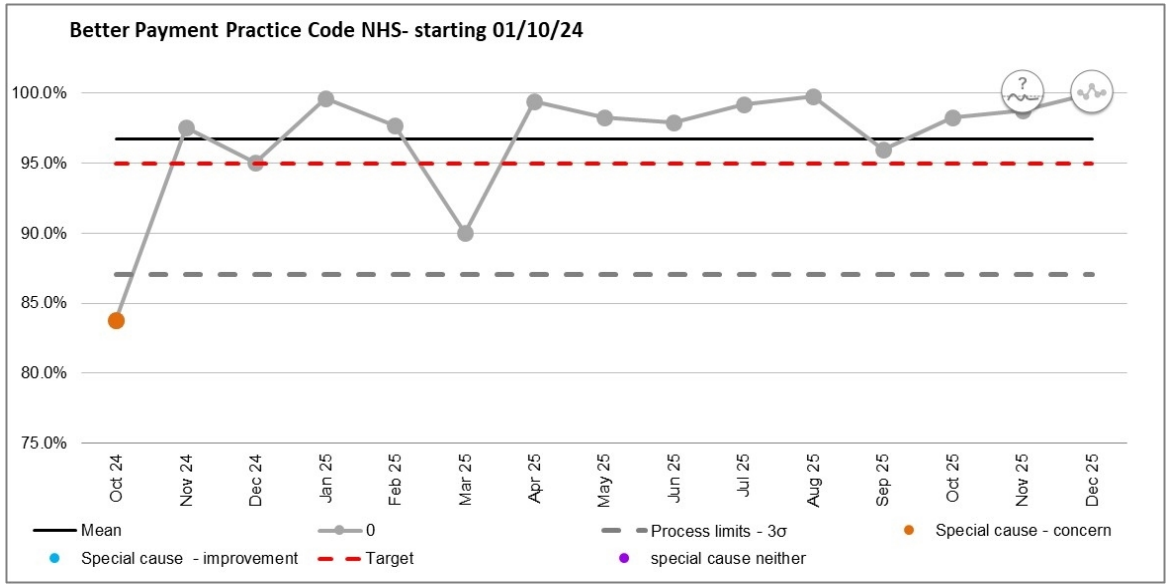
The above table shows the draft NHSE reporting of the cash forecast to March 2026, scheduled to be submitted to NHSE as part of the M9 Accounts exercise on 23/01/26.

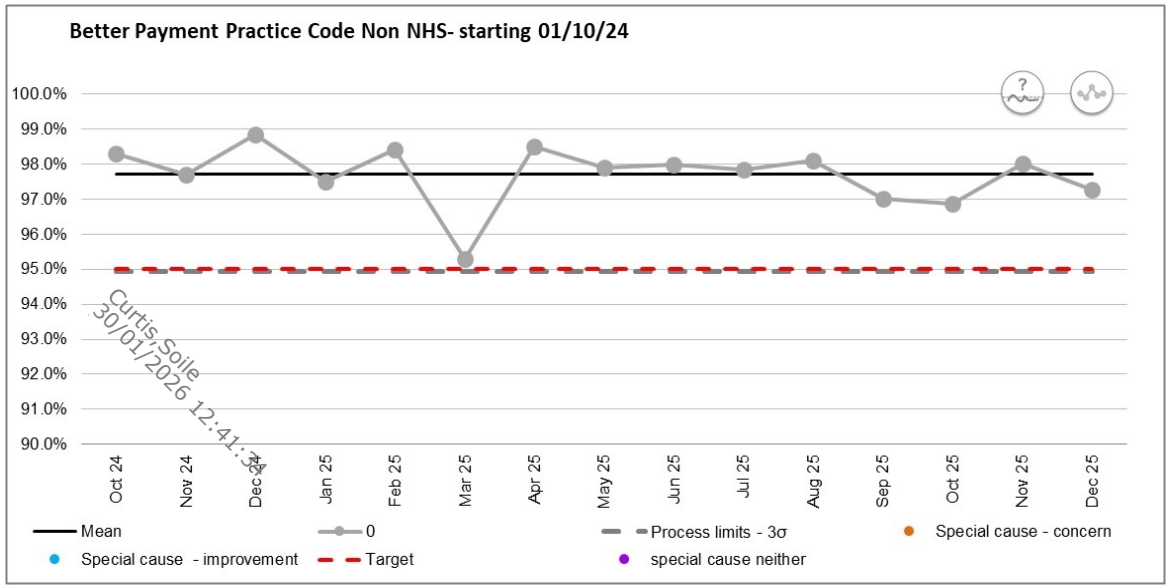
Cash at the end of December is £35.9m which is £3.2m higher than the balance forecast previously, predominantly due to the timing of creditor payments which have been re-forecast into subsequent months.

The forecast highlights where efficiency savings materialise as cash. Planned efficiency savings for the year are £29.2m, of which £18.0m are forecast to be cash-releasing. Cash releasing efficiency savings in December were £1.5m, bringing the total for the year to date to £13.2m.

The Cash Monitoring Group will continue to closely monitor the Trust's cash position..

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 M07		BPPC M08		BPPC M09	
	Number	Value £000's	Number	Value £000's	Number	Value £000's
Non NHS						
Total Bills paid in the year	5509	18,892	4520	16,778	4322	15865
Total bills paid within target	5337	18,702	4430	15,702	4204	15788
Percentage of bills paid within target	97%	99%	98%	94%	97%	99%
NHS						
Total Bills paid in the year	810	2,667	492	742	498	518
Total bills paid within target	796	2,591	486	578	498	518
Percentage of bills paid within target	98%	97%	99%	78%	100%	100%
Total						
Total Bills paid in the year	6319	21,559	5012	17,520	4820	16383
Total bills paid within target	6133	21,293	4916	16,280	4702	16305
Percentage of bills paid within target	97%	99%	98%	93%	98%	99%

Capital Summary

Division £m	December 2025 (M9) Budget £m	Actual £m	Variance £m	Year to Date Budget £m	Actual £m	Variance £m	Forecast Budget £m	Actual £m	Variance £m
Estates	(1.3)	(0.3)	1.0	(11.6)	(7.4)	4.2	(16.6)	(16.6)	-
Equipment	(0.6)	(0.2)	0.4	(1.4)	(0.7)	0.7	(1.6)	(1.6)	-
Digital	(1.0)	(0.1)	1.0	(4.5)	(1.1)	3.4	(9.8)	(9.8)	-
Sub-total	**(3.0)**	**(0.5)**	**2.4**	**(17.5)**	**(9.2)**	**8.3**	**(28.1)**	**(28.1)**	**-**
IFRS16	-	(0.2)	(0.2)	(0.7)	(0.4)	0.3	(0.7)	(0.7)	-
Total Capital	**(3.0)**	**(0.7)**	**2.3**	**(18.2)**	**(9.6)**	**8.6**	**(28.8)**	**(28.8)**	**-**

Key Points

- The capital programme of £28.8m is made up of £17.1m internal funding and £11.7m PDC.
- The above table is based on the submitted NHSE forecasts for 2025/26. Internally however forecasts at present total £25.9m, leaving a gap of **£2.9m** to plan.
- There have been schemes identified as a risk of not progressing to a total of £2.2m, which will further increase the gap to **£5.1m**. These schemes are identified on the next slide.
- The Capital Programme Management Group (CPMG) have bi-weekly meetings in place to manage the position, and plans are being developed to close this gap and deliver 2025/26 capital in full.
- Included within the £17.1m is £1.5m budget in respect of a revenue to capital transfer. This is currently not included within the forecast and would reduce the identified gap.
- The following forecast tables display the current ongoing schemes.

Capital Forecast Risk

Schemes	Forecasted Spend
Voice Recognition / Dictation Solution	1,560
Maternity System replacement	300
Endoscopy System replacement	300
	2,160

- Orders still to be placed total £9.4m of committed schemes and of these the biggest current risks where schemes may be progress as planned are highlighted above - **£2.2m**

- EPR PDC of £2.1m is yet to be approved as of 09/01/26. £468k is due to the contractor in 2025/26 assuming approval of PDC, with the remaining £1.7m being allocated to other schemes and re-provided in future years. This presents a £1.7m risk with committed schemes should PDC not be approved.

- Timing presents the biggest concern as we now enter Q4.

Statement of Financial Position

	As at 31/03/2025 £000's	As at 31/12/2025 £000's
Total Non-current assets	**243,326**	**237,713**
Current assets and (Liabilities)		
Inventories	951	879
Trade receivables and accrued income	15,184	21,397
Assets held for sale	7,050	-
Cash and cash equivalents	36,725	35,581
Current liabilities	(69,480)	(74,741)
Provisions	(1,443)	(1,373)
Net Current Assets/Liabilities	**(11,012)**	**(18,256)**
Total Assets Less Current Liabilities	**232,313**	**219,456**
Non-current (Liabilities)		
Borrowings: leases	(8,040)	(8,523)
Borrowings: DHSC Capital Loans	(12,223)	(12,223)
Provisions	(2,789)	(2,789)
Total Non Current Liabilities	**(23,052)**	**(23,535)**
Total Assets Employed	**209,261**	**195,921**
Financed By Taxpayers Equity		
Public dividend capital	262,692	263,348
Revaluation reserve	59,614	59,614
Income and expenditure reserve	(113,046)	(127,042)
Total Taxpayers Equity	**209,261**	**195,921**

- The draft Trust Statement of Financial Position shown forms part of the Month 9 Accounts to be submitted to NHSE on 23/01/2026
- The increase in receivables includes prepayments increases totalling £3.6m, of which £2m 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.
- Current liabilities as at month 9 includes £1.3m of deferred NHSE Education funding, also includes £1.6m for the repayment of depreciation which is now scheduled to be repaid by the end of the financial year, and also includes a £1.1m accrual for electricity for April to July not yet paid.

NHS Stockport NHS Foundation Trust

				Agenda No.	14
Meeting date	5 February 2026	**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 January 2026, noting areas of alert, advice and assurance.

NHS
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ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Louise Sell, Non-Executive Director
Date of Meeting	27 January 2026
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: • StARS Progress Report (for ratification) • Board Assurance Framework 2025/26: Draft Principal Risks • Quality & Safety Integrated Performance Report • Winter Resilience Planning Alert, Advise & Assure Report • Outcome of Sepsis Transformation Work • Research, Development & Innovation Mid-Year Update • Quality Strategy – Content Approval • Learning from Deaths Report – Q2 • CQC Quarter 2 Update • Clinical Audit Progress Report • Maternity Services – Annual CNST Board Declaration • Standing Subgroup Alert, Advise & Assure Reports: - Trust Integrated Safeguarding Group - Clinical Effectiveness Group - Patient Safety Group - Patient Experience Group • Quality Committee Work Plan & Attendance 2025/26
2.	**Alert**	Quality & Safety Integrated Performance Report and Winter Resilience Planning Alert, Advise & Assure Report - 12 hour wait. While our performance is better than the trajectory we set ourselves it remains well above the 2% target. December saw a period when we declared Opel 4. The position is driven by the poor performance in no criteria to reside, bed occupancy and timely discharge. The committee has previously identified poor patient experience caused by extended stays in the ED, triangulated with findings from Learning from Deaths reviews. It remains concerned about the risk to patient safety which can manifest immediately or later if care is sub-optimal. It is equally concerned about the impact of the sustained strain on staff as they try to mitigate this risk. Quality & Safety Integrated Performance Report and Outcome of Sepsis Transformation Work - the antibiotic administration rate has remained at a distance from target (90%) for over a year and the in-month rate is 40%. The committee received a report on the transformation project which aimed to deliver compliance with new NICE guidelines and to improve the position. The report does not give assurance, and the executive team will consider the next steps to improve our performance. No harm has been identified in the cases where antibiotics were delayed.

3.	**Advise**	StARS Progress Report (for ratification) – the committee approved the requested changes to the standards Quality & Safety Integrated Performance Report – complaints – the rate of complaints received remains above target, the response to informal enquiries has not yet recovered despite staffing support, and the response to written complaints remains beyond the target timescale. This has been impacted by operational pressures leading to diversion of activity to immediate patient care. The commonest reasons for enquiries remain appointments / communication / waiting time which are impacted by continued long waits for elective care. Board Assurance Framework 2025/26: Draft Principal Risks - The committee approved the position. Noting that the health inequalities risk remains at a significant distance from target and an update is due next month, and that the estates risk also remains at a significant distance from target. It requested that where the timing of the risk committee impacts the timeliness of the operational risk review that this is noted on the paper. Research, Development & Innovation Mid-Year Update – The update gave assurance about improvement in the staffing situation but ongoing risk to funding and recruitment rates. Management responses are in hand. Quality Strategy – The committee approved the content of the joint quality strategy between SFT and T&G, and recognised the considerable work from all the contributors. CQC Quarter 2 Update - The committee noted this and recognised the work done to maintain good relationships with regulators. Learning from deaths - The committee were assured that we continue to implement appropriate reviews with responses embedded in governance structures. Findings this quarter about both good practice and missed opportunities in end-of-life care are the subject of ongoing work in the internal trust wide and the locality wide end of life groups. The committee were updated about immediate action taken in response to a case in which there was an outcome 1 finding (sub-optimal care more likely than not to have contributed to the death) and the case is now subject to a patient safety incident investigation. Standing Subgroup Alert, Advise & Assure Reports - The committee received AAA reports from the: - Trust Integrated Safeguarding Group - Clinical Effectiveness Group - Patient Safety Group - Patient Experience Group The committee deferred 3 papers; Health inequalities report and draft mental health plan update until the next meeting QIA process approval until a joint paper is agreed with T&G

4.	**Assure**	Quality & Safety Integrated Performance Report - The committee had sought assurance about the reason for an increase in the rate of incidents with moderate harm and this was explained as likely to be due to an artefact. Historically incidents were reclassified when later information indicated they should be downgraded; this process was stopped for about six months and has been reinstated from January 2026. The indicator will continue to receive close scrutiny. Mortality - SHMI - remains lower than expected. Infection prevention - MRSA reduced in month and no new MSSA cases. E Coli remains above target and actions are ongoing to ensure compliance with basic hygiene. Many cases identified as community acquired / related to retesting. Pressure ulcers – hospital acquired remain below target and while community acquired are above target the rate of those due to lapses in care is within target. Clinical Audit Progress Report – The committee received assurance that we have a robust process to manage and progress clinical audits, with delayed completions related to national audits. Maternity Services – Annual CNST Board Declaration - The committee reviewed the suite of papers in support of the declaration and were assured that our response is accurate Quality & Safety Integrated Performance Report – maternity indicators remain within target except for the rate of 3rd and 4th degree tears. The committee have requested a further update on the actions to address this.
5.	**Referral of Matters/Action to Board/Committee**	The committee refers the matters described above which are driving the unacceptable rate of 12 hour wait breaches for Board discussion and escalation. The committee recommends approval of the maternity CNST declaration.
6.	**Report compiled by:**	Dr Louise Sell (Chair of Quality Committee / Non-Executive Director)
7.	**Minutes available from:**	Mrs Soile Curtis (Deputy Company Secretary)

Meeting date	5 February 2026	**Public**	X	**Agenda No**	15
Meeting	Board of Directors				
Report Title	Clinical Negligence Scheme for Trusts (CNST) Year 7 Maternity Incentive Scheme – Board Declaration				
Director Lead	Nic Firth, Chief Nurse	**Author**	Divisional Director of Midwifery & Nursing.		

Paper For:	**Information**		**Assurance**	**Decision**	X
Recommendation:	The Board of Directors is asked to review the Maternity Incentive Scheme Year 7 Report and approve submission of the board declaration form for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 7 by the 3 March 2026 at 12 noon to NHS Resolution (NHSR); noting compliance is demonstrated with ten out of ten safety actions, including three safety actions that require action plans or escalation to Board as part of the submission, which do not impact on achieving full compliance with the ten safety actions.				

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
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

X	Safe		Effective
	Caring		Responsive
	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities

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

Where issues are addressed in the paper

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

Executive Summary

This report details the position of the Trust's maternity service in relation to the 10 Safety Actions we are required to meet as part of the CNST year 7 maternity incentive national scheme.

On review of the standards and in line with the submission requirements of the board assurance framework, the Trust will be compliant with ten out of ten safety actions, noting that compliance for safety action 7 is achieved through Board approved escalation in line with CNST requirements.

This submission is also subject to the approval of action plans in relation to safety actions 5 and 8 which are outlined as appendices within this report.

Evidence demonstrating the necessary sub requirements is collated within a locally shared drive and is overseen as a standing agenda item under 'CNST Year 7' via the divisional governance structure, Patient Safety Group, Quality Committee and Maternity & Perinatal Safety Champions Meeting – with membership including the Non-Executive Director Maternity Safety Champion. The Chief Nurse and Medical Director have oversight of the collated evidence.

Sub sections of evidence supporting Safety Action 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 have also been submitted and discussed with the Local Maternity and Neonatal System and ICB at a joint assurance meeting. Evidence required by the LMNS and ICB has been uploaded and shared via the NHS future platforms.

Further to review at Quality Committee on 27 January 2026, the Board are asked to note the submission, including the action plans contained within the appendices which meets the national requirements.

All the evidence for Safety actions 1 – 10 is listed in Appendix E against each action requirement. Evidence has been made available for the board of directors to review in preparation for the board declaration submission on the 3 March 2026.

Appendices

- Appendix A - Action plan safety action 5d - One to one care in labour
- Appendix B - Action plans safety action 8 – Rotational medical staff MDT training
- Appendix C – Action plan safety action 8 – Rotational medical staff training
- Appendix D - Escalation for safety action 7 - MNVP
- Appendix E - CNST Year 7 Overall action plan and evidence
- Appendix F - CNST Year 7 Board declaration form

Following review of the CNST Year 7 Maternity Incentive Scheme submission and approval of the Board declaration form, the signature of the Chief Executive will be applied to the Board declaration form.

Furthermore, the Chief Executive has ensured that the Accountable Officer (AO) for the Integrated Care System (ICB) is apprised of the Maternity Incentive Scheme safety actions' evidence and Board declaration form requirements. Subject to approval by the Board of Directors, the Trust Board declaration form of compliance for CNST will be submitted to NHS Resolution.

NHS Stockport NHS Foundation Trust

1. Purpose

1.1. The purpose of this report is to update the current position in relation to the Clinical Negligence Scheme for Trusts (CNST) 10 Safety Actions and to present an overview of action plans and escalation in relation to one-to-one care in labour, rotational medical staff MDT training and Maternity and Neonatal Voices Partnership (MNVP) arrangements.

2. Background

Year seven of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to support the delivery of safer maternity care began in April 2024. As in year six, the scheme incentivises 10 maternity safety actions. This year, the 10 actions are similar to previous years but with additional detail under each theme. The MIS applies to all acute trusts that deliver maternity services and are members of the CNST.

In summary annual CNST premium and incentives are detailed below:

Area	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
General	6,830,719	5,852,774	5,613,309	5,969,453	5,669,517	5,865,673	6,658,658	7,464,074	7,448,130
Maternity - standard	3,358,871	2,872,027	4,159,025	5,316,487	6,197,981	7,014,650	7,536,109	6,310,701	7,187,046
Maternity - incentive	335,887	287,203	415,903	531,649	619,798	701,465	753,611	631,070	718,705
	10,525,477	9,012,004	10,188,237	11,817,589	12,487,296	13,581,788	14,948,378	14,405,845	15,353,881
TOTAL CNST	**10,525,477**	**9,012,004**	**10,188,237**	**11,817,589**	**12,487,296**	**13,581,788**	**14,948,378**	**14,405,845**	**15,353,881**
LTPS	177,942	172,694	193,604	170,681	178,108	231,541	208,370	208,370	240,798
PES	36,847	19,620	26,231	33,775	29,990	33,082	39,279	39,279	34,873
GRAND TOTAL	**10,740,266**	**9,204,318**	**10,408,072**	**12,022,045**	**12,695,394**	**13,846,411**	**15,196,027**	**14,653,494**	**15,629,552**

Trusts that can demonstrate they have achieved all the 10 safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet all 10 safety actions will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them make progress against actions they have not achieved.

The financial and safety impact of not meeting CNST standards is significant. Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Provision for the maternity incentive scheme was built into the CNST maternity pricing for 2025/26.

Each of the 10 actions aims to improve safety in maternity and neonatal care by raising the standard of key themes which can affect outcomes in care, including clinical staffing, service user engagement/collaboration, training, incident reporting and investigation and Board level engagement with maternity services. Every

standard is linked to delivering best practice and a high-quality healthcare experience for all women and babies.

The table below demonstrates the Trust's current RAG rated position against the 10 actions: -

Safety Action	Maternity Safety Action	Action Met? (Y/N/Partial)
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

To demonstrate compliance with safety action 5d and 8 the trust is required to have board approved action plans for elements within the actions. There is a total of three action plans for approval.
To demonstrate compliance with safety action 7 the trust is required to have board approved escalation of concerns in relation to non-compliance, in line with national MNVP guidance, which is presented within this paper.

3. **Matters under consideration.**

- **Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?

  5.d One to One care in Labour

  All women in active labour receive one-to-one midwifery care.

  The required standard is to demonstrate 100% compliance for 1:1 care in active labour, due to the definition provided by RCOG the trust will not achieve 1:1 care in active labour due to the requirement to include Born before arrival (BBA). The data is collected monthly on the Maternity dashboard and monthly non-compliance is documented. To be compliant with this an action plan will be submitted as part of the board declaration (Appendix A)

- **Safety action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

  For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.

  To be compliant with this action an action plan will be submitted as part of the board declaration (Appendix B and C)

- **Safety action 7**: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

  1b Strategic influence and decision-making.

  Terms of Reference and evidence of attendance including minutes/action logs that show the Maternity and Neonatal Voice Partnership (MNVP) Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following:
  - *Safety Champion meetings*
  - *Maternity quality and safety meetings*
  - *Neonatal quality and safety meetings*
  - *PMRT review meeting*
  - *Patient safety meeting*
  - *Guideline committees*

As the Trust is currently unable to fully evidence compliance with this requirement, concerns have been formally escalated through Trust governance arrangements and to the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB), declaring non-compliance with Safety Action 7 in line with national MNVP guidance. To meet CNST Year 7 requirements, board-approved escalation of concerns is submitted as part of the Board declaration (Appendix D).
This escalation is presented to the Board for assurance and does not preclude submission of the CNST Year 7 Board declaration.

4. Recommendations

Our current assessment is that the Trust will be fully compliant with ten out of the ten safety actions following approval of action plans in relation to safety action 5 and safety action 8 and escalation of concerns in relation to safety action 7, which are outlined as appendices within this report.

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form (Appendix F) to NHS Resolution by 12 noon on 3 March 2026 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.

- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services

- The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:

    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.

    - There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

3. The Board of directors is recommended to:

- Receive assurance that actions plans are in place against safety action 5 and 8.
- Receive assurance that concerns in relation to safety action 7 have been escalated appropriately.
- Approve that the evidence provided meets the necessary sub requirements to support submission of the Trust Board declaration.
- Approve for the Chief Executive to sign the Trust Board declaration on behalf of the Board of Directors.

Action Plan - CNST YR 7 – Safety action 5 1:1 care in labour

NHS Stockport NHS Foundation Trust

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Sarah McManus/Jane Ingleby
Position:	Inpatient Maternity Matron + Interim Community Matron
Tel:	
Email:	Sarah.mcmanus@stockport.nhs.uk Jane.ingleby@Stockport.nhs.uk
Address:	SHH

Version	Date
1	*01/08/2025*
2	*10/10/2025*
3	*1/12/2025*
4	*5/1/2026*

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

Ref	Standard	Key Themes + Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?** d) All women in active labour receive one-to-one midwifery care. Target 100% **Achieved 2025** April – 96.5% May – 98.6%	**Born Before Arrival (BBA)** • Midwives to discuss signs of labour and ensure all contact numbers are made available Audit of 36 week contact to be completed.	Inpatient and Community midwifery matron	**31/8/25**	All women have should have birth chat at 36/40 where signs of labour are discussed as part of their Personalised care plan. Audit of 36 week contact as part of Personalised care plan audit completed August 2025. Compliance 96% **Action complete**	**4**

	June – 98.4% July – 98.3% August – 99.3% September – 98.6% An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour	• Increase awareness of signs of labour at antenatal education sessions		**1/8/25**	Online education class available to all birthing people to include signs of labour discussion. **Action complete**	**4**
				28/2/26	Pregnancy circles currently in place with additional provision under development following staff training taking. **1/12/25** 4 Cohorts commenced (September 25- Dec 25) 3 of which are completed and had positive feedback, 28 women in total had ANC care through pregnancy circles 2025. There are 18 women planned to attend on 3 new cohorts launching Jan 26- March 26. Two midwives are trained in each Team; more training booked throughout 2026 to increase roll out further.	**3**
		• Raise awareness of BBA's to midwifery team		**31/8/25**	Incident reporting to take place for BBA's and incident reviews undertaken in a timely manner. Discussed at weekly manager meetings for onward cascade at team meetings. **Action complete**	**4**
				31/12/25	Quarterly audit to be shared with all the staff regarding 1:1 care in labour and themes with a specific focus on BBA's **Action complete**	**4**
		• Quarterly audit of 1:1 care in labour compliance to highlight themes and required actions.		**10/12/25**	Quarterly audit to be presented at Women's Health Risk and Governance meeting. **1/12/25** Action completed on time. Due to be presented at Risk and Governance 7/1/26 **Action complete**	**4**

		• Dedicated midwife for telephone triage	Deputy HOM/Triage Manager	**31/3/26**	5-day telephone triage midwife allocated within current triage staffing establishment. For further review following Birthrate plus staffing review (currently in progress) report due February 2026. **5/1/26** Staffing establishment review to take place due to a number of recent changes within the triage workforce. Telephone triage cover 8am-9pm to be considered as part of this review.	**2**
		Fully Dilated on admission • Increase triage staff understanding of identification of signs of labour • Ensure discussion at 36-week contact to ensure women understand the signs of labour.	Inpatient and Community midwifery matron	**29/11/25**	Quarterly report on 1:1 care in labour to be shared with staff at team meetings and huddles for awareness of identified themes. **1/12/2025 Action completed**	**4**
				31/3/26	Telephone triage training package to be introduced for all triage midwives and linked to ESR for compliance monitoring	**2**
				~~30/11/25~~ **31/12/25**	Telephone IVR to be introduced to stream calls to relevant department to increase the connection of emergency calls. Monitored via Maternity Oversight Group. **1/12/25** Delay in implementation due to system issue. Go live date rescheduled for December 31st. **31/12/2025 Action complete**	**4**
		Precipitate labour • Increase awareness of importance of listening to Women and obtaining history of previous labour.	Inpatient and Community midwifery matron	**31/3/26**	Incorporate enhanced session on personalised care and out of guidance on mandatory Fetal monitoring study day. **1/12/25** Updated session content to include BBA due to commence in the new 2026 programme from April 2026.	**3**

Action Plan Sign Off

Name: … …… **Date**: ……

Action Plan – SA 8.5, 8.7 and SA 8.12 compliance MIS Year 7

NHS Stockport

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Suzanne Whitehead for Emma Galsworthy
Position:	PBE Lead Midwife/ Deputy Head of Nursing & Midwifery
Tel:	0161 419 4984
Email:	suzanne.whitehead@stockport.nhs.uk
Address:	M2, Women's Unit, Stepping Hill Hospital

Version	Date
1	*2/10/25*
2	*28/10/25*
3	*26/11/25*
4	*17/12/25*
5	*8/1/26*

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Ref	Standard not met	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
SA 8.7 **SA 8.12**	*For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.*	**Maternity emergencies and multiprofessional training** MIS Year 7 submission due (clause highlighted in blue)	S Whitehead S Hyde E Galsworthy	Submission by board due by 3/3/26	Including data up to 30/11/25	**4**

	Safety Action – 8a Stockport	Increase compliance Obstetricians PROMPT	S Whitehead E Galsworthy L Tomlinson L Barnes O Joseph	30/11/25	**Compliance as of 2/10/25** **PROMPT** = 76% Consultants =81% (13/16) All other Obstetricians prior to 1/7/25=100% (11/11) Rotational Obstetric Drs since 1/7/25=53% (8/15) **Compliance as of 26/11/25** **PROMPT =** 85% Consultants' 93.75% (15/16) All other Obstetricians prior to 1/7/25=10/11=91% (10/11) Rotational Obstetric Drs since 1/7/25=73% (11/15) **Compliance as of 17/12/25** **PROMPT =** 91% Consultants' 100% (16/16) All other Obstetricians prior to 1/7/25=100% (10/10) 1 left the trust Rotational Obstetric Drs since 1/7/25=80% (12/15) **Compliance as of7/1/26** **PROMPT =** 95% Consultants' 100% (16/16) All other Obstetricians prior to 1/7/25=100% (10/10) 1 left the trust Rotational Obstetric Drs since 1/7/25=93% (14/15)	
	Safety Action – 8b Stockport	Increase compliance Anaesthetists PROMPT	S Whitehead E Galsworthy C Ash S Knowles	30/11/25	**Compliance as of 2/10/25** **Overall Anaesthetists PROMPT =**84% Consultants =95% All other Anaesthetists since 1/7/25=93% Rotational Anaesthetists since 1/7/25=54%	**4**

					(6/11) **Compliance as of 26/11/25** **Overall Anaesthetists PROMPT =91.5**% Consultants =95% (19/20) All other Anaesthetists since 1/7/25=100% (14/14) Rotational Anaesthetists since 1/7/25=73% (8/11) **Compliance as of 17/12/25** **Overall Anaesthetists PROMPT =96**% Consultant =95% (20/21) 1 new All other Anaesthetists since 1/7/25=100% (14/14) Rotational Anaesthetists since 1/7/25=92% (12/13) 2 new **Compliance as of 8/1/26** **Overall Anaesthetists PROMPT =96**% Consultant =**95%** (20/21) All other Anaesthetists since 1/7/25=**100%** (14/14) Rotational Anaesthetists since 1/7/25=**92%** (13/13)	
	SA 8.5	All Consultant Obstetricians booked to attend by November 2025	O Joseph L Tomlinson	30/11/25	By 30/11/25 Predicted 16/16 = 100% 26/11/25 Actual 15/16 = 93.75% 8/1/26 16/16 =**100%**	**4**
	SA 8.7	Rotational Obstetricians that commenced in post after July 2025 require a date booked to attend by end January 2026	O Joseph L Tomlinson	30/11/25	By 30/11/25 Predicted compliance 12/15=80% 26/11/25 Actual compliance 11/15 73%, all have dates booked to attend by January 2026	**4**

				31/12/25	17/12/25 Actual compliance 12/15=80%	**4**
				31/1/26	8/1/26 Actual compliance 14/15=**93%** We have 2 new starters and 2 leavers	**4**
	SA 8.12	Anaesthetists Rotational Anaesthetists that commenced in post after July 2025 require a date booked to attend by end of February 2026	C Ash S Knowles	28/2/26	By 30/11/25 Predicted compliance 9/11=82% 26/11/25 Actual compliance 8/11 73%	**4**
					17/12/25 Actual compliance 12/13=92%, all have attended or have a date booked to attend including 2 new starters 8/1/26 13/13 =**100%**	**4**

Action Plan Sign Off

Name: … …… **Date**: …15/01/2026……

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30/01/2026 12:41:34

Action Plan – SA 8.1 and SA 8.3 compliance MIS Year 7

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Suzanne Whitehead for Emma Galsworthy
Position:	PBE Lead Midwife/ Deputy Head of Nursing & Midwifery
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2	*26/11/25*
3	*17/12/25*
4	*9/1/26*

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4	All actions completed and good supporting evidence provided

Ref	Standard not met	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-	**Fetal monitoring and surveillance (in the antenatal and intrapartum period) training** MIS Year 7 submission due (clause highlighted in blue)	S Whitehead S Hyde E Galsworthy	Submission by board due by 3/3/26	Including data up to 30/11/25	

	month period from their start-date with the Trust.					
	Safety Action – 8 Stockport	Increase compliance Obstetricians Fetal monitoring	S Whitehead E Galsworthy L Tomlinson L Barnes O Joseph S Young	30/11/25	**Compliance as of 15/10/25** **Overall Fetal Monitoring=** 79% Consultants =81%, (13/16) All other Obstetric Drs prior to 1/7/25= 100% (11/11) Rotational Obstetric Drs since 1/7/25=37% (3/8) **Compliance as of 26/11/25** **Overall Fetal Monitoring=** 85% Consultants =100%, (16/16) All other Obstetric Drs prior to 1/7/25= 100% (11/11) Rotational Obstetric Drs since 1/7/25=37.5% (3/8) Strike action affected attendance at November's training, all staff rebooked to attend. **Compliance as of 27/12/25** **Overall Fetal Monitoring=** 94% Consultants =100%, (16/16) All other Obstetric Drs prior to 1/7/25= 100% (10/10) 1 has left Rotational Obstetric Drs since 1/7/25=75% (6/8)	
	SA 8.1	3 Consultants to be booked to attend November 2025	O Joseph L Tomlinson	30/11/25	Booked November 2025 Predicted compliance 16/16 = 100% 26/11/25 actual compliance 16/16 =100% 17/12/25 Compliance **100%**	

	SA 8.3	5 Rotational Obstetricians to be booked to attend 2026 (within 6 months of start date)	O Joseph L Tomlinson	30/11/25	Booked November 2025 Predicted compliance 5/8 = 62.5% 26/11/25 actual compliance 3/8 =37.5% Strike action affected attendance at November's training, all staff rebooked to attend. 18/12/25 Booked December 2025 Predicted compliance 7/8 = 87.5%, 17/12/25 actual compliance 6/8 =75%	
	SA 8.3	2 Rotational Obstetricians to be booked to attend by 12/2/26	O Joseph L Tomlinson	31/1/26	9/1/26 x2 booked January 2026 Predicted compliance 7/8 = 87.5%, DNA x1 resulting in actual compliance 6/8= 75% X2 re-booked for February 12th Predicted compliance 8/8 =100%	

Action Plan Sign Off

Name: … …… **Date**: ……

Escalation to LMNS/ ICB: Maternity Incentive Scheme Safety Action 7 – Year 7

Trust Name: Stockport NHS Foundation Trust

Reporting Period: Year 7

Submitted By: Sharon Hyde, Divisional Director of Midwifery and Nursing

Safety Action 7 – Required standard

Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

a) Infrastructure
b) Strategic influence and decision-making.
c) Engagement and listening to families.

If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.

This document formally escalates concerns to the Local Maternity and Neonatal System (LMNS) and Greater Manchester Integrated Care Board (ICB), declaring that our Trust is currently not compliant with Safety Action 7, as outlined in the Maternity and Neonatal Voice Partnership (MNVP) guidance.

As the required MNVP infrastructure is not commissioned and/or not functioning as per national guidance, we confirm that this issue has been escalated through the appropriate channel at trust level.

Escalation Level	Evidence of Escalation	Date of Escalation	Additional Information - including reason for escalation
Trust Level	Yes – Minutes of Trust Board will be included as evidence of escalation. However will not be available until next Trust Board (4 December 2025)	02/10/2025	The service escalated to Trust Board that evidence for 1b is not fully compliant as the division/directorate do not currently have all 6 meetings in place as outlined in SA7 minimum evidence. The service do not currently have specific maternity Patient Safety meeting or Guideline committee meetings within speciality. These are Trust wide and as such

			MNVP would not be part of the TOR or attend these meetings. The MNVP LEAD has not yet completed PMRT training so do not currently participate in the meetings.

I confirm that the information provided above is accurate and reflects the current status of Safety Action 7 compliance within our Trust.

Please send back to gmec.lmns@nhs.net by: Monday 13th October 2025 to ensure the LMNS reaches deadlines for paper submissions.

Name: **Sharon Hyde**

Role: **Divisional Director of Midwifery and Nursing**

Signature:

SHyde.

Date: **1/10/2025**

Please see below details of the route and time of escalation to the Northwest Regional Team LMNS and ICB. Minutes from these meeting will be shared on Futures. Link to the file here:

Escalation Level	Date of Meeting	Embedded Minutes as evidence of escalation
Northwest Regional Perinatal Surveillance Group	5 November 2025	
GM ICB Quality Performance Committee	5th November 2025	

Maternity & Neonatal System Group (LMNS)	11 November 2025	

Action ID	Specific action to be implemented	Action Owner	Target date	RAG	Comments	Evidence
Deadline for submission to NHS Resolution by 3rd March 2026						
Safety Action 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?						
SA1 a	All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	N Kempson	01/12/2024 - 30/11/2025		Notifications must be made, and surveillance forms completed using the MBRRACE-UK. The PMRT must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**Evidence to support SA1 a,b,c + d - All required evidence submitted within the qualifying time period** - Q4 PMRT quarterly report for reporting period January 2025 - March 2025 - Q1 PMRT quarterly report for reporting period April 2025 - June 2025 - Q2 PMRT quarterly report for reporting period July 2025 - Sept 2025 - Perinatal Quality Report May 2025 - Perinatal Quality Report Q1 2025 - Perinatal Quality Report Q2 2025
SA1 b	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 1st December 2024 onwards.	N Kempson	01/12/2024 - 30/11/2025			As above
SA1 c	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 1st December 2024. 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT	N Kempson	01/12/2024 - 30/11/2025			As above
SA1 d	Quarterly reports should be discussed with the Trust Maternity and Board level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.	N Kempson/ E Galsworthy	01/12/2024 - 30/11/2025			**Evidence to support SA1 d** - Quality Committee agenda and minutes including Perinatal Quality Report for March, May, September, November 2025
Safety Action 2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?						
SA2 1	July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accomnpanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).	Steph Bray	01/07/2025 - 31/07/2025		The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.	**Evidence to support SA2 1 & 2** **All required evidence submitted within the qualifying time period** **-** MSDS July data summary and compliance - Evidence also availible at Microsoft Power BI
SA2 2	July 2025 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101)	Steph Bray	01/07/2025 - 31/07/2025			Same as above
Safety Action 3 Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies?						
SA3 a	Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM transitional Crae Framework for Practice. Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignement with the British Association of Perinatal Medicine (BAPM) Transitional Framework for Practice and submit this to your trust and the Neonatal Operational Delivery Neetwork (ODN) on behalf of the LMNS board.	R Whittington	02/04/2025 - 30/11/2025		Evidence for standard a) to include: Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04.	**Evidence to support SA 3 a - All required evidence submitted within the qualifying time period** - Minimising separation of Mothers and Babies including the provision of Transitional care guideline
SA3 b	Drawing on the insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safey Champions and LMNS.	R Whittington	02/04/2025 - 30/11/2025		By 2nd September 2025, register the QI project with the local Trust quality/service improvement team and by the end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress.	**Evidence to support SA 3 b - All required evidence submitted within the qualifying time period** - Presentation-Enhancing continuity; a quality improvement project on transitional care service. -ATAIN report Q1 2025 - Maternity Safety Champions Agenda and minutes October 2025 -Transitional care/ATAIN GM working Group meeting agenda and minutes November 2025
Safety Action 4 Can you demonstrate an effective system of clinical workforce planning to the required standard?						

SA4 a 1) a,b,c	**Obstetric medical workforce** 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 an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	Kelly Curtis/Lucy Tomlinson	02/04/2025 - 30/11/2025		Trusts/organisations should audit their compliance via Medical Human Resources.	**SA4 a 1) a,b,c All required evidence submitted within the qualifying time period** **-** Audit O&G Locums 01/02/25-31/08/25 – criteria met action plan not required.
SA4 a2	**Obstetric medical workforce** Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS Board.	Kelly Curtis/Lucy Tomlinson	02/04/2025 - 30/11/2025		Trusts/organisations should ensure they are compliant with the engagement of long-term locums using the monitoring effectiveness tool contained within the RCOG guidance document	Same as above
SA4 a3	**Obstetric medical workforce** Trusts/organisations shouldbe working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **Whilst this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**	Kelly Curtis/Lucy Tomlinson	02/04/2025 - 30/11/2025		Trusts/organisations should be working towards developing provide standard operating procedures to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.	**SA 4 a) Point 3** - Working Time Regulations Policy (Trust wide policy) - Evidence of compensatory rest allocation
SA4 a4	**Obstetric medical workforce** Trusts/organisations should ensure they are compliant with consultant attendance in person for the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicvable situations: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service	Kelly Curtis/Lucy Tomlinson	02/04/2025 - 30/11/2025		Trusts' positions with the requirement should be shared with Trust Board, the Board-level safety champions as well as the LMNS	**SA 4 a) Point 4** - Labour Ward consultant duties and responsibilities policy - Consultant presence audit Jan 2025 – April 2025
SA4 b	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Charlotte Ash	02/04/2025 - 30/11/2025		The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota	**SA4 b)** - Anaesthetic rota September 2025 submitted as evidence.
SA4 c	**Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Rachael Whittington	02/04/2025 - 30/11/2025		The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**SA 4 c)** - Neonatal Medical Workforce action plan 2024 completed - Quality Committee perinatal Quality Report May, Q1, Q2 2025 -Quality Committee agenda and minutes May, September, November 2025
SA4 d	**Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards or The standardsare not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Rachael Whittington	02/04/2025 - 30/11/2025		The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**SA4 d)** - NWNNODN return Q1 and Q2 2025
Safety Action 5 Can you demonstrate an effective system of midwifery workforce planning to the required standard?						

SA5 a	A systematic, evidence-based process to calculate midwifery staffing establishment is completed. If this process has not been completd within 3 years due to measures outside your Trust's control, evidence of communication with the BirtRate+ organisation (or equivalent) should demonstrate this.	S Hyde	02/04/2025 - 30/11/2025		The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. It should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.	**SA5 a)** - Birth Rate + final report received March 2023
SA5 b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	S Hyde	02/04/2025 - 30/11/2025			**SA5 b)** - Maternity staffing powerpoint presentation to exec team June 2025 - Bi-Annual Midwifery workforce paper April-September 2025 - Perinatal Quality Report Q1 and Q2 - PPC committee agenda and minutes November 2025
SA5 c	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a roster planned supermumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be in place and must include the process for providing a substitute co-ordinator in situations where there in no co-ordinator available at the start of the shift.	S Hyde	02/04/2025 - 30/11/2025			**SA5 c)** - Bi-Annual Midwifery workforce paper April-September 2025 - Perinatal Quality Report Q1 and Q2 - Manager of the day SOP - Manager of the Day escalation SOP
SA5 d	All women in active labour receive one-to-one midwifery care	S Hyde	02/04/2025 - 30/11/2025			**SA5 d)** As above plus: - Care in labour action plan - Quality Committee front sheet November 2025
SA5 e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every 6 months(in line with NICE midwifery staffing guidance) during the maternity incentive scheme year six reporting period.	S Hyde	02/04/2025 - 30/11/2025			**SA5 e)** - Maternity staffing powerpoint presentation to exec team June 2025 - Bi-Annual Midwifery workforce paper April-September 2025 - Perinatal Quality Report Q1 and Q2 - PPC committee agenda and minutes November 2025
Safety Action 6 Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives care bundle version three?						
SA6	Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB	Sally Meats	02/04/2025 - 30/11/2025		Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.	**SA6 1)** - All evidence to support safety action 6 submitted to the LMNS and ICB. Compliance for CNST across all 6 elements of SBLv3 for CNST met. All evidence recorded on the GMEC SBL Assurances NHS Futures Platform. -Compliance confidence form received from the LMNS. Quarterly meetings held June 2025 and September 2025 with the LMNS and ICB.
Safety Action 7 Listen to women, parents and families using maternity and neonatal services and coproduce services with users						

SA7 1	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure.	S Hyde/ E Galsworthy	02/04/2025 - 30/11/2025		a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan. b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such as: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare costs.	**SA7 1 a,b,c** **-** MNVP vfc grant agreement - MNVP JD - LMNS escalation form -Maternity Safety Champions TOR -Paediatric and Neonatal Risk and Governance TOR -Women's and Children's Risk and Governance TOR -Continuity of Care team evaluation -Brinnington weekly drop in engagement/PCSP -PCSP feedback
SA7 2	Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	E Galsworthy	02/04/2025 - 30/11/2025		Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.xpenses and childcare costs.	**SA7 2)** - CQC Maternity survey action plan 2024/25 signed off - CQC Maternity survey action plan 2025/26 in progress - Minutes and Agenda's Maternity and Perinatal Safety Champions August and October 2025
Safety Action 8 Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?						
SA8	90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. For rotational medical staff that commenced work on or after 1st July 2025 a lower compliance will be accepted. A committment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start date with the trust. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.	S Whitehead/Kelly Curtis	01/12/2024 - 30/11/2025		See technical guidance	**SA8 All evidence submitted in the required time period with the exception of the Rotational Doctors action plans which will contue monitoring via Maternity Safety Champions** -CNST compliance overall RAG rating November 2025 **-** Copy of GMEC core competancy Framework v2 with embedded training plans submitted and approved - TNA update 30 November 2025 - Simulation evidence for NNR, Baby abduction and PPH in pool - Rotational medical staff action plan 8.1 & 8.3 - Rotational medical staff action plan 8.5, 8.7 & 8.12
Safety Action 9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?						
SA9 a	All Trust requirements of the PQSM must be fully embedded with evidence of Trusts working towards the revised Perinatal Oversight Model (PQOM) 2025	S Hyde/ E Galsworthy	02/04/2025 - 30/11/2025		Evidence for point a) and b) • Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. • Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. • Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. • Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024. • Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a	**SA9 a)** - Quality Committee Perinatal Quality Report May, Q1, Q2 2025 - Quality Committee agenda and minutes May, September, November 2025 - Evidence provided for staff engagement initiatives in place such as Maternity Mythbusters, Observation outlet, Bee Positive - Annual PMRT presentation - Recruitment and Retention newsletters - NHS Scorecard 2023-2024 open claims paper - Maternity Safety Champions-Maternity Score card paper 2014-2024 - Maternity Safety Champions-Maternity Score card paper 2015-2025 - Maternity Safety Champions agenda and minutes August and October 2025

SA9 b	The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings	S Hyde/ E Galsworthy	02/04/2025 - 30/11/2025			**SA9 b)** **-** Quality Committee Perinatal Quality Report May, Q1, Q2 2025 - Quality Committee agenda and minutes May, September, November 2025 - Safety SIG Reports April, May, June,July, August,October and November - BBA presentation shared at LMNS safety event May 2025
SA9 c	All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.	S Hyde/ E Galsworthy	02/04/2025 - 30/11/2025		Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include: • Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. • Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented	**SA9 c)** - Maternity and Perinatal Safety Champions Meeting agenda and minutes •May 2025 •July 2025 •August 2025 .October 2025 - Perinatal Score Survey action plan
Safety Action 10 Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?						
SA10 a	Reporting of all qualifying cases to HSIB/CQC//MNSI from 1 December 2024 to 30 November 2025.	Rebecca Barker	02/04/2025 - 30/11/2025		Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour	**SA10 a, b + c** All qualifying MNSI and EN are reported and shared through the serious incident review group and through the divisional governance reporting structure. The reports and outcomes are shared through quality committee. - Perinatal Quality Report May, Q1 and Q2
SA10 b	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025.	Rebecca Barker	02/04/2025 - 30/11/2025			Same as above
SA10 c	For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. Minimum Evidence Requirement for Trust Board.	Rebecca Barker	02/04/2025 - 30/11/2025			Same as above

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Stockport NHS Foundation Trust**
Trust Code	**T572**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.
Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	Yes
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	N/A
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	N/A

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They 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 Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
12	Was the above action plan shared with the LMNS?	N/A
13	Was the above action plan shared with the Neonatal ODN?	N/A
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Yes
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
17	Was the above action plan shared with the LMNS?	N/A
18	Was the above action plan shared with the Neonatal ODN?	N/A

Return to Guidance Sheet

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	No
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	Yes

Return to Guidance Sheet

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

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Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	No
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes

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Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	N/A
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	N/A
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

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Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

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Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

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Section A : Maternity safety actions - Stockport NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

NHS Resolution

Section B : Action plan details for Stockport NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Stockport NHS Foundation Trust**
Trust code	**T572**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Stockport NHS Foundation Trust
Name:	
Position:	
Date:	

Curtis Sutton 30/01/2026 12:11:34

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Stockport NHS Foundation Trust
Name:	
Position:	
Date:	

Stockport
NHS Foundation Trust

Stockport NHS Foundation Trust
Stepping Hill hospital
Poplar Grove
Stockport

SK2 7JE

Sent via email

5 February 2026

To: GM ICB Chief Executive

Re: Confirmation of CNST Declaration sign off by Stockport NHS Foundation Trust Board

Dear Sirs,

On behalf of Stockport NHS Foundation Trust, I would like to confirm that the Maternity CNST Year 7 evidence has been shared with our Trust Board on 5 February 2026 via a joint presentation with the Head/Director of Midwifery and Obstetric Clinical Director. The Trust Board are satisfied that the evidence presented reflects the position documented in the CNST Year 7 Declaration Form.

The Trust Board confirms that:

- The evidence provided to demonstrate compliance with/achievement of the maternity safety actions meet standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
- The content of the Declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- There are no reports covering either this year (2025/26) or the previous financial year (2024/25) that relate to the provision of maternity services that may subsequently provide conflicting information.

The Board are assured and have given their permission to me, as CEO of Stockport NHS Foundation Trust for the Board Declaration Form to be signed prior to submission to NHS Resolution. I am therefore assured that the required process has been followed and that our position is reflected in the declaration form. I enclose the completed declaration form for your signature to enable the submission to NHS Resolutions.

Yours faithfully,

[*insert name and job title*]

c.c: GM LMNS gmec.lmns@nhs.net

NHS Stockport NHS Foundation Trust

				Agenda No.	16
Meeting date	5 February 2026	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	People Performance Committee – Alert, Advise & Assure Report				
Director Lead	David Curtis, Chair of People Performance Committee	**Author**	David Curtis, 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 January 2026, 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 (Committee Chair)
Date of Meeting	8 January 2026
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 • Organisational Development Plan • Joint Equality, Diversity & Inclusion Strategy Divisional Objectives • Improving Resident Doctors Working Lives • Employee Relations & Exclusions Activity • GMC Annual National Trainee Survey • Temporary Staffing • Safer Care (Staffing) Report • 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: • Sickness absence – Increased in November and is above target at 6.56% (target: 5.50%) • Appraisals – Overall appraisal compliance in November was 90.58%, an increase from 89.85% in October (target: 95%) Ongoing improvement actions relating to the above metrics were acknowledged. The Committee received a report detailing divisional Equality, Diversity & Inclusion (EDI) objectives, which would be incorporated into the final EDI Strategy. The Committee received two reports relating to resident doctors: an update on progress being made against NHS England's 10 Point Plan to improve working conditions for resident doctors and the outcome of the General Medical Council (GMC) Annual Trainee Survey. While it was recognised that positive progress has been made, the Committee acknowledged that further work was required and consequently resident doctor representatives would be invited to present directly to the Committee to provide first-hand insight. The Committee received a Temporary Staffing Report providing an update on bank and agency usage, compliance with NHS England agency rules and actions

		being taken to support the reduction in bank and agency usage. The Committee acknowledged positive performance across most indicators, particularly agency spend reduction and improved compliance, however bank usage was noted being off target. 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 agreed to seek clearer evidence of return on investment to demonstrate the impact of pastoral initiatives beyond qualitative benefits. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2025/26 to the Board of Directors in February 2026.
4.	**Assure**	Positive assurance received around the following People metrics: • Time to hire, which measures the time between vacancy authorisation to start date booked, decreased in November to 51.6 days from 54 in October, and meets the overall Trust target of 57 days. • Mandatory training compliance at 96.70%, which is above target of 95%. • Turnover (adjusted) remains compliant at 9.54% and is below target of 11.5%. Positive assurance was provided in relation to the Organisational Development (OD) Plan, with acknowledgement of ongoing work to more holistically determine return on investment and value for money from OD activity.
5.	**Referral of Matters/Action to Board/Committee**	No matters to refer to the Board or other Committees.
6.	**Report compiled by:**	**David Curtis, Non-Executive Director**
7.	**Minutes available from:**	**Soile Curtis, Deputy Company Secretary**

Meeting date	5 February 2026	**Public**	✓	**Agenda No.**	17
Meeting	Board of Directors				
Report Title	People & Organisational Development Plan Update				
Director Lead	Amanda Bromley, Director of People & OD	**Author**	Lisa Gammack – Deputy Director of OD		

Paper For:	**Information**		**Assurance**	✓	**Decision**	
Recommendation:	The Board is requested to formally note and endorse the report's key insights, which provide assurance and support informed strategic oversight.					

This paper relates to the following Annual Corporate Objectives

x	1	Deliver personalised, safe, and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented, and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation, and transformation
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
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'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
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 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	All
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	3.3
Sustainability (including environmental impacts)	N/A

Executive Summary

This report provides the Board of Directors with assurance on progress made against the Trust's People and Organisational Development (OD) priorities since the last update in August 2025. It highlights positive performance trends, key achievements, areas requiring continued focus, and alignment with national workforce priorities. Overall, the Trust continues to make steady progress despite operational and financial pressures, with early indicators of improvement across several people metrics and strategic workforce initiatives.

Key Highlights

- **Workforce Performance**
  - Turnover reduced to 9.86%, within Trust target and a decrease from 10.57% in June 2025.
  - Agency spend at 1.41% of total pay – remaining below the national threshold of 1.5% and fully compliant with off-framework and Band 2/3 zero-usage requirements.
  - Bank spend at 8.09% of pay – above target but within the annual ceiling, reflecting a 14% reduction on the 2024/25 run rate, outperforming NHS England expectations.
  - Sickness absence at 6.74% in December 2025, consistent with seasonal winter rises; trajectory suggests a return toward target as seasonal pressures ease.
- **Progress Against Strategic Priorities:**
  - Organisational Development: All OD actions due by January 2026 are completed or underway, including expansion of the C.A.R.E. Leadership Way, new development offers, and the development of a talent management and succession planning approach.
  - Civility and Sexual Safety: Over 3,400 colleagues trained in civility interventions, with strong progress against national sexual safety standards.
  - Career Progression & EDI: Launch of the Elevate with C.A.R.E. BAME Leadership Programme; strengthened joint staff networks; Board-approved Joint Workforce EDI Strategy 2026-29 now in implementation.

- Place-Based Programmes: Hosting a T-Level Industry Placement Coordinator, positioning Stockport as a system leader in early workforce development.
- Achieved NHS England Gold Award for work experience.
- Collaboration: Significant progress in joint working with SFT, including shared policies, workforce information development, and leadership alignment across POD teams.

- **Recruitment & Retention**
  - Time to Hire reduced to 54 days, under the target by 3 days.
  - Enhanced exit interview process in place to improve insight into reasons for leaving.

Next Steps

- Sustain and accelerate efforts to reduce temporary staffing expenditure, with particular focus on achieving national bank spend targets.
- Maintain progress towards the sickness absence target through strengthened case management and support for long-term absence.
- Embed and expand leadership development, succession planning, and career progression framework, ensuring a strong pipeline of future leaders.
- Deliver year one priorities within the Joint Workforce EDI Strategy 2026-29, reporting progress to the new Joint People Committee.
- Develop the next phase of the People & OD Plan for 2026 onwards, ensuring alignment with new national workforce directives and local operational needs.

1. Introduction

1.1 This report provides assurance to the Board of Directors on the progress made in delivering the People and Organisational Development (OD) priorities. It builds on the update presented in August 2025, offering continued oversight of delivery against our strategic workforce objectives.

2. Impact

2.1 We remain committed to our improvement journey, with ambitious goals in a complex environment. Monitoring progress against key people metrics remains essential.

2.2 We continue to see early signs of positive change and will closely track performance, applying mitigations as needed.

2.2.1 People Key Performance Targets:

As outlined in the previous report to the Board, new workforce expenditure targets have been introduced through the NHS Operating Plan 2025/26, including revisions to existing benchmarks. Providers are expected to reduce agency spend by 30% and bank spend by 10%, with the lowest-performing Trusts required to achieve reductions of 40% and 15%, respectively. SFT has been set a target of a 30% reduction in agency spend and 10% in bank spend.

To support monitoring, the national Temporary Staffing Efficiency Team has updated its metrics:

- Agency spend ≤ 1.5% of total pay bill (national target)
- Bank spend ≤ 6.2% of total pay bill (national target)
- £0 off-framework spend for non-'break glass' usage (provider target)
- 80% compliance with price caps for Agenda for Change roles (national target)
- £0 Band 2 & 3 agency spend for non-'break glass' usage (provider target)

2.2.2 People Key Performance Indicators:

- The annualised (adjusted) turnover rate decreased to 9.86% in December 2025, down from 10.57% in June 2025.
- Agency spend remains below the 1.5% target at 1.41% of total pay in December 2025. We continue to meet the requirements for zero off-framework and Band 2/3 agency usage.
- There has been an increase in the proportion of bank spend of 0.12 to 8.09% of the total pay bill, however, bank spend is in line with the ceiling at £2.6M, a reduction of 14% on 2024/25 run rate (better than NHSE's target of 10%).
- The sickness rate in December 2025 increased by 0.34%, rising to 6.74%, which is 1.24% above the Trust target of 5.5%. This increase is consistent with the seasonal rise in sickness levels typically seen during winter, when respiratory infections, Gastro, Flu, and other winter illnesses are more prevalent. Assuming the sickness patterns remain consistent with previous years and a return to average sickness rates, the Trust is on trajectory to achieve the rolling 12m target.

3. Progress Update

3.1 The following section of this report provides an overview of progress achieved to date against each priority area, this has been summarised 'at a glance' in the table below:

Strategic Priority		Key Area of Focus	Current Status
1.	**Organisational Development**	Board & Executive team development	On-going (BAU)
		Leadership & management development	On-going (BAU)
		Civility & sexual safety programmes	On track
		Onboarding	Completed
		Coaching & mentoring	On-going (BAU)
		Talent management & succession planning	On track
		Career progression	On track
2.		Career progression opportunities for BAME staff	On track

	Equality Diversity & Inclusion	Review of recruitment process to reduce/remove barriers	On track
		Review of disciplinary progress to reduce likelihood of BME staff entering formal process	On track
		Improving the way in which staff networks work	On-going (BAU)
		Disability – improvement of metrics & handling of workplace adjustments	On track
		Career progression opportunities for disabled staff	On track
3.	**Place Based Programmes**	Attracting the local population, partnership working as part of the One Stockport Programme	On track
4.	**Collaboration**	Continue to look at opportunities to collaborate e.g. Knowledge & Library Services (KLS), Resus Faculty, etc.	Completed
		Commence work with Payroll	Completed
		Continue with Occupational Health collaboration programme of work	Completed
		Pilot shared recruitment service	Completed
		Pilot shared workforce information service	On track
5.	**Medical Staffing / Agency Expenditure**	Review opportunities for increased grip/control to reduce expenditure	On track
6.	**Sickness Absence**	Development and implementation of person-centred absence management and wellbeing policy & approach. Reduce sickness absence.	On track

3.2 Organisational Development

Delivery of the OD Plan remains challenging due to ongoing operational pressures. shifting priorities and limited OD expertise and capacity. Nonetheless, all actions scheduled for completion by January 2026 are either completed or underway.

The People Performance Committee received a comprehensive update on the delivery of the OD work programme in January 2026. The following provides a high-level summary to offer assurance to the Board on progress to date:

3.2.1 Leadership and Management Development

We have continued to enhance the leadership and management development offer to improve organisational performance and culture. Between August 2025 and January 2026 we:

- Publicised our C.A.R.E. Leadership Way offer and launched a SharePoint hub consolidating development sessions, tools, diagnostics and resources. Resources are aligned to the NHS Expectations for Line Managers, and the draft NHS Leadership and Management Framework, expected to be published in February 2026.
- Created a 'learning owners' network for colleagues who have responsibility for designing different elements of the C.A.R.E. Leadership Way offer. This enables consistent messaging and feedback mechanisms, as well as a community of practice for developers to enhance the overall learning offer.
- Introduced a C.A.R.E. Leadership Way self-assessment to support leaders to identify priority development needs, and the C.A.R.E. Leadership Way introductory workshop to support leaders to embed our core values into their day-to-day practice. This is for both existing and aspiring leaders, with new line managers. This is alongside a new Leaders and Managers Welcome Kit which will be available from February 2026.
- Introduced new development such as Engaging Your Team sessions to strengthen everyday leadership practices aligned to the C.A.R.E. values, an on-demand AI in Everyday Leadership webinar and a curated leadership booklist through our Knowledge and Library Services.

- Co-ordinated five cohorts (involving 72 leaders) of our multi-disciplinary Leading with Impact Programme (Band 8A–8D). The programme has been aligned to the C.A.R.E. Leadership Way approach, enhancing the underpinning elements of emotional intelligence, EDI and taking a coaching approach. During the first cohort's end of programme celebration, leaders shared how they had applied compassionate, inclusive approaches and evidence-based tools to improve psychological safety, communication and team wellbeing in their practice. Participants reported increased confidence, self-awareness and influence, translating their leadership learning into service impact.

3.2.2 Civility and Sexual Safety Programmes

The second phase of the Trust's Civility Saves Lives (CSL) Programme, *Having the Conversation*, is now well underway, with 3479 colleagues having completed the programme and a further 1631 booked. This practical session aims to equip staff with the tools and techniques to have conversations to tackle incivility in the workplace. This is supported by a new, practical guide for managers as part of the *People Management Excellence* strand of the *C.A.R.E. Leadership Way,* that helps managers apply the principles in line with our values including examples of internal good practice.

We have completed our gap analysis against the sexual safety standards and are working towards meeting all of the gaps in the standards, with progress being reported through the Health and Safety Group.

We are currently reviewing all communications relating to unwanted behaviours and planning to enhance the promotion of both the dedicated webpage and the anonymous reporting form.

As part of our ongoing support offer, the Survivors Network has delivered 25 training sessions during November 2025 for staff across both Trusts. In addition, sexual safety training is available to all staff via ESR. However, uptake of the ESR module has been lower due to the focus on and active promotion of the Survivors Network sessions.

As we refresh our communication plan, we will ensure stronger promotion of the ESR sexual safety training to encourage increased completion rates alongside the continued availability of the Survivors Network sessions.

3.2.3 Talent Management and Succession Planning

An inclusive framework for talent management and succession planning has been developed for use across TGICFT and SFT. The initial phase of this involves agreeing and implementing a co-ordinated approach to talent conversations towards deputy-level roles across both Trusts. This aims to strengthen operational resilience by ensuring robust backfill arrangements, identifying talent pools for development that can make the most of the NWLA offer as well as opportunities within both Trusts, and clarifying the skills and experiences needed to prepare future deputy leaders. Structured job analysis conversations with current post-holders will help define success factors and development opportunities, supported by a job role succession planning template. These conversations will be handled sensitively, acknowledging the current financial climate while reinforcing the long-term strategic intent of this work.

The outcomes of these conversations will enable us to calibrate findings across both organisations to identify shared development themes and opportunities for coordinated support. Career conversations with potential successors will be embedded into appraisal and development planning processes. This will give the opportunity to make the most of cross-site secondments and development opportunities to enhance retention and broaden experience. The approach will have in-built flexibility to acknowledge that, as our system evolves, the skills required for future leadership will shift.

A detailed proposal will be presented to the Joint Executive Management Team in February – it will include a plan to complete phase one in March ahead of the 2026 appraisal window.

3.2.4 Career Progression

The Career Progression Task Group continues to maximise data insights to drive initiatives aligned with the Trust's EDI priorities. Since July 2026 progress includes:

- Designing and launching the new *Elevate with C.A.R.E. BAME Leadership Programme* for Band 5-6 staff. This is a bespoke joint-Trust development offer designed to strengthen the Band 7–9 leadership pipeline by addressing systemic barriers and improving confidence, visibility and progression for BAME colleagues. The programme is a key deliverable within the new Joint

Workforce EDI Strategy 2026-29. The application window is currently open, and 20 participants will start the pilot programme in March 2026.

- Launching a new pilot mentoring scheme for newly appointed Band 7 and 8A midwifery staff across both Trusts, supported by experienced Band 7+ mentors. The aim is to support the transition into senior roles by strengthening leadership, clinical decision-making and overall professional confidence. The scheme aims to boost retention, morale and continuous learning through structured mentoring, knowledge transfer and succession planning. Early evaluation from April 2026 will identify whether the scheme should be extended across both organisations.
- Extending the staff networks with the introduction of a Women's Network launching in March 2026, following International Women's Day on 8 March.

The OD Service continues to support divisions/directorates with the recruitment and hosting of NHS graduate management trainees. One of the graduate trainees is currently working within the OD Service, supporting the Career Progression Task Group priorities. In addition to the three trainees reported in August 2025, two additional trainees started in Health Informatics in September 2025.

3.3 Equality Diversity and Inclusion

Over the past six months, we have maintained a strong strategic focus on delivering the Trust's consolidated EDI Action Plan. This has resulted in measurable progress across key priority areas, reinforcing our commitment to fostering an inclusive and equitable organisational culture. Key achievements over the last six months include:

- Career Progression Initiatives: The Collaborative Career Progression Task Group has developed targeted interventions to address barriers to career progression, as outlined in section 3.2.4 of this report.
- Strengthening Staff Networks: We have combined networks across SFT and TGICFT and now have a Joint Race Inclusion Support Equity (RISE) Staff Network, Joint Disability & Wellbeing Network, Joint LGBTQ+ Staff Network and Joint Carers Network. The aim is to enhance collaboration, amplify staff voices, and deliver a more strategic and unified approach to inclusion. We have assigned a People & OD senior manager to each joint network to act as their 'buddy' and help drive forward the network's agenda and increase the impact of the networks, alongside the Board sponsor's support.

  We have established a new Neurodiversity Staff Network at TGICFT, initially supported by the Chair of SFT's Neurodiversity Staff Network. For now, the two networks will operate separately to reflect their differing stages of development and membership levels. As TGICFT's network grows, our intention is to explore the potential for bringing the two networks together.
- Strategy Development: In December 2025 the Board approved the new Joint Workforce EDI Strategy 2026-29. Subsequently the People Performance Committee approved the divisional EDI objectives in January 2026. The Board will receive an update on the progress of year one of the new joint strategy in February 2027 and in the interim the Joint People Committee will receive updates via the statutory EDI monitoring reports.

3.4 Place Based Programmes

Planning and delivering a workforce that is fit for the future is intrinsically complex, particularly in the context of rapid technological advancement and the evolving nature of healthcare roles and skills. Through strong collaboration across the Integrated Care System (ICS) we continue to co-develop and influence education curricula and training programmes to ensure our workforce has the right skills, at the right time, and in the right place.

We have established and continue to strengthen strategic partnerships with Stockport Metropolitan Borough Council (SMBC), the Trafford and Stockport College Group, UCEN Manchester, The Manchester College, the Department for Work and Pensions, The King's Trust, and a range of voluntary and community sector organisations. These partnerships support people from across our communities to access careers within health and care reinforcing our role as an anchor institution within Stockport.

We have successfully supported internal career progression through well-established pathways, including the Nursing Associate to Registered Nurse apprenticeship route and a range of Allied Health

Professional apprenticeship programmes. These pathways are designed to enable colleagues to progress into registered roles supporting workforce retention, improving skills sustainability, and creating progression opportunities for local people.

Our widening participation programmes continue to focus on improving access to healthcare careers for those from some of our most deprived and under-represented communities in Stockport. This includes targeted support for Pre-employment programmes; Care Leavers, Young people not in education, employment or training (NEET) and learners through, Pure Innovations supported internships and Cadet and T-Level pathways.

These programmes are designed to remove barriers to entry into health and social care, improve social mobility, and build a workforce that better reflects the diverse communities we serve.

Following the success of our Cadet and T-Level programmes, NHS Greater Manchester invited us to partner in a joint national bid. As a result, we were successfully awarded one of only seven national posts to host a T-Level Industry Placement Coordinator (IPCO). This role works in partnership with the Department for Education to increase high-quality T-Level industry placement capacity across the Greater Manchester footprint, and as such positions Stockport as a system leader in early workforce development.

Our work experience programme has been awarded the NHS England Gold Award recognising the quality, structure, and meaningful placements offered. These experiences play a critical role in shaping early career aspirations and supporting informed career choices in health and care.

In October 2025, building on our successful offer at our Trust we developed and co-delivered the first One Stockport Safari at Stockport Town Hall. This innovative, place-based work experience event provided “taster” opportunities and showcased the breadth of careers across health and social care. It brought together partners from across the local health and care system, reinforcing a collective approach to workforce development.

From a Stockport perspective, our work presents several key place-based opportunities. As an anchor institution alongside SMBC we support inclusive economic growth, skills development, and social value within our borough. Our One Stockport Approach aligns careers, education, health, and employment initiatives to improve life chances and reduce health inequalities. Through the engagement with schools, colleges, and community organisations we build aspiration and awareness of health and care careers from an early age tapping into an early talent pipeline.

Through strong partnerships, inclusive workforce pathways, and a clear place-based approach, we are developing a sustainable, skilled, and diverse workforce that meets both current and future needs. This supports not only service delivery, but also wider economic, social, and health outcomes for Stockport and the wider GM system.

3.5 **Collaboration**

The People and OD Directorates at SFT and TGICFT continue to collaborate closely, sharing best practices, minimising duplication, and aligning policies and processes wherever feasible. Over the past six months, we have made further strides in our joint efforts, including:

- Evaluating the pilot of the joint leadership model of the two Recruitment Teams – the recommendation to move to permanent adoption has been supported recognising there is further work to do to achieve maximum benefits of the model.
- Working together on shared people policies with agreement to have a single policy development group with local trade unions.
- Combining the two People & OD Wider Leadership Teams into a joint bi-monthly meeting with a refreshed focus on strengthening leadership, intelligence sharing, learning, and transforming our services through new technology.
- Participation with GM Transforming People Services Programme with the potential for our Recruitment Service to be part of a wider GM wide service.

3.6 **Temporary Staffing Expenditure**

Bank spend accounts for 86.7% of the total temporary staffing spend, with 91.9% of shifts filled via bank, exceeding the GM target of 75%. The main drivers for bank usage remain vacancies (40%) and sickness (25%).

Agency usage has reduced by 0.8%, since the last report (May), with reductions across most staff groups. Agency usage in November accounted for 1.22% of the total pay bill, remaining comfortably within the 1.50% target and representing a 0.28% reduction compared to the previous month. The year-to-date position stands at 1.7%, a significant improvement from 3% in November 2024, demonstrating sustained progress in reducing reliance on agency staffing.

The Trust continues to progress actions to reduce temporary staffing spend with the weekly, executive led, Staffing Approval Group and the monthly Workforce Efficiency Group, which focuses on the drivers of the temporary staffing needs and widening oversight of variable pay.

The collaborative NHSP bank between Stockport & Tameside, for all staff went live on 3 December 2025. This will enable staff registered with NHSP to work bank shifts for either Trust on the bank share arrangement.

The table below outlines our temporary staffing performance against key targets as of December 2025:

Measure	Target	Trust Position
% of Workforce Spend Related to Bank Usage	<6.2%	8.09%
% of Workforce Spend Related to Agency Usage	<1.5%	1.41%
% Price Cap Compliance – Agenda for Change	>80%	99.50%
% of Off Framework usage – Agency	0%	0%
Agency use of bands 2&3 – Agency	0	0

3.7 **Sickness Absence**

The managing and supporting of staff who are off due to sickness remains an on-going priority. Over 2025 we have seen an increase from 6.24% in December 2024, to 6.74% in December 2025, which is above the 5.5% target. This increase is consistent with the seasonal rise in sickness levels typically seen during winter, when respiratory infections, gastro, flu, and other winter illnesses are more prevalent. The Trust is actively promoting its Winter Wellbeing Campaign, including reminders about flu vaccinations. Flu vaccination uptake: As of 16 January 2026, 43.5% of all staff and 42.4% of frontline staff have received their flu vaccination, against the GMICB target of 41.6%.

The menopause service continues to be well received and positively supports staff and managers.

We continue to benefit with the support of our Staff Psychological Wellbeing Service. SPAWS deliver a range of wider activity including training, webinars and group facilitation and are supporting the delivery of the wellbeing module within our leading with impact leadership development course.

3.8 **Time to Hire**

In December 2025, our average 'Time to Hire' reduced to 54 days – 3 days below target. Work continues to align recruitment processes, embed best practices, and drive performance improvement.

Focus on delivering of day-to-day operational activities has allowed us to reduce variations in service delivery which can be seen within the reduced time to hire.

3.9 **Turnover**

As of December 2025, staff turnover was 9.86%, within the Trust target of 11.50%. Over the past 13 months, turnover has reduced from a peak of 10.91% in February 2025 to its current low.

Deep dive reviews have been conducted across departments with high turnover. These have explored patterns and trends to develop action plans in line with broader staff survey results.

The exit interview has been updated to include questions around career progression and development and additional demographic questions; the aim of this is to gain a more meaningful understanding of the reasons for leaving and people's experiences of working in the Trust.

4. Next Steps

4.1 Our People and OD priorities remain central to our workforce strategy, with continued focus on improving retention, sustaining positive turnover trends, reducing temporary staffing costs, and advancing internal career development through a 'grow our own' approach.

4.2 Delivery of the People and OD priorities will continue alongside the new Joint Workforce EDI Strategy 2026-29 approved in December 2025. Together, this will underpin our commitment to building a compassionate, inclusive, and high-performing culture.

4.3 Building on progress to date, we are now developing the next phase of our People & OD Plan for 2026 and beyond, ensuring alignment with national priorities and local workforce needs.

5. Recommendation

5.1 The Board is requested to formally note and endorse the report's key insights, which provide assurance and support informed strategic oversight.

NHS
Stockport
NHS Foundation Trust

				Agenda No.	18
Meeting date	5th February 2026	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Q3 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 Q3 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 Q3 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 have been two changes to the risk score since the end of Q2 2025/26:

Principal Risk 2.1 - *Failure to sufficiently engage and support our people's wellbeing* - has reduced from 9 to 6, with a reduction in the impact rating (from 3 to 2). This reflects impact being more akin to temporary service restrictions rather than full service closure due to sickness absence and turnover.

Principal Risk 6.1 - *Failure to deliver annual revenue (including cash) and capital financial plans* - has increased from 16 to 20, reflecting an increased likelihood score from 4 to 5. This follows confirmation that the Trust will not achieve its annual revenue plan. However, as previously reported to the Board, a control total of a £6.6m deficit has been agreed with Greater Manchester ICB and the NHS England Regional Team. Delivery of the control total continues to be managed through rigorous expenditure control and continued focus on the Trust Efficiency Programme.

Principal risks to achievement of the Corporate Objectives are prioritised as follows at end Q3 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
6.1	Failure to deliver annual revenue (including cash) and capital financial plans which may lead to increased regulatory intervention.	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
6.2	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
2.2	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.	9
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
2.1	Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, higher turnover and sickness absence.	6

In addition, the Trust's significant risks from the corporate risk register approved at Risk Management Group at the end of Q3, 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.

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			2.1		
3 - Moderate			1.2, 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, 6.2	6.1
5 - Catastrophic				7.2	

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	
Gap score 1 - 5	1.1, 2.1, 1.2, 1.4, 2.2, 3.1, 4.1, 4.2, 5.1, 6.2, 7.1, 7.3
Gap score 6 - 9	1.3, 3.2, 6.1, 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)	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)	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)	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)	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 (2x3)		4 (2x2)	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)	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	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)	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)		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)	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)	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)	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)	20 (4x5)		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)	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)	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)	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)	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)	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 including harms due to long waits - 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 action plan in response to CQC Maternity Inspection and LMNS.	Indirect harm from operational pressures challenging to identify & quantify Expired SFT Quality Strategy Compliance with new NICE Sepsis Guidance	**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		Interrogation & triangulation of data relating to incidents due to operational pressures (Development of Patient Safety Report) Review of Violence & Aggression Standards (Patient & Staff) commissioned by Risk Management Committee Update Advantis (Go Live) to monitor patients in line with new NICE Sepsis Guidance. Review of staffing risk in relation to NICE Sepsis Guidance.	September 2025 Q1 2026/27 Q4 2025/26 Q4 2025/26	4	3	12	15	12	12	12		4	2	8
				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		~~Development~~ Approval of Joint Quality Strategy (SFT and T&G)	~~October 2025~~ March 2026										

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		- Guardian of Safe Working / Freedom to Speak Up Report to Board (Annually / Bi-annually) - Learning from Deaths (Annual) Annual Quality Accounts 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.	Evidence of continued hospitalisation and investigation at end of life care (EoL) out with expressed preferences. Emergent themes from Complaint Analysis / Surveys	**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: o Patient Experience Board of Directors: - Patient Story - Integrated Performance Report (Quality & Safety Metrics) Council of Governors: - Quarterly Formal Meetings		~~Trust EoL Committee deep dive of cause of continued EoL hospitalisation out with preference & solutions.~~ End of Life Care: Programme of work with Stockport system to reduce inappropriate admissions and expedite discharge Implementation of Action Plans from National Surveys & Complaints Learning	~~December 2025~~ Q4 2025/26 Ongoing (Action Plan includes actions spanning the year with differing dates for completion)	3	3	9	NEW RISK	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 1 - Deliver personalised, safe and caring services																		
		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 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.		- 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 - 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. Urgent Care Delivery Board: Frailty Review	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 2. Change in Derbyshire ICB hospital discharge process for complex discharges, impacting patient flow due to increased length of stay.	**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: Agreed priority metrics - Locality Board **Level 3 – Independent** NHS England – Activity Returns		~~Urgent Care Delivery Board to agree priority metrics to support improvement to 4 hour standard.~~ ~~Urgent Care Delivery Board undertaking deep dive into approach to frailty with view to reducing attendances & admissions.~~ Review Frailty Offer following deep dive & options appraisal ~~Agree & Test Locality Winter Resilience Plan.~~ Review St Thomas Intermediate Care offer for future development. NHSE Follow Up – Agree further support from ECIST to support 4 hour standard.	~~Q3 2025/26~~ ~~Q3 2025/26~~ Q1 2026/27 ~~Q3 2025/26~~ Q2 2026/27 Q4 2025/26	4	4	16	16	16	16	16		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																		
		Locality Winter Resilience Plan		NHS GM: - Urgent & Emergency Care Oversight Meeting (Trust & Locality) - Contract Monitoring Meeting - Provider Oversight Meeting ECIST Review & Discharge Mapping		Escalation to ICB Commissioners via Monthly Contract Meeting & Provider Oversight Meeting	Ongoing											
Principal Risk Number: PR1.4																		
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.	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~~ exit criteria 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.	**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~~ Q4 2025/26 ~~Q3~~ Q4 2025/26	4	3	12	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 for medical specialties. Mitigation Plan deployed to address loss of robotic assisted surgery capacity at The Christie. Refresh capacity & demand models for all specialties.as part of Medium Term Operational Planning.	~~Q3 2025/26~~ ~~Q3~~ Q4 2025/26 Q4 2025/26 ~~Q3~~ Q4 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 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 & Wellbeing Environmental Audit Health & Safety Mandatory 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.		~~Health & Wellbeing Environmental Audit~~ Establish Wellbeing Champion Roles	~~Nov 2025~~ March 26	~~3~~ 2	3	9	9	9	9	6		2	2	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 2 - Support the health and wellbeing needs of our communities and colleagues																		
		Reasonable Adjustments Training 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	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 ~~Outcome of GM community services review led by GM ICB~~ Deconstruction of block contract exercise by GM ICB	~~Q3 2025-26~~ Q4 2025-26 ~~Q3 2025-26~~ Q1/Q2 2026/27										
				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~~ Steering Group in place (TASCC) between both Trusts with Case for Change for clinical services for Radiology, Gastroenterology, Pathology and Pharmacy 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 – Structure of joint governance arrangements approved by SFT and TGICFT Boards with legal opinion ~~High Level Road Map~~.	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. Collaboration Agreement.	**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** Legal advice note in support of corporate governance and wider collaboration work		~~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~~ Q4 2025/26 ~~October 2025~~ ~~Q4 2025/26~~ Q1 2026/27	3	3	9	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 Explore implementation of GM Prioritisation Tool to support health inequalities and system wide approach and matrix.	~~December 2025~~ Q4 2025/26 Q2 2026/27	3	4	12	NEW RISK	12	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~~ Joint NHS England Stat Mand Programme Review completed and revised programme refresher period implemented. Mandatory Training Accountability Framework agreed and implemented. 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	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 review completed and revised programme refresher period to be implemented~~ ~~Non-compliance escalation framework agreed and will be implemented from October~~	~~October 2025~~ ~~October 2025~~	3	3	9	12	12	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 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
		Established partnerships with Locality / GM. Director of People & OD part of GM HR Directors Forum																
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) - Widening Participation Report (Biannually) 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 Launch BAME Leadership Development Programme Pilot 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 March 26 Q3 2025-26	3	3	9	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 Compliance with new NICE Sepsis Guidance	**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		Update Advantis (Go Live) to monitor patients in line with new NICE Sepsis Guidance. Review of staffing risk in relation to NICE Sepsis Guidance	Q4 2025/26 Q4 2025/26	3	3	9	NEW RISK	9	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)		~~Development~~ Approval of Joint Quality Strategy (SFT and T&G)	~~October 2025~~ March 2026											
				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	9		3	2	6
				Level 2 – Corporate Quality Committee: - Annual Research & Innovation Report - Alert, Advise, Assure Report: Clinical Effectiveness Board of Directors:		Full joint RD&I function (in line with Strategy), specifically establishment of Joint Research Office. Full integration to follow - Case for Changes to be completed.	~~Q3 2025/26~~ Q4 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). Subsequent control total agreed with GM ICS & NHS England Regional Team. 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.	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 5	16	12	16	16	20		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~~ Ongoing review all expenditure, with immediate controls applied to mitigate financial risk.	~~October 2025~~ Ongoing									
				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																		
		Submission of National Cost Collection exercise (PLICS). 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 (Improved position end Q3)		Deconstruction of block contract exercise by GM ICB Independent assurance on 2025/26 Key Financial Systems & Controls	Q1/Q2 2026/27 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	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.~~ Deconstruction of block contract exercise by GM ICB ~~SFT Drivers of Deficit Review - Development of Action Plan to be incorporated in Medium Term Operational Planning~~ Medium Term Plan to be developed in line with national planning guidance	Monthly ~~October 2025~~ Q1/Q2 2026/27 ~~December 2025~~ Q4 2025/26									
				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														

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																		
				reconciliation of workforce, productivity/finance and performance data. GM Provider Oversight Meeting (Monthly) **NHSE** NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3 NHS Oversight Framework – SFT: Segment 3 (Improved position end Q3)														

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 Confirmed successful bid for £1.5m of cyber-security funding. 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 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 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'. Draft 2025-26 Data Security and Protection Toolkit submission submitted by national deadline.		External bids for capital funding. Actions from Medical Devices Management Internal Audit Information Commissioners Office Audit Action Plan Develop plan to roll out technology from successful cyber-security bid. 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 Q1 2026/27 Ongoing (Action Plan includes actions spanning the year with differing dates for completion)	4	3	12	12	12	12	12		4	2	8
Principal Risk Number: PR7.2	**Risk Appetite: Moderate**																	

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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 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 **Level 2 – Corporate** Quality Committee - Annual Health & Safety Report - Alert, Advise & Assure Report o Health & Safety Group Finance & Performance Committee - Estates & Facilities Assurance Report - Site Development Strategy Progress Report - Alert, Advise & Assure Reports: o Capital Programme Management Group o Estates Strategy Group Board of Directors - Site Development Strategy Progress Report **Level 3 - Independent** Estates Return Information Collection (ERIC) Six Facet Survey PLACE Assessment		Operational review of backlog maintenance funding (SFT & T&G) Procurement of master planning exercise for SFT & T&G to support development of estates strategy	Q3 2025/26 Q3 2025/26	5	4	20	20	20	20	20		5	2	10
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	New Joint Green Plan for T&G and SFT approved by Board, August 2025. Action tracker in place to monitor progress. 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	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 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 CEF assessment of viability of decarbonising Stepping Hill Hospital site. Invitation to mini competition issued to commence the procurement for a delivery partner.		**Level 2 – Corporate** Finance & Performance Committee: - Green Plan (Sustainability) Progress Report (Biannual) Board of Directors - Annual Green Plan Report Annual Report including Sustainability Report **Level 3 - Independent** Estates Return Information Collection (ERIC) ICB Contacting Requirement Annual Check		Work with Carbon Energy Fund (CEF) to procure a contractor to deliver the decarbonisation of heat at Stepping Hill Hospital site ~~to assess the viability of decarbonising the Stepping Hill Hospital site and connecting to the Stockport Heat Network~~ Development of a Climate Change Adaptation Plan	Q3 2026/27 ~~2025/26~~ Q4 2025/26									
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** **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) **Level 3 - Independent**		Review of funding approach with partners.	Ongoing	3	5	15	20	15	15	15		3	3	9

Risk ID	Division	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
3091	Estates & Facilities	There is a fire risk to the Trust due to an inadequate amount of fire safety resource.	4	4	16	4	NEW
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	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
2196	Estates and Facilities	Dangerous & obstructive car parking occurring across the SHH Site	3	5	15	6	↔
2971	Corporate – Learning & Education	There is risk of Health and Safety to staff and visitors from water leaks in Pinewood House	5	3	15	6	↔
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	↔
2817	Surgery	Risk to patient care as there is only one ENT microscope in theatres.	4	4	16	4	NEW
2452	Clinical Support	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔

	Services						
2964	Microbiology	There is a risk associated with the microbiology estate. Floor damaged, remedial work is required and CL3 needs to be maintained.	5	3	15	6	NEW
101	Finance	There is a risk that the Trust will run out of cash and therefore have insufficient cash reserves to operate.	5	3	15	5	↑
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	↔
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	↔
2650	Surgery	Risk of harm to paediatric patients if the audiology service does not comply with best practice recommendations	4	5	20	3	↔
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	↔
3074	Operations (Cancer performance)	Risk of delayed or missed cancer diagnosis or recurrence due to deficiencies in follow-up processes.	4	4	16	8	↔