BOARD OF DIRECTORS

PUBLIC MEETING

4 JUNE 2020

Making a difference every day.

NHS
Stockport
NHS Foundation Trust

Board of Directors Meeting
Thursday, 4 June 2020

Held at 9.30am in the Committee Room, Oak House / via Webex

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		**A Belton**
0935	**4.**	Minutes of Previous Meeting – 6 May 2020	✓	**A Belton**
0935	**5.**	Action Log	✓	**A Belton**
	6.	**FOR ASSURANCE**		
0940	6.1	Covid-19 • Covid-19 Sitrep • Covid-19 Update and Recovery Planning	 ✓ ✓	 **S Toal** **S Bennett / C Wasson**
0955	6.2	Update on the Trust Strategy	✓	**S Bennett**
1005	6.3	ED Improvement Programme	✓	**S Toal**
1015	6.4	CQC Action Plan – subject to change	✓	**P Moore**
1030	6.5	Performance Report	✓	**L Robson**
1050	6.6	Key Issues Reports from Assurance Committees • Audit Committee • Quality Committee	 ✓ ✓	**Committee Chairs**
1055	6.7	Risk Report	✓	**P Moore**
	7.	**FOR DECISION / APPROVAL**		
1105	7.1	Governance Declarations	✓	**C Parnell**
	8.	**CONSENT AGENDA**		
	8.1	Nil items.		
	9.	**DATE, TIME & VENUE OF NEXT MEETING**		
	9.1	Thursday, 9 July 2020, 9.30am, Committee Room, Oak House.		
	9.2	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*		

STOCKPORT NHS FOUNDATION TRUST

Minutes of a public meeting of the Board of Directors held remotely at 9.30am, on Wednesday, 6 May 2020

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Mr S Bennett	Director of Strategy, Partnerships and Transformation *
Dr G Burrows	Medical Director
Dr M Cheshire	Non-Executive Director
Mr J Graham	Director of Finance
Mr D Hopewell	Non-Executive Director
Dr M Logan-Ward	Non-Executive Director
Ms A Lynch	Chief Nurse
Mr P Moore	Director of Governance and Risk Assurance *
Mr G Moores	Director of Workforce & OD
Mr H Mullen	Director of Strategy, Planning & Partnerships
Mrs C Parnell	Director of Communications & Corporate Affairs *
Mrs L Robson	Chief Executive
Mr M Sugden	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Executive Medical Director

** indicates a non-voting member*

In attendance:

Mrs S Curtis	Membership Services Manager
Mr S Goff	Deputy Chief Operating Officer *(for part of the meeting)*
Mrs C Griffiths	Transformation Director NHSE/I

82/20 Apologies for Absence

There were no apologies for absence.

83/20 Declaration of Interests

There were no interests declared.

84/20 Opening Remarks by the Chair

Mr Belton welcomed all Board members to the meeting, and made particular reference to Mr Bennett and Mr Moore who were attending their first Board meeting at the Trust. Mr Belton noted that this would be the last Board meeting attended by Mr Mullen before he retired at the end of May 2020. On behalf of the Board, Mr Belton and Mrs Robson paid tribute to Mr Mullen's 41+ year NHS career, and thanked him for everything he had done for the Trust and wished him well in his retirement.

85/20 Minutes of the previous meeting

The minutes of the previous meetings of the Board of Directors held on 27 February 2020 and 14 April 2020 were agreed as a true and accurate record of proceedings. It was noted that the meeting held on 14 April 2020 had been an Amended Board meeting, and had mainly been attended by the Chair, Chief Executive and Non-Executive Directors, with relevant Executive Directors attending as necessary to present on specific items.

Mr Sugden referred to minute no. 49/20 in the February meeting minutes, and it was agreed that reference to the need to review SLAs with other providers to establish any issues would be added to the action log.

86/20 Action Log

The action logs from February and April were reviewed and annotated accordingly. It was noted that many of the actions from the February action log were currently on hold due to the Covid-19 pandemic.

With regard to the action relating to Ethical Considerations, the Board heard that the position had moved on and, while the risk of being overwhelmed had reduced, the Trust intended to establish an ethical panel going forward. Dr Wasson advised that it was anticipated that a formal plan would be agreed in three months' time. Mrs Robson commented that this would be brought forward, if the position was to change again. She also noted that this linked with the GM system setting up a formal ethical framework, which had not existed for the patch before.

87/20 Covid-19

Mr Goff presented a sitrep that included data for Stockport, with benchmarked acute activity, delayed patients in acute hospital beds, and actual and projected growth of Covid-19.

Mr Goff briefed the Board on the content of the report and highlighted a continued increase in the number of stranded patients, as anticipated due to the numbers of Covid patients on inpatient wards. He also briefed the Board on the improved Delayed Transfers of Care (DTOC) position, and noted that the total numbers of Covid patients continued to plateau, both locally and regionally. Mr Goff advised that the Trust was beginning to project ICU numbers, and was starting to look at recovery and de-escalation plans.

Ms Toal highlighted ongoing issues with discharging MOAT patients to Bramhall Manor and Marbury, but that it was hoped that the Bramhall Manor issue would be resolved soon. Mrs Robson advised that there had been a lot of discussion to resolve these issues, including issues with Viaduct and Borough Care, and the way the support was commissioned by the CCG. She highlighted a significant risk if the patient flow issues were not resolved soon.

In response to a question from Mrs Barber-Brown, Mr Goff briefed the Board on preparations for post lock down. He advised that the Trust was tracking the numbers of "hot" and "cold" presentations to ED and inpatient wards, and noted that there

were currently more empty beds on Covid wards compared to non-Covid wards. He briefed the Board on work to balance the position and how the existing staff base could be used to remodel the bed configuration to be fit for purpose for a revised demand.

In response to a question from Mrs Barber-Brown regarding a possible second peak of the pandemic, Mrs Robson advised that this was a key area of focus that occupied a huge amount of time and effort. Dr Wasson acknowledged the risk for a second surge once the lock down rules relaxed and noted that the challenge was to be ready for a steady demand, as well as any occasional surges, and getting the prioritisation right. Mrs Robson advised that Mr Bennett was leading on the recovery work for the Trust, bringing everything together on what was a very prescribed process, nationally and regionally.

In response to a question from Dr Cheshire about the involvement of Primary Care Networks (PCNs), the Board heard that while Viaduct was the central co-ordinating voice for PCNs, the Trust was working with PCN leads to ensure that its line of sight was with PCNs, particularly around the recovery phase.

- Noted the content of the sitrep and the current situation regarding Covid-19.

88/20 Personal Protective Equipment (PPE) and Risk Assurance Report

Mr Moore presented a report providing an overview of the level of exposure to the potential risk associated with the lack of PPE, the inherent and residual risk following assessment, and the handling of the risk internally and externally as part of a wider Greater Manchester command and control response. He briefed the Board on the content of the report and advised that the risk remained high due to ongoing volatility of supply and distribution of PPE, but noted that the report provided reasonable assurance that the risk was being kept under prudent control. The Board heard of contingencies developed in the event of low numbers of PPE and surges in demand.

Dr Wasson commented that in the early days of the pandemic, there had been some PPE shortages in the system but the position had been brought under control in a timely manner. He commended the Trust’s procurement team for their hard work in ensuring a sufficient supply of PPE. Dr Wasson highlighted that the interpretation and implementation of Public Health England (PHE) guidance had at times been challenging, and the Clinical Advisory Group (CAG) had done a lot of work to reassure staff regarding PPE and emphasise the importance of following the PHE guidance.

Mr Moore referred the Board to s8 of the report and provided an overview of the risks relating to Covid-19. In response to a question from Dr Logan-Ward, Dr Wasson advised that the Trust had been very clear in its communication to staff to only follow the PHE guidance and the importance of having the appropriate PPE to do the job. He added that staff had been advised to escalate any PPE-related issues via CAG. Ms Lynch advised that the Trust had a plan in place with regard to the prioritisation of PPE in case of extremis, but noted that due to the sterling efforts of the procurement department, it had not yet proven necessary to utilise the plan.

In response to a question from Mrs Barber-Brown about how the guidance had been followed, Mr Moore noted that this would need to be tested from time to time and Dr

Wasson and Mrs Robson reiterated that staff had been asked to raise any concerns relating to PPE shortages via CAG. Ms Griffiths commented that it was encouraging to see the incident reporting coming through.

Mr Graham commented that the PPE stock dashboard, included in s5.3 of the report, was shared in Gold Command on a daily basis and it provided a useful early indication if stocks were getting low. Mrs Robson noted that the national Chief Executives' network also received national early warning issues, and Mr Belton advised that the Chairs' network also received the same national figures regarding PPE. With regard to stock levels, Mrs Robson commended the role of the procurement team and advised that she had received a formal response from the GM procurement lead recognising the team's efforts, and highlighting some individuals for their exemplar performance on a 24/7 basis.

In response to a question from Mr Belton regarding Covid-related risks, Mr Moore advised the Board of ongoing work to rigorously review the corporate risk registers, with a view to rebuilding the risk registers across the organisation. He noted that the thorough review was due to be completed by the end of May.

The Board of Directors:

- Received and noted the PPE and Risk Assurance Report.

89/20 Cancer Management during the Covid-19 Pandemic

Dr Wasson presented a report setting out the steps being taken to manage cancer patients during the pandemic. He briefed the Board on the content of the report and highlighted that two-week wait referrals were 75% less than usual, and emphasised the risk posed to cancer patients in treatment from Covid-19. He highlighted the need to balance the risk of Covid against the risk of deferring surgery.

The Board heard that treatment for 168 patients had been suspended due to the level of risk to patients and the constraints around what treatments could be safely offered. Dr Wasson advised that these patients were being actively tracked with regular catch ups, and the Executive Team received regular updates in this area. Dr Wasson highlighted the arrangements in place in GM with the Christie and the private sector being used for some surgery.

With regard to next steps, Dr Wasson advised that the Trust was setting up a process to enable on site surgery in as safe an environment as possible, noting that the Trust was liaising with the Christie.

In response to a question from Mr Sugden, Dr Wasson provided further clarity on the way in which the private sector was being used for surgery, noting the prioritisation of colorectal surgery. He commented that an on site solution would help with timely delivery, and also noted the importance of supporting smaller neighbouring organisations who may find the establishment of ultra clean sites more challenging. Dr Wasson commended the GM collaboration, noting that the GM Gold Hub had been really helpful in offering and co-ordinating support.

Mrs Robson noted the balance between what surgery would be undertaken in the GM vs. locally, and noted that this would be informed by demand and capacity work and having a single approach regarding needs and demands.

The Board of Directors:

- Received and noted the Cancer Covid Report.

90/20 Single Escalation Plan

Mr Goff presented a Single Escalation Plan, noting that the report provided a single overview of the Trust's escalation plan to deal with the anticipated surge in demand associated with the Covid-19 outbreak, and brought together planning undertaken by the Trust's senior clinical and operational leads. He briefed the Board on the content of the report and highlighted the importance of clinical involvement. He commented that the report detailed a position at a point in time, and noted that some areas had developed or been superseded since the report had been written.

Ms Lynch and Mr Moores briefed the Board on the work of the staffing hub and the Workforce Advisory Group (WAG), and it was agreed that the Board would receive a report on all the associated work at the June meeting. In response to a comment from Mr Belton regarding staff wellbeing, Mr Moores advised that there was a donations centre in Pinewood that co-ordinated the receipt and distribution of donations to staff, including food and drink.

Mr Graham advised that the Financial Advisory Group had considered a report on donations and donated assets to ensure these were appropriately channelled through the Trust's charity. He also referred to the Single Escalation Plan and noted that any financial decisions would be escalated to the Executive Team or the Board as necessary.

Mr Moores applauded the clinical involvement in the development of the Single Escalation Plan and noted the powerful learning for the future.

The Board of Directors:

- Received and noted the Single Escalation Plan and agreed to receive updates at future meetings.

Mr Goff left the meeting.

91/20 Performance Report

Mr Mullen presented an Integrated Performance Report and an Annual Review of Performance report, detailing the year-end performance of key standards. He briefed the Board on the content of the year-end report and highlighted issues regarding the Cancer 62-day referral to treatment standard. Ms Toal provided an overview of the issues that had affected the cancer pathway during the year, as detailed in s2.1 of the report.

Mr Mullen then briefed the Board on performance against the following areas of concern and provided an overview of associated mitigating actions: 18-week referral to treatment standard, the six-week diagnostic standard, the A&E four-hour standard and clinical correspondence.

In response to a question from Mr Belton, Mr Mullen acknowledged that clinical leadership was fundamental to enable sustainable improvements and noted the need to balance national 'must do' standards with what could be done locally. Ms Toal advised the Board that the Trust had commissioned Ms Barbara Cummings as an Improvement Consultant in the Emergency Department. She noted that Ms Cummings would review the performance management arrangements and the prominence and quality of the data to ensure the Executive Team and the Board received the necessary assurance.

Dr Wasson commented that as part of the post-pandemic reform of the organisation, it was important that the approach to urgent and emergency care was thought through properly, including the implementation of the necessary cultural shift. He made reference to the way in which the stroke pathway had been restructured, and noted that the approach should also be implemented in other areas of the Trust, including the Emergency Department, to drive quality improvement. Dr Wasson advised that Mr Bennett was leading on the clinical strategy work, including cultural change.

Mr Bennett reiterated the importance of putting clinical leadership at the forefront of transformational change, and noted the exciting opportunity for the Trust to change the way it operated. He referred to the figures in the Annual Review of Performance report and noted that there were some important challenges for both the Trust and the system to resolve as part of the recovery plan.

Ms Lynch noted that it was important to ensure the work with nursing and allied health professional staff was aligned with the work led by the Medical Director. She commented that the delivery of safe care was key and noted a link to the quality strategy and quality improvement plan.

Mrs Robson highlighted the importance of clinical leadership being a single principle with multi-disciplinary teams working together, rather than developing in professional silos.

The Board of Directors:

- Received and noted the Integrated Performance Report and the Annual Review of Performance Report, and noted the challenges associated with the operational recovery plans to be developed in response to Covid-19.

92/20 Key Issues Reports from Assurance Committees

Mr Belton welcomed Committee Chairs to raise any key issues that had not been covered during consideration of the Performance Report.

Quality Committee

Dr Logan-Ward referred the Board to the 'Alert' section of the report and highlighted concerns in relation to blood transfusion traceability across the Trust. Ms Lynch noted that the position was improving following focused review and monitoring, and advised that the position would continue to be closely monitored until 100% compliance was obtained.

Ms Lynch advised the Board of a significant increase in C-Difficile cases in the Trust, noting that there had been four cases since 1 April 2020. She advised that antimicrobial stewardship was key to improving the position as a large amount of patients were on antibiotics, and noted work undertaken by matrons and clinical directors in this area.

Ms Lynch and Mr Moores raised concerns about the risk associated with 235 nurse vacancies. They commented that staffing concerns had been highlighted in the recent CQC inspection, and noted that the current position was further exacerbated by the number of absent staff due to Covid-19. Mrs Robson acknowledged the risk caused by the vacancies and stressed that it was important for the Board to be sighted on what had changed since the nurse staffing business case was considered in January 2020, including the significantly altered external context, actions taken in response to the Board's previous discussion, and next steps.

Mr Graham commented that a number of wards had been closed due to Covid, and noted that one of the key tasks for the staffing hub was to manage the staffing risk, with daily assurance reports provided to Gold Command. He highlighted the financial constraints and made reference to the recovery planning work led by Mr Bennett, which provided an opportunity to look at different ways of working, including new roles, and the way services were provided, including virtual outpatient clinics. Mr Moores acknowledged the opportunity for workforce redesign, but also highlighted that there were minimum statutory nursing numbers that the Trust was required to meet.

Mr Bennett noted the need for a holistic Board conversation about recovery and the associated risks, including staffing. Mr Graham commented that the output from Mr Bennett's work needed to be supported by workforce, finance and operational plans, in a holistic way.

Mr Sugden queried what information the Board would receive at the June meeting, in the context of monitoring performance metrics, emerging risks against the backdrop of the underlying financial position, the recovery plan, nurse recruitment and staffing model, taking into account East Cheshire developments.

Mr Belton asked Mrs Parnell to think about what should be covered in the Board meeting and what should perhaps be discussed in a workshop regarding the "new world" and the recovery plan.

Finance & Performance Committee

The Board of Directors noted the key issues report from the meeting of the Finance & Performance Committee held on 18 March 2020.

The Board of Directors:

- Received and noted the Key Issues Reports.
- Agreed the need for a holistic Board conversation about recovery and the associated risks, including staffing. Mrs Parnell would consider what should be covered in a Board meeting vs. a workshop regarding the recovery plan.

93/20 Financial Position to the end of March 2020

Mr Graham presented a report detailing the Trust's draft financial position for 2019/20, subject to audit approval. He briefed the Board on the content of the report and acknowledged the hard work of the finance team to ensure the cost savings were achieved at year-end. Mr Graham reported that the Trust had achieved the NHSI control total, including an additional stretch target of £250k, and had delivered the recovery plan. The Board also heard that as a consequence of delivering the additional stretch target and Greater Manchester Health and Social Care Partnership achieving the system control total, the Trust had received an additional £3.2m Financial Recovery Fund.

Mr Graham commented that while this was an excellent position, it was important to highlight the underlying risk in performance, including a significant under-delivery on recurrent CIP and a deterioration of the underlying financial position.

The Board heard that trusts were in a different financial regime under Covid-19, which brought with it positives as well as negative challenges. Mr Graham noted that trusts needed to be aware of financial probity, value for money and the potential for increased attempts of fraud.

The Board of Directors:

- Received and noted the End of Year Financial Position Report and the NHSI letter regarding End of Year Central Funding.

94/20 Going Concern Declaration

Mr Graham presented a Going Concern Declaration report, noting that International Accounting Standard 1 required the Trust to assess its ability to continue as a Going Concern as part of preparing its Annual Accounts. He advised that the report had been written in the context of the revised financial regime, which meant that the Trust was being funded on a cash basis.

Mr Hopewell referred to s1.6 of the report and commented that, given the material uncertainty, he felt that the scenario s1.6 b) appeared the most appropriate declaration. In response to a question from Mr Hopewell, who queried Mazars' view about the Going Concern declaration, Mr Graham advised that the external auditors were aware of the recommendation being proposed to the Board. He noted that the main difference compared to last year's position was that for the first four months of 2020/21 there was clarity that the Trust would have enough cash to suffice. He added that the strong indication was that the revised financial regime would continue for the rest of 2020/21, subject to a reasonableness test and audit of Covid spending. The Board heard that the suspension of the Payment by Results (PBR) regime, and the fact

that the Trust was not required to make efficiency savings for at least the first four months of 2020/21, provided a higher level of assurance than in previous years.

The Board of Directors:

- Received and noted the report.
- Approved the following Going Concern declaration:

  "After careful consideration and making due enquiries, the Directors have a reasonable expectation that Stockport NHS Foundation Trust has adequate resources to continue its operations on an on-going basis for the foreseeable future. For this reason, the Directors continue to adopt the going concern basis in preparing the accounts."

95/20 Capital Programme 2020/21

Mr Mullen presented a report seeking Board approval of the capital programme 2020/21. He briefed the Board on the content of the report and advised that more capital than expected had been made available in year, and it was predicted that the position was likely to continue into 2020/21. The Board heard that following the reconciliation of year-end accounts for 2019/20, a number of capital commitments made in 2019/20 would need to carry forward to the 2020/21 programme. Mr Mullen advised that these had mainly arisen due to the Covid-19 situation and they were in addition to the capital programme endorsed by the Finance & Performance Committee.

The Board heard that progress against the capital programme would be reviewed on a quarterly basis, with mitigating action taken should the approach need to be revised and expenditure commitments reduced. Mr Sugden commented that the Finance & Performance Committee had been happy to support the plan on the basis of an over commitment to spending on the capital programme.

The Board of Directors:

- Received and noted the report.
- Formally approved the capital plan for 2020/21 for a total value of £17m.
- Agreed to the proposal to plan on the basis of an over commitment to spending on the capital programme and keep the position under review on a quarterly basis.

96/20 Consent Agenda

The Board of Directors took the following actions with the Consent Agenda items:

- **Governance & Assurance During Covid-19 Pandemic**

  The Board of Directors approved to implement the approach to maintaining effective governance and assurance as set out in the paper, and agreed to review the approach on at least a monthly basis, or when new relevant guidance was published.

In response to a comment from Dr Logan-Ward, it was agreed to extend the length of Quality Committee meetings from one hour to 1.5 hours.

- **Rates Bill**

  The Board of Directors approved the non-domestic rating demand notice for the amount of £1,222,096.34, for the period of 1 April 2020 to 31 March 2021.

97/20 Date, time and venue of next meeting

The next public meeting of the Board of Directors would be held on Thursday, 4 June 2020, commencing at 9.30am.

98/20 Resolution

The Board resolved 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

Ref:	Meeting	Minute reference	Subject	Action	Bring Forward	RO
08/20	7/4/2020	50/20	Emergency powers	Keep the approach to oversight of quality and safety issues under review. **Update 14 Apr 2020 –** At the next meeting the Board would receive a report and be asked to endorse a recommendation for revised governance arrangements, including the reinstatement of monthly Board and Quality Committee meetings. The weekly briefing meetings would continue for Non-Executive Directors to be kept up to date with key issues in relation to Covid-19, and also to address any other urgent business.	21/04/20	All C Parnell
09/20	7/4/2020	50/20	Emergency powers	Committee Chairs and relevant Executive Directors to determine key issues to be presented to the weekly Board meeting. **Update 14 Apr 2020 –** Committee Chairs provided an update on the status of this action in respect of their Committees, noting that this was still work in progress. Mrs Robson briefed the Board on actions relating to the new Risk Committee, which she was discussing with Mr Moore.		Committee chairs and link Executive Directors
11/20	7/4/2020	51/20	Ethical considerations	Consider the principles under which the ethics panel would operate and the circumstances under which it would operate **Update 14 Apr 2020 –** Dr Wasson briefed the Board on work being undertaken by Dr Catania to review		Dr Wasson

				other organisations' processes around ethics. He agreed to feed back the outcome of that piece of work to the Board. **Update 6 May 2020 –** The Board heard that the position had moved on and the Trust was in a very different place now with regard to ethical considerations. While the risk of being overwhelmed had reduced in this area, the Trust would like an ethical panel going forward. Dr Wasson estimated that a formal plan would be agreed in three months' time. It was noted, however, that this would be brought forward if necessary, if the position was to change again.	August 2020	
13/20	7/4/2020	53/20	Covid-19 sitrep	Receive an update on the decision making process established to support Covid-19 at a future meeting. **Update 14 Apr 2020 –** Mrs Parnell advised that a paper on revised governance arrangements would be presented to the Board on 21 April 2020.	21/04/2020	Mrs Parnell
14/20	7/4/2020	54/20	Integrated performance report	Non-Executive Directors and Mrs Griffiths would review the proposed standards and forward any additions to Mrs Parnell **Update 14 Apr 2020 –** Mrs Parnell noted that this action linked with the discussion on quality standards, and advised that she had forwarded any comments / information she had received to Ms Lynch and Dr Wasson.		Non Executive Directors Mrs Griffiths
15/20	7/4/2020	57/20	Trust risk register	Receive a new style report or a progress report to the Board in a month's time.	4/6/2020	Mr Moore
16/20	14/04/2020	69/20	Covid-19	Board would receive assurance reporting, inc	6/5/2020	Mr Moore

				around PPE, starting at the May Board meeting.		
17/20	14/04/2020	70/20	Quality & Patient Safety	Dr Logan-Ward agreed to arrange a discussion with Dr Wasson, Ms Lynch and Mr Moore to consider the quality and safety assurances required via the Quality Committee.		Dr Logan-Ward
18/20	06/05/20	90/20	Single Escalation Plan	Ms Lynch and Mr Moores briefed the Board on the work of the staffing hub and the Workforce Advisory Group (WAG), and it was agreed that the Board would receive a report in this area at the June meeting.	(incorporated as part of the Covid-19 Update and Recovery Planning Report)	G Moores / A Lynch
19/20	06/05/20	92/20	Quality Committee KIR	Mr Bennett noted the need for a holistic Board discussion about recovery and the associated risks, including staffing. Mr Graham commented that the output from Mr Bennett's work needed to be supported by workforce, finance and operational plans, in a holistic way. Mr Belton asked Mrs Parnell to think about what should be covered in the Board meeting and what should perhaps be discussed in a workshop regarding the "new world" and the recovery plan.		C Parnell / S Bennett / A Lynch / G Moores

On agenda
Not due
Overdue
Closed

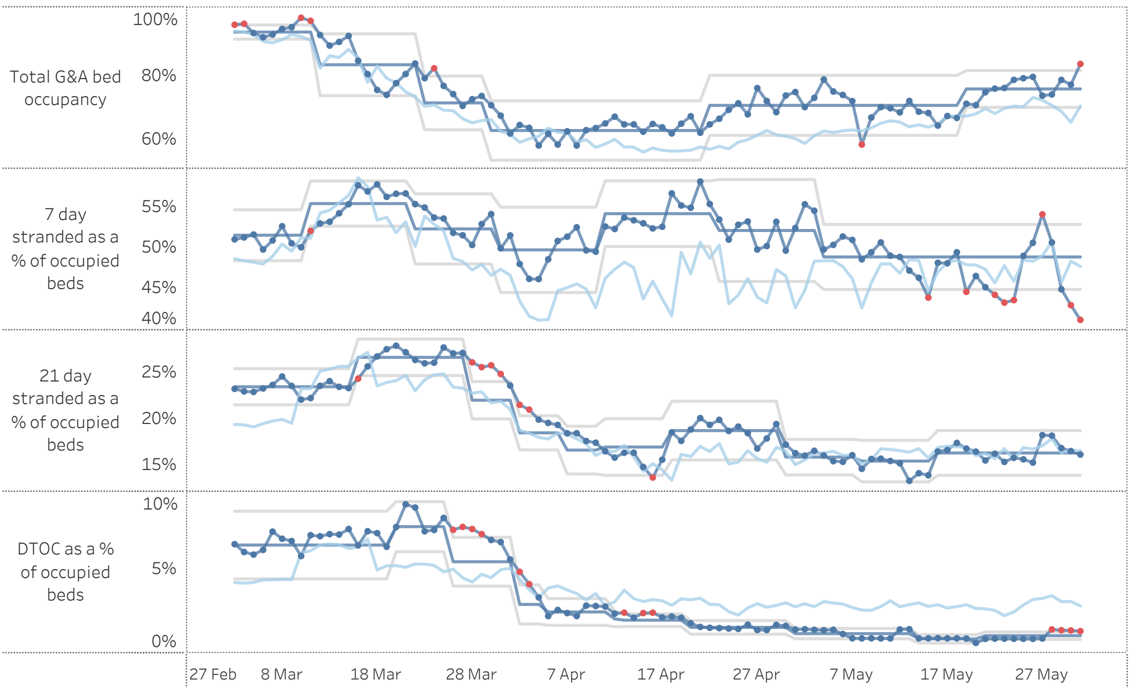
COVID-19, benchmarking acute activity

A look at 4 key metrics for acute care over time

Key metrics for the latest period comparing Stockport FT Vs. North of England
As at 31/05/2020

Total G&A Bed occupancy	7 day Stranded as a % of occupied beds	21 day Stranded as a % of occupied beds	DTOC as a % of occupied beds
83.4%	40.8%	16.0%	0.8%
Vs. 70.0%	Vs. 47.5%	Vs. 16.4%	Vs. 2.5%

90 day benchmarking, Stockport Foundation Trust Vs. North of England average



Raw data: SFT summary for the last 2 weeks

		G&A beds open	G&A beds occupied	DTOC	7 day stranded	21 day stranded
May	19	485	343	1	152	57
	20	498	350	0	162	57
	21	500	372	1	167	57
	22	470	355	1	156	57
	23	470	356	1	153	54
	24	466	365	1	158	57
	25	468	369	1	180	57
	26	468	371	1	187	56
	27	468	343	1	185	62
	28	452	333	3	168	60
	29	452	354	3	158	59
	30	470	361	3	154	59
	31	458	382	3	156	61

Source: NHS Improvement daily SitRep, data is unvalidated and refreshed at 1pm daily | **Author:** aaron.atkinson@nhs.net
Pdf: https://www.gmtableau.nhs.uk/t/StockportCCG/views/DailyUrgentCareSitRepv7/COVID-19SituationReport.pdf

6.1

COVID-19, delayed patients in acute beds

Quantifying delay reasons & medically optimised patients (MOAT) using 'Red to Green' codes using inpatient data

6.1

'Red 2 Green' delay reasons for MOAT patients at SFT as at 01/06/2020 09:55:01

Note: this excludes short stay wards, Bluebell, the Devonshire Unit and Stroke wards and as such will not match the total MOAT numbers reported.

			Number of patients	Avg. MOAT LOS	Total MOAT Bed days
Stockport CCG	External Delay	Waiting for Community Bed or any other bedded intermediate ..	2	0	0
		Waiting for Care Home (NH/RH) Identification / Placement	2	10	19
		Waiting for Social Care Assessment	1	12	12
		Waiting for Short Term Placement	1	4	4
		Waiting for POC	1	5	5
		Total	7	6	40
	Internal Delay	Waiting for Test Results	2	14	27
		New admission - medical review required	2	5	10
		No recorded R2G reason	2	2	4
		Undergoing Active Therapy	1	0	0
		Fit - No Clear Discharge Plan	1	6	6
		Total	8	6	47
	Total		15	6	87
Other CCGs	External Delay	Waiting for POC	2	4	8
		Waiting for Out of Area POC	1	3	3
		Waiting for Out of Area Placement	1	6	6
		Waiting for Mental Health Assessment	1	1	1
		Total	5	4	18
	Internal Delay	Waiting for therapy assessment/plan/decision for discharge	1	1	1
		Waiting for Test Results	1	3	3
		Waiting for Internal Test to be done	1	3	3
		New admission - medical review required	1	18	18
		Total	4	6	25
	Total		9	5	43
			24	5	130

MOAT patients since 17th March

Live, unvalidated system capacity morning of 01-Jun-2020

Capacity	Total	Occupied	Available	% Occupancy
COVID beds	77	51	26	66.2%
Critical care beds	22	7	15	31.8%
G&A Beds	495	395	100	79.8%
Medicine beds	240	194	46	80.8%
Surgery beds	77	62	15	80.5%
Supported Living Flats	11	7	4	63.6%
Bramhall Manor T2A	71	47	24	66.2%
Nursing EMI			33	
Nursing General			31	
Residential EMI			76	
Residential HD			0	
Residential Standard			45	
REACH (Hours)			39	
Marbury	41	4	37	9.8%
Bluebell	25	22	3	88.0%

Source: SFT inpatient list (unvalidated, live data); Live system capacity collection (unvalidated, live data) | **Author:** aaron.atkinson@nhs.net
Pdf: https://www.gmtableau.nhs.uk/t/StockportCCG/views/DailyUrgentCareSitRepv7/COVID-19SituationReport.pdf

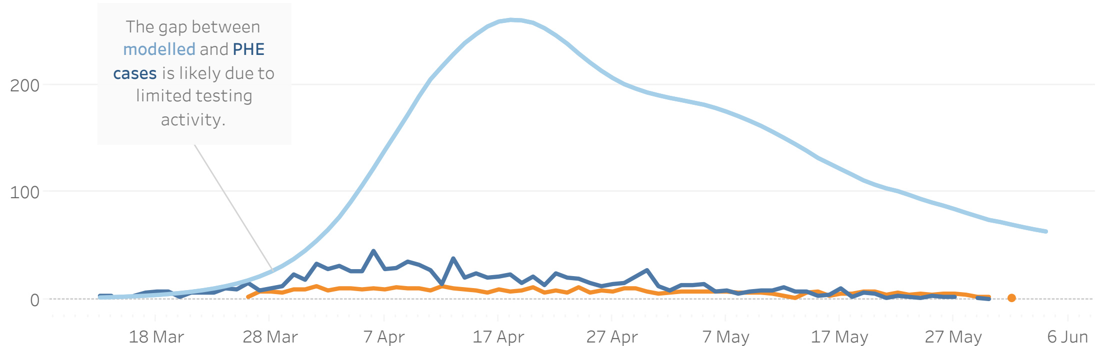
Actual and projected growth of COVID-19

Local and national data; projections based on Italy growth rates & Imperial college hospitalisation rates.

How many cases have we got in Stockport?

There are no sources of data that tell us exactly how many cases we have. Public Health England (PHE) report on numbers positive cases but we know that not all people will be tested. We can count the differential diagnoses coming through the emergency department at SFT to give an indications of those cases with symptoms, but this is unlikely to cover all people with symptoms. Another approach is to take the first reported cases and project the growth rate for this based on what we have seen elsewhere. The default rates in the chart below take the first 2 cases reported by PHE on 13/3 and use growth rates similar to those seen Italy. But again, there are many other variables that may have been impacting their number of cases.

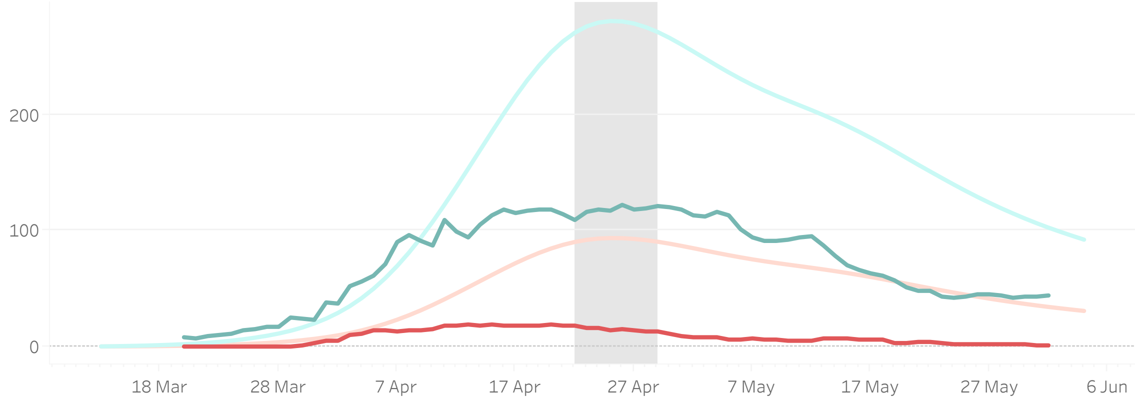
PHE cases (All) | Projected cases | SFT cases
Daily



How many beds are occupied and how many are we likely to need?

We have a fairly good estimate of the number of people who are in a bed with COVID-19 but there will be a time lag as people await results of swab testing. The projected data here is derived from the estimated cases above. We use the Imperial College report to get an overall average rate of hospitalisation for both acute and critical care and assume a 21 day length of stay. This then enables us to compare our actuals with our projected bed demand.

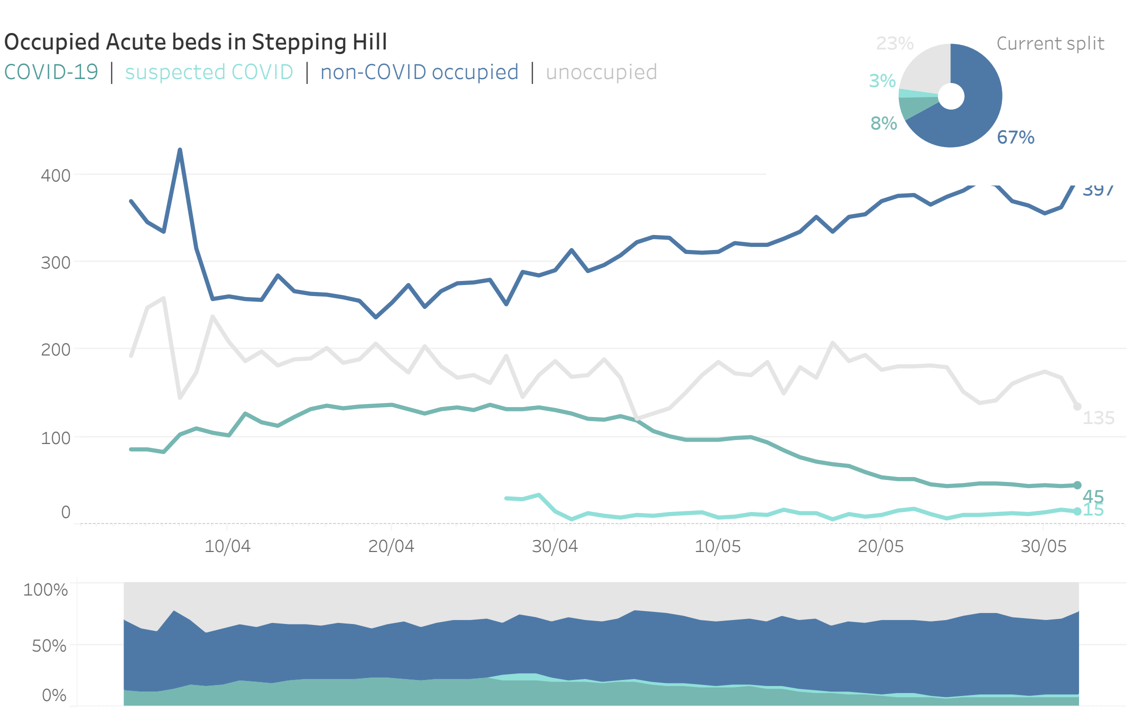
Beds occupied (projected) | Citical care (projected)
Assuming acute LOS = 14; critical care LOS = 14; banding denotes tolerance of peak bed demand +/-3days

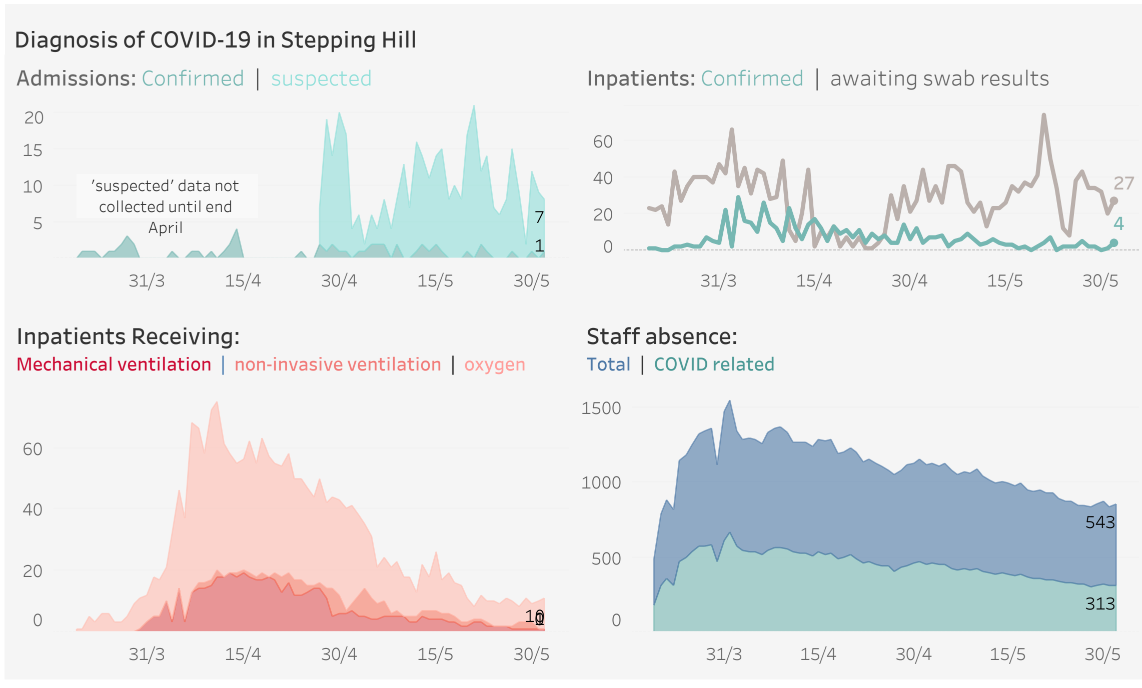


Source: PHE known cases; SFT actual; NHSi Beds Occupied. All projections are based on user defined growth assumptions + Imperial College rates of hospitalisation | **Author:** David Lyons, SFT; david.goswell@nhs.net
Pdf: https://www.gmtableau.nhs.uk/t/StockportCCG/views/DailyUrgentCareSitRepv7/COVID-19SituationReport.pdf

NHSI daily COVID-19 situational operational report

Please note, the data is sensitive and unvalidated. Please do not share any further





Source: NHS Improvement daily COVID-19 situational operational dashboard | Author: Aaron Atkinson

Pdf: https://www.gmtableau.nhs.uk/t/StockportCCG/views/DailyUrgentCareSitRepv7/COVID-19SituationReport.pdf

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Report to:	Board of Directors	**Date:**	4 June 2020
Subject:	**Covid-19 update and Recovery Planning**		
Report of:	Medical Director & Director of Strategy, Partnerships and Transformation	**Prepared by:**	Medical Director Associate Director Strategy & Planning

REPORT FOR INFORMATION

Corporate objective ref:	C4,C6, C8, C9, C10, C16, C17	**Summary of Report** The impact of Covid 19 on the structure and function of the trust has been huge. We are now formally in 'phase 2', this paper summarises the current challenges and priorities as well as setting out the expectations on further recovery planning. The report summarises the results as the organisation passed through the 'surge'. We also present the priorities for this next phase of our Covid response. This report is provided for information.
Board Assurance Framework ref:	S2, S3, S5	
CQC Registration Standards ref:	9, 10, 11, 12	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Exec Management Group ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. PURPOSE & OVERVIEW

1.1 This paper provides a summary of the impact of Covid-19 and the current position. It also outlines the phases of recovery planning and how we are preparing for the next phase of our covid response.

This report is provided to the board for information.

2. BACKGROUND - COVID-19

2.1 The peak of the Covid surge hit in Stockport in mid-April. At its zenith, we had 22 patients ventilated across four intensive care units, and almost 140 inpatients with covid infections.

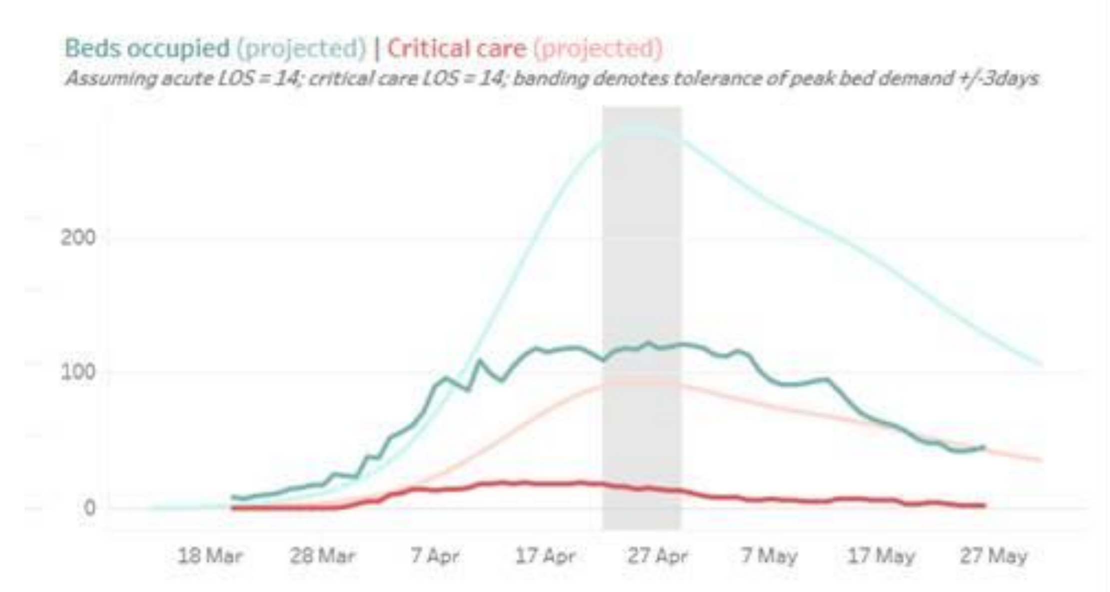

Figure 1: Tracking ward based admissions (green) and ICU (red) in Stockport
(against projected – shown in lighter colours)

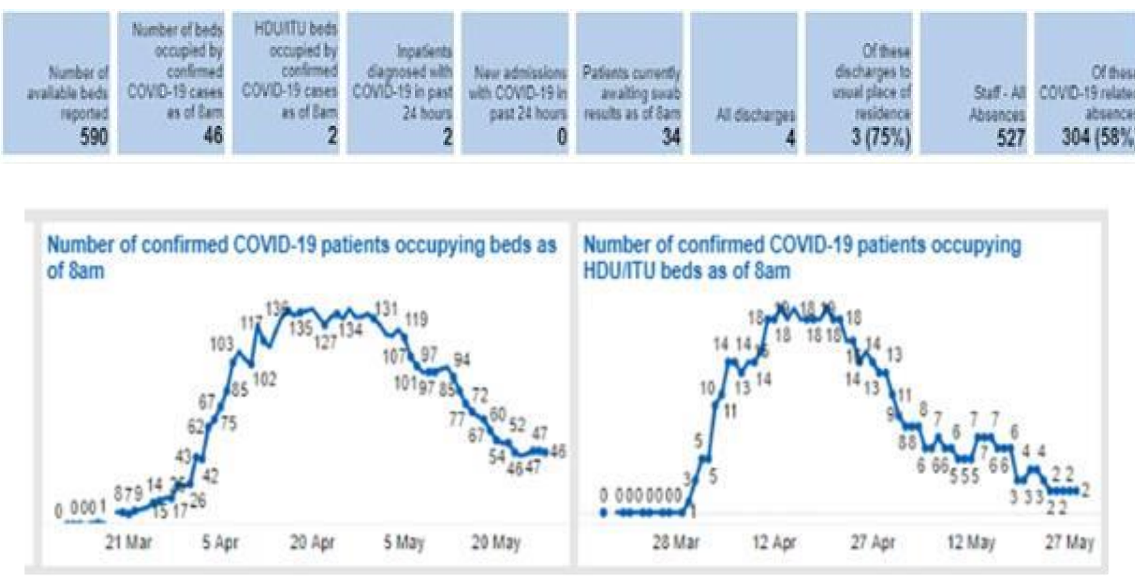

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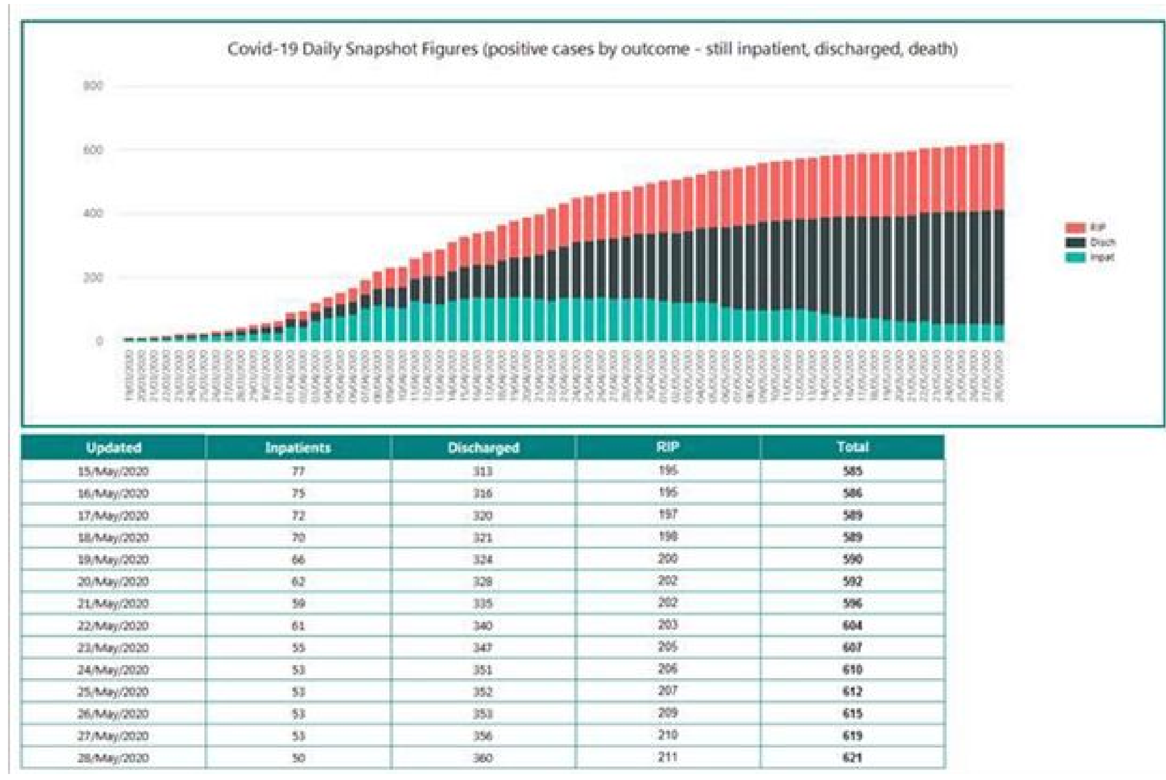
Figure 2: Numbers of patients in hospital beds, in ICU and diagnosed in Stockport.



Updated	Inpatients	Discharged	RIP	Total
15/May/2020	77	313	196	585
16/May/2020	75	316	196	586
17/May/2020	72	320	197	589
18/May/2020	70	321	198	589
19/May/2020	66	324	200	590
20/May/2020	62	328	202	592
21/May/2020	59	335	202	596
22/May/2020	61	340	203	604
23/May/2020	55	347	205	607
24/May/2020	53	351	206	610
25/May/2020	53	352	207	612
26/May/2020	53	353	209	615
27/May/2020	53	356	210	619
28/May/2020	50	360	211	621

Fig 3: Cumulative trust ourcome figures

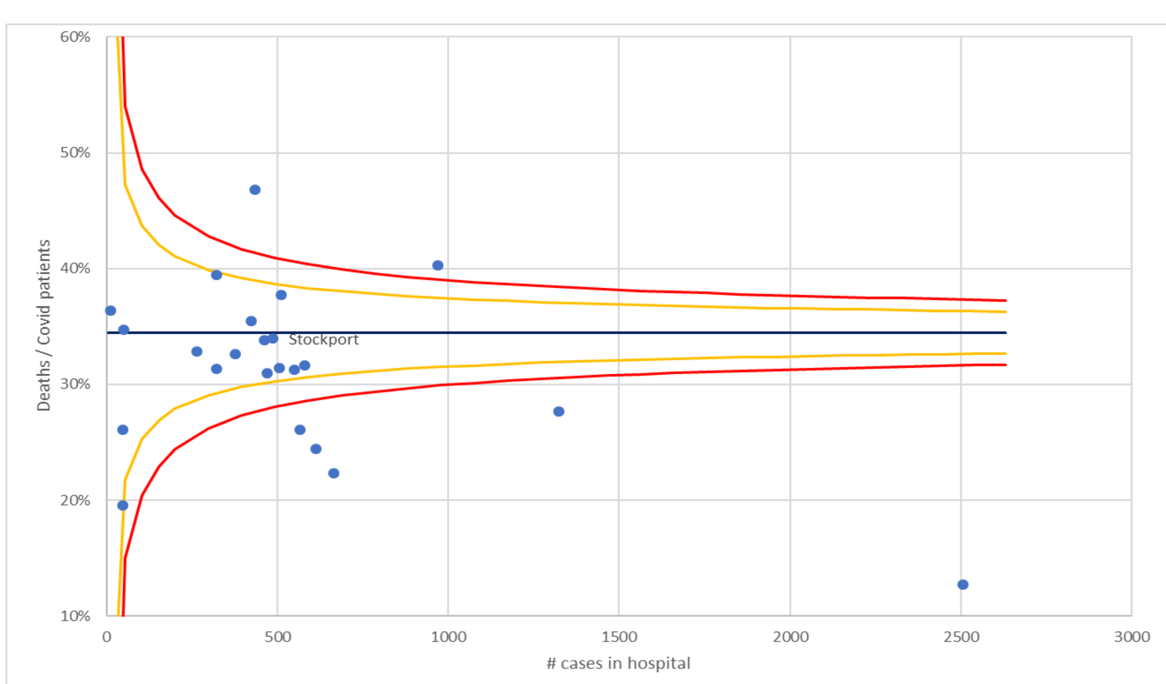


Fig 4: North West of England outcome figures by hospital

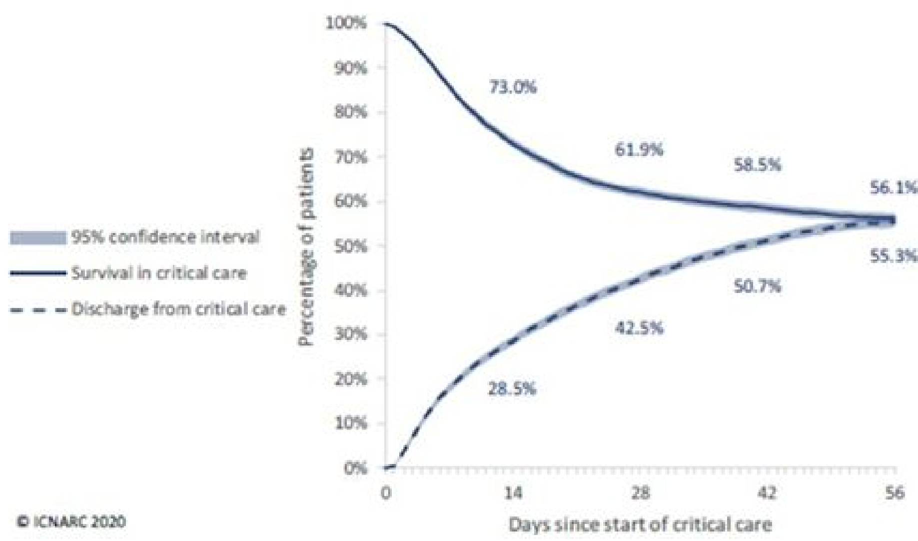


Fig 5: ICU outcomes for Greater Manchester are shown above.

2.1.1 The data shows that the 'surge' while presenting a significant challenge, did not reach the magnituted that was anticipated. We have now had a gradual but consistent reduction in covid related illness for the past month. We currently have 53 inpatients, of which 4 are ventilated on the intensive care unit. On Tuesday we had our first day for two months with not a sigle covid positive result for 24 hours.

2.1.2 We anticipate a further rise in covid numbers 2-3 weeks after the relaxation of the 'lockdown' rules, and a clear trend for an increased frequency of public interactions. The rise in new cases this week may be the beginning of the resurgence trend and serves as a reminder not to drop our guard.

2.1.3 Overall trust mortality for patients admitted with Covid has been approximately 35%, which aligns with that experienced elsewhere. The GM ICU mortality rate was 43%. We have not formally received our ICNAC feedback but believe that we compare favourably with that outcome. Of note is the duration of care in ICU – over one month for 25% of patients.

2.2 **Phase 2 of our Covid response.**

2.2.1 We are now formally in 'phase 2' of Covid. While phase 1 prioritised preparing capacity for the surge, phase 2 is about:

- Maintaining flexibility to address future surge.
- Reducing the risks of in hospital transmission of covid.
- Assessment and safety of all staff.
- Initiation of elective work
- Reducing risk presented by treatment delays.

2.2.2 To support the development of a regional (Greater Manchester) capacity plan, the COOs, MDs and Chief Nurses have identified a number of principles to guide prioritisation of activity:

1. The priority is to maintain safe patient flow at all times and such we will adhere to national IPC guidance
2. Subject to any restrictions this brings, patients should be treated as locally as possible where clinically appropriate
3. Prioritisation will be based on clinical urgency
4. Where services are provided at specialist sites or on a sectorial basis consideration should be given to the overall impact of staffing, equipment and supplies at all sites
5. Occupancy levels are to be a maximum of 80% (subject to the impact of national guidance on social distancing and IPC), including the principle of seven day working across the system
6. Maintain discharge to assess and rapid discharge process to maintain reduced levels of DTOC and stranded patients
7. Use of the independent sector should be clearly planned in advance as part of an overall capacity plan for GM and may include both planned and unplanned activity

2.3 **Maintaining flexibility to address future surge**

2.3.1 Relaxation of the 'lockdown' measures will be gauged at a rate that will limit the transmission of Covid through the community. Success will see a constant, limited rate of Covid infections presenting to our hospitals over the coming months. Failure of this strategy could see infections rise, and a 'second surge' develop. All commitments to direct care resource into planned care must be flexible enough to stop at any point and revert to our 'surge' planning.

2.3.2 In the past two months we have seen non elective presentations to the trust dramatically down. As the public regain confidence, patient numbers will increase. There will be undiagnosed pathology that will present late (as patients have avoided hospital attendance) and some will require urgent intervention. This non covid surge also presents a considerable risk.

2.4 **Reducing infection risks between patients – Zoning the hospital.**

2.4.1 For the past three weeks we have been routinely screening all non-elective admissions for Covid, and keeping all patients in an 'amber' screening area until their results are available. We now have the hospital arranged into a number of 'zones'.

- **Blue Zone** – Known Covid positive patients.
- **Amber Zone** – Screening areas for non-elective admissions awaiting their swab result.
- **Green Zone** – includes patients with a negative screening swab and symptoms not typical of Covid infection. Also includes patients at least two weeks after their Covid infection and in whom respiratory symptoms and temperature have been settled for at least 48 hours.
- **Higher risk Acute Care Areas (HACA)** - These are areas where aerosol generating procedures (risk of airborne transmission) regularly occur.

These areas are all clearly demarcated and staff use enhanced PPE precautions.

- **Ultra- green zone** - Elective surgery carries an increased mortality rate of +20% should covid infection be acquired in the peri-operative period. Development of a surgical offer on this site requires meticulous zoning of an 'ultra-green' approach. This area will initially be within the D block theatre complex. Over the next week, we plan to expand this zone to include all of the wards of floor two of the theatre complex (D5, 6, 7, and 8) as well as the lifts and two connecting corridors.

2.4.2 We plan a phased increase in elective surgery using this ultra-green zone, such that we can offer reduced waiting times for as many of our urgent surgeries as possible.

2.4.3 We plan to expand our offer of surgery through the Alexandra hospital for as long as this facility is made available to the NHS. We also have access to theatre capacity at the Christie hub for suitable cancer surgery.

2.4.4 Specialised robotic surgery and surgery requiring post op critical care has been hard to locate on other sites. By developing our own offer here, we will be able to meet the needs of a number of our patients. Our first elective surgery was successfully undertaken last week.

2.4.5 As part of the planning for Phase 3, we are preparing our plans for the period July 2020 – Mar 2021 – these will need to be submitted to GM in late June.

2.5 **Assessment and safety of all staff**

2.5.1 While the risk from a known Covid infected patient is well recognised, the risk from patients with non Covid admissions, and from other members of staff can often be forgotten, but may be every bit as significant. Being around 'people' carries risk. While this risk can be mitigated in part, it cannot be eliminated altogether.

2.5.2 As part of our phase 2 response, we are developing a suite of measures, each of which will support the dual goal:

- Reduce the risk of staff transmission in the workplace.
- Minimise the exposure of those staff at greatest risk.

2.5.3 Throughout this time, we have maintained standards of PPE, and been clear with our staff that 'no PPE means no work'. We had a temporary shortage of visors in our first weeks of the pandemic, with some re-use of single use items, and more recently a shortage of hoods (used for staff who fail fit testing in all available masks) resulting in shared equipment between staff after decontamination. We now have plenty of visors and plenty of hoods. A brief shortfall in surgical hats last week was soon resolved. Our procurement teams are to be commended on their management of this time and continue to consistently deliver the required PPE.

2.5.4 We will be offering face coverings to our staff to reduce the risk of asymptomatic staff transmission, particularly in areas where social distancing is difficult or impossible.

2.5.5 The relative increased risks of our black and ethnic minority staff has been widely reported, and has caused considerable anxiety for many staff. In addition, risks associated with diabetes, high blood pressure, age and obesity are also very significant. Staff with the highest risks are formally designated as 'shielding' at home, having received a letter from the hospital or GP practitioner.

2.5.6 For those not formally shielding we carry out an individual risk assessment, and agree a working environment that is proportionate to their risk.

- Working from home
- Working on site, in a non-patient facing environment
- Working in low risk, patient facing environment
- Normal work

2.5.7 In recognition of the increasing numbers of clinical staff restricted to working from home, we are developing means of delivering virtual clinical care. Virtual clinics are now routine, but we are now also piloting virtual ward rounds, and use these staff to offer advice and guidance to primary care and to on site staff. Non patient facing staff are able to support national guidance reviews, supported governance functions, and assisted family communications.

2.5.8 The benefits of developing tasks for those unable to fulfil their usual roles are in; service resilience, skill retention, staff wellbeing, teamwork and sustainability.

2.5.9 Finally, we will be offering risk reduction advice to our staff, including prioritisation of existing process such as diet and nutrition advice, exercise classes and smoking cessation support.

2.6 **Initiation of elective work**

2.6.1 Along with the increasing recognition of patients awaiting urgent clinical care, and those patients too afraid to present to hospital, an urgent priority is the safe introduction of planned care.

Key principles:

- Maximise all opportunities for remote, multi-professional virtual consultations.
- Only admit elective patients who are asymptomatic having isolated for 14 days prior to admission.
- Outpatients only if asymptomatic and can comply with social distancing.
- Enhanced protection for those shielding (e.g. mask provided on arrival).
- Any symptomatic patients immediately isolated.
- Maximise separation between elective and unplanned patient pathways.

- Limit staff movement and crossover of care.
- Solutions must be flexible (on / off).
- Ensure elective demands for testing/ PPE/ consumables are compatible with covid needs.

2.6.2 During the covid pandemic, we have delivered a massive breakthrough in the use of virtual healthcare, with the delivery of on line clinics with ever increasing frequency. Development of a ‘drive through’ phlebotomy service on site has really supported this development.

2.6.3 We do not plan to return to the ‘old’ ways; rather will focus upon sustaining and building on our current approach.

2.6.4 We have been undertaking urgent planned local anaesthetic procedures for some time, more recently began day case urgent diagnostic procedures including general anaesthesia, and last week undertook our first major surgery in our ‘ultra – green zone’ (outlined above).

2.6.5 In addition to our onsite surgical work, we have been working closely with the BMI Alexandra hospital in Cheadle, and our staff have completed over 40 urgent operations there. We will be working closely with them in the coming weeks to increase the work undertaken in collaboration with them.

2.6.6 Phase two seeks to initiate our elective capacity. We will need to develop this rapidly over the coming weeks if we are to meet the desperate need that we are soon likely to face. Surgical, diagnostic and endoscopic capacity will be an absolute priority.

2.6.7 Streamlining care, to maximise capacity, while maintaining optimal infection prevention measures between patients, and staff will be pivotal to optimising our response.

2.7 Reducing risks associated with treatment delays

2.7.1 During the acute phase of the pandemic, bringing patients into hospital was an unjustified risk other than for the most important of investigations. We currently have a large number of patients awaiting investigation or treatment;

- 4000 diagnostic procedures on our waiting list.
- 1500 endoscopic examinations requested.
- 600 patients being investigated for a new cancer diagnosis

2.7.2 These cases have been triaged and prioritised by our clinicians. Most have been deemed appropriate for some delay, but the risks associated with prolonged delays will be different from an anticipated short delay.

2.7.3 Dealing with the backlog of investigations, while working in a slower process due to infection prevention measures, and in the context of an increasing demand (non covid surge) will mean that some patient delays will result.

Our key focus will be;

- Initiating efficient use of capacity and resources as soon as possible
- Efficient stratification, such that priority cases are done first
- Regular risk assessment of cases with prolonged wait
- Good communication with patients, to minimise anxiety
- Oversight of delays, such that resource can be redirected to best effect; and

- Liaison with GM organisations, offering and receiving mutual aid where clinical risk develops.

3. RECOVERY PLANNING

3.1 Second Phase of NHS response to Covid19

3.1.1 The initial requirements for 'recovery' were set out in a letter dated 29 April from Simon Stevens and Amanda Pritchard. This was followed by regional requirements for the North West communicated via a further letter dated 29 April from Bill McCarthy.

3.1.2 Each of the 'phases' are described in the table below:

	Phase 1	**Phase 2**	**Phase 3**	**Phase 4**
PHASE	Covid 19 level 4 incident response	Covid 19 level 4 incident response and critical services switch on	Ongoing Covid 19 management and NHS open for business	New NHS
TIMELINE	March 2020 - April 2020	May 2020 – 30 June 2020	July 2020 - March 2021 May need to be broken into shorter periods, or reviewed at the end of the calendar year	April 2021 onwards
PURPOSE	Enable NHS to deal with peak covid 19 demand	Identify critical services risks and impacts during Covid 19 preparation and peak Start to restore safe service levels for critical services, lock in service innovation and signal re start to some routine services Develop monitoring tools to measure and reassure	Ensure capacity in place for ongoing Covid 19 activity Return critical services to agreed standards Address backlog of services Retain changes from pandemic we wish to keep	BaU covid 19 service in place including sufficient critical care headroom NHS priorities established Improved service models as BaU

3.1.3 For Phase 2, each business group undertook a high level assessment against national priorities set out by NHS England (Stevens/Pritchard letter). At a summary level:

- A total of 41 priority activities to restart were identified - 31 are applicable to the trust.
- Business Groups rapid self-assessment provided assurance that we are in a generally good position.
- The Trust had continued to offer all priority activities in some form, but not across all Business Groups.

3.1.4 GM also set out a number of areas agreed as priorities due to the potential for these being life threatening / life changing:

- Cancer – surgery, screening (breast, bowel and cervical), diagnostics (endoscopy).
- Cardiovascular – including cardiac surgery, cardiology, stroke, vascular surgery, AAA screening.
- Maternity – neonatal and antenatal screening, high risk elective, elective C-section.
- Mental Health – CAMHS, ECT, Mental Health support to Adult providers.

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- Ophthalmology – sight limiting / threatening - retinal detachments, AMD.
- Respiratory pathway for post COVID patients.

3.1.5 We were required to submit a high level capacity plan to GM on 13 May which covered physical beds defined by: Critical care, Ward beds (General & Acute) and adjusted capacity - revised expected capacity taking into account workforce, oxygen, IC policy etc. We also set our self-assessment against the GM priorities and identified a number of small capital priorities for recovery. The plan also identified a number of significant risks to recovery, most notable of which was workforce.

3.2 **Phase 3 Planning**

3.2.1 The requirements for Phase 3 capacity plans are starting to be communicated by NHSE/I. The aim of Phase 3 is to ensure the NHS has the headroom to deal with winter pressures and other activity as well as having the flexibility and resilience to deal with ongoing Covid-19 demand. GM has agreed to develop a single integrated capacity plan across both the Hospital and Out of Hospital Cells.

3.2.2 We will need to submit a plan to GM by 22 June reflecting some key hospital capacity planning assumptions:

- Protection of hospital bed occupancy at 80%.
- Separation of Covid/non-Covid, PPE and decontamination can be supported.
- A&E attends do not rise above 75% of pre-Covid levels.
- DTOC remains at May 2020 levels.
- Potential for 60-70% outpatients to be undertaken through virtual means.

3.3 Each locality will be required to provide a narrative to support the assumptions set out above.

3.3.1 **Governance**

The executive lead for recovery is the Director of Strategy, Partnerships & Transformation. We have in place a weekly Planning Group (via our Senior Management Team), as well as a Technical Group (corporate leads form finance, workforce, planning, informatics, performance). This is overseen by an Executive Oversight Group ensuring key issues and risks are reported to the Executive team.

4. **OUTSTANDING RISKS TO QUALITY AND SAFETY**

4.1 The following risks need to be reflected in our recovery capacity plan:

- Risk of further covid or non covid surge
- Staffing risks of 579 staff ‘off work’ and many more unable to do patient facing roles
- Capacity risks with 7 wards closed, the need to maintain a ‘zoned’ approach to patient care, and a need to maintain social distancing in hospitals
- Essential equipment and PPE supply being maintained
- Diagnostic and treatment delays for patients with cancer
- Treatment delays to patients with non-cancer pathology and resultant morbidity.
- Public perception of hospital risk deferring presentation, resulting in an increased risk of disease, with and late presentations and associated mortality / morbidity
- Risk of in - hospital transmission between patients and staff alike
- Minimising the risk of exposure of our most ‘at risk’ staff groups

5. CONCLUSION

5.1 The organisational response to Covid has been a good one thus far, and delivery of high standards of care were maintained through the Covid surge.

5.2 We are now in phase 2, and planning for phase 3, with ever increased focus on reducing Covid transmission in hospital, and on safely initiating urgent elective activity. A number of Covid and non-Covid risks remain.

6. RECOMMENDATION

6.1 The Board are asked to note this report.

Report to:	Board of Directors	**Date:**	4th June 2020
Subject:	Trust Strategy		
Report of:	Director of Strategy, Partnerships and Transformation	**Prepared by:**	Strategy & Planning Team

REPORT FOR APPROVAL

Corporate objective ref:	All	**Summary of Report** The Board of Directors approved a new Trust Strategy in January 2020. This has been updated in light of the recent CQC report, experience of the COVID-19 response, and recent governance review. The updated Trust Strategy is presented here for Board approval. The Board is recommended to approve the content of the updated Trust Strategy.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	Annex A – Draft Trust Strategy

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Exec Management Group ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. **INTRODUCTION**

1.1 The Board of Directors approved a new five-year Trust Strategy in January 2020. This has been updated to reflect the recent CQC report, experience of the Trust's response to Covid-19 and a review of governance undertaken by NHSE/I. The scale of the impact of these three issues warranted an update of the Strategy document.

1.2 The updated Trust Strategy document is presented here for Board approval.

2. **COMMUNICATING THE STRATEGY**

2.1 A number of key next steps are referenced within the document, including launching our new Trust Strategy.

2.2 A public version of the strategy will be designed using new Trust branding in June. This will be made available to download from the Trust website and intranet. The Strategy will be promoted via usual Trust mechanisms such as screen savers, Team Brief and CEO Update.

2.3 Plans to engage staff teams in embedding the Trust Strategy will need to be modified in light of social distancing rules. A communication plan is being developed to launch the Strategy via a video conference and webinar, with a broader plan incorporating other ways of engaging our staff. This will build on the success and positive feedback received from the recent CQC video briefing sessions with the Chair and Chief Executive.

2.4 The Strategy & Planning team will also work with teams from across the Trust to communicate the new Trust Strategy via appropriate forums to help teams to understand how they can contribute to our overall mission of "Making a Difference Every day".

3. **RECOMMENDATION**

3.1 Trust Board is recommended to approve the updated Trust Strategy and plans for launch.

TRUST STRATEGY

2020-2025

6.2

Making a Difference Every Day

Contents

1. FOREWORD....4
1.1 Why do we have a strategy?....4
1.2 What is our strategy and how has it been developed? 4
1.3 How will the strategy be delivered? 5
2. OUR PLAN ON A PAGE....7
3. WHAT OUR TRUST WILL LOOK LIKE IN 2025....8
4. OUR TRUST....9
4.1 Our services....9
5. OUR POPULATON & DEMOGRAPHICS 11
5.1 Stockport....11
5.2 Cheshire East....12
5.3 North Derbyshire 13
6. OUR PERFORMANCE 14
7. OUR IMPROVEMENT JOURNEY....16
7.1 Emergency and urgent care 16
7.2 Improvements made....16
7.3 Accreditation for continued Excellence (ACE) 17
7.4 Capital investment 17
8. OUR FINANCES....18
8.1 Stockport Place Strategy....23
9. OUR STRATEGIC ENVIRONMENT....20
9.1 NHS Long Term Plan....20
9.2 Greater Manchester Health and Care Devolution 21
9.3 Stockport Locality....22
9.4 Impacts of Change....22
9.5 Locality Plan Work Programmes .... **Error! Bookmark not defined.**
10. BEYOND STOCKPORT 23
10.1 Derbyshire North 23
10.2 East Cheshire....23
10.3 Greater Manchester....24
10.5 Our role and influence 25
11. OUR STRATEGY 2020-2025 26
11.1 Process for developing our strategic plans 26
11.2 Our Mission 27
11.3 Our Strategic Objectives 27
12. OUR VALUES....33

6.2

13. OUR ENABLING THEMES 34
14. DELIVERING OUR STRATEGY 35
14.1 Supporting Strategies 35
15. GOVERNANCE 36
15.1 Operational Plan 37
15.2 Business Group Plans 37
16. NEXT STEPS 38
16.1 Launching our strategy 38
16.2 Corporate objectives 38
16.3 Clinical Services Strategy 38

6.2

1. FOREWORD

Stockport NHS Foundation Trust is no ordinary Trust. It holds a unique position in the Stockport community as the provider of health care to its population, and it is one of its largest employers. It offers a number of specialist services, including our highly rated stroke service, and plays a key partnership role within Greater Manchester, Stockport and East Cheshire.

Like many other NHS organisations, Stockport NHS Foundation Trust has its challenges in terms of improving the quality and performance of its services, as well as managing its finances. We have made improvements to many services over the last few years, but these changes have not always been sustained for a number of different reasons. This is reflected in our most recent inspection from the Care Quality Commission (CQC). As a Trust, we will not be satisfied until the care we provide to all our patients, every day, is of the standard we would want for our own families.

We are not content to just deal with the challenges of the here and now. We have ambitious plans for major changes to how and where care is delivered. In responding to the unprecedented challenge of the Covid-19 pandemic our staff have demonstrated every day their commitment to providing the best possible care for our patients. They have also been innovative in rapidly adopting new ways of working and changing how some of our services are delivered. We will harness the enthusiasm and commitment from the way we responded to Covid-19 to help shape the delivery of our recovery and future plans.

1.1 Why do we have a strategy?

The challenging environment facing us presents an opportunity for us to deliver our services in new ways; working across traditional boundaries and seeking innovative solutions that will help all parts of our health and social care system become truly integrated around the needs of our communities.

We also know that the role of the hospital is changing, and we recognise the part we must play in preventing ill health. More services will be provided closer to or at patients homes, with many provided via digital technologies.
In this strategy we describe:

- the role the organisation will play in the local and regional health and social care system;
- the actions we will take to continue to improve the quality and performance of our services, and achieve financial sustainability;
- our horizon scanning towards the future beyond 2025; and
- how we will support our staff to do this and realise our collective potential.

Our strategy will guide us through the transformation and change required to deliver our ambitious future underpinned by our values.

1.2 What is our strategy and how has it been developed?

We have undertaken a major piece of work to re-fresh our strategy for the future. Our previous strategy incorporated the system approach set out in 'Stockport Together' but this did not maintain the momentum anticipated, hence there was a need for us to refresh our own Trust strategy.

This document sets out Stockport NHS Foundation Trust's vision for its medium-term future, and its aims and aspirations as an organisation that punches above its weight in terms of influencing the development of the local and regional health and social care system, delivering more than just an ordinary district general hospital trust.

Our strategic priorities and objectives have been developed and informed through engagement and listening exercises with our staff and stakeholders. We have also engaged our staff and patients in re-defining the values and behaviours that underpin successful delivery of our strategy.

Our high level strategy is:

- to continue to develop our position as an anchor institution for Stockport (the Borough's second largest employer) to benefit local people and the economy;
- to be the leading provider of integrated services locally;
- to "punch above our weight" in Greater Manchester;
- to become a clinically led and managerially enabled organisation;
- to develop our capacity and capability for transformation so that we lead this across the local patch; and
- to forge strategic partnerships with neighbouring Trusts and local partners to ensure sustainability and development of services.

1.3 How will the strategy be delivered?

We will identify annual delivery programmes linked to our strategic and corporate objectives. These will be led by Senior Responsible Officers (SROs) and will identify quantifiable and measurable outcomes, timescales and clear lines of accountability and governance by which to monitor delivery.

We cannot deliver this strategy alone. It has been developed in the context of partnership. Our patients rightly expect their care to be integrated and we will achieve this by working together with partner organisations.

As the NHS starts to plan for the next ten years following the publication of the NHS Long Term Plan - a longer-term funding approach to health and social care - our strategy describes how we will meet these demands differently, creating and taking opportunities to integrate.

Our strategy has been shaped by what we know about the people we serve, including:

- Demographic changes and the ageing population.
- Deprivation in some of our communities .
- The national move towards integrated care systems.
- The need to avoid unnecessary hospital admissions and longer stays.
- Public perception and expectations.
- Increased diversity within the communities we serve.

Within our Trust there have also been some changes:

- New members of the Board of Directors, including the Chief Executive, Director of Finance, Director of Workforce and Organisational Development, Director of Strategy, Partnerships and Transformation and Non-Executive Directors, all of whom bring fresh experience, skills and focus to the Trust.
- A drive to improve the quality of services following recent CQC inspections, with a focus on moving to “Good” and eventually “Outstanding” ratings.
- A commitment to improving the performance of a range of services to consistently achieve local and national standards.
- A determination to move towards a stable financial position that will underpin successful delivery of quality and performance improvements.

Our refreshed strategy aims to set out a clear road map for how we will adapt to the changing NHS and social care landscape, and sustain a thriving organisation that provides safe, high quality care for the people who need our support, and makes Stockport NHS Foundation Trust a great place for our staff to work and develop.

2. OUR PLAN ON A PAGE

Mission	Strategic objectives		Values	Enabling themes
Making a difference every day	A great place to work	• To deliver the 5 aims of the People Strategy • Provision of resources; Culture and engagement; Education and Development; High performing - Striving for excellence; Leadership development • To improve the Health and well-being of staff • To provide equally positive employment experience for our staff from all backgrounds and communities	We care	**Digital** - Optimisation, business intelligence, infrastructure & agile working
	Always learning, continually improving	• To embed a culture of Safety and create an environment of continuous quality improvement, research and innovation • Increase our levels of innovation, increasing the pace of change and improving long term decision making • Positively act upon learning To develop support packages for medical and nursing students, trainees and clinical development roles		**Innovation** - Clinical and service innovation and research & innovation
	Helping people live their best lives	• To embed an approach of realistic care in order to deliver better outcomes for our patients before, during and after their treatment and to meet the preferences of our patients at the end of life • Improve the health & well-being and experience for our staff and patients • Play a key role in supporting the priorities of the Locality Plan and CCG strategy – Start Well, Live Well, Age Well, Die Well • To provide an equally positive experience of services for patients and carers from all backgrounds and communities	We respect	**Leadership, Culture & Workforce** - Clinical leadership, quality improvement faculty, Staff development and communication
	Investing for the future by using our resources well	• Optimising our clinical outcomes through effective clinical leadership • Clinical service line strategies will achieve financial and clinical sustainability • Achieve a break even financial position in line with expectations • Invest in the development and wellbeing of our staff, to support retention and recruitment. • Ensure a shared vision for a fit for purpose environment		**Assurance, Governance & Standards** - Systems & processes, our planning approach and PMO
	Working with others for our patients and communities	• Contribute to narrowing health inequalities & supporting health & well-being • Develop strong partnerships with organisations in Stockport • Engage with local communities and neighbourhoods to shape services around local needs • Develop strong partnership working with Trusts in GM and East Cheshire to support sustainable clinical networks, • Positively influence our reputation	We listen	**Place** - Estates (acute & community), right service, right place

3. WHAT OUR TRUST WILL LOOK LIKE IN 2025

For our patients and their communities

- We will improve the role patients, their families and carers have in their care and decision making ensuring they have a great experience, which matches their expectations.
- We will improve our urgent and emergency care access standards performance and build a brand new Emergency Care and Pathology Campus including an urgent treatment centre.
- We will improve flow in the hospital ensuring we reduce days away from home for our patients.
- We will improve accessibility to our services, ensuring equality for our diverse local communities, making sure our services meet the needs of all our patients.
- We will be in the lowest quartile nationally for clinical errors.
- We will embrace the latest technology and modernise key parts of our estate to improve our services.
- We will develop more joined up services ensuring patients receive the right care, in the right place and at the right time.

For our staff

- Our organisation will be a great place to work.
- Staff from all backgrounds will have an equally positive experience of working for us.
- We will strive to have happy staff and satisfied patients making us an attractive place to work.
- Our leaders will better reflect the diversity of our workforce and local communities.
- We will have a stable, highly motivated workforce, with the skills and expertise to deliver improvements.
- We will lead improvement and innovation across the local patch in line with national and regional delivery programmes.
- We will improve the well-being and resilience of our staff.

For our partners

- We will forge strategic partnerships with neighbouring Trusts and local partners to ensure clinically led, sustainable services
- We will lead and contribute to aspects of developing a different system model which further integrates Health & Social care for patients, making the best use of our collective resources
- We will work with local partners to deliver a borough wide approach to improve health and social care, so that Stockport is known for its areas of excellence and not its challenges

4. OUR TRUST

We are no ordinary trust.

We hold a unique position in the Stockport community as the provider of healthcare and we are one of its largest employers. We are an integrated provider of acute hospital and community services to the people of Stockport, as well serving the populations of East Cheshire and the High Peak in North Derbyshire.

We offer a number of specialist services and play a key partnership role with Greater Manchester, Stockport and East Cheshire. With an annual budget of around £300 million and about 5,000 staff we provide healthcare for residents in Stockport, East Cheshire and North Derbyshire as well as patients we treat from other borough in Greater Manchester who choose our services.

The marked variation in deprivation across the area we serve - one of the 5 most polarised populations in England in terms of health and wealth - has an impact on the health and care needs of local people. While the health of the local population is generally improving many people are living with one or more long term condition, such as diabetes or dementia as shown in the graphic on page 11.

We are also seeing advances in healthcare, which mean we can care for people who would previously have been untreatable, and as a result are living longer. However, they are increasingly frail and need more health and social care support.

4.1 Our services

Our main hospital is currently known as Stepping Hill, which provides emergency, surgical and medical services for people living in Stockport and surrounding areas. Our stroke services have been rated as the best in England, and we also run one of the largest orthopaedic services in the region. We offer a range of core district general hospital services as well as some specialist services, such as Orthopaedics, Stroke, and Urology that have a national reputation for excellence. We are also one of four designated specialist sites for acute and general surgery in Greater Manchester.

We also run the Meadows in Stockport which is a community Transfer to Assess, intermediate nursing care facility and Swanbourne Gardens which provides overnight breaks for children and young people with severe learning disabilities. We also currently run the Devonshire Centre for neuro-rehabilitation although this service will soon transfer to Salford NHS Foundation Trust.

We are proud of our community health services that run across 24 health centres and community clinics in Stockport. Our vision for neighbourhood services is to provide a joined up, high quality, sustainable, modern and accessible health and care system.

The new community models of care address the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport.

We are an associate teaching hospital, helping to train doctors and nurses for the future.

In our region, we are one of four specialist hospitals for emergency and high risk general surgery; one of three specialist stroke centres; and one of only two orthopaedic departments delivering C-spine surgery in Greater Manchester.

5. OUR POPULATON & DEMOGRAPHICS

We deliver healthcare services to meet the needs of the populations of Stockport and neighbouring areas of North Derbyshire and East Cheshire. Within these demographic areas, all boroughs have a higher than average population aged 65+ with more acute health needs.

5.1 Stockport

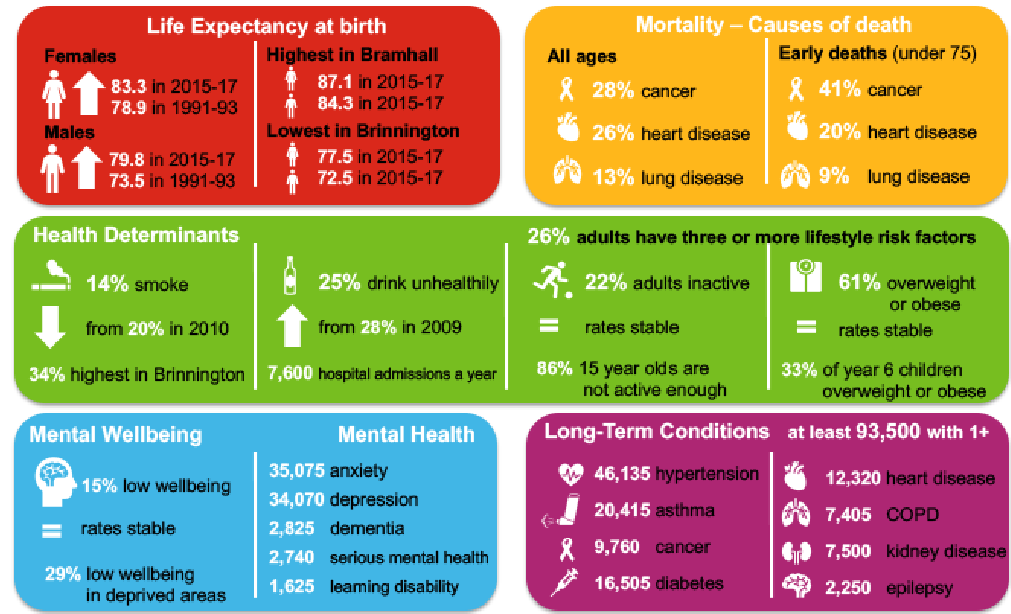
Stockport has a population of 291,045 residents, with 313,610 people registered at one of Stockport's 37 GP Practices. The population is growing by around 1,000 people a year and is expected to continue to grow at this rate over the life-span of this Strategy.

Overall, Stockport is one of the healthiest places to live in Greater Manchester, and the wider North West, with health outcomes broadly in line with national averages. Rates for deaths from cardio-vascular disease, road injuries, childhood obesity and physical activity in adults are all better than national averages. However, rates of alcohol harm, breast feeding initiation, and infant mortality are all below the national average.

These borough wide figures mask significant health inequalities between different parts of the borough, for example life expectancy is 11 years longer for men in the most affluent parts of the Borough than for those living in the most deprived. Declining health starts earlier in the more deprived parts of the Borough; 55 years compared to 71 years.

Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over. This presents a significant challenge to our community and acute services often resulting in more frail elderly patients requiring hospital admission with increasing complex care needs.

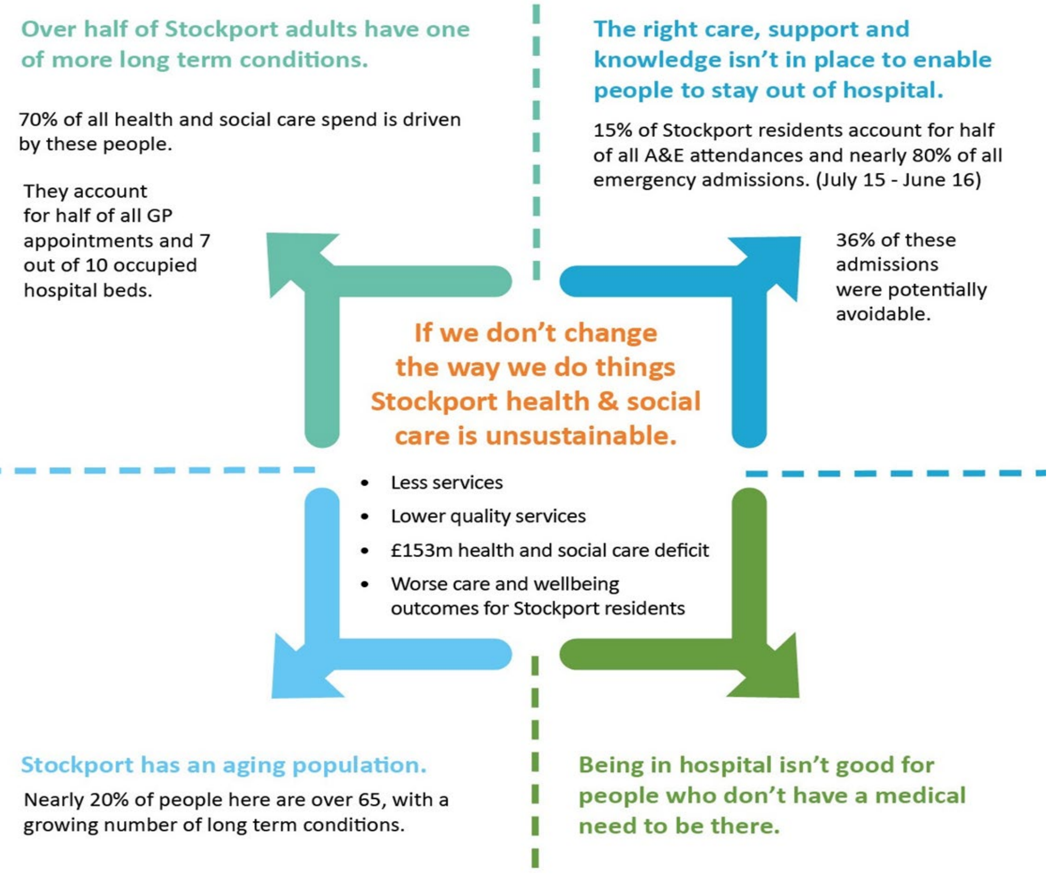
Stockport's population has a wide range of health needs



6.2

Cancer is the main cause of death in Stockport, but 40% of cancers are preventable through lifestyle choices such as improved diet and exercise. Liver disease is the only area where mortality rates in Stockport are significantly worse than the national or peer average, making alcohol consumption a key issue for the borough.

40% of people registered with a Stockport GP have one or more long-term health conditions, increasing the complexity of care needs in the borough (see full list in appendix 3). Hypertension is the most common condition, affecting 46,135 people. Asthma is the major condition affecting school aged children – more than 2,000 cases – and anxiety is the major long-term condition among young adults, affecting over 3,000 people between the ages of 15 and 24.



5.2 Cheshire East

The Cheshire East Council Borough profile for 2019/20 estimates the population of Cheshire East to be 378,900.

- 67,400 (17.8%) are aged 0-15,
- 226,100 (59.7%) are aged 16-64
- And 85,300 (22.5%) are aged over 65.

Between 2017 and 2027 the population is expected to increase by 11,400 (a 3% increase), but this figure masks the fact that the working age population is expected to fall by 6,100 (a 2.7% decrease) and the number of people aged 65 and above is expected to increase by 17,000 (a massive 20%

increase). These figures indicate an increasing demand on health and care services from an ageing population.

Overall Cheshire East is a relatively affluent area; however, there are a number of pockets of deprivation – where health and wellbeing are likely to be worse than the average – whose figures are often masked by Borough wide statistics. Latest (2015) data indicates there are 18 small areas in the most deprived 20% nationally; six of these areas are in the most deprived 10% of areas nationally. We see approximately 26,000 patients from East Cheshire which equates to 7% of population.

5.3 North Derbyshire

Approximately 786,000 people are estimated to live in Derbyshire County. The population is older than the England average. The population is expected to increase by 79,000 (10%) over the next 20 years and the number of people aged over 90 years old will treble.

Average life expectancy and healthy life expectancy for both men and women is significantly lower than the England average. There is a large difference in healthy life expectancy between men and women living in the most and least deprived communities.

The High Peak area of North Derbyshire borders Stockport. It is this area where most of the patients we see and treat from Derbyshire live. As with other parts of Derbyshire, the population is generally older than the England average. We see over 50,000 patients from this area annually, which is more than10% of our annual patient activity.

6. OUR PERFORMANCE

We are committed to providing the highest quality and safest care for patients, as well as contributing to the health and wellbeing of the people we serve. Our performance is examined critically so that we can build on good practice and keep on learning. Achieving key national and local clinical and performance standards is a priority as the visible measurable of the quality of our services.

Like many other NHS organisations we face challenges in consistently achieving these standards, and our performance has followed national trends, but our aim is always to improve.

Stockport CCG has identified six delivery programmes in their recently published strategy; four of these directly align to our services:

6.2

Community Care	Community health services cover an extensive and diverse range of activities and are sometimes difficult to define. Our community services include • Child health services • Community therapies • District nursing • Falls services • Intermediate care • Active recovery • Crisis response • Specialist nurses (e.g., diabetes, heart failure, incontinence, tissue viability) • Wheelchair services Our services are delivered in a wide range of settings – including all 24 of Stockport's health centres, as well as in people's own homes - this means they are often less visible than the services we deliver at Stepping Hill. This doesn't mean they are any less important. By being an integrated provider of both acute hospital and community services we can make sure that our patients get the right care, in the right place and the right time. Stockport Family is an integrated service for children, young people and families; it brings together social workers with the wider children's workforce, such as health visitors, school nurses and midwives. Staff from our Trust are part of the dedicated workforce that is committed to different ways of working with children, young people and families.
Maternity & Children	Some 2,750 babies are born at Stepping Hill each year, and our maternity services are well regarded with high patient satisfaction levels. We are always striving to improve the safety and quality of maternity services and as such we are working towards full implementation of Better Births and Saving Babies Lives Care Bundles. We are also part of wave 3 of the national Maternity and Neonatal safety collaborative. We are part of the 'Stockport Family' integrated service working with partners in the

	local authority, commissioners, primary care and schools. This service is regarded as an exemplar model for the delivery of integrated children's services. We are also proactively working with teams at East Cheshire NHS Trust to support the future design of services for Macclesfield patients.
Elective Care	Nationally, demand for planned, elective, care has grown by 26% over the last decade. As demand for hospital services has grown, so too have waiting times. In collaboration with our local partners, we will manage demand for elective care by diagnosing, treating and managing follow-up care for more people out of hospital, where clinically appropriate, in line with the ambition of the NHS Long Term Plan. The resulting reduction in pressure on hospital services will allow us to reduce waiting times and meet all national standards. In partnership with Stockport CCG, we are working as a locality leading work on behalf of Greater Manchester to reform elective care.
Urgent Care	The Stockport health and care economy has been significantly challenged in managing urgent care in recent years. This has resulted in emergency and urgent care performance across the system remaining below the national standard. The introduction of same day emergency care, whereby patients with some medical concerns can be assessed, diagnosed, treated and safely discharged home the same day rather than being admitted, has been introduced. This is being delivered through, our Clinical Decision Unit, an Ambulatory Ill GP stream, our FRESH team, multidisciplinary Frailty Intervention Team, Community Crisis Response Team, GPs in the emergency department, and extended opening times for the Ambulatory Care Unit, all providing a collaborative approach with partners working together to respond to system challenges Stockport's Urgent & Emergency Care Delivery Board brings together partners from across health and care to support alternatives to emergency hospital admissions in the community; to improve processes within the Emergency Department; and to enable better patient flow in hospital, helping people to get home and regain their independence. The partnership approach is underpinned by the strategic aims set out in Stockport CCG's strategy of *Start Well, Live Well, Age Well, and Die Well*. A recent capital award of £30.6m to build an ambitious Emergency Care and Pathology Campus at Stepping Hill will help to transform the way we are able to provide urgent care in the future.

6.2

7. OUR IMPROVEMENT JOURNEY

The Trust has been inspected a number of times by the Care Quality Commission (CQC) in the last three years. We have been rated as 'Requires Improvement' on each occasion. While specific improvements have been identified by the CQC following individual inspections, the report of the most recent inspection, published in May 2020, indicates that these have not been sustained.

We do not aspire to be a 'Requires Improvement' Trust. We want to be rated as 'Good' and eventually 'Outstanding'. While there is clearly much work still to do, the Trust is determined to redouble our efforts and build on changes that have been made recently to make the necessary improvements to get us there. It is the right thing to do for both our patients and our staff.

7.1 Emergency and urgent care

A key part of us achieving a CQC 'Good' rating will be tackling the pressure on our emergency and urgent care services, and in achieving the four hour wait for treatment standard target. Our Emergency Department (ED) was designed for 50,000 attendances per annum and we currently receive >100,000 per annum.

In the longer term, the building of an Emergency Care and Pathology Campus at Stepping Hill Hospital and changes in practice will help us to redesign provision of urgent and emergency care on the Stepping Hill site and aid great inter-agency working. Learning from the experience of managing the COVID-19 pandemic will also be important. We are working closely with partners to help create a fit for purpose and sustainable urgent care system in Stockport and we are supporting our clinical and professional leaders to do this.

In 2018/19, we spent £1.2m provided by NHS England to expand the number of consulting and treatment rooms in the existing emergency department to incorporate additional capacity for the number of patients attending our ED. The new funding will enable the Trust to construct a three storey purpose built Emergency Care and Pathology Campus. It will include an urgent care treatment centre, GP assessment unit, and planned investigation unit.

7.2 Improvements made

There are huge challenges currently facing the NHS, and Stockport is no different – scarce workforce, an ageing population, a rising demand for health and care services, financial pressures, to name just a few. And when things are tough, as they undoubtedly are currently, we quickly forget the positives, but just looking back over the last 12 months we have lots to be proud of.

We've seen:

- the number of compliments received by our services rise;
- patients highly recommend us as a place to be cared for;
- new clinical staff join us;
- huge engagement from staff across the Trust in the development of our new values and behaviours;
- hundreds of Proud to Care certificates awarded to staff throughout the organisation;

- great developments driven by patient feedback such as the veteran's passport to health and care that has been hailed nationally as an example of good practice;
- national accreditation for a number of services, including Macmillan accreditation for our cancer care and Baby Friendly recognition for our integrated maternity services; and
- a host of regional and national awards for everything from our services and staff, to our approach to equality and diversity.

All of these positives are down to the dedication, enthusiasm and commitment of our staff, who despite all the pressures continue to work every day to make a difference to our patients and their colleagues. They demonstrate the power of strong teams that care about and support each other. This is never been more evident than in the magnificent way our staff have responded to the COVID-19 pandemic.

Areas where we are still working to make improvements include:

- pressure ulcers have been reduced but we are working to reduce them further;
- reducing the number of times we move patients during their hospital stay; and
- improving our discharge planning process.

7.3 Accreditation for continued Excellence (ACE)

The introduction of our ACE programme is helping to drive quality improvement and highlight key areas for improvement, recognise and share best practice, celebrate success and instil pride in clinical areas. The programme provides leadership for exceptional standards in all patient areas including communication, training, cleanliness, efficiency, and quality. All wards have now received their ACE accreditation and are working toward bronze, silver, gold and platinum standards.

7.4 Capital investment

To improve our performance against the Cancer 62 days treatment standard, we have announced a large-scale investment in two new CT scanners at the hospital, and expansion of our endoscopy services with two new assessment rooms and facilities. The new facilities will increase our capacity and mean swifter treatment for patients undergoing endoscopy and CT scan procedures, including those being scanned for signs of cancer. They come from a major investment of £4.4m, a proportion of which comes from the Healthier Together Programme to improve patient outcomes across Greater Manchester.

8. OUR FINANCES

We are committed to the safe delivery of a financially sustainable future for Stockport NHS Foundation Trust.

Our income

Overall Trust	c£340m
Patient Care activities	£278m • Acute commissioned services - £246m • Community services - £32m
Other operating income	£62m • External support (PSF/FRF/MRET) - £28m Other income - £34m

Stockport CCG accounts for around 70% of our contracts with Derbyshire CCG being our second biggest commissioner (10%). Eastern Cheshire CCG accounts for around 6%, Specialist Services 5% and Tameside 4%. We have a contract with 19 commissioners in total and a number of other commissioners from many areas not under a contract providing the Trust with its income.

Approximately 72% (around £245m) of our budget is spent on staffing. Ensuring the most effective spending and use of our resources on staffing is crucially important, and the Trust is committed to reducing the amount we spend on agency and bank staff each year – this remains a major priority.

Each year we invest around £9m on capital improvements to the Stepping Hill site and our community locations, this includes upgrades to our estate and IT infrastructure and new and replacement medical equipment.

Since 2014, NHS funding has grown much more slowly than historic long-term trends. NHS providers are facing significant financial challenges, and very little central investment in transformation and capital is available. Local authority budgets are under significant pressure, affecting social care and public health provision. The impact upon us directly is that we have continually had a high proportion of patients in hospital beds who are medically fit for discharge and awaiting social care packages or placements, which results in a delay to their discharge from hospital.

In line with the publication of the NHS Long Term Plan (the LTP), the Government announced an increase in NHS funding to support the development of a new 10-year long-term plan for the NHS. While this funding is welcome we recognise that this will not match the levels of increased demand the NHS is expecting to see and we will have to redouble our efforts to ensure the increased funding is used as efficiently and effectively as possible to increase productivity, reduce waste and face the challenges we foresee.

The ageing population and increasing demand for our services places a significant financial strain upon acute and community services. We need to work in partnership with primary care, health and social care and commissioners to lead transformation programmes to meet these challenges. Emblematic of this is the approach being led by ourselves, with the CCG, on a system response to frailty. The Trust's involvement in the national Acute Frailty Network from mid-2019 is pivotal to this system approach.

The Trust's underlying financial deficit is currently in excess of £43m. Our long term financial plan therefore indicates that we will require continued support through Financial Recovery Funding (FRF), and will require efficiency savings at levels in excess of the national requirement. Having delivered £47m in efficiency savings over the previous 5 years, the Trust is finding the continued delivery of savings in excess of the national requirement extremely challenging.

We have recently been awarded funding for a £30.6m Emergency Care and Pathology Campus development. This will help us to improve our Emergency Department estate and also introduce new services in line with increased provision of Same Day Emergency Care for patients as set out in the LTP. This forms part of a longer term estate and site redevelopment plan which will require additional external capital funding. We continue to plan for the release of external capital funding associated with being designated a Specialist Site for urgent and acute general surgery as part of the Healthier Together Programme.

NHS England & Improvement (NHSE/I) and other national bodies are increasingly developing approaches to help with improving hospital productivity (including clinical productivity), though a focus on reducing agency and locum spending, the Carter Review, and the Getting It Right First Time (GIRFT) programme.

The Trust will work closely with NHSE/I, system and local health partners to develop a single ambitious plan for Stockport's health & care system, embedded within the Greater Manchester Spatial Framework and Stockport Metropolitan Borough Council's Borough Plan. It will be critical to achieve our ambition to ensure a financially sustainable future for Stockport NHS Foundation Trust whilst also helping to secure the sustainability of the health and care system locally.

9. OUR STRATEGIC ENVIRONMENT

9.1 NHS Long Term Plan

The NHS Long Term Plan (the LTP) was published in January 2019, following an announcement in June 2018 of a £20.5bn annual real terms increase in NHS funding by 2023/24. It follows on from the publication in 2014 of the Five Year Forward View of the NHS (5YFV) which in many ways can be seen as a blue print for the new Plan; many of the themes with the 5YFV such as care being delivered closer to home through greater integration of primary, community and hospital care, focus on population health and long term conditions, and further acute care collaboration are expanded in the LTP.

The LTP sets out to bring about big changes including:

- moving the NHS to a **new service model** of fully integrated care in which patients get more options, better support and properly joined up care at the right time in the optimal care setting;
- **improving outcomes for major diseases**, including cancer, heart disease, stroke, respiratory disease and dementia;
- **boosting out-of-hospital care**, supporting primary medical and community health services with spending on these services £4.5bn higher in five years' time;
- **ensuring all children get the best start in life** by continuing to improve maternity safety, including halving the number of stillbirths, maternal and neonatal deaths and serious brain injury by 2025;
- **supporting older people** through more personalised care and stronger community and primary care services;
- making **digital health services** a mainstream part of the NHS; and
- **better access to mental health services**, giving 370,000 adults with severe mental illness and 345,000 children greater support, with an additional £2.3bn being invested in mental health by 2023 to 2024.

The Trust's own strategy aims to align its vision, mission and priorities with the changes outlined in the LTP.

The LTP reinforces our recent strategic direction of travel, endorsing our commitments to locality working and collaboration with acute hospital partners. It also sets some new challenges and opportunities for the Trust to respond to, specifically in terms of advancing new technologies and digital solutions to deliver our clinical services.

9.2 Greater Manchester Health and Care Devolution

Greater Manchester (GM) has acted as a trailblazer for English devolution. In 2016 GM was the first region in the country to take control of its combined health and social care budgets – a sum of more than £6 billion, under a programme known as 'Taking Charge'. GM proposed to do this by:

- transforming the health and social care system to help more people stay well and take better care of those who are ill;
- aligning our health and social care system to wider public services such as education, skills, work and housing;
- creating a financially balanced, sustainable system; and
- making sure our services are clinically safe throughout.

We have been actively involved in all aspects of Taking Charge and the wider Health and Care Devolution agenda. This has included discussions on potential changes to key hospital services such as Musculoskeletal (MSK) and orthopaedics, benign urology, paediatric surgery, breast surgery, cardiology, respiratory, vascular and neuro-rehab services. We have acted as 'Provider Transformation Lead' for the benign urology work stream in recognition of our expertise and leadership in this field, working with clinicians, managers and commissioners from across GM to develop a Case of Change and new Model of Care.

In 2019, GM were asked to respond to the LTP and have agreed the following system priorities for the next two years:

A Model of Care and Support for the 21s Century

- Local Care Organisations
- Primary Care
- Social Care
- Improving Mental Health and Well Being
- Improving Hospital Care
- Reform of the Urgent & Emergency Care System

Our Population's Health

- Creating a Population Health System
- GM's Cancer Plan

Building a Sustainable System

- Continued Reform of the Commissioning System
- Delivering our Workforce Strategy
- Sustainable Development

Unlocking Economic Potential

- Innovation (including Digitally-Enabled Care)

9.3 Stockport Locality

The Stockport Locality Plan is the health and care strategy for the Borough. Partners in Stockport worked together to refresh this in 2019. The Locality plan refresh:

- recognises where good progress has been made over recent years;
- restates partners' commitment to reforming the health and care system together; and
- provides an outline of important next steps.

The Stockport Locality Plan also serves as our local 'road map' for the delivery of local and national commitments under 'Taking Charge' and the LTP.

Over the next five years, we will play our role in reforming health and care in Stockport to create a sustainable, person-centred system where organisations work together to improve population health, reduce health inequalities, and deliver better outcomes for local people. We have a large part to play in this; both leading and playing a role alongside partners.

We are the integrated provider of both hospital and community services - community services are crucial to keep people well, treating and managing acute illness and long-term conditions, and supporting people to live independently in their own homes.

To do this, we will work together with partners in the following three broad areas:

1. addressing population health and health inequalities;
2. building and integrating new models of person-centred care; and
3. ensuring best outcomes from hospital services.

9.4 Impacts of Change

These changes will ultimately deliver the following outcomes:

- our citizens will see tangible improvements in health for everyone in Stockport;
- residents will recognise improvements in services, making a real difference to lives;
- people will recognise their role in maintaining their own health and be supported to be independent, well and connected to their communities;
- the people of Stockport will have access to a high quality health, care and wellbeing services;
- people will be able to make a social and economic contribution to the local economy where inequalities are reduced;
- across Stockport, partners will work together across the public, private, voluntary and community sectors to give individuals and neighbours seamless health and social care services;
- the Stockport System will lead the way in meeting the challenge of reducing dependence on the acute health and care sector and focus on building prevention and quality of care at home;
- delivery of a health and care system fit for the future.

The Stockport Health and Wellbeing Board will work with local people to build on our draft outcomes framework, making it reflective of an all-age approach.

9.6 Stockport Place Strategy

The Greater Manchester Spatial Framework (GMSF) is tasked with assessing economic and housing needs across the 10 GM boroughs to 2035. This work has assessed the need for new housing and has identified the requirement for Stockport to deliver 15,500 dwellings in the period up to 2035.

Work within the Borough is ongoing to identify sites for the expected development of housing. We will continue to work with partners to ensure that future developments are in line with an overarching estates plan in Stockport, as well as regional strategies, such as the Greater Manchester Primary Care Strategy, as well as Stockport Locality Plan.

We have commenced our own estates planning for our hospital site and community locations. This will continue to evolve over the course of this strategy, responding to the changing demands in health care needs, whilst starting to deliver ambitious plans to modernise our estate.

10. BEYOND STOCKPORT

10.1 Derbyshire North

A significant number of patients seen at Stepping Hill Hospital live in Derbyshire, particularly those patients who live near to the border of Stockport in areas of the High Peak such as New Mills and Whaley Bridge. For many of these residents, Stepping Hill is seen as their local hospital because it is the most accessible.

The Trust also delivers outpatient and community services to residents in the Buxton area. The Trust is excited to work with local partners in the development of a new facility known as the Buxton Community Hub Project. This new development offers the potential for the Trust to develop and to work with others. The Trust has particularly close links with the Primary Care Network covering the High Peak.

10.2 East Cheshire

A significant number of our patients also live in East Cheshire, in areas such as Poynton and Disley. We are an active partner in the Cheshire Sustainability and Transformation Partnership (STP) sustainability review that has taken place in East Cheshire. This is shaping the future provision of health and care services for East Cheshire residents.

We are pivotal to a number of key work streams delivering programmes associated with the East Cheshire Place 5 year plan.

Joint executive and clinical discussions continue to take place between the Trust and East Cheshire NHS Trust about how we jointly develop a strategic alliance. This will enable and support clinical diligence on the development of clinically sustainable services.

We have a real opportunity to lead and collaborate with partners in Cheshire and Derbyshire to offer innovative and sustainable clinical services to the local populations, delivering integrated health and social care, building on the strengths we have and making a positive difference to our patients.

10.3 Greater Manchester

We are a committed partner in Greater Manchester's Health and Social Care partnership (GMHSC), commonly referred to as GM devolution. Alongside all health and care partners we have committed to make the greatest and fastest improvement to our residents' health. Over the next few years, GMHSC has agreed a number of system priorities.

We have an interest in all these system priorities, however, a number speak directly to our own strategic areas of interest:

- making sure our community services work seamlessly across primary, community, secondary and social services to deliver excellent care and support to our communities;
- improving urgent and emergency care, including implementing the Healthier Together Model of Care and the Stockport Emergency Care and Pathology Campus proposals; and
- transforming the care we offer in hospital to achieve consistently high standards for the benefit of all patients:
    - over the course of this 5 year strategy we will work proactively with GM partners on the Improving Specialist Care (ISC) programme on developing new models of care for services such as benign urology, neuro rehabilitation, breast services, vascular, respiratory, cardiology, orthopaedics and paediatrics,
    - within each of these services there is general recognition that hospitals need to work more collaboratively with each other and with closer alignment with primary and community care,
    - we will also continue to develop our clinical support services such as pathology, radiology and pharmacy services in line with the proposed GM partnership plans.

10.4 South East Sector – Healthier Together

We continue to strengthen our role as one of four designated hub sites for emergency medicine and acute surgery as part of the Greater Manchester Healthier Together programme. We continue to work with partners in the South-East Sector to implement the service models identified to improve outcomes for patients and save lives.

Fundamental to the implementation of the programme is the principle that sector general surgical services should be provided by combined teams of clinicians working together as a single service. We will continue to progress the development of this services, acting as the specialist hub with Tameside and Glossop Integrated Care Organisation as our partner in the sector.

10.5 Our role and influence

As well as making direct improvements to the services we provide it is also important that our clinicians are involved in local, regional and national networks – using their skills and knowledge to influence at the highest level. And we're already making an impact in this area with our Executive Medical Director representing all District General Hospital Medical Directors on key networks, while our Chief Nurse leads the region's nurse network. Our joint Medical Director is also building strong partnerships across High Peak and East Cheshire with primary care colleagues. Other members of the senior team are also well connected regionally and nationally, ensuring Stockport's voice is heard and that we're influencing local and national service and policy development.

We have a lead role in parts of the reform agenda in urgent care, cancer and the elective care programme - chaired by our Chief Executive jointly with Stockport CCG chair on behalf of GM. Our Trust executives play key leadership roles in system partnership governance arrangements in place across GM and East Cheshire, building relationships and developing the way GM works as a system comprising 10 Local Care Organisations (LCOs)

Our clinicians have to be at the forefront of developing the clinical strategies for our services, whether that's working with colleagues in other trusts to create a speciality hub for South East Manchester, stabilising services in East Cheshire, building elective capacity, shaping our diagnostic capacity, improving our approach to frailty, or changing the way urgent care is delivered. Clinical leadership will be crucial to the success of all those initiatives that will help to shape a health and care system that fits the needs of the population we serve.

11. OUR STRATEGY 2020-2025

11.1 Process for developing our strategic plans

We have undertaken a major piece of work to re-fresh our strategy for the future, envisaging the role the organisation will play in the local and regional health and social care system. Our previous strategy incorporated the system approach set out in 'Stockport Together' but this did not maintain the momentum anticipated, hence there was a need for us to refresh our strategy.

In developing our strategy we have engaged with our staff, governors, commissioners, patients and partners. We have looked at the national, regional and local changes that have occurred over the last two to three years, we have considered the needs of the population we serve, and explored what new national policy may mean for health and social care services in Stockport.

Taking into consideration our strategic environment, the Board of Directors have developed a new strategic view. This has been developed via Board development sessions, engagement with our staff and partners and reviewing the significant changes that have occurred since 2015 and envisaging the future changes ahead of us.

Steps we took to develop our strategy

Received external support to develop a refreshed strategic view – we consulted with over 600 of our We incorporated feedback from this engagement into our strategy

Our Board of directors held strategy sessions, discussing some key questions to reach agreement on important aspects of our future aspirations, including our approach to partnerships, culture, transformation and what we stand out for

We began an engagement exercise to determine a new set of values as it was felt the existing ones were not inspiring and did not capture the essence of the Trust – we engaged all staff and met with almost 1,000 to hear their views to inform a revised set of values

The publication of the Long Term Plan provided an opportunity to ensure consistency with the expectations of the plan with our own strategy. Updates were incorporated for review by our Board of Directors.

This final version of our strategy incorporates our new mission, aims and values for the organisation, which have been shaped from engagement with our staff and from workshop sessions with the executive team and senior leadership group

11.2 Our Mission

Our mission is **"Making a Difference Every Day"**

What do we mean by this?

Through our engagement work to develop new Values for the Trust, it was clear that, for many, the most important aspect of working here and of working in the NHS is to be able to make a difference to people's lives.

Through this strategy every member of staff will understand the mission of our organisation is to make a difference every day; whether this is a nurse delivering vital community services, a doctor performing life changing surgery, a health care assistant caring for an ill patient and their family, a porter making sure that patients are moved safely from one part of the hospital to another.

We aim to motivate colleagues throughout the Trust to see what needs to be done and take ownership for delivering on what we say we're going to do. We aim to give people the confidence to take the responsibility their role gives them and make decisions for themselves within a framework of accountability and responsibility.

We know our staff and our teams will do everything they can to make a difference every day.

From the launch of this Strategy we want every team to take ownership of our strategic aims and our values. We want teams to use these to shape how they will make a difference in their services, with the patient at the heart of these conversations.

It is because of the unique group of staff at Stockport NHS Foundation Trust that we can look forward to 2020 and beyond with confidence that we can continue to make the improvements we need to make at a pace that will ensure we are able to rise to the challenges facing all health and care services, but also achieve our ambitions for the future.

11.3 Our Strategic Objectives

The 2020/25 Strategic Plan includes five new strategic objectives. Each has a number of objectives, improvement measures and details of how we will monitor these. Each reflects our intention to continue as an integrated, acute and community provider of services.

Our five strategic objectives are:

- **A great place to work**
- **Always learning, continually improving**
- **Helping people live their best lives**
- **Investing for the future, using our resources well**
- **Working with others for our patients and communities**

11.3.1 A great place to work

Objectives	• To deliver the 5 aims of the People Strategy • Provision of resources; Culture and engagement; Education and Development; High performing - Striving for excellence; Leadership development • To improve the Health and well-being of staff • To provide equally positive employment experience for our staff from all backgrounds and communities
Improvement Measures	• Improved retention • Improved vacancy rates • Improved substantive infrastructure • Improved sickness absence • Improved levels of staff engagement and morale • Reduced levels of agency staffing • Increase in apprenticeships and the numbers of staff in 'new roles' • Career development
How we will monitor this	• People Strategy - pipeline development and succession planning • Equality Delivery System and Senior Leadership Diversity profile (NHSE/I) • Workforce Race Equality Scheme (WRES) & Workforce Disability Equality Scheme (WDES) • Quality Improvement Plan • Staff survey – and associated action plans • Nursing, Midwifery and Allied Health Professionals strategy • Communication and engagement strategy •

What does these mean for….		
Our patients	**Our staff**	**Our partners**
• Skilled and responsive workforce • Learning organisation • Compassionate, realistic care • Timely treatment • Quality of care Agility – adapt to and influencing changing times	• Great experience at work • Increased retention • Opportunities for training and career prospects • Teamwork • Recognition of contribution	• Integrated working • Shared responsibility

What does 2025 look like?
The organisation will be a Great place to work. We will strive to have happy staff and satisfied patients We will have a great reputation for the work we do and people will want to work here

6.2

11.3.2 Always learning, continually improving

Objectives	• To embed a culture of Safety and create an environment of continuous quality improvement, research and innovation • Increase our levels of innovation, increasing the pace of change and improving long term decision making • Positively act upon learning (e.g. learning from deaths/Morbidity & Mortality/improving flow) and learning what goes well • To develop support packages for medical and nursing students, trainees and clinical development roles
Improvement Measures	• Integrated Performance report (IPR) metrics • Benchmark outcomes; Model hospital, National Clinical Audits • Staff satisfaction survey • Outcomes from GMC trainee survey • Measurement against quality improvement priorities • Quarterly governance and mortality reports • ACE accreditation
How we will monitor this	• Delivery of our quality strategy & Improvement plan • Research and Innovation studies • Clinical audit plan • Mortality review group • Deteriorating patient group • Quality Faculty / QI training • Through our complaints and compliments

What does these mean for….		
Our patients	**Our staff**	**Our partners**
• Better care, improved service and satisfaction, confidence in the organisation • More patients to attend for their treatment locally • An environment to match the quality of care given	• Proud of care provided • Desire to develop and improve themselves within the organisation • Enthusiasm to be a team member/leader and fully demonstrating there is no 'I' in a team	• They will have confidence in us to work with us and vice versa • We will fulfil our potential with our partners • We will demonstrate our future strategy

What does 2025 look like?
There should be no organisational boundaries, ensuring care is seamless. We will have a stable, highly motivated and engaged workforce, with the skills and expertise to enable us to deliver improvements in line with national and regional delivery programmes We will be in the lowest quartile nationally for clinical errors

6.2

11.3.3 Helping People Live their Best Lives

Objectives	• To embed an approach of realistic care in order to deliver better outcomes for our patients before, during and after their treatment and to meet the preferences of our patients at the end of life • Improve the health & well-being and experience for our staff and patients • Play a key role in supporting the priorities of the Locality Plan and CCG strategy – Start Well, Live Well, Age Well, Die Well • To provide an equally positive experience of services for patients and carers from all backgrounds and communities
Improvement measures	• Friends and family results • National Clinical Audits and other outcome measures • Mortality dashboard • Safeguarding metrics • End of life metrics • Staff survey
How we will monitor this	• Patient experience group • Realistic care programme • End of life strategy

What does these mean for….

Our patients	Our staff	Our partners
• More emphasis on self-care • An increased level of independence • More emphasis on being involved in 'what does it mean for me' - An asset based approach	• Makes every role more meaningful • More days where you feel satisfied as opposed to dissatisfied • Developing a healthy workforce and role modelling behaviours for the wider population	• A shared vision across the system to improve lives

What does 2025 look like?

Patients have had a great experience, which matches their expectations
We will improve the role patients, their families and carers have in their care and decision making

11.3.4 Investing for the future by using our resources well

Objectives	• Optimising our clinical outcomes through effective clinical leadership, and understanding where we should be developing, collaborating or disinvesting • Clinical service line strategies will have to achieve financial and clinical sustainability • To achieve a break even financial position in line with expectations • To invest in the development and wellbeing of our staff, to support retention and recruitment. • To ensure a shared vision for a fit for purpose environment, reducing our carbon footprint, utilising technology to support patient care, visitor and staff experience
Improvement Measures	• Getting it Right First Time programme • Reducing unwarranted variation; model hospital • Performance against SOF access standards • Delivery of financial plan/Cost improvement plans • Measuring impact of QI • New investment in capital development • Reducing our carbon footprint, measuring effective and efficient use of our estate
How we will monitor this	• Clinical services strategy • Estates strategy and delivery of our site masterplan • Financial strategy • Clinical Service Efficiency plans • Digital strategy

What does these mean for….		
Our patients	**Our staff**	**Our partners**
• Great environment • Enabled to go home quickly • Care is delivered by the right staff, at the right time in the right place • Consistent high standards • Will only come to hospital when appropriate	• Feel valued and listened to • Empowered to make changes • Well led – leadership at every level	• Trust and confidence • Investment across the system • Shared vision

What does 2025 look like?
We will have modernised key parts of our estate from capital investment. We will improve the well-being of our staff We will be a clinically outstanding rated organisation, ensuring we maximise the use of our resources We will play our part in delivering a medium term financial strategy for the Stockport system

6.2

11.3.5 Working with others for our patients and communities

Objectives	• Contribute to narrowing health inequalities and supporting health and well-being • Develop strong partnerships with organisations in Stockport including PCNs; SMBC; CCG; voluntary sector to reduce reliance on hospital care and promote independence. • Engage with local communities and neighbourhoods (PCNS) in Stockport, East Cheshire and North Derbyshire to shape services around local needs • Develop strong partnership working with Trusts in GM and East Cheshire to support vibrant and sustainable clinical networks, providing services matched to need • Positively influence our reputation to further develop public confidence and assurance for our regulators
Improvement Measures	• Health inequality metrics • Urgent & Emergency Care demand and flow as a measure of how well Stockport Partnership is going • Community engagement metrics – tracked through outcomes around shaping service delivery on a neighbourhood basis • Improving Specialist Care – metrics for 7day service priorities in the next five years • Opportunities created by partnership working and influencing reputation
How we will monitor this	• Health & Wellbeing Strategy for Stockport • Improving Specialist Care programme in GM • East Cheshire PLACE Strategy • Communication and Engagement Strategy based on stakeholder mapping exercise

What does these mean for….		
Our patients	**Our staff**	**Our partners**
• Joined up care • Fewer days away from home • More care in the community • Better access to core/specialist services	• Pride to work here • A clear future for staff • Working towards broader integration • Stronger community engagement	• Working for the best interests of patients • Mutual trust • Shared problems – ownership of performance

What does 2025 look like?
Development of a different system model which has further integration of Health & Social care. We will be known for our areas of excellence and not our challenges People ownership, not paternalistic view of Trust

6.2

12. OUR VALUES

We have listened to over 650 staff and partners as we consulted on our new Strategy. We have engaged with 5,200 staff and met with almost 1,000 staff to hear their views on the Trust values and behaviours – in addition receiving over 2,500 comments and suggestions from staff as to what matters to them.

The Board held a number of strategy sessions to determine what we want to stand out for as an organisation. This led to an engagement exercise to inform a new set of values and behaviours for the organisation.

An engagement programme - 'How we Live our Values' – was undertaken to ensure that the outputs are truly understood, embraced and owned by all our staff, patients, partners and stakeholders. This took place between July to October 2019.

Engagement was carried out via informal conversations and face to face briefing sessions delivered by the Executive team, senior managers and clinicians, supported by a briefing pack for staff. The engagement sessions provided the opportunity for conversations about what makes our staff feel proud to work here, what a good day feels like for our staff and our patients, and what our staff and patients value.

Feedback was also provided, on 'How we Live our Values' postcards (designed specifically as part of the engagement programme), via emails to a dedicated address and from photographs taken by staff of their engagement sessions.

Based on the feedback, a working group identified key themes and proposed a new set of values which were agreed by the Board of Directors. Our new values were launched in December 2019.

We care	We respect	We listen
about: • each other • our patients and their families • the communities we serve • the environment	• each other • our patients and their families • Our partners	to: • each other • our patients and their families • Our partners
We support them and deliver on our promises	**We are kind and helpful, and we expect the same in return**	**We act on and learn from what we hear**

Our values form a central part of our working culture, and help to support the care we provide for patients and the community.

We want to see our new values and behaviours embedded in every aspect of our organisation, from our job descriptions and annual appraisals to the everyday way we work together. We want to maximise opportunities for staff to help shape the development of the organisation going forward, and proactively build our reputation as an organisation that actively "**cares, respects and listens"** to our staff, our patients and our partners.

13. OUR ENABLING THEMES

The Trust has identified five themes that will support the development and implementation of our strategy, these are:

- **Digital -** Optimisation, business intelligence, infrastructure & agile working
- **Innovation -** Clinical and service innovation and research & innovation
- **Leadership, Culture & Workforce -** Clinical leadership, quality improvement faculty, Staff development and communication
- **Assurance, Governance & Standards -** Systems & processes, our planning approach and PMO
- **Place -** Estates (acute & community), right service, right place

Using these themes to underpin how we deliver our strategic objectives will ensure we can achieve our ambitions, make improvements in quality, in our performance and finances and recruit and retain a highly skilled, motivated and energised workforce. We will be developing specific enabling strategies for each of the five enabling themes (see Section 14).

Together we can make a difference every day.

14. DELIVERING OUR STRATEGY

We will identify annual delivery programmes linked to our strategic and corporate objectives. These will be led by Senior Responsible Officers (SROs) and will identify quantifiable and measurable outcomes, timescales and clear lines of accountability and governance by which to monitor delivery.

Each of our Business Groups will develop a summary plan, identifying their key deliverables and outcome measures in relation to the strategic objectives over the next 3-5 years. This will form the foundation of annual business planning, supported by our overall approach to quality improvement, financial planning, and delivering our performance measures.

All of us have a crucial part to play in helping to achieve our strategy. We will work to ensure that every member of our staff understands their contribution to delivering our strategic objectives and that this is included in their individual and team objectives.

Embedding change is a key challenge and issue. We will utilise opportunities with external strategic partners and our internal resources in strategic planning, improvement and transformation to support the delivery of changes. The growth of our quality improvement faculty and improvements led directly by our services will lead to innovation and new ways of working.

As the NHS and the wider world continue to change we will annually regularly review our strategy, maintaining our flexibility and responsiveness and ensuring it is fit for purpose.

14.1 Supporting Strategies

Detailed service changes and the impact of all strategic development programmes will be developed through an overall clinical strategy for the organisation and clinical service line strategies, which will underpin this.

In order to achieve our ambitions we also need a number of supporting strategies, plans and frameworks to enable delivery of our vision for the future of local health and care services. They include:

- Clinical services strategy
- Digital strategy
- Estates strategy
- Finance strategy
- Nursing, midwifery and allied healthcare professionals strategy
- Patient experience strategy
- People strategy (including Inclusion & diversity and organisational development)
- Quality improvement strategy
- Risk management strategy and associated framework.

The list above is not exhaustive; we have other supporting strategies e.g. dementia, communication and engagement, and research and innovation. Those already in place will be reviewed to ensure alignment, while others may require further development to best support delivery of our overarching strategy.

15. GOVERNANCE

The strategic objectives established by the Board of Directors will be operationalised through a process of annual planning, agreeing service priorities and the allocation of team and personal objectives. A Board Assurance Framework (BAF) will be developed and kept under review to ensure full alignment to the strategic goals. The BAF will focus and drive accountability for delivery, support the management of risk and enable the Board to make strategic adjustments as and when the Board determine these are necessary for organisational success.

Following annual planning and determination of service priorities, detailed implementation plans will be developed with support from the Trust's Programme Management Office. Programme management will be coordinated and reviewed by a new management group to be known as the Transformation Board; their work will be overseen by the Trust Management Board who in turn provide assurance on implementation to one or more of the Board's Committees as outlined in the table below.

	STRATEGIC OBJECTIVES	A great place to work	Always learning, continually improving	Helping people live their best lives	Using our resources well to invest in the future	Working with others for our patients and communities
ASSURANCE COMMITTESS	Quality Assurance Committee		✓	✓		✓
	People & Performance Committee	✓			✓	
	Finance & Performance Committee				✓	
	Audit Committee				✓	
	Trust Board					✓

The Trust will develop and keep under review the adequacy of the performance reporting system in order to ensure key performance indicators are developed for each strategic goal, performance is measured and reported, assurances are reviewed and, where necessary, decisions taken to enable improvement.

15.1 Operational Plan

Each year, NHS England & Improvement (NHSE/I) require Foundation Trusts to produce an Operational Plan that details the Trust's approach to activity, quality, workforce, finance, sustainability and for the forthcoming year. It is important that our annual operational plan aligns with those of Stockport CCG, other commissioners and the wider GMH&SC to form a coherent system-wide operating plan that contributes towards our collective aims and objectives.

Our new 2020-25 strategy sets out longer term aims and priorities for the Trust which will help to shape and guide annual operational plans over the next five years.

15.2 Business Group Plans

In support of our new strategy, and to underpin annual corporate objectives and the operational plan, Business Groups will be supported to set out five year strategies aligned to our new strategy.

Annually, plans will be developed that highlight key priorities, risks and ambitions in relation to our priorities and 5 strategic objectives. Our annual planning cycle will be reviewed and refreshed to ensure that it is consistent with the requirements of NHSE/I in relation to the submission of the Trust operational plan, and that it remains relevant for the environment we operate in.

16. NEXT STEPS

Successful realisation of our new strategy will involve a number of key next steps:

16.1 Launching our strategy

We will formally launch our strategy with our staff, patients and partners. This will involve a communications plan with regular briefings for staff to ensure it is fully understood and all staff plays their part in developing each delivery programme to achieve our ambitions

16.2 Corporate objectives

We will develop a set of annual objectives to underpin our 5 strategic objectives set out in this strategy which will inform a revised Board Assurance Framework (BAF). These will include key performance measures, with progress reported quarterly to our board assurance committees and Board of Directors.

16.3 Clinical Services Strategy

Our clinicians will be at the heart of delivering our future aspirations for the local population, utilising horizon scanning and intelligence from international developments in clinical fields as well as national best practice to inform our future developments in health care. It is vital our clinicians shape our overall clinical strategy as well as individual service line strategies. The clinical service line strategies will have to achieve financial and clinical sustainability as a key objective.

By working with our doctors, nurses and allied health professionals to explore the opportunities and challenges facing each of our services we will together develop a robust and effective clinical strategy that will provide a road map for how the Trust will evolve over the coming years.

The process for the development of clinical strategies will be clinically led, engaging teams throughout the Trust. When completed, the strategy will need to have addressed the complexity of regional and national issues such as:

- Greater Manchester Health and Social Care Partnership Improving Specialist Care reviews of individual services;
- the introduction of the new models of care in relation to Urgent Care and high risk Elective General Surgery;
- local plans for fully integrated community based care; and
- primary care reform and the transformation of social care service.

The new clinical strategy will require that all community and acute services currently delivered by the Trust are reviewed and that each service within the Trust portfolio has an agreed strategic direction. This could include whether the service:

- has the opportunity to have an increased role in the local health and social care economy;

6.2

- needs to be delivered as part of a robust, safe and sustainable district general hospital model; and
- may need to look to collaborate with other organisations to ensure a robust and sustainable service is provided.

Every acute service also needs to focus on care that can be delivered outside the hospital in community settings, utilising digital technology and in partnership with primary and community colleagues or other providers.

The table below is an example of some of our acute services and the potential opportunity:

SPECIALTY	***OPPORTUNITY***
ORTHOPAEDICS	Increased sector role
GENERAL SURGERY	Increased sector role
UROLOGY	Increased sector role
PAEDIATRICS	Increased sector role
OPHTHALMOLOGY	Increased sector role
STROKE	Increased sector role
GASTRO	Increased sector role / DGH model
OLDER PEOPLE	DGH model
OBSTETRICS and GYNAE	DGH model
DIAGNOSTICS	DGH model
CRITICAL CARE	DGH model
RESPIRATORY	DGH model
EAR, NOSE, THROAT (Paeds)	DGH model / Collaboration with partners
HAEMATOLOGY	Collaboration with partners
ORAL SURGERY	Collaboration with partners
NEURO-REHAB	Collaboration with partners

We anticipate that developing our overall clinical strategy, and the individual clinical service line strategies, in a really comprehensive and engaged way will take most of 2020/21. The clinical strategies will also need to continue to evolve and develop over the period of this 5 year strategy and will therefore be reviewed on a regular basis.

MONITORING COMPLIANCE

The Trust is committed to ensuring compliance with documents and will actively monitor the effectiveness of such documents.

Process for monitoring compliance with this policy

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
8, 17,18,20	Annual review	Board of Directors Director of Strategy, Planning & Partnerships	Annual	Board of Directors Director of Strategy, Planning & Partnerships	Finance & Performance Committee Director of Strategy, Planning & Partnerships	Finance & Performance Committee Director of Strategy, Planning & Partnerships

EQUALITY IMPACT ASSESSMENT

Office Use Only

Submission Date:	
Approved By:	
Full EIA needed:	Yes/No

Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design

1	**Name of the Policy/SOP/Service**	Trust strategy	
2	**Department/Business Group**	Corporate	
3	**Details of the Person responsible for the EIA**	**Name:** **Job Title:** **Contact Details:**	Andy Bailey Associate Director, Strategy & Planning Andrew.bailey@stockport.nhs.uk Ext 4568
Associate Director	**What are the main aims and objectives of the Policy/SOP/Service?**	The main purpose of this strategy is to describe the future strategic direction for Stockport NHS Foundation Trust for the period 2020-202. This articulates our organisational mission, strategic objectives and values and our future aims and aspirations by which the organisation will inform its decision making.	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics below? Please state whether it is positive or negative. What data do you have to evidence this?** **Consider:** • What does existing evidence show? E.g. consultations, demographic data, questionnaires, equality monitoring data, analysis of complaints. • Are all people from the protected characteristics equally accessing the service?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Produce action plan if further data/evidence needed ✓ Re-visit after the designated time period to check for improvement.	**Lead**
Age	Positive – development of our services will look to improve known health inequalities experienced by younger / older people, for example, in relation to isolation and older people.		
Carers	Positive – the development of our services will ensure reasonable steps that can be taken to accommodate carer's requirements, such as: o Time of meetings or interviews o Flexible working o Carer's assessments The strategy sets out a specific intention for carers to have more involvement in decision making of patients they care for We encourage a workforce that can recognise and react to the individual needs of staff and recognise the support staff may require as carers, and consequently looking to develop a Carers Staff Network.		
Disability	Positive – the development of services will look to improve known health inequalities experienced by disabled people, for example, people with learning disabilities have a shorter life expectancy than the general population. Our estates strategy and planning to modernise our facilities will make all reasonable steps that can be taken to improve the experience for disabled persons, patients, visitors or staff		

6.2

	Our People plan, including our equality and diversity strategy, will take steps to make reasonable adjustments employment practices to ensure 'accessible to all' in line with the Reasonable Adjustments Policy which provides a Health Passport for all staff requiring any reasonable adjustments. We hold the Disability Confident Employer accreditation Scheme and is working towards the Disability Confident Leader accreditation. We have published a Workforce Disability Equality Standard (WDES) action plan.		
Race / Ethnicity	Positive – the development of services will look to improve known health inequalities experienced by different ethnic groups, for example, high rates of diabetes amongst Bangladeshi community We submit the WRES national data annually and the have developed a Workforce Race Equality Standard (WRES) action plan.		
Gender	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals We encourage a workforce that can recognise and react to the individual needs of staff and will support a staff member's gender identity choice.		
Gender Reassignment	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals We are signed up to the Manchester Pride All Equals Charter and are developing an LGBT action plan to support equal access to health care and employment within health care.		
Marriage & Civil Partnership	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals		

Pregnancy & Maternity	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals We encourage a workforce that can recognise and react to the individual needs of staff and will support staff members in line with Pregnancy and maternity policy. The Trust provides agile working to support flexible working.		
Religion & Belief	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals We are committed to working towards providing a multi faith/health and wellbeing space for patients and staff.		
Sexual Orientation	Positive – our Trust policies ensure equal access to recruitment, personal development, promotion and retention and the Equality of opportunity in relation to health care for individuals The Trust has signed up to the Manchester Pride All Equals Charter and developing an LGBT action plan to support equal access to health care and employment within health care.		
General Comments across all equality strands	We are committed to promote equality, inclusion and diversity for both our staff and our patients, tackling all forms of discrimination and removing inequality in the provision of both health services and employment.		

6.2

Action Plan

What actions have been identified to ensure equal access and fairness for all.

Action	Lead	Timescales	Review &Comments

Report to:	Board of Directors	**Date:**	4 June 2020
Subject:	Emergency Department Improvement Programme		
Report of:	Chief Operating Officer	**Prepared by:**	Associate Director Strategy & Planning ED Triumvirate

REPORT FOR DISCUSSION

Corporate objective ref:		**Summary of Report** This report provides an update on the Emergency Department Improvement Programme put in place in response to the quality and safety issues highlighted by the CQC inspection. The focus of this report is to provide assurance of; • The actions and improvements we have made in respect to the broader ED Improvement Plan, what has been implemented to date and what the impact has been • How we are measuring and monitoring quality and safety • Our approach to delivering other actions included in the CQC report • How we will ensure the current improvements are sustainable This report was presented to Stockport Improvement Board on Thursday 28 May 2020.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	Appendix 1 - Patient feedback Appendix 2 - Quality & Safety dashboard Appendix 3 - ED Integrated Performance Report Appendix 4 - ED 4 hour performance Appendix 5 - Discharge to Assess pathway

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Exec Management Group ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

6.3

6.3

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CQC RESPONSE & EMERGENCY DEPARTMENT IMPROVEMENT PLAN

1. Introduction

1.1 In response to the CQC inspection and subsequent Warning Notices issued to the Trust, an immediate and 30-day action plan was put in place to address the findings from the inspection.

1.2 All actions identified within the immediate and 30-day plans have now been completed. Some of the immediate actions led to;

- A Quality Risk Summit facilitated by NHSE/I to develop the quality and safety priorities for the Trust and system partners
- Introduction of daily quality & safety checklists in ED and strengthening the existing safety huddle specifically to ensure mental health patients are cared for safely in line with national guidance
- Standard Operating Procedures (SOP) reflected national guidance (RCEM & PLAN Quality Standards for Liaison Psychiatry Services) with awareness training on the SOPs delivered to staff
- Environmental risk assessments undertaken in both Adult and Paediatric areas of ED in accordance with Quality Standards for Psychiatric Liaison Services (2020)

1.3 One of the actions was to develop a single composite Improvement Plan for the Emergency Department (ED). A new leadership team was put in place from 1st March 2020 within ED to deliver this plan supported by an executive SRO triumvirate approach, alongside specialist support from NHSE/I and ECIST which included mental health expertise.

1.4 The aim of our Improvement Plan is to improve patient outcomes for patients attending ED. The Improvement Plan has been created to deliver quality and effective safe care and sustain a performance of minimum of 80% against the 4hour ED quality standard.

1.5 The focus of this report is to provide assurance of;

- The actions and improvements we have made in respect to the broader ED Improvement Plan, what has been implemented to date and what the impact has been
- How we are measuring and monitoring quality and safety
- Our approach to delivering other actions included in the report
- How we will ensure the current improvements are sustainable and become ‘business as usual’ when ED attendances significantly increase as non Covid pressures come back on line

6.3

2 ED Improvement Plan

2.1.1 We have identified two key phases to delivery of our Improvement Plan:

- Phase 1: To have made significant improvements relating to Governance and Safe Staffing issues identified by the CQC by 29 May 2020 from the 29A Warning Notice issued on 9 March 2020

- Phase 2: To embed the improvements, there will be a continued programme of work to ensure ED continues to make further improvements and sustainable changes from June 2020 - May 2021

2.1.2 We have monitored progress against phase 1 of our Improvement Plan action plan via:

- Executive SRO oversight (COO) plus Chief Nurse and Medical Director in place via weekly assurance meeting with ED leadership team and PMO
- Utilising a PMO approach to support management of the plan and tracking progress
- Supported by NHSE/I Improvement Director and ECIST – with clear roles and responsibilities defined for delivery owners and support functions.
- Focus has been to consolidate approach and all existing plans/actions into one Single Improvement Plan specific to the Emergency Department
- Identified improvement themes and key actions associated

2.1.3 The Plan lists 74 actions in total, with 50 as part of Phase 1, these cover the following themes:

Model of Care
Patient safety
Governance
Safe Staffing
Staff Engagement
Mental health
Environment
Information Governance

Each action on the plan has been RAG rated dependant on progress throughout phase 1.

Status	Classification	Description
B	Blue “Complete”	Completed: Improvement / action delivered and evidence provided
G	Green “On track”	Improvement on trajectory either: a) On track – not yet completed *b)* On track – not yet started *(only applies to phase 2 actions which are not included in table 1 below)*
A	Amber “Problematic”	Delivery remains feasible issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red “Delayed”	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Table 1 – Phase 1 current progress (split by the 8 themes identified)

Theme	Status >>	B	G	A	R
Model of Care	>>	1	4	-	-
Patient Safety		1	5	-	-
Governance		1	4	-	-
Safe Staffing		3	7	-	-
Staff Engagement		3	3	-	-
Mental Health		4	8	-	-
Environment		-	3	-	-
Information Technology		-	3	-	-
TOTAL:		13	37		

This snapshot of progress was taken as at Friday 23 May 2020.

All green actions have evidence in place - this continues to be reviewed by the SRO triumvirate prior to approving as complete. We also wish to be able to demonstrate that the evidence and assurance has been in place for a number of weeks prior to agreeing an action is complete

2.1.4 The following sections describe a series of key actions and improvements we have put in place in response to the immediate quality concerns from the CQC inspection. Within this report we have specifically focused on safe staffing, mental health and systems and processes to monitor the quality and safety of patient care.

6.3

2.2 Safe staffing

2.2.1 Table 2 below is a summary of the actions and improvements made in relation to safe staffing in ED. Each area is supported by an evidence repository – an approach similar to the Provider Information Request and subsequent submissions has been utilised to capture the supporting evidence.

Table 2

Safe Staffing	
Actions & Improvements	Impact & outcome
External support from ECIST, to review ED staffing model and establishment against ED workforce tool, capacity and demand requirement	• Support has been commissioned from ECIST – this work is due for completion in 6 weeks • Working with the senior team from within ED to inform a revised staffing model in line with best practice to ensure appropriately trained staff linked to demand
Implementation of 6 week rotas with an associated set of rules and limits on staff taking leave-	• Rotas are published 6 weeks in advance via Healthroster • Protected time is allocated for band 7 nurses and matrons to complete rotas • This ensures there is adequate staffing in place for all shifts with early identification of any gaps for resolution
Safer staffing and nursing escalation – development and introduction of a Standard Operating Procedure (SOP) Escalation process in place for both Operational and Nursing issues	• A documented escalation process is in place that ensures the rota is reviewed regularly after they have been published • Shift leaders can escalate any gaps in shifts via an appropriate route for staffing issues to be resolved • Weekly diary meetings are in place to review of rota and plan for week ahead • Daily reviews of staffing for the next 24 hours are undertaken by matrons • Throughout shift, matrons/ Associate Nurse Director visit the unit to ensure staffing remains within required levels to match numbers and acuity of the patients
Review access and use of temporary nursing staff including allocation, capability and induction, ensure inductions are effective and staff are aware of the processes and expected standards to deliver safe, effective care	• Wehave ensured staff have clear roles and in relation to clinical practice and delivery of safe and effective care and are supported in practice • Specific induction packs have been introduced for bank and agency staff – feedback has been received that these are positive • Shift leaders understand the competencies of temporary staff via the induction process and close support of the staff on shift
Emergency Department inductions for Trained Staff, HCA's and volunteers, including feedback for analysis has been completed	• Welcome packs for staff have been introduced for all staff with specific induction documentation for bank/agency staff • A feedback process has been put in place with the feedback from the induction processes being reviewed by the senior nurses • Ensure staff are aware of the processes and expected standards to deliver safe effective care – conversations are reflected in meeting minutes and senior nurse meetings
Development of a nursing workforce plan in place to	• A workforce, recruitment and retention plan and wellbeing plan have been developed with bespoke recruitment work and retention strategies identified.

support recruitment and retention	• The workforce plan is regularly discussed at the nursing workforce meeting and is reported via the ED Quality Board if off track • The wellbeing programme has been established to ensure staff feel valued, developed and empowered and is monitored through the nursing workforce meeting
Training and Appraisal Trajectory in place which is supported by identified Appraisal groups Ensure role specific and mandatory plan for all staff	• A nursing appraisal group has been established to ensure an improvement trajectory is in place for mandatory & role specific training is and place and for appraisal to be undertaken • All staff have either had an appraisal or have a date set when their's is next due • A clear training plan have been devised (with support from Pennine Care to deliver training in the management of patients with mental health presentations) • A trajectory is in place for mandatory training for the teams within ED

2.2.2 Appraisal groups led by the ED matrons, with clear functions and targets have been set up to review broader staffing challenges, staff experience and visibility of issues through current reporting mechanisms. Group membership includes senior nurses (band 7), nursing and Health Care Assistant (HCA) staff and Emergency Practitioners and (ENPs/Advanced Clinical Practitioners (ACPs).

2.2.3 Some of the key areas these groups are reviewing include:

- Clinical practice/competences
- Recruitment & Staffing
- Mental Health, Dementia and LD
- Staff wellbeing and retention
- End of Life care
- Compassionate care
- Privacy and dignity
- Safeguarding
- Patient Experience
- Patient Flow – support improvement for patient outcomes within 4 hours
- Harm free care
- Nutrition and hydration

2.3 Mental Health

2.3.1 Following the initial Quality Risk Summit, we were able to secure support of a mental health expert from ECIST whom the team have worked closely with to develop a clear and focused plan. All actions and improvements have been put in place around caring for patients presenting with mental health needs. The associated systems and processes are now in place and have been supported and assured with the ECIST lead, alongside close working with our partners at Pennine Care NHS Foundation Trust.

2.3.2 Table 3 below is a summary of the key actions and improvement put in place.

Table 3

Mental Health	
Actions & Improvements	Impact & outcome
Processes put in place to provide assurance that the appropriate records are maintained for patients who present at ED with mental health needs	• In line with the current standard operating procedure, observations are undertaken and documented as dictated by clinical assessment and risk assessment in patients who present to the ED with mental health problems • Specific prompts and checks are carried out as part of the risk assessment documentation: - related to risk of self-harm - related to risk of suicide - related to risk of leaving the department • The risk assessment is monitored daily and fed into the quality and safety dashboard which identifies key measures/indicators. The dashboard is reviewed daily to ensure compliance and quality of documentation and for early action to address as required • Issues are also escalated via ED safety huddles which take place throughout the day
Undertake a gap analysis to understand demand and appropriate pathway development	• A gap analysis utilising the RCEM tool kit has been completed. A mental health task and finish group has been established to ensure appropriate review of pathways and risk assessments in place • External mental health support has provided assurance that the pathways that are in place are appropriate. A deep dive audit has been undertaken with recommendations incorporated into an overall action plan from the gap analysis
Ensure there is an appropriate mental health expertise and input on each shift	Mental health liaison will ensure co-location within the department 24/7 • All triage nurses have received Manchester Triage Training and all Rapid Access Treatment (RAT) clinicians have been socialised to a SOP which ensures robust risk assessment and immediate risk management of patients presenting in mental health crisis • There is an identified mental health clinical lead • The ED nursing team are now in defined appraisal groups and each has been assigned a 'topic'. One cohort has been allocated to champion mental health • This cohort and wider ED team will receive a rolling programme of mental health awareness training and development provided by Pennine Care NHS FT. The cohort will be provided with a mental health 'Knowledge and Skills Framework' which will help guide learning and development needs

Develop and implement a revised Standard operating procedure (with guideline on risk assessment and observation)	• An updated SOP has been produced in partnership with ECIST mental health support and Pennine Care • The compliance with the risk assessment will be monitored by the regular mental health liaison meetings with ED representatives • Development of mental health awareness training has been completed in partnership with Pennine Care - session on 21 May took place on Risk Assessment, mental health presentation and response
Development of the senior clinical role to ensure delivery of care in line with RCEM and PLAN for paediatrics	• Consultant mental health leads for both adults and paediatrics are in place with defined roles and responsibilities and provision in consultant job plans • This ensures senior consultant oversight of mental health provision within ED
Environmental ligature assessments	• An environmental ligature assessment has been carried out and modifications made to the estate to enhance the provision of safe care of mental health patients • Walk-arounds of the department have taking place with staff from the Trust and Pennine Care to assess where further improvements can be made for mental health patients

2.4 Systems & processes in ED for monitoring and reviewing the quality, safety and risk of patient care

2.4.1 The ED leadership team have improved our governance via the systems and processes we have put in place and made more robust.

2.4.2 Table 4 below provides a summary of the key actions and improvements to strengthen governance

Table 4

Systems & Processes	
Actions & Improvements	Impact & outcome
We have reset the expectations regarding the patient wait for treatment	• Visible and supportive leadership of the new and adapted senior team to work with teams to ensure expectations for compliance with the 4 hour standard to improve the patient journey • Quality Improvement (QI) processes have been used to map out key triggers for 'time to decide' metrics • Robust analysis has been carried out on breaches of the 4 hour standard– a detailed SOP and reference pack has been produced • Daily ED internal meetings taking place at 8am, to validate the breaches, which is then followed by a clinical review to identify key reason, issues and key learning. This daily feedback is presented at a weekly meeting with the senior ED team • A validation SOP is in place –the process now in place is designed to ensure earlier engagement with speciality teams to avoid future breaches (in line with time to decide metrics) • Learning will be shared weekly at the Performance Wall, monthly at business groups Performance Reviews, Associate Medical Directors meeting and with mental care via mental health liaison meetings
Clinical pathways reviewed and updated	• Clinical pathways have been reviewed by clinical leads and updated on our microsite • Compliance with pathways have been carried out in relation to patients presenting with sepsis, chest pain and trauma
Quality and Safety Dashboard in place, which is supported by ED safety Checklists and ED safety huddles	• An electronic solution has been designed and implemented for the daily checklists and Improved templates for the safety huddles • Use of escalation tools has led to earlier identification of issues and better performance against the 4 hour standard
PDSA cycles to support the improvement of 4 hour target	• A process mapping session has been held to determine PDSA cycles to improve achievement of the 4 hour standard – specifically on triage and breach analysis processes • Sessions have included identification of key issues causing corridor care – PDSA cycles and plans link to eradicating these • Themes from any areas of poor performance are captured and reviewed weekly by the ED senior team to shared learning and dissemination as appropriate

6.3

Patient experience feedback gathered to ensure learning and improvements	• Patient experience surveys are undertaken via Friends & Family Tests *(see appendix 1)*. There is also the opportunity of inputting into care opinion and there are monthly internal IPad surveys of our patients • Engagement with patient experience team – working towards a dementia friendly area within ED and patient involvement in decision making • Engagement with Health Watch for them to support learning from patients and future developments for the ED
Learning from incidents and complaints	• Incidents and complaints are reviewed at an ED governance meeting and reported to a new ED Quality Board – themes are fed back to specific groups – matrons/sisters or consultants meetings for learning and key actions to be put in place • Recent improvements include new mattresses purchased to reduce pressure ulcers • Falls assessment up to 90% - no falls of harm for a month
Staff engagement and well being	• Leadership surveys undertaken for senior team and wider ED team ascertain the present team dynamics and to create an action plan for support and development required for the team • A wellbeing plan has been produced –team meetings over see the plan which ensures effective communication, ideas for support and availability of support for the team • Support from the Organisation Development team to support the wellbeing plan for staff, addressing the issues of low morale, stress identified in the previous staff survey • Dedicated HR support is in place to support the workforce – with attendance at the nursing work force meetings and attending the in ED once a week for to offer support and advice

3 How we are measuring and monitoring quality and safety

3.1.1 We have defined a series of measures that determine what is now different for patients and staff in our ED. These improvements are summarised in table 6 below.

Table 5

Theme	*The following improvements have been achieved:*
Patient Safety	• No patients receiving care on a corridor • Time for decision to admit to leaving the department to a specialty bed has reduced • Time to initial review within an hour by doctor has improved • Patients receive all aspects of care as prescribed in the ED quality metrics and ED safety checklist • Improvements in achievement of the ED 4 hour target
Safe staffing	• A reduction in gaps in the rota and evidence of escalation when required • Rotas produced six weeks in advance • Levels of mandatory training will have improved (level 3 safeguarding and others) • All staff will have had an appraisal date in place • Improved staff engagement and satisfaction, displaying a renewed sense of pride in their work • The staffing review supported by ECIST will have been completed and an action plan in development
Governance	• Development of a dashboard with a full range of metrics being monitored from ED to Board • Improved reporting - fewer harms and increased no harm continuing numbers of incidents reported
Model of care	• Streaming direct to specialty or primary care • Discharge to Assess Hub in place with a reduction in MOAT patients
Mental Health	• Mental Health risk assessment in place for all patients • Mental Health breaches having a full analysis and actions following • The Mental Health Liaison team in the department working with ED staff • A developed operational working group – with minutes describing work and outcomes • Improved liaison between two providers • The Trust working toward PLAN accreditation • An evaluation of the 21 May study day
Environment	• Ligature reassessment • Calmer environment

3.1.2 Initially our measures are being monitored via our quality and safety dashboard *(see Appendix 3)* and via an ED Integrated Performance Report *(see Appendix 4)*. We also review incidents, complaints and patient feedback to ensure close monitoring and learning and timely responses.

3.1.3 Our measures of improvement will also include staff measures from training to turnover; this will ensure that the department is a high performing area that has engaged staff to ensure quality, safe care for our patients and their families. We have identified development work to bring all this information into one single dashboard which is being supported by our Business Intelligence team – this is anticipated to be complete by the end of June.

4 Our approach to delivering other actions included in the report

4.1.1 A wider action plan has been developed which is designed to;

- Address the ‘must do’ actions in order to ensure regulatory compliance, as set out in the CQC 2018 framework (25)
- Address the ‘should do’ actions to ensure that repeated failures do not lead to regulatory breaches in the future (54)
- To drive improvement thematically across the Trust by applying the actions to all core services in order to achieve a minimum standard of ‘Good’ at the next inspection

4.1.2 To achieve the outcomes, the following has been undertaken

- Clearly define what Good looks like
- Include must do and should do actions into improvement themes
- Allocation of must do and should do to action leads and SRO’s
    - Action leads are Business Group Directors or Deputy Directors
    - SRO’s are Executive Directors
- Meetings held with all action leads and actions agreed
- Meetings held with each SRO and actions agreed
- Completion of final action plan

Our action plan will be approved by the Executive Team, week commencing 1st June.

5 How we will ensure the current improvements are sustainable and become ‘business as usual’ when ED attendances significantly increase

5.1.1 Key to the success of the improvement plan is the sustainability of the changes. The leadership team introduced to support the department have utilised established change management processes. The key aspect of this has been the staff engagement to ensure that the whole team identifies the issues, understands the challenges and the improvements are then owned by everyone within the department.

5.1.2 Empowering our staff, enabling them to identify what needs to change and supporting them to do this has been vital. The change in culture is in its infancy and will need the continued support of a cohesive senior team. This will ensure the continuation of training and development of the staff. This is not exclusively clinical and mandated training, but including leadership, quality improvement methodology and team building.

5.1.3 The creation of appraisal groups within nursing supported by other disciplines has been an excellent starting point for quality improvement projects to be undertaken, responding to the data that have identified key issues. Work with the transformation team to understand our QI methodology has ensured that the changes undertaken address root causes. Work to engage appropriate stakeholders will result in more sustainable changes owned by teams.

5.1.4 As outlined at the beginning of this report, the aim of our Improvement Plan is to improve patient outcomes for patients attending ED to deliver quality and effective safe care and sustain a performance of minimum of 80% against the 4hour ED quality standard.

5.1.5 Attached as Appendix 2 demonstrates improvement of our 4hr performance. As attendances have increased (post Covid-19 peak) to over 200 a day, performance has not only been maintained but improved further. Since 17 April 2020, performance against the 4 hour standard has consistently been above 90% (with only on exception). The average performance in May has been 95%.

6 Next Steps

6.1.1 We initially split our improvement plan into two phases, with phase 1 focusing on the immediate ED actions. We will now develop more detail around phase 2 of the improvement plan in order to ensure the positive changes are sustained. This will include:

- Further development of the work that has started with the Organisational Development team
- Driving forward the momentum of the workforce and wellbeing plans to reduce turnover and vacancies
- Recruitment to key senior management posts to ensure a robust senior structure and capacity for clinical education opportunities

6.3

6.1.2 We have commenced work to develop an overarching Trust clinical strategy – this will have a primacy of focus on urgent and emergency care to ensure that the wider organisation prioritises emergency pathways and responds appropriately in times of increased demand. This will support the positive improvements seen during the Covid-19 outbreak which have been made a real impact on flow and discharge. Underpinning these changes will be the role of our clinical leadership models to embed longer term change.

6.1.3 Linked to the Trust clinical strategy development is the design of future clinical pathways informing the Emergency Care and Pathology Campus (ECPC) capital investment. These pathways will inform the Outline Business Case due for submission in August.

6.1.4 Incorporating lessons learnt from Covid-19 and building on the commitment and leadership shown from teams to innovate and introduce new ways of working quickly.

6.1.5 Progressing opportunities to deliver an Urgent Treatment Centre and model and multi-specialty assessment in advance of the capital development in partnership with system partners.

6.1.6 Progress discussions with commissioners and local authority partners to:

- agree how we make the Discharge-to-assess hub sustainable to continue D2A pathway (attached as appendix 5)
- establish a longer term plan for the intermediate care offer

Both of which will enable effective flow in an acute setting and discharges of MOAT patients to the most appropriate care setting.

6.1.7 Develop system partnership work to understand our urgent and emergency care demand and urgently work towards a potential ‘referral to ED’ model

APPENDIX 1 – Patient Feedback

The comments below provide a of feedback from patient experience surveys in April and May 2020

- Due to being a member of staff when being examined there was another member of staff in the room which made me feel like it was to ensure there was no bias and treated the same as other patients.

- Everybody has been very informative and efficient. I am full of admiration for how they`ve all got on with it. Very impressed.

- On the whole the treatment has been very good.

- I was looked after from the word go from the paramedics to the clinical team at stepping hill.

- I was scared as I was alone but I was very well cared for and the team put my mind at ease.

- I was very impressed by my recent experience at A&E. I was seen promptly, had various investigations, saw the Dr and was discharged with a plan in just over 1.5 hours which was fantastic.

- The department was very efficient with obvious strict social distancing measures in place. The staff was respectful and caring. Unhurried in dealing with my injuries. Nothing seemed too much trouble despite the Covid-19 challenges that you are facing.

- Fast efficient care. Staff where very friendly and helpful. Thank you NHS

- All of the staff that dealt with me were brilliant and I could not have received better treatment if I had paid. Thank you for all your kindness

- A really fantastic group of nurses and doctors who made me feel safe and informed without a fuss. The speed at which I was taken for scans was amazing. Wonderful.

- I felt nothing could have been done better it was evident my safety and the safety of all working in the A&E department was paramount. The service given was delivered to a high standard from reception, triage, X-ray technician, Doctor and finally the lovely Nurse who fitted my boot. A big thankyou to you all for being there !!!

- Outstanding care from whole A&E team. Took great care of me and very detailed examinations. A huge thank you to all staff, especially during this horrible time we are in currently. Their commitment and professionalism a credit and lesson to us all
- Very caring the care and the kindness is so overwhelming and all the staff from reception to nurses and doctors can't do enough for you.

- Stepping Hill is the best hospital I have ever been to, your staff are always happy, helpful and go the extra mile where they can. Every single one of them is a credit to the trust.

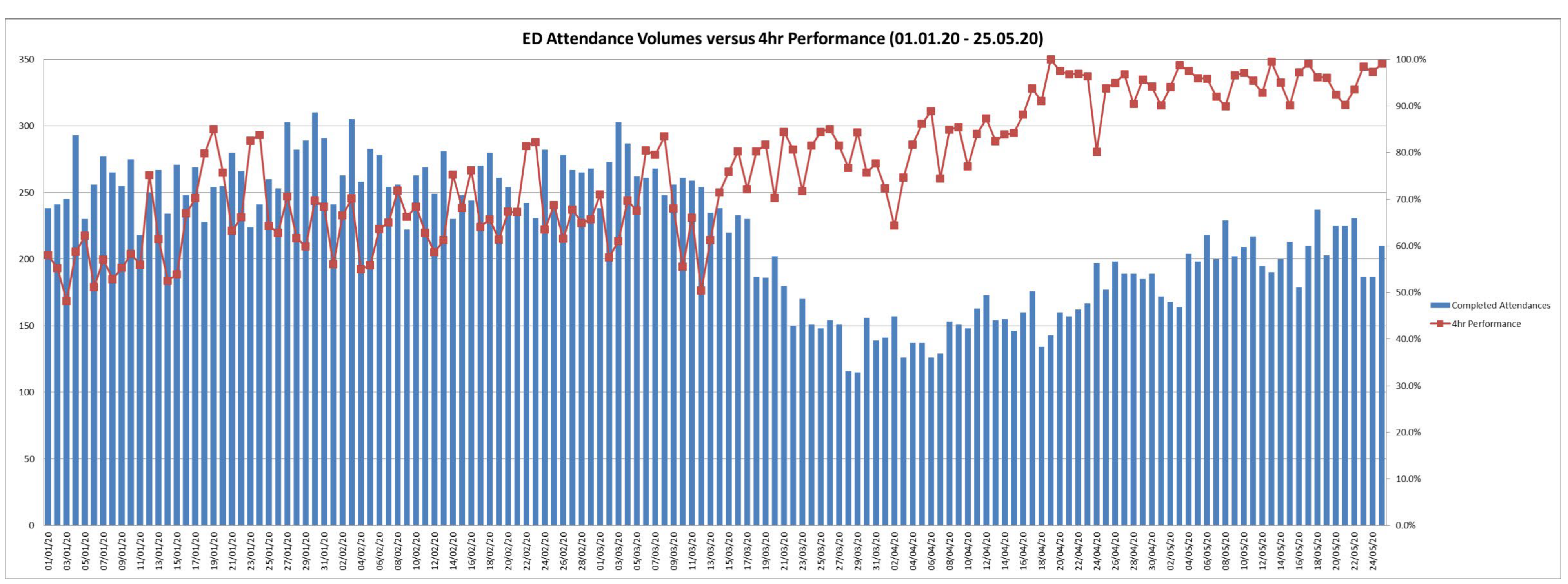
- I was allowed to accompany father in law who cannot speak english. Everyone there was so kind and efficient, it made us feel safe, comfortable and well taken care of. Caring for patients in this current situation is a challenge and everyone did brilliantly for which we are so grateful. We couldn't have asked for more.

APPENDIX 2 – ED 4 hour performance

A clear outcome form the ED improvement work has been our improved 4 hour performance

The chart below shows ED attendances alongside 4hr performance. The impact of Covid-19 is clearly seen from mid-March. Performance has steadily increased since this point. As attendances have continued to increase to over 200 a day, performance has not only been maintained but improved further.

Since 17 April 2020, performance against the 4 hour standard has consistently been above 90% (with only on exception). The average performance in May has been 95%.



APPENDIX 3 – Quality & Safety Dashboard

ED Audit Checklist Daily Dashboard

		01/05/2020	02/05/2020	03/05/2020	04/05/2020	05/05/2020	06/05/2020	07/05/2020	08/05/2020	09/05/2020	10/05/2020	11/05/2020	12/05/2020	13/05/2020	14/05/2020	15/05/2020	16/05/2020	17/05/2020	18/05/2020	19/05
Risk Assessment Completion Rate for Patients with Mental Health Presentations		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Visual Observations Completion Rate for Patients with Mental Health Presentations		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ED Patient Safety Checklist:		100%	81%	100%	100%	95%	96%	100%	89%	85%	86%	93%	93%	85%	100%	100%	100%	100%	100%	100%
Waiting Room Checklist:	AM	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	PM																			
Absconded Patients:	Number of patients	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
	Compliance with police protocol	n/a	100%	n/a	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100%	n/a	n/a	n/a	n/a	n/a	100%	n/a

Key
95% -100%
85% - 95%
< 85%

APPENDIX 4 – ED Integrated Performance Report (IPR)

An ED specific IPR has been introduced to enabling monitoring of key quality and safety measures, these include:

- Performance metrics
- Quality metrics (e.g. falls/pressure ulcers)
- Incidents
- Patient experience
- Workforce (sickness, appraisals, bank and agency use)

Historic data is not in place against a number of these indicators, as they've not historically been captured at a granular level for ED. However, this is now in place. The focus is now on quantifying specific measures for improvement against indicators which are not achieving agreed levels.

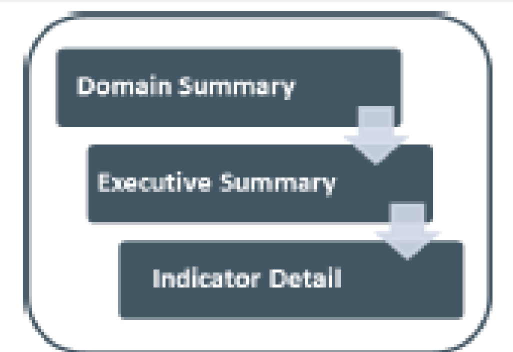
The attachment provides oversight of what we're working towards. As referenced we are developing a more concise dashboard of all measures pulling together the quality and safety dashboard in appendix 3 and the IPR measures.

An example of the IPR is included in the following pages

ED Integrated Performance Report (IPR)

Introduction

The Board report layout consists of three sections:



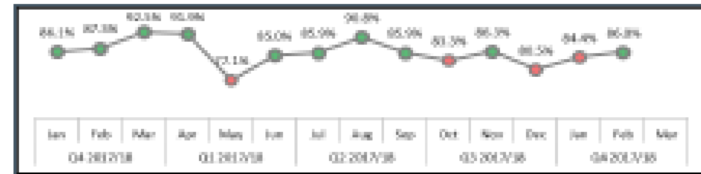
Domain Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

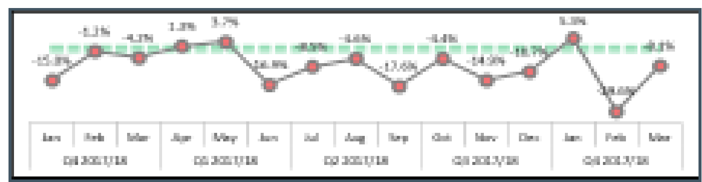
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

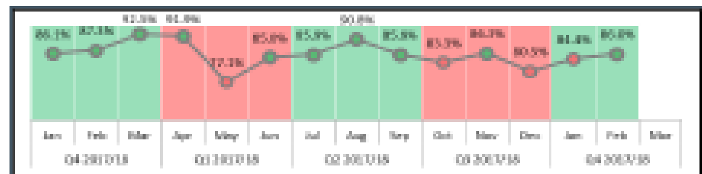
The following chart types are in use throughout the report:



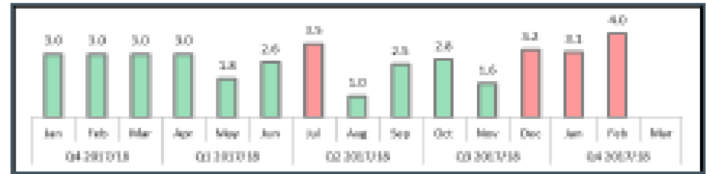
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



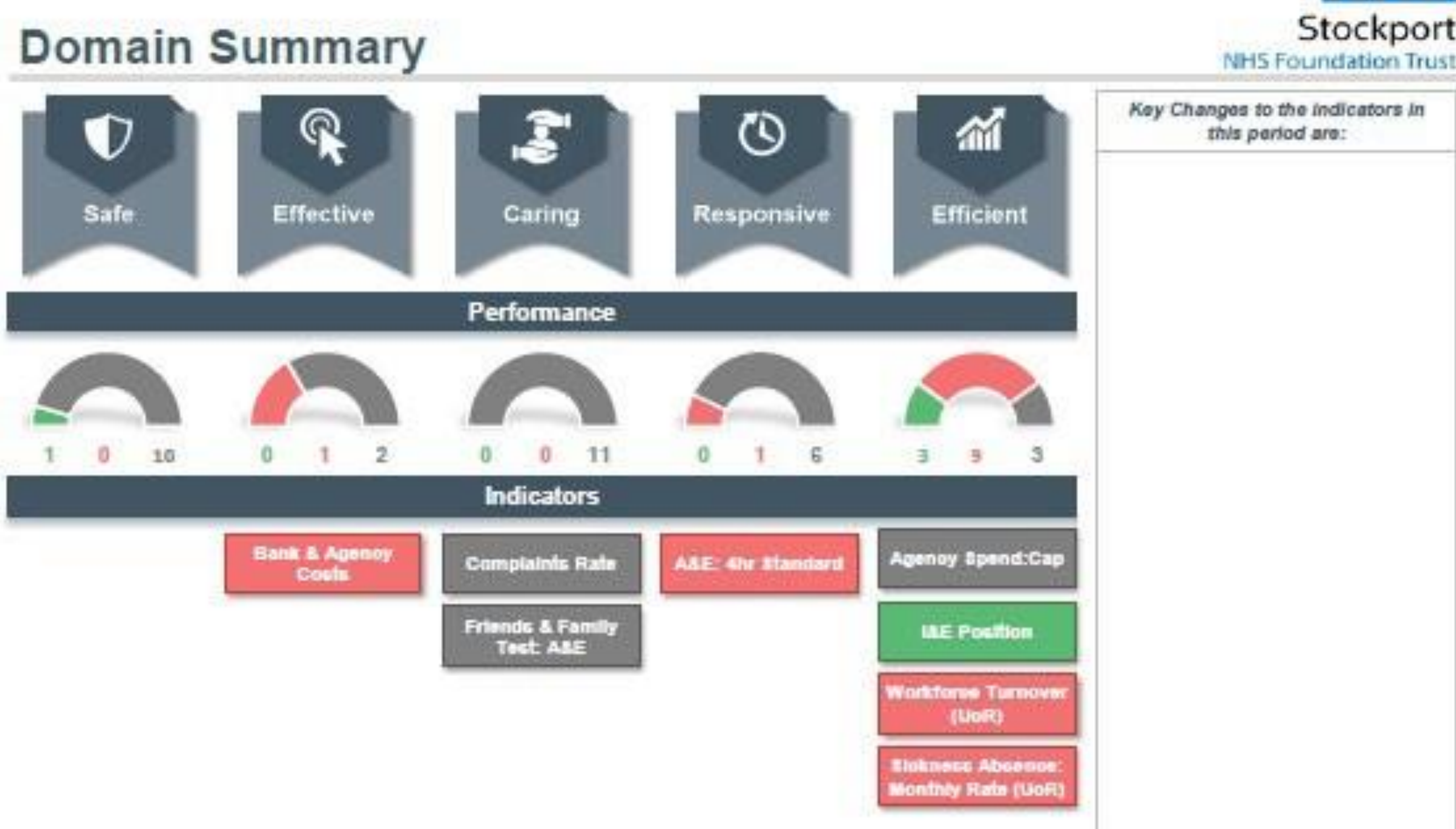
Where applicable, quarterly performance is indicated as coloured columns behind the main trend line.



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

Performance PAT Rating

Please note, for indicators that have an asterix attached to their target, the PAT rating applies to the current YTD value, not the in-month value



Domain Summary
NHS
Stockport
NHS Foundation Trust
Safe
Effective
Caring
Responsive
Efficient
Performance
1 0 10
0 1 2
0 0 11
0 1 6
3 3 3
Indicators
Bank & Agency Costs
Complaints Rate
Friends & Family Test: A&E
A&E: 4hr Standard
Agency Spend:Cap
I&E Position
Workforce Turnover (UoR)
Sickness Absence: Monthly Rate (UoR)
Key Changes to the indicators in this period are:

Stockport
NHS Foundation Trust

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Chief Operating Officer													
Ambulance handovers delays of 30 to 60 minutes	Responsive	Apr-20		157									8
Ambulance handover delays of over 60 minutes	Responsive	Apr-20		5									8
A&E: Overnight Breaches	Effective	Apr-20		372									9
A&E: 4hr Standard	Responsive	Apr-20	>= 95%	87.8%							87.8%		9

Stockport
NHS Foundation Trust

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Medical Director													
A&E: 12hr Trolley Wait	Responsive	Apr-20		0							0		10
Sepsis: Timely Identification	Safe	Feb-20		100.0%							100.0%		10
Sepsis: Timely Treatment	Safe	Feb-20	>= 90%	100.0%							100.0%		11
Duty of Candour Breaches	Effective	Apr-20		0							0		11
Serious Incidents: STEIS Reportable	Responsive	Apr-20		0							0		12

Executive Summary

Stockport
NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Hospital Acquired Device Related Bacteraemia	Safe	Mar-20		0							0		12
Falls: Total Incidence of Inpatient Falls	Safe	Apr-20		6							6		13
Falls: Causing Moderate Harm and Above	Safe	Apr-20		0							0		13
Pressure Ulcers: Hospital, Category 2	Safe	Mar-20		0							0		14
Pressure Ulcers: Hospital, Category 3	Safe	Mar-20		0							0		14
Pressure Ulcers: Hospital, Category 4	Safe	Mar-20		0							0		15
Pressure Ulcers: Device Related, Category 2	Safe	Mar-20		0							0		15
Pressure Ulcers: Device Related, Category 3	Safe	Mar-20		0							0		16
Pressure Ulcers: Device Related, Category 4	Safe	Mar-20		0							0		16
Friends & Family Test: A&E	Caring	Mar-20		88.2%							86.0%		17
Patient Experience	Caring	Apr-20											17
Compliments	Caring	Apr-20		0							0		18
Complaints Rate	Caring	Apr-20		0.0%							0.0%		18

Executive Summary

Stockport
NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I M S W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance										
Complaints: Response Rate 45	Caring	Apr-20	>= 95%							19
Complaints: Parliamentary & Health Service Ombudsman Cases	Caring	Apr-20		0				0		19
Complaints Closed: Overall	Caring	Apr-20		0				0		20
Complaints Closed: Upheld	Caring	Apr-20		0				0		20
Complaints Closed: Partially Upheld	Caring	Apr-20		0				0		21
Complaints Closed: Not Upheld	Caring	Apr-20		0				0		21
Complaints: Returned Complaints	Caring	Apr-20		0				0		22
Litigation: Claims Opened	Responsive	Apr-20		1				1		22
Litigation: Claims Closed	Responsive	Apr-20		1				1		23

Domain Summary

Stockport
NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Director of Workforce & Organisational Development													
Substantive Staff-in-Post	Well-Led / Efficient	Apr-20	>= 90%	71.1%							71.1%		26
Sickness Absence: Monthly Rate (UoR)	Well-Led / Efficient	Apr-20	<= 3.5%	4.6%							4.6%		26
Sickness Absence: Rolling 12-Month Rate (UoR)	Well-Led / Efficient	Apr-20	<= 3.5%	4.6%									27
Sickness Absence: Long-term	Well-Led / Efficient	Apr-20		0									27
Workforce Turnover (UoR)	Well-Led / Efficient	Apr-20	<= 13.94%	25.1%									28
Appraisal Rate: Medical	Well-Led / Efficient	Apr-20	>= 95%	89.5%							89.5%		28
Appraisal Rate: Non-medical	Well-Led / Efficient	Apr-20	>= 95%	59.3%							59.3%		29
Statutory & Mandatory Training	Well-Led / Efficient	Apr-20	>= 90%	88.6%							88.6%		29
Bank & Agency Costs	Effective	Apr-20	<= 5%	34.3%							34.3%		30
Agency Shifts Above Capped Rates	Well-Led / Efficient	Apr-20		0							0		30
Staff Suspensions	Well-Led / Efficient	Apr-20		0									31

APPENDIX 5 – Discharge to Assess Pathway

Stockport COVID- 19
Discharge to Assess Hub Pathway
(revised to include Health TACH Team)

22.05.2020 v0.7

Scope:

This process is for patients who are in hospital and require a complex discharge – Discharge to Assess pathways 1 - 3

Patient identified as clinically safe for discharge at whiteboard round

Going home

- ITT/Therapy: Telephone D2A Hub provide details of referral
- D2A Admin: Take basic details of referral and input basic information on EMIS
- D2A Admin: Assign D2A Referral to Triage and coordination EMIS
- D2A Triage and Coordination: Take details of referral and allocate to a trusted assessor
- D2A Assessor: Contact patient/ carer to arrange assessment visit
- D2A Assessor: Complete assessment and confirm care plan with patient
- D2A Triage and Coordination: Arrange care and wrap around care (support work) if required
- D2A Assessor: Co-ordinate referrals for long term assessments (Inc CHC)

Needs community bed

- Refer to TACHT using agreed template
- Health TACH Team: Complete TACHT Assessment
- Phone referral to D2A Hub and email assessment to hub
- D2A Admin: Take basic details of referral and input basic information on EMIS
- D2A Admin: Assign D2A Referral to Triage and coordination EMIS
- D2A Triage and Coordination: Input referral onto EMIS and confirm type of community bed
- D2A Triage and Coordination: Input referral onto EMIS and confirm type of community bed

Assessment bed / **Rehab**

- D2A Triage and Coordination: Identify vacant bed confirm placement with provider and notify ward
- **Patient placed in bed**
- D2A Trusted Assessor: Commence therapy, review patient in placement and revise plan if required
- D2A Trusted Assessor: Co-ordinate referrals for long term assessments (Inc CHC)

Short term placement

- D2A Triage and Coordination: Notify Commissioner of placement and request contract
- **Patient placed in bed**
- D2A Triage and Coordination: Notify SMBC and request long term needs are assessed and care arranged.

Short term placement → D2A Triage and Coordination: Refer to Age UK → AGE UK: Source Placement, confirm placement with patient/Care/ Family → AGE UK: Notify ward and hub of placement → (Notify Commissioner of placement and request contract)

Patient has Nursing needs

- Complete Nursing Determinaton (ND) and specify category of care
- Send Nursing Determination (ND) to Health TACH Team and AGE UK if EMI Nursing

Report to:	Board of Directors	Date:	4 June 2020
Subject:	Improvement plan in response to the CQC report 2020		
Report of:	Interim Director of Governance, Risk & Assurance	Prepared by:	Deputy Director Quality Governance

REPORT FOR APPROVAL

6.4

Corporate objective ref:	2a,3a,3b
Board Assurance Framework ref:	SO2, SO3, SO5, SO6
CQC Registration Standards ref:	17
Equality Impact Assessment:	☐ Completed ☐ Not required

Summary of Report

The CQC published the results of their inspection of Stockport NHS Foundation Trust on the 15 May 2020.

On behalf of the Board of Directors, the Quality Committee received a detailed report on the key issues and summary of the regulatory action. This paper includes the improvement plan and the information that will be submitted to the CQC on or before the 9 June.

Please note, this paper was written prior to the detailed action plan being presented to the Executive Team on the 2 June 2020 and therefore may be subject to minor , non-material changes, prior to the meeting of the Board.

Members are asked to approve the CQC submission.

Attachments: https://www.cqc.org.uk/provider/RWJ

This subject has previously been reported to:

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

6.4

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1. INTRODUCTION

1.1 On the 15th May 2020, the CQC published its report following an unannounced, well led and use of resources inspection of Stockport NHS Foundation Trust. On behalf of the Board of Directors, the Quality Committee received a detailed report on the key issues and summary of the regulatory action. This paper describes a high level overview that details the improvement plan that has been designed to address the concerns raised by the CQC. The overview will be submitted to CQC on their mandated template on or before the 9 June 2020 following approval.

2. BACKGROUND

2.1 The CQC undertook an unannounced inspection between the 28 - 30 January 2020 in four core services; Medical care including older peoples, Urgent & Emergency Care, Maternity and Children and Young People. A second unannounced inspection of Urgent & Emergency Care was undertaken on the 17 February 2020.

2.2 The Use of Resources assessment was started on the 12 February 2020 and the Well Led inspection on the 26 February.

2.3 During the inspection the Trust received a Section 31 letter in relation to the Emergency Department which requested assurance with regard to several areas:

- Patients with mental health needs that are seen in the Emergency Department are cared for in line with national guidance and their care is recorded accurately.
- Appropriate risk assessments in relation to the environment are completed.
- Appropriate systems and processes are put in place to assess, monitor and improve the quality and safety of the services provided and how these will be monitored to ensure they are embedded.

2.4 On 6 March 2020, a Section 29A warning notice was received stating that the CQC had determined that the quality of care provided by the Trust required significant improvement in relation to the Emergency Department. Areas of concern were

- Safe staffing
- Governance systems to monitor quality, safety and risk across the department

3. CQC RATINGS

3.1 Overall, the Trusts position has remained the same, that is, Requires Improvement.

3.2 However the underlying position has declined since the 2018 inspection.

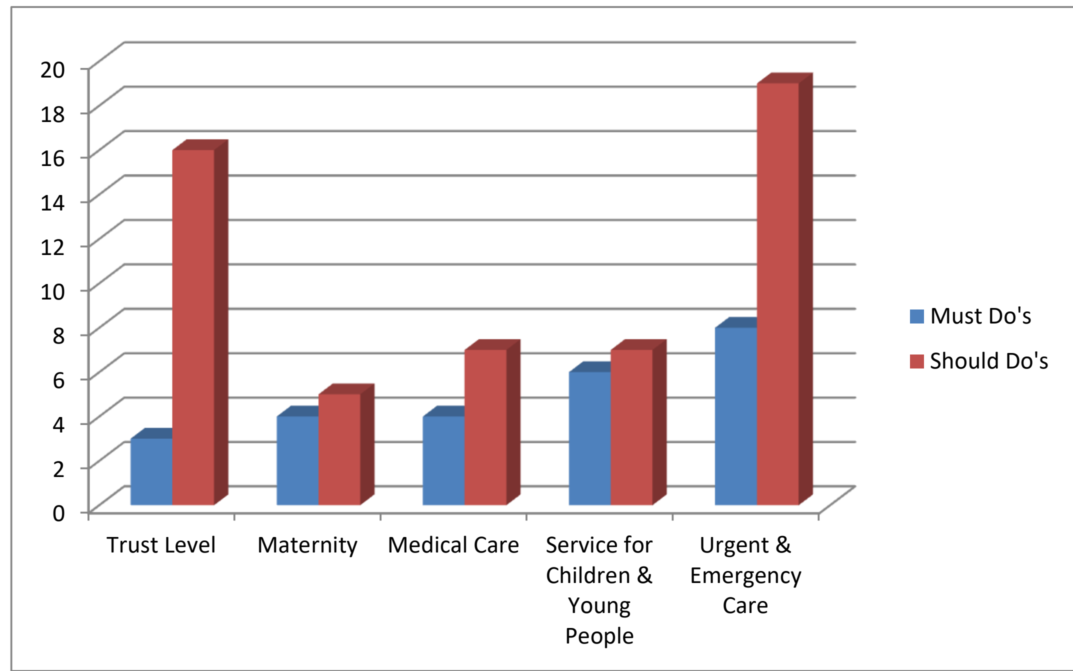
3.3 In summary for the core services:

- 1 area improved by 1 rating
- 14 areas declined by 1 rating
- 1 area declined by 2 ratings

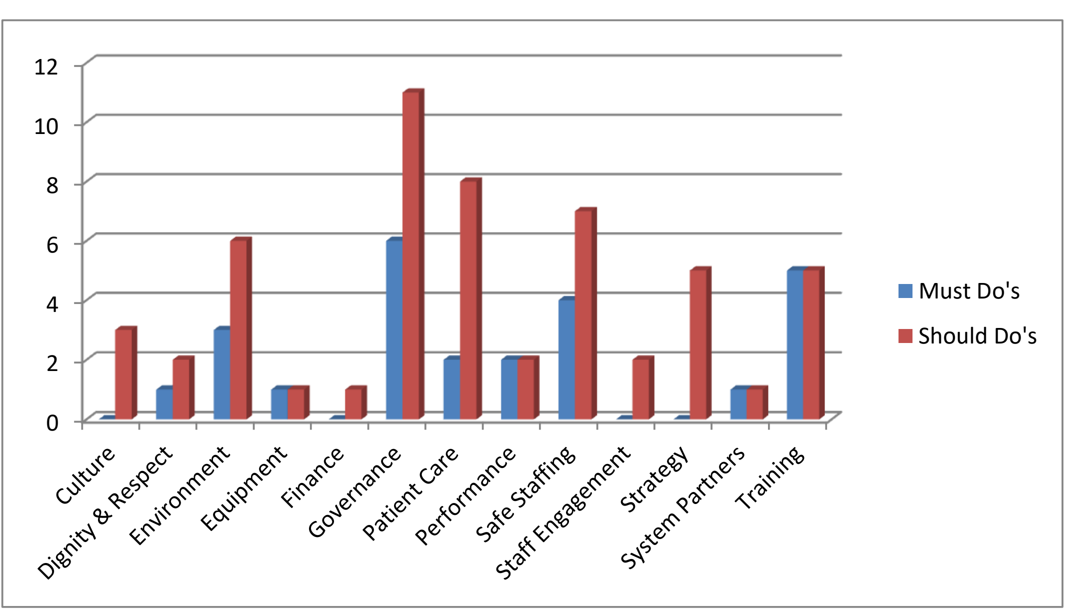
3.4 The use of resources improved by 1 rating, from inadequate to requires improvement

4.0 KEY FINDINGS

4.1 There are 25 'must do' actions and 54 'should do' actions which need to be addressed in addition to the actions identified in the Section 29a Warning notice. The graph below shows the split of the 'must do' and 'should do' actions by core service.



4.5 There are 13 themes



5. IMPROVEMENT PLAN

5.1 The CQC action plan is designed to;

- address the 'must do' actions in order to ensure regulatory compliance, as set out in the CQC 2018 framework (25)
- address the 'should do' actions to ensure that repeated failures do not lead to regulatory

breaches in the future (54)
- to drive improvement thematically across the Trust by applying the actions to all core services in order to achieve a minimum standard of 'Good' at the next inspection

5.2 To achieve the outcomes, the following process is being undertaken
- Clearly define what 'Good' looks like
- Include must do and should do actions into improvement themes
- Allocation of must do and should do to action leads and SRO's
- Action leads are Business Group Directors or Deputy Directors
- SRO's are Directors
- Meetings held with action leads and actions agreed
- Meetings held with SRO's and actions agreed
- Completion of final draft action plan
- Copy of main actions into CQC template for submission (9June)
- Executive Team sign off 2 -9 June

6.0 TIMELINE FOR SUBMISSION OF IMPROVEMENT PLAN

6.1 The CQC request a plan to be submitted to them, outlining the actions that the trust intends to take in response to their findings. In addition to the ED improvement plan, an overarching action plan has been devised to address the must do and should do actions.

6.2 The CQC submission is required to address the regulation breaches only (the must do actions) and they do not require the detailed plan that sits behind this.

Date	Action
Week beginning 2 May 2020	SRO's and action leads identified for each Must do and should do action. Required CQC standards identified
Week beginning 9 May 2020	Identification of actions by action leads to reach required standard with milestones identified
Week beginning 18 May 2020	Standards and actions agreed with SRO's Monitoring process outlined
26 May 2020	Update presented to Executive Team
2 June 2020	Final detailed plan and CQC high level plan presented and approved by Executive team
4 June 2020	Detailed plan and CQC submission supported by Board of Directors
9 June 2020	Final approval if amendments required by Executive Team
9 June 2020 (or before)	CQC plan submitted

6.3 Once agreed, actions will be driven through a check and challenge process on a fortnightly or monthly basis with the action leads and SRO's. A monthly report on progress will be submitted to the Board of Directors.

7. RECOMMENDATIONS

7.1 Members are asked to approve the CQC submission.

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RWJ
Our reference	INS2-5864512041
Location name	Stockport NHS Foundation Trust

Regulated activity	Regulation
Person centred care	**Regulation 9** **Person-centred care**
	How the regulation was not being met:
	Within the emergency department, the care and treatment provided to service users during periods of heavy demand was not always appropriate to meets the needs and reflects the preferences of patients. The maternity unit was increasingly closed for women.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
1. The ED department will establishment and implement a fundamental care standards framework including: a. Implementation of a dynamic service acuity assessment process that identifies demand pressure early and ensures patients are managed safely especially during periods of high demand through deployment of resources through Staffing Hub function
2. The ED department will Implement a fundamental care standards framework that includes a requirement for all patients have in place fully documented care plans
3. Implementation of a fundamental care standards framework that includes a requirement for all patients have documented in the patient record all appropriate *'patient level risk assessment'* (SEPSIS; Falls; VTE; Pain; Metal Health etc)
4. Establishment and implementation in ED of a monthly point-prevalence audit of patient records focusing on full completion of patient level risk assessments

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
5. Establishment of an assurance and reporting process against the ED fundamental care standards process through Trust governance systems (Reporting to the Trust senior operational patient safety and quality meeting) 6. The Maternity service will re-submit the Midwifery staffing business case to Executive Team and Trust Board for approval. 7. On approval of the Midwifery staffing business case, the service will initiate a fast-track recruitment process against enhanced staffing model. 8. In order to reduce vacancies, the Midwifery service will enhance proactive recruitment through the *'opt in'* scheme securing trainee midwives as soon as they qualify	
Who is responsible for the action?	Overall responsibility Actions 1 to 5: Chief Nurse; Delivery Director Overall responsibility Actions 6 to 8: Chief Nurse; Director for Women's, Children & Diagnostics (WC&D) **Action responsibility:** • ED Senior Leadership Team, ED Matron and Band 7 Sisters. • ED Senior Leadership Team, ED Matron and Band 7 Sisters. • ED Senior Leadership Team, ED Matron and Band 7 Sisters. • ED Matron and Band 7 Sisters. • ED Senior Leadership Team & ED Matron • Chief Nurse & WC&D Senior Leadership Team • Nurse & WC&D Senior Leadership Team • Nurse & WC&D Senior Leadership Team

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Monitoring implementation and effectiveness of actions through the CQC Improvement Programme governance and reporting systems. • Monitor Datix, complaints and PALS concerns relating to Maternity closures for admissions • Monitoring of ED flow key indicators through Urgent Care Governance and the Urgent Care operational performance meetings	
Who is responsible?	Governance Advisor Deputy Director of Quality Governance

What resources (if any) are needed to implement the change(s) and are these resources available?

- Financial support of business case for Maternity staffing model.

Date actions will be completed:	All actions are work in progress; however, changes may be temporarily applied in relation to the management of COVID-19*. 1. 30 September 2020 2. 30 June 2020 3. 30 June 2020. 4. 30 June 2020 5. 30 June 2020 6. 30 August 2020. 7. 30 September 2020 8. 30 September 2020 *Updates to the progression of actions will be provided through the CQC Improvement Programme confirm and challenge/relationship meetings.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust is committed to ensuring the safety and effectiveness of all patients is protected. No adverse impact anticipated on service users.

Completed by: (please print name(s) in full)	Paul Linehan Helen Kershaw
Position(s):	Governance Advisor Deputy Director of Quality Governance
Date:	28/05/20

Regulated activity	Regulation
Safe Care and Treatment	**Regulation 12** **Safe care and treatment**

6.4

	How the regulation was not being met:
	Within the emergency department and the hospital, service users were not always assessed, treated, admitted and discharged in a safe, timely manner. Within the emergency department and services for children and young people, there was a lack of assessment of the risks to the health and safety of service users receiving the treatment, including service users presenting with mental health conditions, and doing all that was practicable to mitigate the risks. Premises were not all safe to use for their intended purpose. There was not sufficient quantities of equipment available to staff to provide care in a safe way and to meet the needs of patients. Premises and equipment were not all suitable and risks associated with ligature points had not been identified and assessed. Staff were had not completed safeguarding training appropriate for the services and in accordance with guidance in 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019'.

6.4

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

9. The Trust will establish a clinically led system-wide programme focused on flow through the hospital system and beyond.
10. The Trust will obtain buy-in from all System partners and establish a weekly improvement cycle.
11. Adoption of a PDSA approach across the system to embed sustainable improvements
12. Establishment of a quarterly monitoring and reporting process (Reporting to the Trust senior operational patient safety and quality meeting
13. Implementation of a fundamental care standards framework that includes a requirement for all patients have in place fully documented care plans
14. Estates and ED to complete series of environmental review/assessments PLACE Assessment; Fire risk assessment; Disability access audit
15. Actions arising from the PLACE assessment to be addressed through a specific estates action plan
16. Establish process for EBME maintained Medical equipment to be audited to ascertain the appropriate level of held stock items; for current bay capacity.
17. EBME & ED to ascertain through review the required levels of stock needed to manage patient numbers during surge.
18. EBME & ED to review and implement improvements in the process of tracking equipment
19. Estates & ED to complete the Manchester Method for Anti-ligature assessment
20. Medicine will work to improve the service provision between primary care and community services and neighbourhood teams (including social care) in order to enhance same day emergency care provision, weekend discharge rates and admission avoidance pathways
21. Medicine will review existing discharge processes and streamline with focus on reducing the number of assessments individuals require before being discharged with the aim of reducing length of stay/delayed discharges.

22. Medical services will adapt and implement the Greater Manchester's Frailty Model, developing a system-wide frailty plan to support more people in Stockport outside of the acute setting.
23. Complete a review of the cleansed CYP training database to ensure a clear understanding of training compliance which meets Trust targets, in line with the children's safeguarding training strategy.
24. Establish across CYP a new Reporting Format - RAG rating for managers to identify areas requiring attention.
25. Implement proactive oversight of competency training compliance rates
26. Implement process for the explicit inclusion and recording of mandatory and competency training within all staff appraisals
27. Implement WebEx training sessions (Safeguarding) twice a week to meet the training requirements of the workforce.
28. Working in partnership with Pennine Care, agree standards of care. All risk assessments to be reviewed to ensure they are age appropriate and meet the needs of the individual. Ensure the staff have knowledge and skills to provide safe care to CYP with mental health concerns.
29. All Business groups must have in place up to date risk registers that full encompass all areas of risk relating to the health, safety and welfare of people using service
30. Development of a staff competency framework to measure knowledge and skills against. Regular reporting of compliance audit shared in BG, to ET and to Board to demonstrate risk assessments are completed on the children's wards and in a timely manner.
31. Implementation of a fundamental care standards in CYP that includes a requirement for all patients have in place fully documented care plans
32. Implementation of a fundamental care standards framework that includes a requirement for all patients have documented in the patient record all appropriate 'patient level risk assessment' (SEPSIS; Falls; VTE; Pain; Metal Health etc) Establishment and implementation of monthly point-prevalence audits of patient records focusing on full completion of patient level risk assessments
33. Establishment of an assurance and reporting process through Trust governance systems (Reporting to the Trust senior operational patient safety and quality meeting)
34. Establish ligature free cubicle to be designed with Treehouse Ward footprint
35. Estates and WC&D/CYP to complete series of environmental review/assessments PLACE Assessment; Fire risk assessment; Disability access audit
36. Actions arising from the WC&D/CYP PLACE assessment to be addressed through a specific estates action plan

Overall responsibility Actions 9-12; 20-22: Chief Operating Officer; Deputy Chief Operating Officer
Overall responsibility Actions13; 31-34: Chief Nurse; Director for Women's, Children & Diagnostics (WC&D)
Overall responsibility Actions 14-19; 35-37: Director Finance and Associate Director of Estates and Facilities
Director of Workforce and OD and Business group Director WC&D: 23-28
Interim Director of Governance & Assurance and Business group Director WC&D: 29-30

Action responsibility:

6.4

- ED Senior Leadership Teams, Matrons and Band 7 Sisters.
- Medicine Senior Leadership Teams, Matrons and Band 7 Sisters.
- WC&D Senior Leadership Teams, Matrons and Band 7 Sisters.
- Chief Operating Officer; Deputy Chief Operating Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Monitoring implementation and effectiveness of actions through the CQC Improvement Programme governance and reporting systems (2/4 weekly confirm and challenge meetings).
- Monitoring key performance indicators through Urgent Care Governance and the Urgent Care operational performance meetings
- Review of audits and associated action plans.

Who is responsible?	Governance Advisor Deputy Director of Quality Governance

What resources (if any) are needed to implement the change(s) and are these resources available?

- Management support to ensure staff mandatory training sessions are included in the rota and are fully protected
- Short term funding for specialist Health & Safety advisor/PLACE assessor

Date actions will be completed:	9. 30 September 2020 10. 30 September 2020 11. 30 September 2020 12. 30 September 2020 13. 30 June 2020 14. 30 June 2020 15. 30 June 2020 16. 30 June 2020 17. 30 September 2020 18. 30 September 2020 19. 30 June 2020 20. 30 September 2020 21. 30 August 2020

	22. 30 December 2020 23. 30 September 2020 24. 30 September 2020 25. 30 September 2020 26. 30 September 2020 27. 30 October 2020 28. 30 December 2020 29. 30 September 2020 30. 30 September 2020 31. 30 September 2020 32. 30 August 2020 33. 30 September 2020 34. 30 September 2020 35. 30 September 2020 36. 30 December 2020 37. 30 December 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust is committed to ensuring that patients are treated in a safe and healthy environment and that staff working in conditions that ensure their individual and collective health and safety. No adverse impact anticipated on service users.

Completed by: (please print name(s) in full)	Paul Linehan Helen Kershaw
Position(s):	Governance Advisor Deputy Director of Quality Governance
Date:	**28/05/20**

Regulated activity	Regulation
Good Governance	**Regulation 17**

	Good governance
	How the regulation was not being met:
	There were not effective governance systems in place to monitor quality, safety and risk. Without these patients were, or may be, at risk of harm through the lack of identification of, and subsequent review and mitigation of risks. Trust policies for managing violence and aggression needed to be reviewed and implemented. There was a lack of assurance that safety procedures, designed to improve safety for mothers and babies, such as the World Health Organisations five steps to safer surgery were carried out regularly. There was a lack of effective systems for oversight of required training.

6.4

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

38. Initiate and conclude independent Health & Safety audit
39. Rebuild performance management framework and IPR
40. Review, repurpose and approve Terms of Reference for all standing committees/Groups (subject to the Board's preference for meeting structure)
41. Review, repurpose and approve Terms of Reference for all Business Groups/Speciality level governance and performance meetings committees/Groups (subject to the Board's preference for meeting structure)
42. Develop Duty Holder's Matrix and appoint responsible officers 30/12/2020
43. Establish Safety Management as a scheduled regular Board agenda item (4 times per year)
44. Rebuild Board Assurance Framework
45. Realign BAF for year ahead (2020/21)
46. Implement review of Trust policy for managing violence and aggression and where appropriate make improvements in line with best practice models
47. Implement training programme in the management of violence and aggression based on best practice model set out in the Trust policy
48. Monitor effectiveness of the management of violence and aggression through review of all reported incidents
49. Monitor effectiveness of the management of violence and aggression through review of all reported incidents

Who is responsible for the action?	Interim Director of Governance & Assurance and Business group Direc WC&D: 38-45 Overall responsibility Actions 46-48: Chief Nurse; Director for Women's, Children & Diagnostics (WC&D) **Action responsibility:** • WC&D Senior Leadership Teams, Matrons and Band 7 Sisters. • Associated Director off Governance

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Monitoring implementation and effectiveness of actions through the CQC Improvement Programme governance and reporting systems (2/4 weekly confirm and challenge meetings).	
Who is responsible?	Governance Advisor Deputy Director of Quality Governance

What resources (if any) are needed to implement the change(s) and are these resources available?
• No additional resources required

Date actions will be completed:	38. 30 December 2020 39. 30 April 2021 40. 30 September 2020 41. 30 September 2020 42. 30 December 2020 43. 30 September 2020 44. 30 December 2020 45. 30 December 2020 46. 30 September 2020 47. 30 September 2020 48. 30 September 2020 49. 30 September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
No adverse impacts anticipated on service users.

Completed by: (please print name(s) in full)	Paul Linehan Helen Kershaw
Position(s):	Governance Advisor Deputy Director of Quality Governance
Date:	28/05/20

Regulated activity	Regulation

Staffing	**Regulation 18** **Staffing**
	How the regulation was not being met:
	The compliance levels for mandatory training were low in some areas. There was a lack of evidence of staff competencies There were insufficient suitably qualified, competent, skilled and experienced persons to provide safe care to women and babies and children and young people. There was not always a supernumerary labour ward co-ordinator at all times. There was a lack of staff trained in recognising and responding to children and young people with mental health needs, learning disabilities and autism.

6.4

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

50. Establish and implement standards for completion of rosters, to ensure appropriate allocation of safe staffing on a six-week forward planner.
51. Develop KPIs for completion of nursing rota including reporting of completion of nursing rotas
52. Establish staffing hub for the purpose of managing resources against acuity.
53. Implement standard whereby additional bed capacity is never opened unless appropriate numbers and skill mix of staff can be made available to manage care of patients safely
54. Empower clinical site coordinator team to make autonomous decisions
55. Implement safe staffing processes that ensure the correct the number and skill mix are available in ED to meet demand.
    - Objective to meet all national standards
    - 15 min triage
    - 4 hour wait
    (These metrics will be revised if national standards change)
56. Implement competency assessments programme for Nursing staff
57. Establish monitoring systems for competency assessments
58. Establish assurance reporting on status of staff competency assessment through WAG
59. Establish training programme for senior Nursing staff covering key skills:
    - Rota management
    - Management of staff budgets
    - People management and HR
60. Proactively recruit through the ‘opt in’ of student nurses & midwives as soon as they qualify to reduce vacancies
61. Develop and implement a improved recruitment and retention plan
62. Establish/Implement new Reporting Format - RAG rating for managers to identify areas requiring attention. (Piloted March – April 2020)
63. Implement system for proactive oversight of mandatory training compliance rates
64. Implement process for the explicit inclusion and recording of mandatory training within all staff appraisals
65. Implementation of process for Email reminders to all staff where at least one training

<table>
<tr><td colspan="2">topic has expired. (Piloted March –May 2020).
66. Increased communication networks will be used to promote statutory and mandatory training information including corporate welcome, team meetings, twitter and other platforms.
67. Enhanced/Increased promotion of ESR Self Service – “Pop up Shop” pilot
68. Facilitate access for staff to their personal learning records and book sessions on their own devices.
69. Undertake review (TNA) of role specific training competencies - to ensure that staff are only flagged for training that is necessary for their role
70. Re-submit Midwifery staffing business case to Executive Team and Trust Board for approval
71. Initiate recruitment process against enhanced staffing model
72. Undertake Establishment review of treehouse staffing against RCN standards for paediatric care (2013).
73. Review required staffing for Paediatric Assessment Uniform (PAU), against RCPCH Standards for Paediatric Assessment Units (2018).
74. Continue to progress Safe Care live to ensure accurate information with regards to level of acuity and calculation of workforce required to deliver safe care
75. Introduction of twice daily Sit Rep reports for the clinical area and implementation of clear escalation pathway for instances of staffing concern
76. Establish assurance reporting on status of staff competency assessment through WAG
77. The trust to enrol with the 'We Can Talk' programme. The intro of the ‘We Can Talk’ Children and Young People’s Mental Health (CYP MH) as a pilot project produced in collaboration with hospital staff, young people and mental health experts, together with a competency framework for hospital staff.
78. - Triumvirate to lead on staff engagement (surveying, raising awareness of project, working with Trust communication teams).
79. - Work with the 'We Can Talk' CAMHS lead to identify skills transfer and
80. shared learning opportunities between mental health and acute care.
81. Establish new Reporting Format - RAG rating for managers to identify areas requiring attention. (Piloted March – April 2020)
82. Implement proactive oversight of competency training compliance rates
83. Implement process for the explicit inclusion and recording of mandatory and competency training within all staff appraisals</td></tr>
<tr><td>Who is responsible for the action?</td><td>Overall responsibility: Actions 49-61: Chief Nurse and Deputy Chief Nurse
Director of Workforce and Organisational Development and Deputy Director of Workforce and Organisational Development: Actions 62-69
Chief Nurse and Business Group Director for Women’s, Children & Diagnostics Actions 70-71
Director of Workforce and Organisational Development and Group Dire Women’s, Children & Diagnostics Actions 72-80

Action responsibility:
• Senior Leadership Teams, Matrons and Band 7 Sisters.
• Corporate HR Team</td></tr>
</table>

6.4

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Monitoring implementation and effectiveness of actions through the CQC Improvement Programme governance and reporting systems.	
Who is responsible?	Governance Advisor Deputy Director of Quality Governance

What resources (if any) are needed to implement the change(s) and are these resources available?
• Support for staff in use of nurse rota system • Financial support for the Midwifery staffing business case

Date actions will be completed:	50. 30 July 2020 51. 30 September 2020 52. 30 September 2020 53. 30 September 2020 54. 30 September 2020 55. 30 September 2020 56. 30 October 2020 57. 30 October 2020 58. 30 October 2020 59. 30 October 2020 60. 30 December 2020 61. 30 September 2020 62. 30 September 2020 63. 30 September 2020 64. 30 September 2020 65. 30 September 2020 66. 30 September 2020 67. 30 September 2020 68. 30 September 2020 69. 30 June 2020 70. 30 August 2020 71. 30 October 2020 72. 30 September 2020 73. 30 September 2020 74. 30 September 2020 75. 30 September 2020 76. 30 September 2020 77. 30 December 2020 78. 30 September 2020

	79. 30 September 2020 80. 30 September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
No adverse impacts anticipated on service users.

Completed by: (please print name(s) in full)	Paul Linehan Helen Kershaw
Position(s):	Governance Advisor Deputy Director of Quality Governance
Date:	28/05/20

Regulated activity	Regulation
Dignity and Respect	**Regulation 10** **Dignity and respect**
	How the regulation was not being met:
	The intention of this regulation is to make sure that people using the service are treated with respect and dignity at all times while they are receiving care and treatment. There were concerns that patient's confidentiality was not always protected

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Monitoring implementation and effectiveness of actions through the CQC Improvement Programme governance and reporting systems.	
Who is responsible?	Governance Advisor Deputy Director of Quality Governance

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
81. Ensure that patient experience including confidentiality is part of the planning and delivery of compassionate care 82. Increased staff awareness of patient confidentiality issues and the importance of voice

level moderation in open areas
Overall responsibility: Actions 81-82: Chief Nurse and Deputy Chief Nurse Director of Workforce and Organisational Development and Deputy Director of Workforce and Organisational Development: Actions 62-69 Chief Nurse and Business Group Director for Women's, Children & Diagnostics Actions 70-71 Director of Workforce and Organisational Development and Group Director for Women's, Childr Diagnostics Actions 72-80 **Action responsibility:** • ED Senior Leadership Teams, Matrons and Band 7 Sisters. • Corporate Estates Team

6.4

What resources (if any) are needed to implement the change(s) and are these resources available?
• Financial support for procurement of sound dampening technologies where appropriate

Date actions will be completed:	81. 30 June 2020 82. 30 September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
No adverse impacts anticipated on service users.

Completed by: (please print name(s) in full)	Paul Linehan Helen Kershaw
Position(s):	Governance Advisor Deputy Director of Quality Governance
Date:	28/05/20

Report To:	Trust Board	Date:	04 Jun 2020
Subject:	Integrated Performance Report		
Report of:	Director of Strategy & Planning	Prepared by:	B.I. and Performance Teams

REPORT FOR ASSURANCE

Corporate Objective Ref:	SO2, 2a, 2b, 3a, 3b, 5a, 5c, 6a	**Summary of Report** The Board is asked to note the performance against the reported metrics, particularly noting the key areas of change from the previous month. Attention is drawn to the Domain Summary page which details - those metrics which have been temporarily withdrawn due to the absence of an agreed activity plan - a change to target /standard levels NB) In line with national, regional and local decisions, data collection for some metrics ceased in March 2020 to allow staff to respond to COVID-19.
Board Assurance Framework Ref:	SO2, SO3, SO5, SO6	
CQC Registration Standards Ref:	10, 12, 17 & 18	
Equality Impact Assessment:	☐ Completed ☑ Not Required	

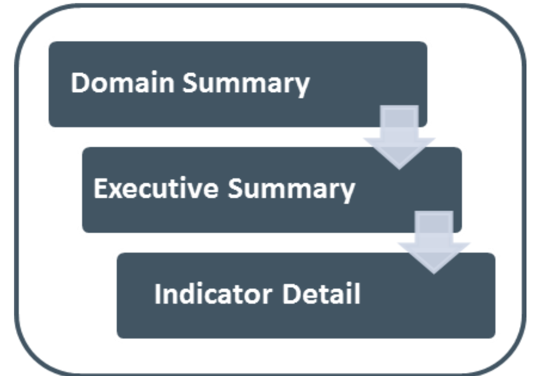
Attachments:

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

6.5

Introduction

The Board report layout consists of three sections:



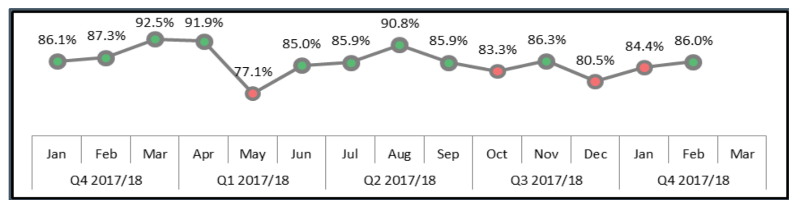
Domain Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

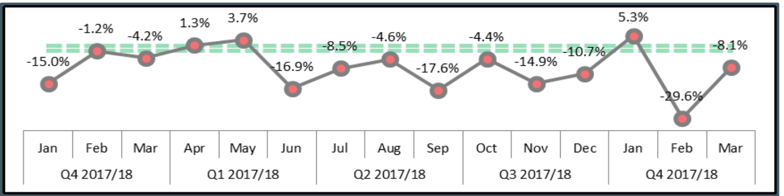
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

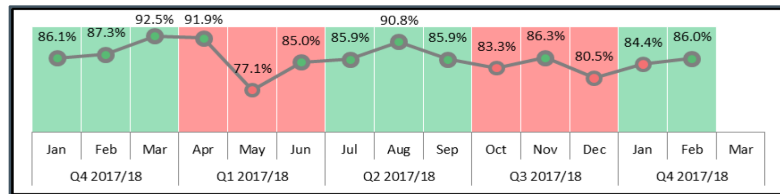
The following chart types are in use throughout the report:



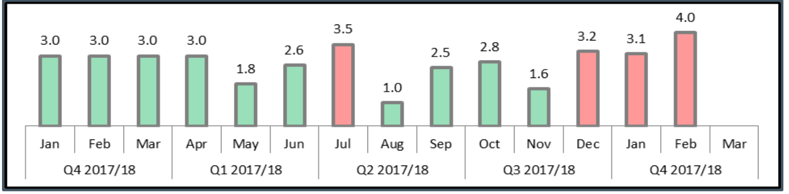
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



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



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

Performance PAT Rating

Please note, for indicators that have an asterix attached to their target, the PAT rating applies to the current YTD value, not the in-month value

NHS
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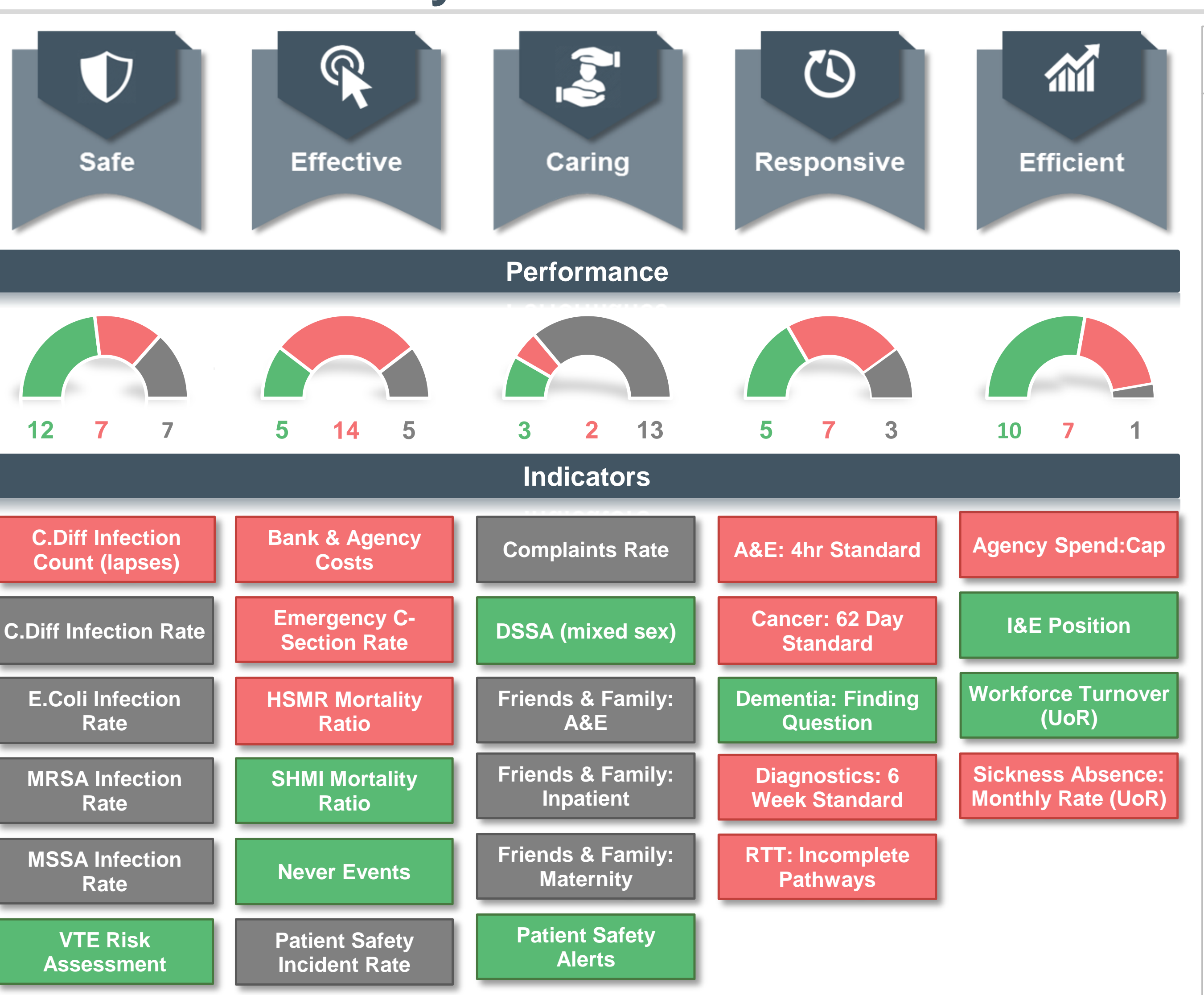
Domain Summary



Key Changes to the indicators in this period are:

Please note, the following metrics have been temporarily removed from the IPR report due to the absence of an agreed activity plan during the COVID-19 pandemic:

~Elective Activity v Plan
~Daycase Activitu v Plan
~Outpatients Activity V Plan
~Elective Income v Plan
~Daycase Income v Plan
~Outpatient Income v Plan
~Theatre Sessions v Plan

In the absence of agreed improvement trajectories, the targets for the following metrics have been set to the Nationl set standards:

~A&E 4hr standard
~Cancer 62 day standard
~RTT Incomplete standard

As per the latest planning guidance, the target for RTT Waiting List Size has been set at the January 2020 level.

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Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Chief Operating Officer													
Diagnostics: 6 Week Standard	Responsive	Apr-20	<= 1%	35.1%							35.1%		13
Cancer: 62 Day Standard	Responsive	Apr-20	>= 85%	69.4%							69.4%		13
Cancer: 104 Day Breaches	Responsive	Apr-20	<= 0	3.0							3.0		14
Referral to Treatment: Incomplete Pathways	Responsive	Apr-20	>= 92%	67.3%							67.3%		14
Referral to Treatment: Incomplete Waiting List Size	Responsive	Apr-20	<= 24637	23504									15
Clinical Correspondence	Safe	Apr-20	>= 95%	63.8%							63.8%		15
Outpatient Hospital Cancellation Rate (UoR)	Responsive	Apr-20	<= 9%	38.0%							38.0%		16
Outpatient DNA rate (UoR)	Effective	Apr-20	<= 7.4%	6.0%							6.0%		16
Outpatient Clinic Utilisation (UoR)	Effective	Apr-20	>= 90%	60.3%							60.3%		17
Outpatient New to Follow-up Ratio (UoR)	Effective	Apr-20	<= 1.77	2.50							2.50		17
Theatres: Overall Touch-time Utilisation (UoR)	Effective	Apr-20	>= 85%	48.5%							48.5%		18
Theatres: In-Session Touch-time Utilisation (UoR)	Effective	Apr-20	>= 85%	38.0%									18
Length of Stay: Non-Elective (UoR)	Effective	Apr-20	<= 9	11.37							11.37		19

* Target/performance applies to the cumulative YTD value, not the in-month value

NHS Stockport NHS Foundation Trust

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Chief Operating Officer													
Length of Stay: Elective (UoR)	Effective	Apr-20	*<= 2.6*	2.67							2.67		19
Long Length of Stay 7 Days	Effective	Apr-20	*<= 32%*	37.7%							37.7%		20
Long Length of Stay 21 Days	Effective	Apr-20	*<= 11%*	13.0%							13.0%		20
Delayed Transfers of Care (DTOC) (UoR)	Effective	Apr-20	*<= 3.3%*	1.9%							1.9%		21
Medical Optimised Awaiting Transfer (MOAT)	Effective	Apr-20	*<= 40*	59							59		21
Discharges by Midday	Effective	Apr-20	*>= 33%*	20.3%							20.3%		22
A&E: Overnight Breaches	Effective	Apr-20		372									22
A&E: 4hr Standard	Responsive	Apr-20	*>= 95%*	87.8%							87.8%		23

* Target/performance applies to the cumulative YTD value, not the in-month value

NHS
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Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
A&E: 12hr Trolley Wait	Responsive	Apr-20	<= 0	0							0		23
Emergency Readmission Rate (UoR)	Effective	Feb-20	<= 7.9%	8.2%							8.5%		24
Diabetes Reviews	Caring	Dec-19	>= 90%	89.3%							84.2%		24
VTE Risk Assessment	Safe	Dec-19	>= 95%	97.6%							97.4%		25
Sepsis: Timely Identification	Safe	Feb-20		81.0%							76.1%		25
Sepsis: Timely Treatment	Safe	Feb-20	>= 90%	42.9%							41.3%		26
Medication Errors: Rate	Safe	Apr-20		3.52									26
Discharge Summaries	Safe	Apr-20	>= 95%	90.9%							90.9%		27
Mortality: Deaths in ED or as Inpatient	Effective	Apr-20		215							215		27
Mortality: Case Note Review Rate	Effective	Apr-20		4.2%							4.2%		28
Mortality: Specialist Palliative Care Length of Stay	Caring	Apr-20		15.33							15.33		28
Mortality: HSMR	Effective	Feb-20	<= 1	1.01									29
Mortality: SHMI	Effective	Nov-19	<= 1	0.98									29

* Target/performance applies to the cumulative YTD value, not the in-month value

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Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
Never Event: Incidence	Effective	Apr-20	<= 0	0							0		30
Duty of Candour Breaches	Effective	Apr-20		0							0		30
Serious Incidents: STEIS Reportable	Responsive	Apr-20		9							9		31

* Target/performance applies to the cumulative YTD value, not the in-month value

NHS
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NHS Foundation Trust

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
C.Diff Infection Rate	Safe	Mar-20		26.71							22.95		31
C.Diff Infection Count	Safe	Mar-20	<= 51 *	2							56		32
MRSA Infection Rate	Safe	Mar-20		0.00							0.00		32
MSSA Infection Rate	Safe	Mar-20		7.16							6.18		33
E.Coli Infection Rate	Safe	Mar-20		22.42							21.46		33
E.Coli Infection Count	Safe	Mar-20		2							47		34
Falls: Total Incidence of Inpatient Falls	Safe	Apr-20	<= 91 *	93							93		34
Falls: Causing Moderate Harm and Above	Safe	Apr-20	<= 2 *	2							2		35
Pressure Ulcers: Hospital, Category 2	Safe	Mar-20	<= 93 *	9							100		35
Pressure Ulcers: Hospital, Category 3	Safe	Mar-20	<= 22 *	1							11		36
Pressure Ulcers: Hospital, Category 4	Safe	Mar-20	<= 3 *	1							3		36
Pressure Ulcers: Community, Category 2	Safe	Mar-20	<= 193 *	18							136		37
Pressure Ulcers: Community, Category 3	Safe	Mar-20	<= 46 *	3							27		37

* Target/performance applies to the cumulative YTD value, not the in-month value

Executive Summary

NHS
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NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Pressure Ulcers: Community, Category 4	Safe	Mar-20	<= 9 *	1	Red	→	Grey	Grey	Grey	Grey	10	△ (amber)	38
Pressure Ulcers: Device Related, Category 2	Safe	Mar-20	<= 33 *	2	Green	→	Red	Green	Green	Green	31	△ (green)	38
Pressure Ulcers: Device Related, Category 3	Safe	Mar-20	<= 8 *	0	Green	↓	Green	Red	Green	Green	4	△ (green)	39
Pressure Ulcers: Device Related, Category 4	Safe	Mar-20	<= 1 *	0	Green	→	Red	Green	Green	Green	1	△ (green)	39
Safety Thermometer: Hospital	Safe	Mar-20	>= 95%	95.7%	Green	↓	Green	Red	Green	Green	96.2%		40
Safety Thermometer: Community	Safe	Mar-20	>= 95%	97.1%	Green	↓	Green	Grey	Grey	Grey	97.0%		40
Patient Safety Incident Rate	Effective	Apr-20		57.41	Grey	↓	Grey	Grey	Grey	Grey			41
Patient Safety Alerts: Completion	Caring	Apr-20	>= 100%	100.0%	Green	↑	Grey	Grey	Grey	Grey	100.0%	△ (green)	41
Emergency C-Section Rate	Effective	Apr-20	<= 15.4%	16.3%	Red	→	Grey	Grey	Grey	Red	16.3%		42
Term Babies Admitted to the Neonatal Unit	Effective	Apr-20	<= 5	5	Green	↑	Grey	Grey	Grey	Grey			42
Dementia: Finding Question	Responsive	Feb-20	>= 90%	94.8%	Green	↓	Green	Green	Green	Green	95.7%	△ (green)	43
Dementia: Assessment	Responsive	Feb-20	>= 90%	100.0%	Green	→	Green	Green	Green	Grey	99.6%	△ (green)	43
Dementia: Referral	Responsive	Feb-20	>= 90%	100.0%	Green	→	Green	Green	Green	Grey	100.0%	△ (green)	44

* Target/performance applies to the cumulative YTD value, not the in-month value

NHS Stockport NHS Foundation Trust

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Friends & Family Test: Response Rate	Caring	Mar-20		19.5%							21.6%		44
Friends & Family Test: Inpatient	Caring	Mar-20		93.0%							94.7%		45
Friends & Family Test: A&E	Caring	Mar-20		88.2%							86.1%		45
Friends & Family Test: Maternity	Caring	Mar-20		97.8%							96.4%		46
DSSA (mixed sex)	Caring	Apr-20	<= 0	0							0		46
Learning Disability: Adjusted Care Plans	Caring	Mar-20	>= 100%	71.4%									47
Compliments	Caring	Apr-20		83							83		47
Complaints Rate	Caring	Apr-20		0.2%							0.2%		48
Complaints: Response Rate 45	Caring	Apr-20	>= 95%	100.0%							100.0%		48
Complaints: Parliamentary & Health Service Ombudsman Cases	Caring	Apr-20		0							0		49
Complaints Closed: Overall	Caring	Apr-20		21							21		49
Complaints Closed: Upheld	Caring	Apr-20		1							1		50
Complaints Closed: Partially Upheld	Caring	Apr-20		7							7		50

* Target/performance applies to the cumulative YTD value, not the in-month value

Executive Summary

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Complaints Closed: Not Upheld	Caring	Apr-20		13							13		51
Litigation: Claims Opened	Responsive	Apr-20		5							5		51
Litigation: Claims Closed	Responsive	Apr-20		4							4		52
Referral to Treatment: 52 Week Breaches	Responsive	Apr-20	<= 0	34							34		52

* Target/performance applies to the cumulative YTD value, not the in-month value

Executive Summary

NHS
Stockport
NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Director of Finance													
Financial Controls: I&E Position	Well-Led / Efficient	Apr-20	<= 0%	0.0%	●	↑	●	●	●	●		△	53
Cash	Well-Led / Efficient	Apr-20	<= 0%	0.0%	●	↑	●	●	●	●		△	53
CIP Cumulative Achievement	Well-Led / Efficient	Apr-20	>= 0%	0.0%	●	↑	●	●	●	●		△	54
Capital Expenditure	Well-Led / Efficient	Apr-20	+/- 10%	0.0%	●	↑	●	●	●	●			54
Financial Use of Resources	Well-Led / Efficient	Apr-20	<= 3	0	●	↓	●	●	●	●			55

* Target/performance applies to the cumulative YTD value, not the in-month value

Domain Summary

NHS
Stockport
NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Director of Workforce & Organisational Development													
Substantive Staff-in-Post	Well-Led / Efficient	May-20	>= 90%	94.0%							94.0%		55
Sickness Absence: Monthly Rate (UoR)	Well-Led / Efficient	Apr-20	<= 3.5%	7.7%							7.7%		56
Sickness Absence: Rolling 12-Month Rate (UoR)	Well-Led / Efficient	Apr-20	<= 3.5%	4.9%									56
Sickness Absence: Long-term	Well-Led / Efficient	Apr-20	<= 0	1									57
Workforce Turnover (UoR)	Well-Led / Efficient	Apr-20	<= 13.94%	12.7%									57
Staff Friends & Family Test: Recommend for Work	Well-Led / Efficient	Sep-19		51.9%							51.7%		58
Staff Friends & Family Test: Recommend for Care	Caring	Sep-19		70.4%							70.6%		58
Appraisal Rate: Medical	Well-Led / Efficient	Apr-20	>= 95%	87.5%							87.5%		59
Appraisal Rate: Non-medical	Well-Led / Efficient	Apr-20	>= 95%	74.5%							74.5%		59
Statutory & Mandatory Training	Well-Led / Efficient	Apr-20	>= 90%	90.8%							90.8%		60
Bank & Agency Costs	Effective	Apr-20	<= 5%	15.4%							15.4%		60
Agency Shifts Above Capped Rates	Well-Led / Efficient	Apr-20	<= 0	1639							1639		61
Agency Spend: Distance From Ceiling (UoR)	Well-Led / Efficient	Apr-20	<= 3%	32.1%							32.1%		61

* Target/performance applies to the cumulative YTD value, not the in-month value

Domain Summary

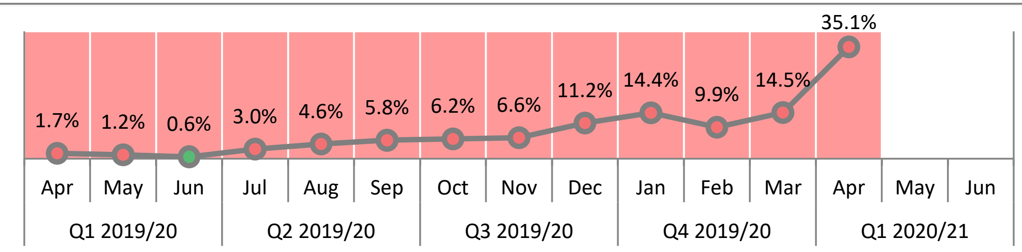
Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Director of Workforce & Organisational Development													
Staff Suspensions	Well-Led / Efficient	Apr-20	<= 0	0									62
Recruitment Lead Time	Well-Led / Efficient	Apr-20	<= 20	16.49									62
Flu Vacination Uptake	Safe	Mar-20	>= 80%	80.0%									63

* Target/performance applies to the cumulative YTD value, not the in-month value

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Diagnostics: 6 Week Standard
35.1%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target <= 1%	At the end of April 35.1% of patients on the diagnostic waiting list had waited more than 6 weeks.

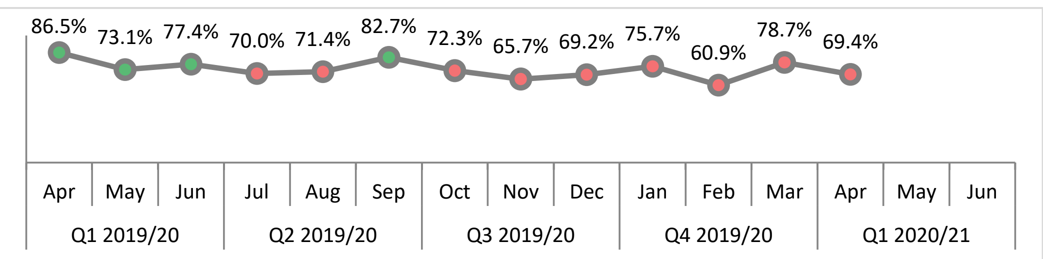


Actions

75% of patients waiting more than 6 weeks are awaiting an Endoscopy procedure.
The recovery action plan had started to take effect in February, with a reduction in the number of surveillance patients overdue. The cancellations in response to COVID-19 has significantly increased the number of Endoscopy cases that are outstanding.

The Trust is determining how to safely resume undertaking aerosol generating procedures, which includes Endoscopy, as part of the elective recovery planning.

Apr-20	Cancer: 62 Day Standard
69.4%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of GP referral. Screening referrals are not reported as not statistically viable due to low number received
Target >= 85%	Performance for April was 69.4% against the 85% standard. It should be noted that the number of patients treated in month is significantly lower than usual due to the impact of COVID-19 on elective activity.



Actions

The Trust continues to adapt and refine practices in line with published local and National Guidance to ensure safe management of patients during COVD-19.

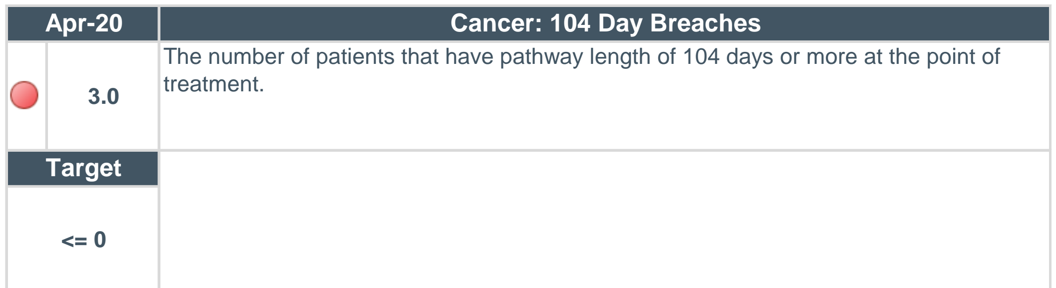
Recovery planning at GM level is underway led by GM Cancer. This consists of a 4 stage recovery plan framework; Escalation, Stabilisation, Recalibration an Recovery phases. The Trust is closely linked to this work programme. Locally, the use of the Independent Sector continues for appropriate surgical cases. To date, 41 of our patients have been successfully operated.

Patients on a suspended pathway continue to be subject to regular clinical reviews.

The Trust has just started to operate on a small number of cancer cases within its newly created COVID-secure area on site.

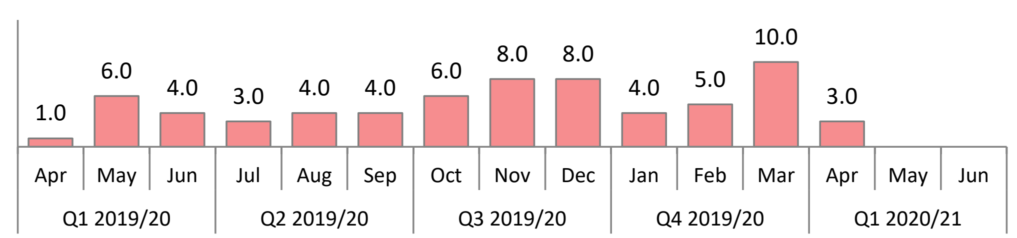
Indicator Detail

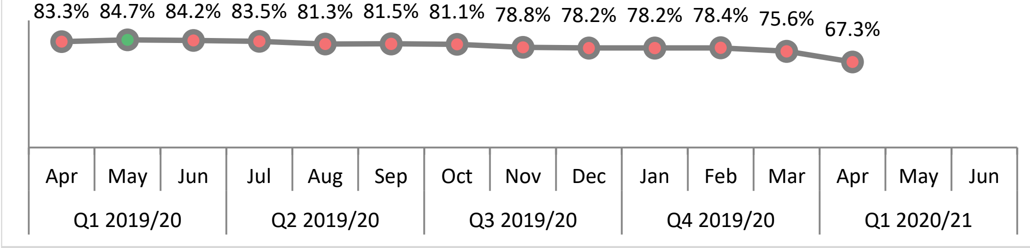
Apr-20	Cancer: 104 Day Breaches
3.0	The number of patients that have pathway length of 104 days or more at the point of treatment.
Target	
<= 0	



Actions

Apr-20	Referral to Treatment: Incomplete Pathways
67.3%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	Performance against the 18 week standard decreased significantly in month, due to the cessation of non-urgent elective activity in response to the covid-19 pandemic. From the end of March to the end of April, the number of patients waiting more than 18 weeks for definitive treatment increased by around 1900.
>= 92%	





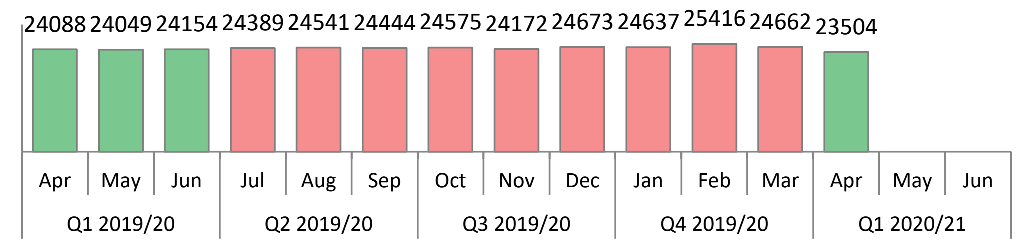
Actions

The recovery plan will start to detail how elective activity for the longest waiting patients can safely resume,. This will be balanced and prioritised in keeping with clinical urgency.

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Referral to Treatment: Incomplete Waiting List Size
23504	The total number of patients on an open pathway. Please note: This indicator is measured against January 2020 level as per NHSI/E Planning Guidance
Target <= 24637	Despite the continued cessation of the vast majority of elective work in April due to COVID-19, there was still a net reduction in the RTT waiting list size of 1159 between March and April which reflects the significant reduction in referrals into the Trust



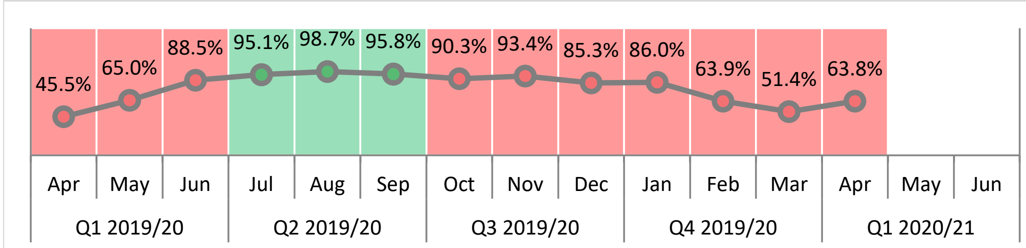
Actions

The Organisation is currently developing its recovery plan to incrementally resume the elective programme.

The referral route for GPs remains open and any referrals received continue to be clinically triage and appointed to either a telephone consultation, video conferencing consultation or a traditional face to face appointment if deemed clinically necessary.

To facilitate elective operating, a COVID-secure area is being identified, considering National guidance on how to safely manage elective patients on an acute hospital site.

Apr-20	Clinical Correspondence
63.8%	The percentage of clinical correspondence typed within 7 days.
Target >= 95%	As described last month, performance for April was expected to be low whilst the backlog of typing was being cleared.



Actions

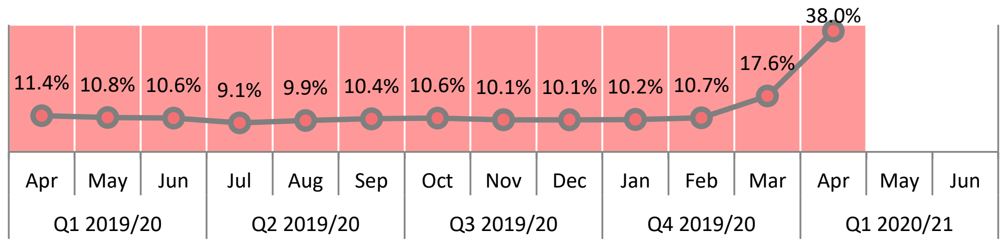
At the time of writing, the turn-round time within 7 days for May is 100%.

Phase 2 of the admin and clerical review will progress to ensure the improvements that have been made are sustained.

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Outpatient Hospital Cancellation Rate (UoR)
38.0%	The percentage of outpatient appointments where the hospital has cancelled the appointment. This indicator combines new and follow-up appointment types.
Target	The cancellation rate appears high in month due to the directive to cancel non-urgent face to face appointments.
<= 9%	

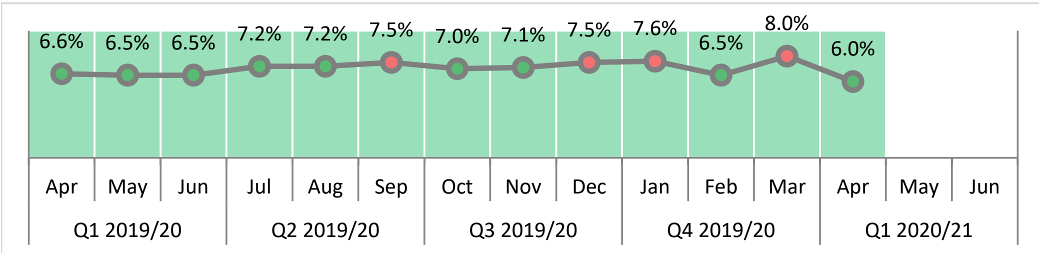


Actions

These face to face appointment cancellations have been rebooked following clinical review and triage.

This process of triage to alternative service models will continue.

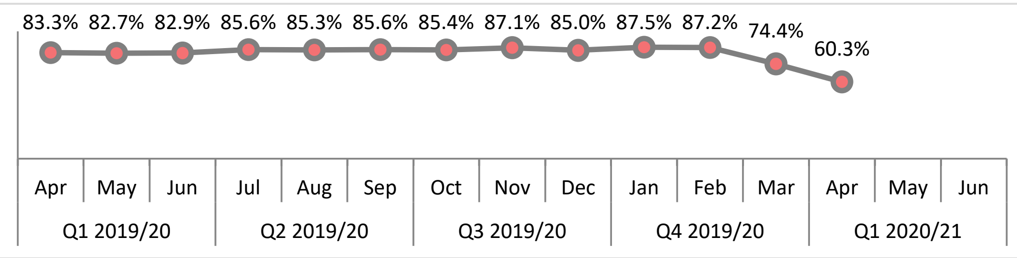
Apr-20	Outpatient DNA rate (UoR)
6.0%	The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types.
Target	The DNA rate has returned to within target levels this month as patients are offered alternative means of accessing outpatient care.
<= 7.4%	



Actions

Indicator Detail

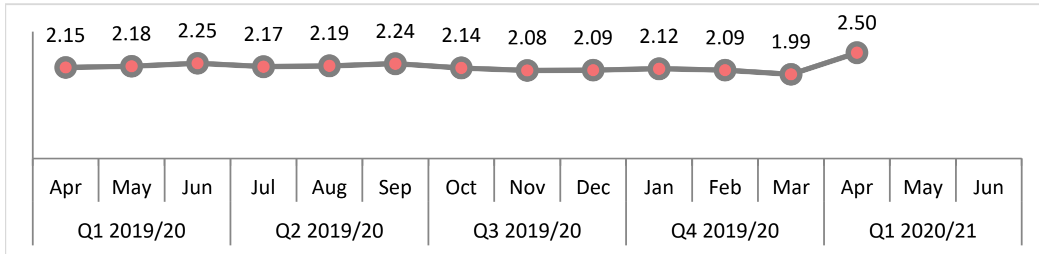
Apr-20	Outpatient Clinic Utilisation (UoR)
60.3%	The percentage of planned clinic appointment slots that were booked. Planned slots include all appointment slots on clinic templates that went ahead - cancelled clinic templates are excluded.
Target	Clinic utilisation appears low in month due to Business Groups requiring a high degree of flexibility within their clinic templates to be able to accommodate and respond to the changing landscape of outpatient delivery during COVID-19.
>= 90%	



Actions

More standardised operating procedures will develop as the Trust works on recovery plans and clinic template more reflect the move to different models of Outpatient delivered care.

Apr-20	Outpatient New to Follow-up Ratio (UoR)
2.50	The number of outpatient follow-up attendances that took place for every one outpatient new attendance.
Target	The new to follow-up ratio increased in month. Overall, the Trust delivered 31.5% outpatient activity. However there was a disproportionate split across new and follow-up appointments with a 41% reduction in new activity and 29% reduction in follow-up activity.
<= 1.77	



Actions

The balance will redressed as the Trust starts to resume its full elective programme.

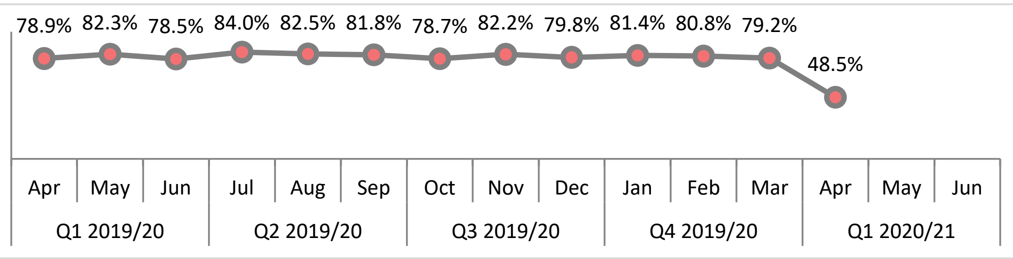
NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Theatres: Overall Touch-time Utilisation (UoR)
48.5%	The overall time spent operating, calculated as a percentage of the overall planned session time. Touch-time will include any case overlap time and session over-run time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target >= 85%	Theatre sessions have been adversely impacted in month as elective operating ceased in response to COVID-19.

Actions

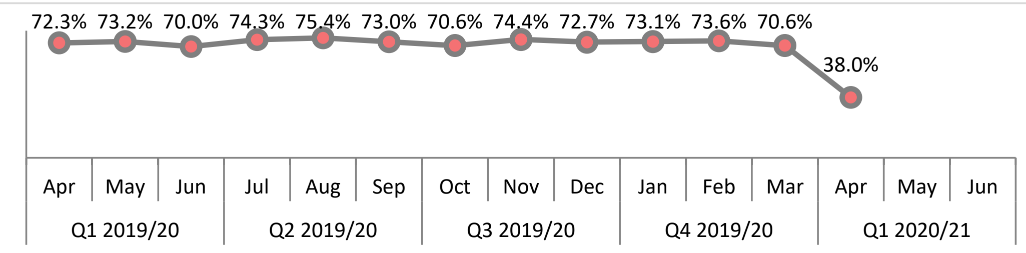
Although CEPOD and Trauma operating lists continue, the proportion of downtime between patients has significantly increased to allow for adherence to COVID-19 infection prevention guidelines.



Apr-20	Theatres: In-Session Touch-time Utilisation (UoR)
38.0%	The overall time spent operating within the planned hours of the session, calculated as a percentage of the overall planned session time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target >= 85%	Theatre sessions have been adversely impacted in month as elective operating ceased in response to COVID-19.

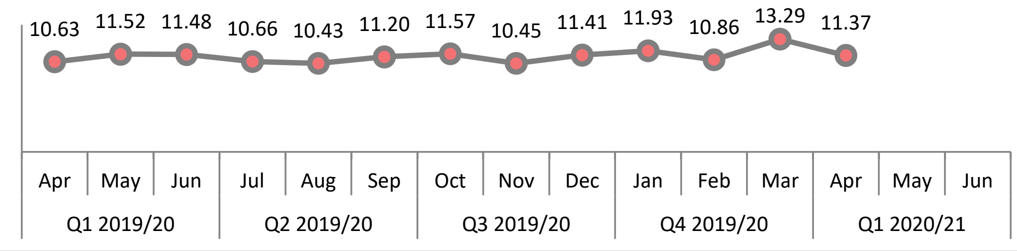
Actions

Although CEPOD and Trauma operating lists continue, the proportion of downtime between patients has significantly increased to allow for adherence to COVID-19 infection prevention guidelines.



Indicator Detail

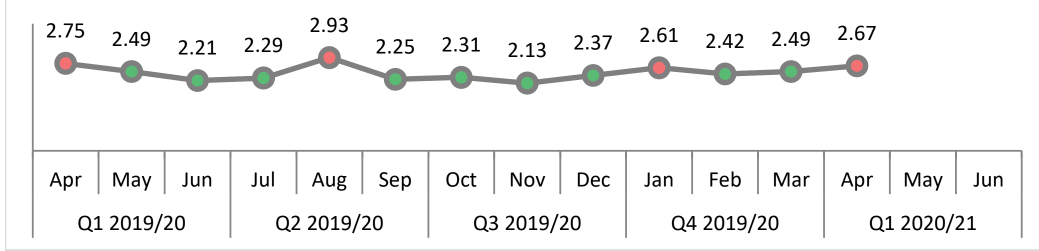
Apr-20	Length of Stay: Non-Elective (UoR)
11.37	The average length of a patient spell, from admission to discharge. Calculated using non-elective admissions only. Excludes Obstetrics/Maternity. Excludes admissions of 0 and 1 days length of stay. Reported by month of discharge.
Target <= 9	Non-elective length of stay decreased in April, following the drive to discharge the long-stay patients in March due to the covid-19 outbreak.



Actions

The ongoing work through the Discharge to Assess hub and the additional Discharge to Assess capacity outside of the hospital has seen a significant reduction in the number of DToC, MOAT and Stranded patients and as a result has also had a positive impact on the average length of stay for non-elective patients in the hospital.
It is imperative that this continues as the organisation moves to the next stage of pandemic management and the potential for a “second surge” in COVID cases alongside the return of those patients who had otherwise not been attending the hospital because of the outbreak

Apr-20	Length of Stay: Elective (UoR)
2.67	The average length of a patient spell, from admission to discharge. Calculated using elective admissions only. Excludes day case admissions with length of stay of 0 days. Excludes Obstetrics/Maternity. Reported by month of discharge.
Target <= 2.6	The elective length of stay appears high in month. This is due to the case-mix of the limited number of patients that were operated on which included major cancer cases whose length of stay has artificially inflated the data.



Actions

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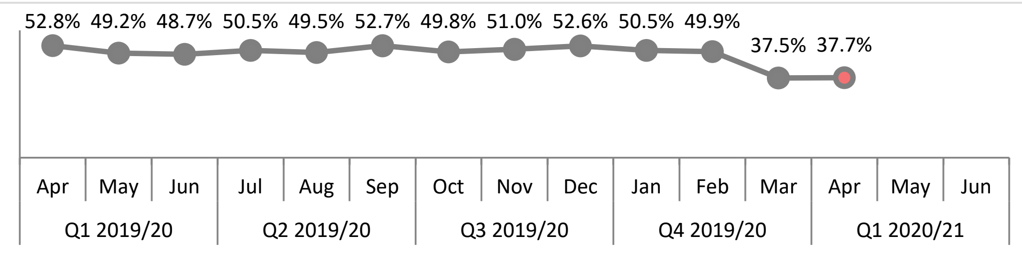
NHS Foundation Trust

Indicator Detail

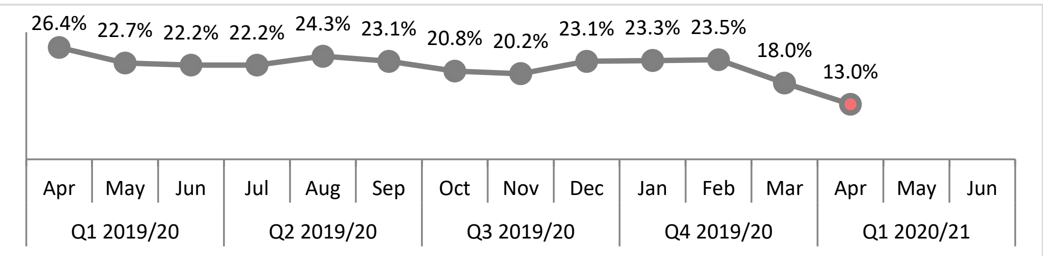
Apr-20	Long Length of Stay 7 Days
37.7%	Patients that have had a length of stay of 7 days or more, as a percentage of all open general & acute beds. Calculated using snapshot data from the last Monday of the reporting month.
Target <= 32%	The number of long length of stay patients decreased in April, to 174, from 202 in March; this is a 13.9% reduction in the raw number of long stay patients. This shows a maintained position, in keeping with the drive to reduce LoS across the Trust.



Actions

The focus still remains on reducing length of stay for our patients, with the RDAFH initiative, which runs twice a week across all wards.
The Trust is working closely with the Nightingale to move patients who are in the recovery phase, who are not necessarily medically optimised. There is a process where each day, the clinical site team identify patients who meet the criteria to be transferred to Nightingale.

Apr-20	Long Length of Stay 21 Days
13.0%	Patients that have had a length of stay of 21 days or more, as a percentage of all open general & acute beds. Calculated using snapshot data from the last Monday of the reporting month.
Target <= 11%	There were 97 long length of stay patients >21 days in March which reduced to 60 in April. This reduction in the number is reflected in the reduction in the percentage of long length of stay patients >21 days.



Actions

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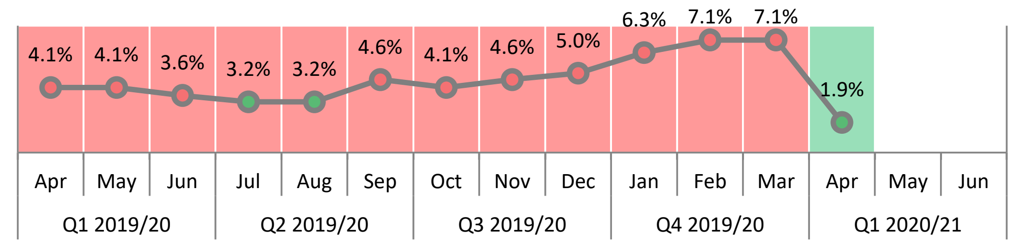
The Trust is working closely with the Nightingale to move patients who are in the recovery phase, who are not necessarily medically optimised. There is a process where each day, the clinical site team identify patients who meet the criteria to be transferred to Nightingale.

Indicator Detail

Apr-20	Delayed Transfers of Care (DTOC) (UoR)
1.9%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target <= 3.3%	The improvement in performance in April, resulting in performance of 1.9%, is reflective of the work that has been done to meet the national guidance around discharge in light of the covid-19 pandemic.

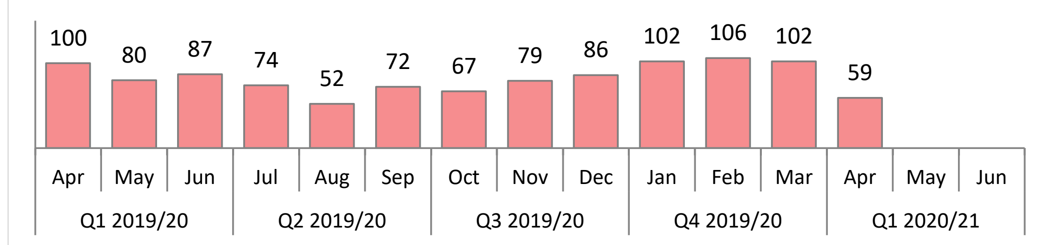


Actions

The following initiatives have commenced:
Implementation of transfer to assess
Formation of discharge hub
Opening of additional transfer to assess unit - 71 beds

At the time of writing, there was 1 DTOC in the organisation.

Apr-20	Medical Optimised Awaiting Transfer (MOAT)
59	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target <= 40	There has been a significant improvement in the number of MOAT patients, with a reduction from 102 in March to 59 in April. It should be noted however that this figure does include the Bluebell ward.



Actions

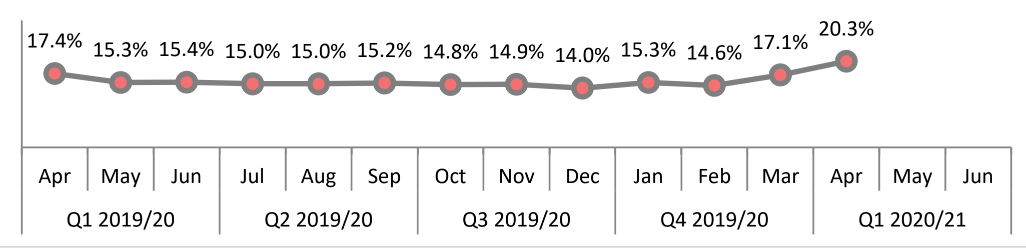
Introduction of the Discharge to Assess (D2A) hub, ensuring that patients leave hospital as a matter of priority once they are declared medically fit
The D2A hub allows community assessments at home or in a community setting as appropriate.
The ITT reps attend daily ward rounds.
There is a huddle 7 days per week to ensure appropriate actions followed i.e. refer to hub
Bramhall Manor/Bluebell are now available to support the Trust in transferring patients who require bed based support for further assessment.
The twice weekly MDT round is enforcing the need to record MOAT patients on Advantis Ward.

Indicator Detail

Apr-20	Discharges by Midday
20.3%	The total number of patients discharged by midday, calculated as a percentage of the total number of discharges for the period. Includes SAFER wards only.
Target	There has been an improvement in the percentage of discharges by midday, with the April figure being at 20.3% in comparison the yearly average of 15%.
>= 33%	

Actions

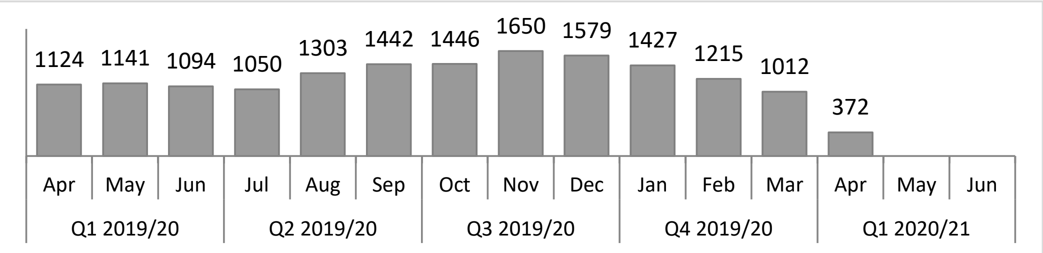
The Reducing Days Away from Home programme continues with twice weekly multidisciplinary rounds taking place on the wards.
In addition, a Discharge to Assess hub has been introduced to expedite discharges and one of the lead managers is also attending the twice weekly rounds from 20th May 2020.
PwC have been working with the clinical site team to develop a site daily performance review which ultimately will give a true, live bed state.



Apr-20	A&E: Overnight Breaches
372	The total of patients who were admitted, discharged, or leave A&E over 4 hours after their arrival between 20:00 and 07:59.
Target	There has been a significant reduction in the number of overnight breaches from 1012 in March down to 372 in April.

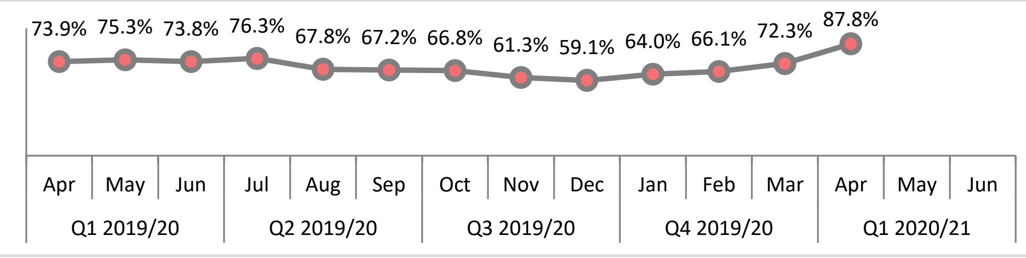
Actions

A robust breach analysis process has been introduced within the Emergency Department which forensically examines every 4 hour breach and the reason for the breach.
This information is then distributed to the appropriate Business Groups and Pennine Care for them to introduce the appropriate actions to reduce the number of 4 hour breaches within their areas.
This is monitored at the Performance Wall and will be on the agenda for the Performance Reviews.



Indicator Detail

Apr-20		A&E: 4hr Standard
●	87.8%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target		The ED continues to be split between query covid-19 (hot) and not suspected covid-19 (cold). April showed an improvement in performance from 72.3% to 87.8%.
>= 95%		



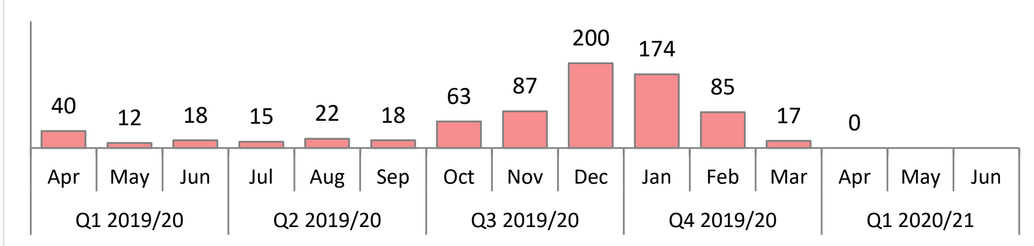
Actions

A number of positive changes within the ED pathways have resulted in a significant improvement in performance, with the first two weeks in May showing performance of 94.8%.

The recovery plans post-covid will recommend that the pathway changes continue, to move towards sustaining this improved position.

The non-admitted patient total time in ED in May is currently at the 95th percentile, 3 hours 58 minutes.

Apr-20		A&E: 12hr Trolley Wait
●	0	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target		There were zero 12 hour breaches in April
<= 0		



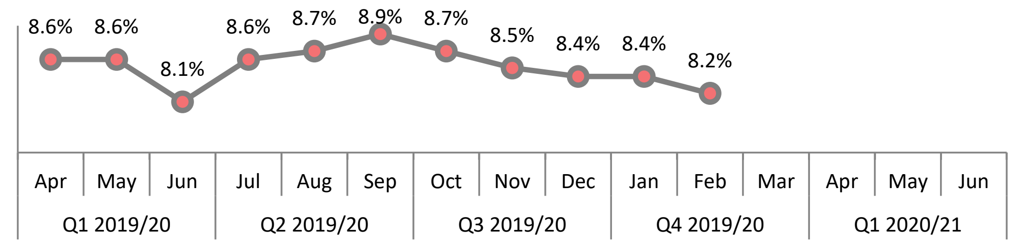
Actions

During the first two weeks in May, there have been zero 12 hour breaches.

The focus within the ED is on preventing 4 hour breaches.

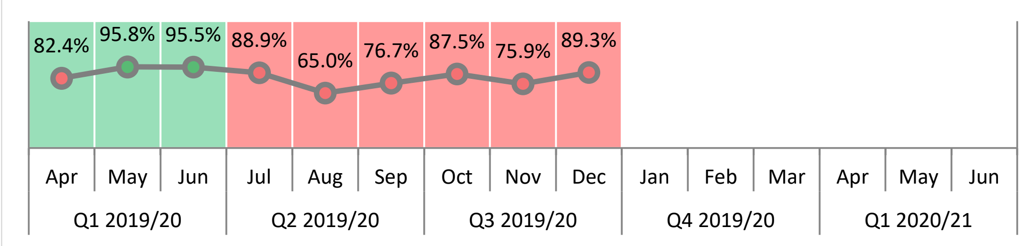
Indicator Detail

Feb-20	Emergency Readmission Rate (UoR)
8.2%	The percentage of emergency re-admissions within 28 days following an inpatient discharge. This indicator includes admissions for all conditions, and is not restricted to re-admissions for the same condition as the original admission.
Target	
<= 7.9%	



Actions

Dec-19	Diabetes Reviews
89.3%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	Data for this metric is routinely reported two months in arrears to allow time for analysis. Assessments have been undertaken but a decision was made to discontinue monitoring so that physician time normally attributed to analysis could focus on extended patient care during the pandemic.
>= 90%	

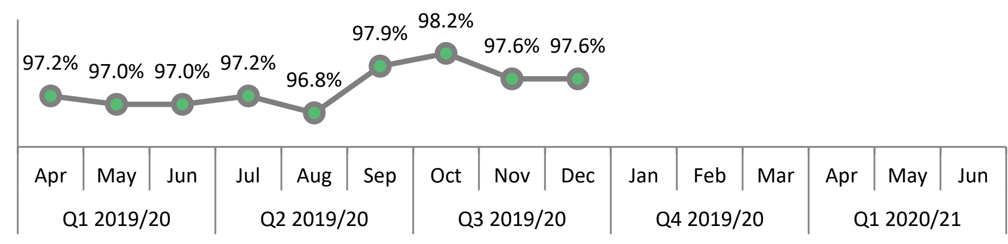


Actions

Improved staffing in the diabetes team prior to the pandemic outbreak should show improvement in this metric once analysis is complete - serving as a marker of the service standards as a whole.

Indicator Detail

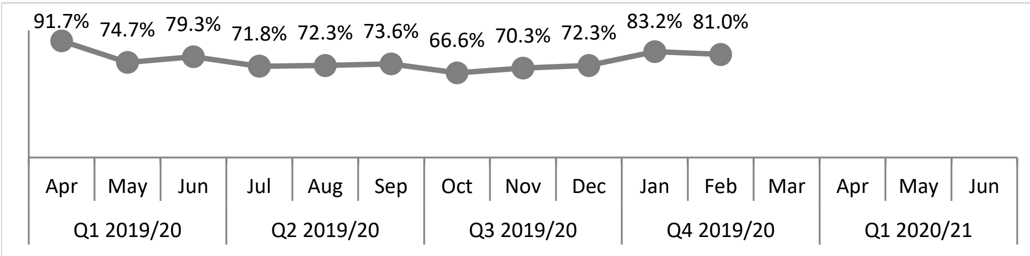
Dec-19	VTE Risk Assessment
97.6%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target >= 95%	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).



Actions

The target has been achieved in month.

Feb-20	Sepsis: Timely Identification
81.0%	The number of patients who are screened for sepsis, as a percentage of all eligible patients who meet the criteria .
Target	Competing priorities with COVID19 preparation are delaying our planned actions for the sepsis action plan.



Actions

The new screening tool was piloted in 3 wards across the trust, all wards were enthusiastic and welcomed the improved form and the trust aspiration.

The new tool provided autonomy to the nurses enabling medics to focus on 'true' red sepsis.

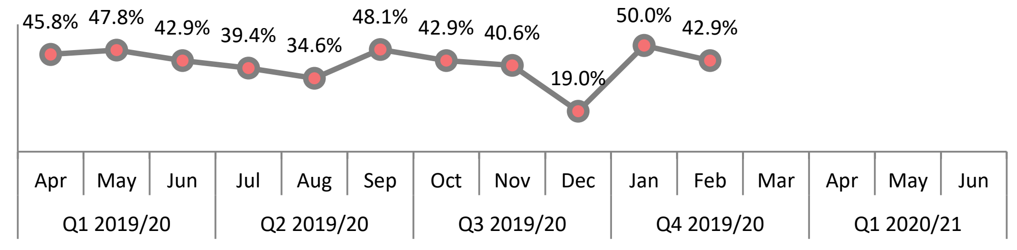
Although a deep dive into the data has currently not been undertaken, a quick review shows an approximate compliance of 80%. There appears to be areas especially on nights and weekends where compliance is not as robust which will form part of the action plan.

A flag has been introduced on advantis that highlights patients with suspected sepsis to enable business groups to monitor at a glance there high risk patients.

Sepsis management has been a feature of the medical directors update.

Indicator Detail

Feb-20	Sepsis: Timely Treatment
42.9%	The number of patients who received IV antibiotics within 1 hour, as a percentage of all eligible patients found to have sepsis.
Target	Competing priorities with COVID19 preparations are delaying our planned actions for the sepsis recovery plan.
>= 90%	

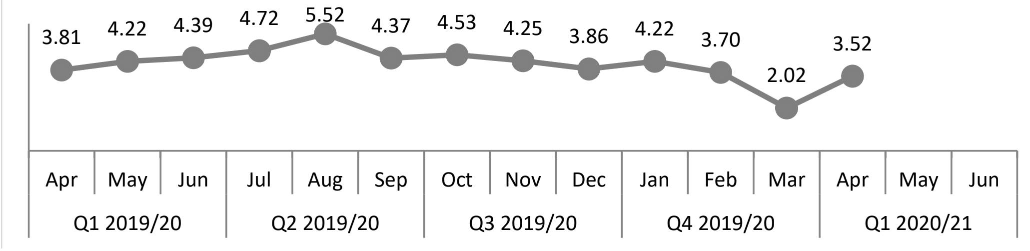


Actions

The actions captured within the sepsis action plan are currently on hold, whilst resources are redistributed during the COVID pandemic.

We continue to cascade the key messages over sepsis, Including during new doctor induction, and in the medical directors update.

Apr-20	Medication Errors: Rate
3.52	Rate of medication errors, calculated as incidence per 1000 bed days.
Target	In April 2020, the rate of medication errors increased, when compared with the March 2020 figures.



Actions

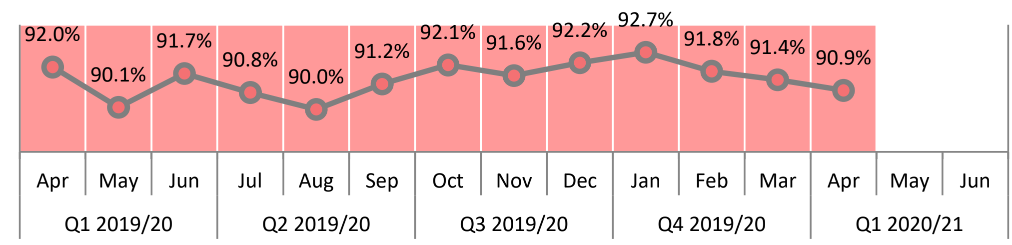
Medication Error incidents are discussed each week at the Patient Safety Summit.

Alerts concerning medication are circulated in the Patient Safety Summit Update to raise awareness.

In April, controlling the risk of an incorrect strength or dilution of a controlled drug by using a robust checking procedure, was highlighted.

Indicator Detail

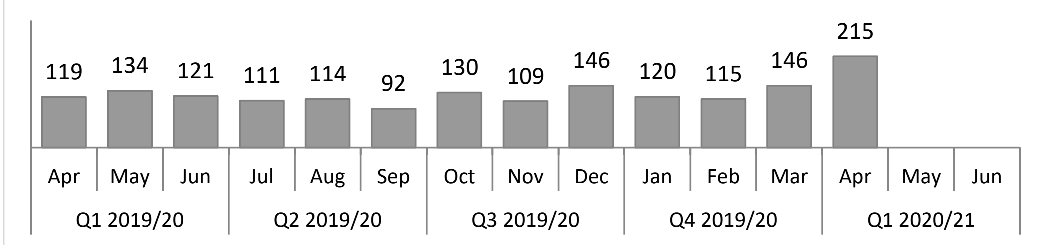
Apr-20	Discharge Summaries
90.9%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Performance consistent with that of 2019-20
>= 95%	



Actions

Remains an area of focus in Performance Reviews

Apr-20	Mortality: Deaths in ED or as Inpatient
215	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	There has been a significant increase in the number of deaths during the month of April. This is due to the Covid-19 pandemic



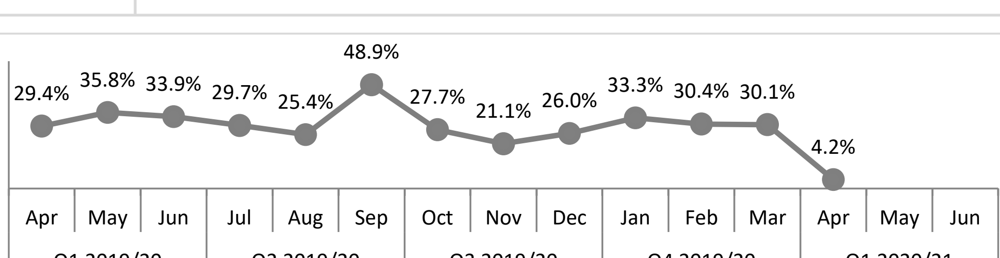
Actions

In March 2020, all NHS acute providers were asked to repurpose our services to meet the projected demand of Covid-19. Admissions and death rate are monitored on a daily basis through the command structure that is in place.

NHS Stockport NHS Foundation Trust

Indicator Detail

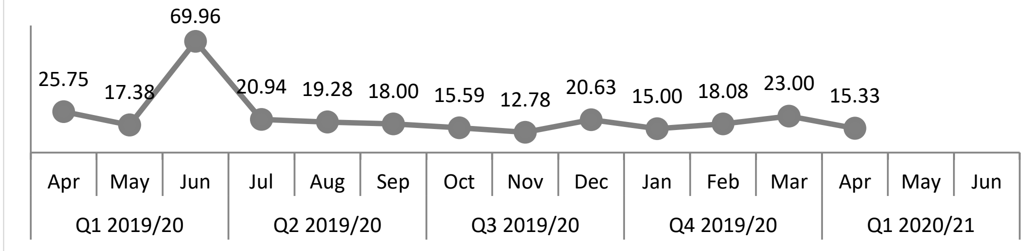
Apr-20	Mortality: Case Note Review Rate
4.2%	The number of case note reviews that taking place in month, as a percentage of all patient deaths while patient was in the emergency department or as an inpatient.
Target	The case note review process has been suspended for a period of 3 months.



Actions

All SPA activities have been discontinued, to focus on the delivery of clinical work, in response to the Covid-19 pandemic. Case note reviewers have been requested to complete the reviews if they have capacity to do it.

Apr-20	Mortality: Specialist Palliative Care Length of Stay
15.33	The average length of a patient spell, from admission to death. Includes specialist palliative patients who die in hospital only. Reported by month of discharge/death.
Target	It is currently of limited use as a standalone metric.



Actions

Work continues with Business Intelligence to agree more appropriate data metrics.

NHS Stockport
NHS Foundation Trust

Indicator Detail

Feb-20	Mortality: HSMR
1.01	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	Our lowest HSMR of recent times.
<= 1	Impact of Covid on HSMR is hard to predict, as the validity of comparative outcomes will depend upon effective and consistent coding practice between sites.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Quarter	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		
HSMR	1.06	1.06	1.06	1.05	1.06	1.04	1.05	1.04	1.02	1.02	1.01				

Actions

Nov-19	Mortality: SHMI
0.98	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	Remains below national average
<= 1	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Quarter	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		
SHMI	0.95	0.96	0.97	0.97	0.98	0.97	0.98	0.98							

Actions

Indicator Detail

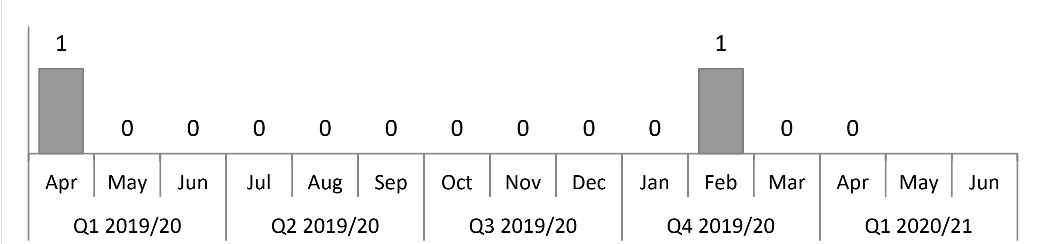
Apr-20	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There have been no Never Event occurrences recorded in April 2020.
<= 0	

Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0	0	0	0	0	0	1	1	0	0	0	0	0		

Actions

There have been no incidences of Never Event occurrences since November 2019.

Apr-20	Duty of Candour Breaches
0	Total number of duty of candour breaches of regulation in month.
Target	There were no breaches of duty of candour reported in April 2020



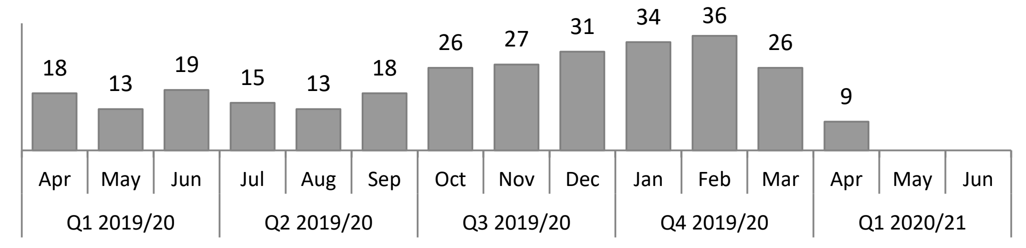
Actions

The opening of Duty of Candour is monitored on a weekly basis.

NHS Stockport
NHS Foundation Trust

Indicator Detail

Apr-20	Serious Incidents: STEIS Reportable
9	The total number of STEIS reportable incidents.
Target	The number of StEIS reportable incidents has decreased from 26 reported in March 2020 to 9 reported in April 2020.

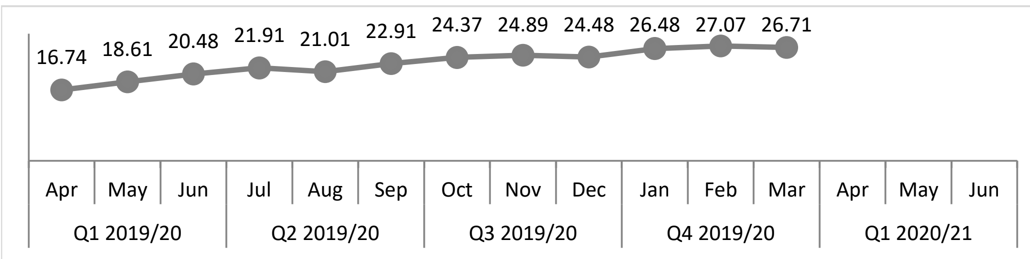


Actions

In month there were no instances reported where a patient waited more than 12 hours in the emergency department and met the criteria for a 12 hour trolley wait. However, there is a significant backlog of 12 hour breach investigations that are over the 60 day timeline. An assessment of harm is being undertaken for each patient by the senior nursing team in the Business Group. A simplified process of review and sign off has been agreed with the CCG.

There were 5 incidents relating to category 3 pressure ulcers
There was 1 incident relating to a patient fall that resulted in a sub-arachnoid haemorrhage
There was 1 incident relating to a failed instrumental delivery resulting in an lower segment caesarean section. The baby was transferred for head cooling
There was 1 incident relating to a patient with an MRSA bacteraemia
There was 1 incident where a patient had a delay in treatment subsequently died.

Mar-20	C.Diff Infection Rate
26.71	Average number of C.Diff infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable C.Diff infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The average number of Clostridium difficile infections for every 100,000 bed days, calculated using a rolling 12month number of Trust –attributable Clostridium difficile infections compared to a rolling 12 month average number of bed days per 100,00.



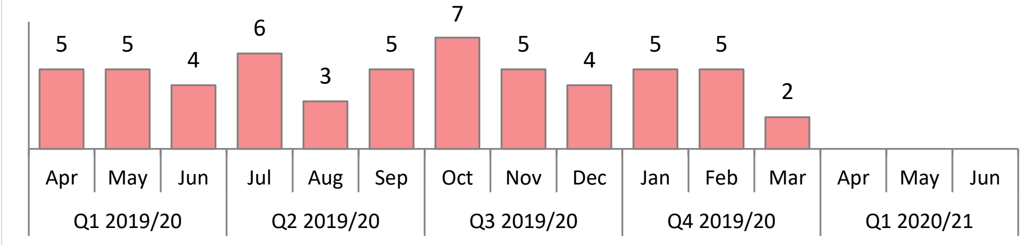
Actions

The trust is increasingly concerned about our Clostridium Difficile numbers.

The CDI recovery action plan was presented to the IP&C group in April.

Indicator Detail

Mar-20		C.Diff Infection Count
	2	Total number of C.Diff infections.
Target		The 2019-20 target set by the Department of Health for hospital acquired Clostridium difficile toxin positive cases is 51
<= 51 *		



Actions

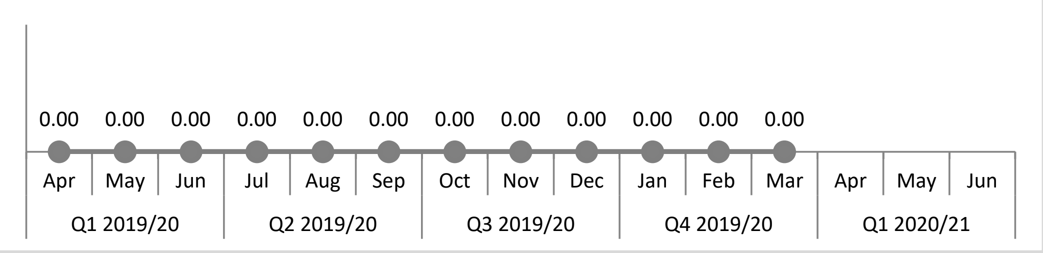
During March there were 2 cases of Clostridium difficile

Each CDI case is listed for the Healthcare Acquired Infections (HCAI's) panel chaired by the Director of Infection Prevention & Control (DIPC) immediately the case is confirmed.

Each CDI case is investigated and presented to the HCAI panel; themes highlighted by the panel are related to over-subscription of antibiotics which is in line with a national trend.

The CDI recovery action plan was presented to the IP&C group in April.

Mar-20		MRSA Infection Rate
	0.00	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target		Rolling 12-month count of all MRSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions

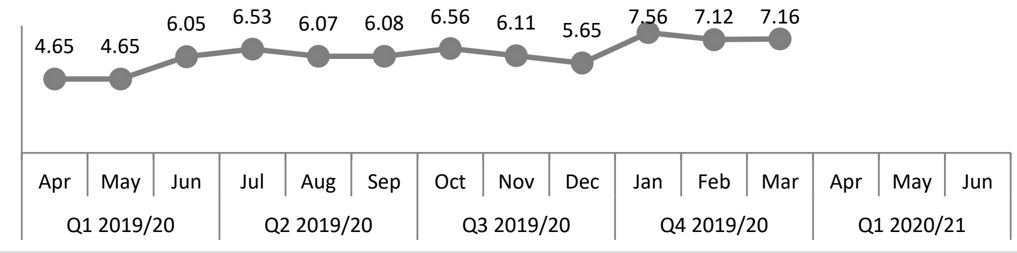
The MRSA target set by the Department of Health is zero for2019-20. In March there were zero cases of MRSA

The target is monitored through the infection prevention & control group

The Trust had an MRSA bacteremia in April that is currently being investigated to determine any lessons learnt

Indicator Detail

Mar-20	MSSA Infection Rate
7.16	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions

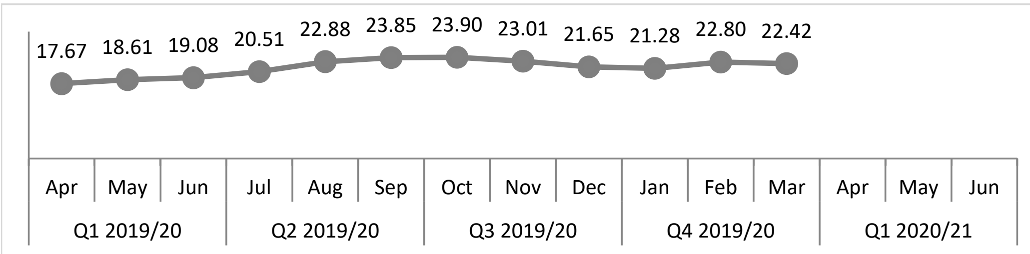
The MSSA infection rate is monitored as a whole health economy. The figures represented within this report are Trust acquired cases

This is monitored through the Infection prevention & control group

Following consultation, the CCG have agreed a target tolerance of 12 for the Trust in relation to MSSA infections. To meet this target the Trust needs = 3 per quarter; during quarter four there have been 6 MSSA infections

Concurrent to this agreement is the development of a pro-forma to undertake concise investigations. Unfortunately the pro-forma development has been delayed due to Coronavirus; the aim will be for the pro forma to be developed by Q1 2020-21

Mar-20	E.Coli Infection Rate
22.42	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions

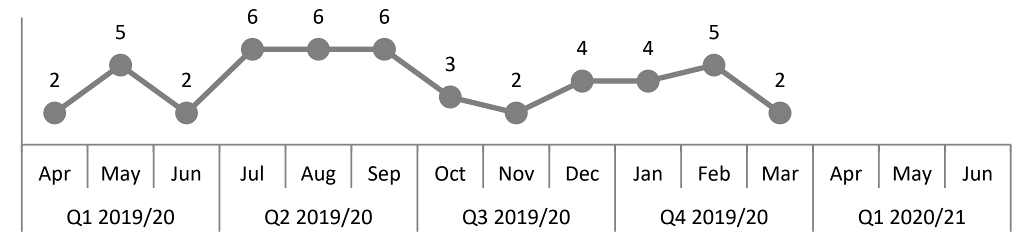
Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2022, firstly focusing on E coli infection as one of the largest groups. The figures represented within this report are trust acquired cases

A reduction plan owned by the CCG has been developed collaboratively between the Trust, Health protection nurses and CCG.

This plan is monitored through the Infection Prevention & Control group.

Indicator Detail

Mar-20	E.Coli Infection Count
2	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases



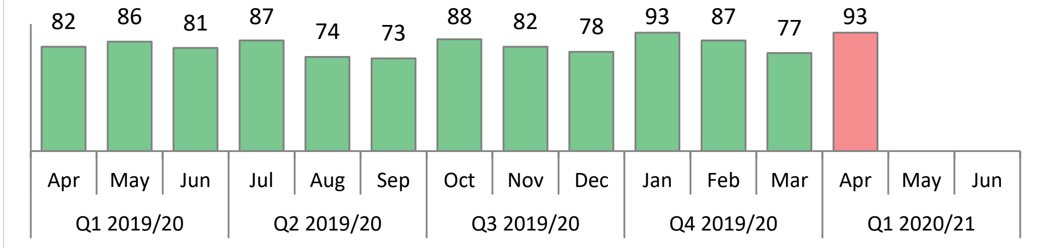
Actions

This is monitored through the Infection Prevention & Control group

Following consultation, the CCG have agreed a target tolerance of 36 for the Trust in relation to E-coli infections. To meet this target the Trust needs = 9 per quarter; during quarter four there have been 10 E-coli infections

The development of a pro-forma to undertake concise investigations has been delayed due to coronavirus; the aim will be for the pro forma to be developed by Q1 2020-21

Apr-20	Falls: Total Incidence of Inpatient Falls
93	Total number of Inpatient falls
Target <= 91 *	There have been 93 in-patient falls for April 2020. Falls have increased in April in comparison to March 2020 and to April 2019. 12% increase in comparison to April 2019 and a 17% increase in comparison to March 2020.The case mix, acuity and bed base should be noted due to Covid19 as data may not be comparable month on month.



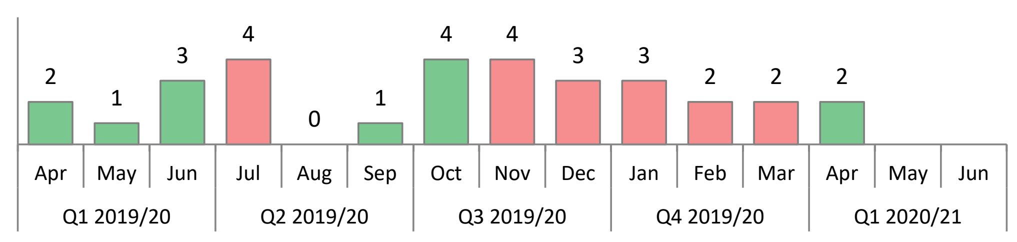
Actions

Large increase in falls at Bluebell (24 in month). Deep dive by senior team currently underway. Specific actions will be confirmed after this has occurred.

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Falls: Causing Moderate Harm and Above
2	Total number of falls causing moderate harm and above.
Target <= 2 *	There have been 2 falls in month resulting in moderate or above harm. These falls are currently being investigated

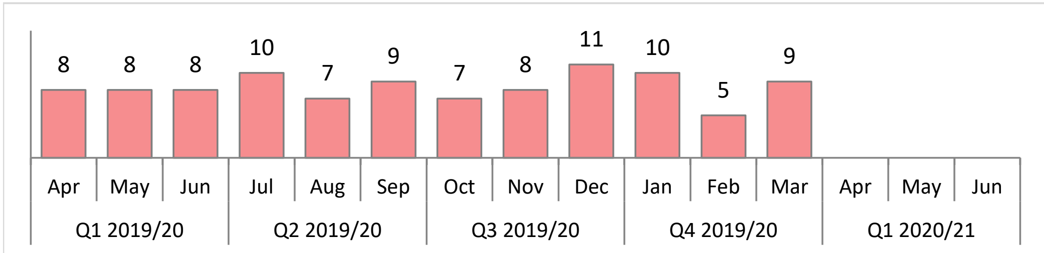


Actions

The breakdown and harm caused is as follows:

Both falls resulted in the patients suffering a head injury. These both occurred on Ward A3 in Medicine and Clinical Support BG

Mar-20	Pressure Ulcers: Hospital, Category 2
9	Total number of category 2 pressure ulcers in a hospital setting.
Target <= 93 *	The Trust set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the preceding 12 months. This month (March data) we have had 9 category 2 pressure ulcers reported



Actions

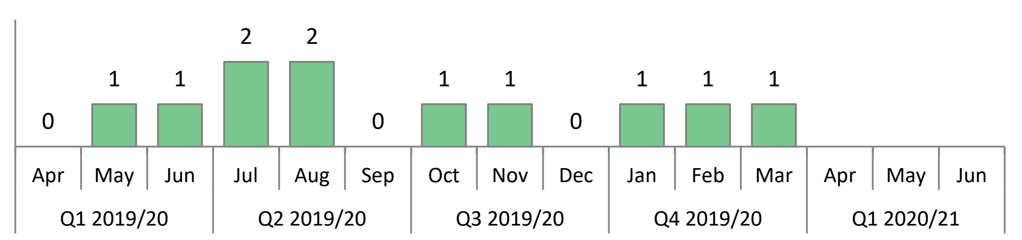
The Acute Trust has achieved its overall target to reduce hospital acquired pressure ulcers by 10%, as it has recorded 114 pressure ulcers in total against a target of 118.

However, when this data is separated by category of damage, it can be seen that slightly more category 2 pressure ulcers were reported than predicted, as we had 100 category 2 pressure ulcers reported against a target of 93, this gives a red PAT rating for this category 2 target.

However this result does not reflect the overall improvement seen in terms of the severity of damage reported. As the total numbers of category 3 and 4 Pressure ulcers has reduced from a set target of 25 to 14 over the preceding 12 months

Indicator Detail

Mar-20	Pressure Ulcers: Hospital, Category 3
1	Total number of category 3 pressure ulcers in a hospital setting.
Target	The Trust set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the preceding 12 months. This month (March data) we have had 1 category 3 pressure ulcers reported.
<= 22 *	

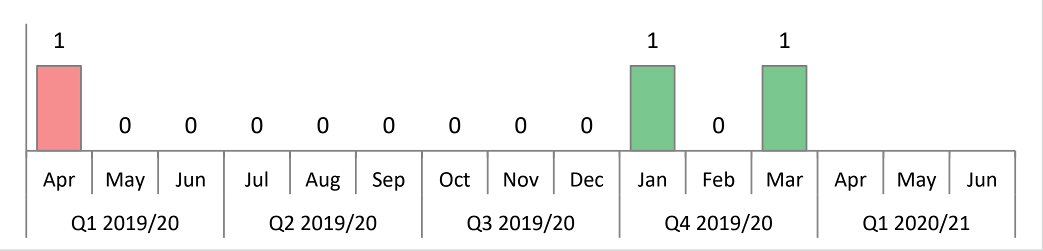


Actions

The Acute Trust has achieved its overall target to reduce hospital acquired pressure ulcers by 10%, as it has recorded 114 pressure ulcers in total against a target of 118.

In total we had a total of 11 new category 3 pressure ulcers reported against a target of 22, which is a significant reduction in the severity of new category 3 pressure damage harm sustained

Mar-20	Pressure Ulcers: Hospital, Category 4
1	Total number of category 4 pressure ulcers in a hospital setting.
Target	The Trust set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the preceding 12 months. This month (March data) we have had 1 category 4 pressure ulcer reported
<= 3 *	



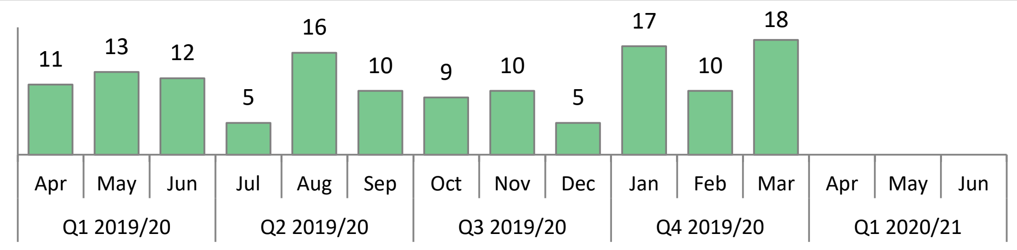
Actions

The Acute Trust has achieved its overall target to reduce hospital acquired pressure ulcers by 10%, as it has recorded 114 pressure ulcers in total against a target of 118.

the predicted target was no more than 3 category 4 pressure ulcers to have developed in year and this target was met

Indicator Detail

Mar-20	Pressure Ulcers: Community, Category 2
18	Total number of category 2 pressure ulcers in a community setting.
Target <= 193 *	The Trust set a target to reduce the overall number of community acquired pressure ulcers by 10% over the preceding 12 months. This month (March data) we have had 18 category 2 pressure ulcers reported.

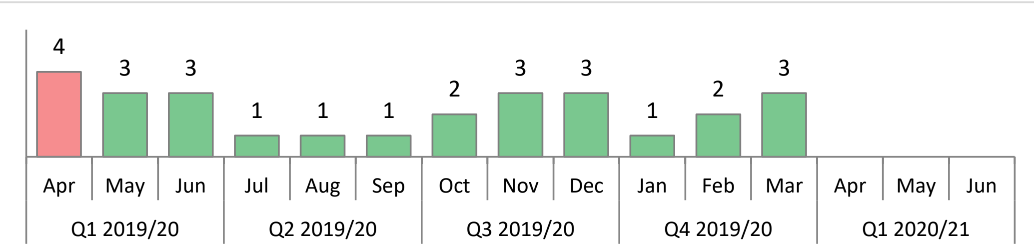


Actions

The community Trust has achieved its overall target to reduce community acquired pressure ulcers by 10% as it has recorded 173 pressure ulcers in total against a target of 248

In total there were 136 category 2 pressure ulcers reported against a target of 193

Mar-20	Pressure Ulcers: Community, Category 3
3	Total number of category 3 pressure ulcers in a community setting.
Target <= 46 *	The Trust set a target to reduce the overall number of community acquired pressure ulcers by 10% over the preceding 12 months. This month (March data) we have had three category 3 pressure ulcers reported



Actions

The community Trust has achieved its overall target to reduce community acquired pressure ulcers by 10% as it has recorded 173 pressure ulcers in total against a target of 248

In total there were 27 category 3 pressure ulcers reported against a target of 46 indicating, that the severity of harm as well as an overall reduction in numbers has been achieved.

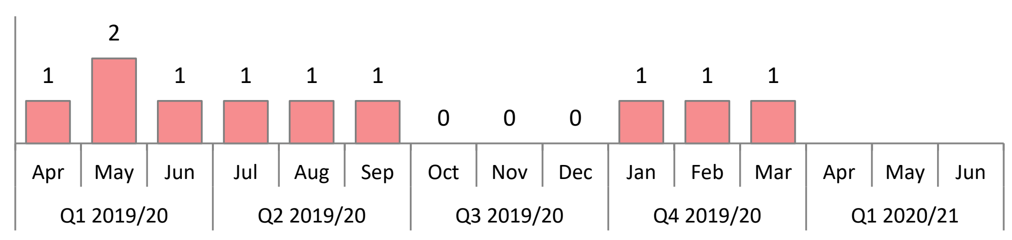
Indicator Detail

Mar-20	Pressure Ulcers: Community, Category 4
1	Total number of category 4 pressure ulcers in a community setting.
Target <= 9 *	The Trust set a target to reduce the overall number of community acquired pressure ulcers by 10% over the preceding 12 months. This month (March data) we have had one category 4 pressure ulcers reported

Actions

The community Trust has achieved its overall target to reduce community acquired pressure ulcers by 10% as it has recorded 173 pressure ulcers in total against a target of 248

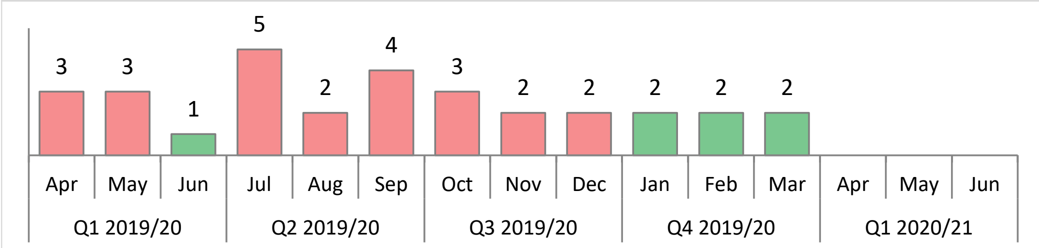
In total there have been 10 category 4 pressure ulcers reported against a target of 9.



Mar-20	Pressure Ulcers: Device Related, Category 2
2	Total number of device-related category 2 pressure ulcers. Includes those from both a hospital and community setting.
Target <= 33 *	The Trust set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (March data) we have had two Category 2 MDRPU reported.

Actions

In total there has been 36 medical device related pressure ulcers reported against a target of 42, indicating that the 25% reduction target has been met



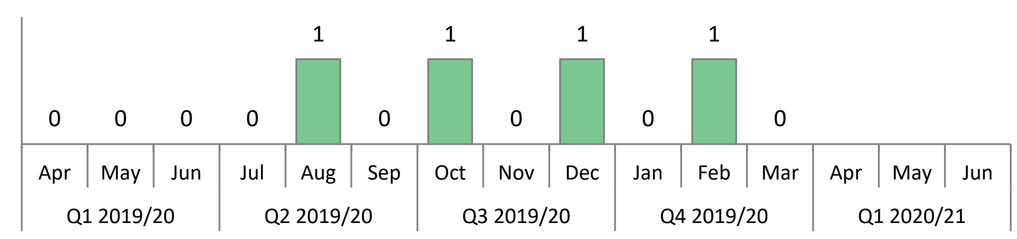
NHS Stockport NHS Foundation Trust

Indicator Detail

Mar-20	Pressure Ulcers: Device Related, Category 3
0	Total number of device-related category 3 pressure ulcers. Includes those from both a hospital and community setting.
Target <= 8 *	The Trust set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (March data) we have had no Category 3 MDRPU reported.

Actions

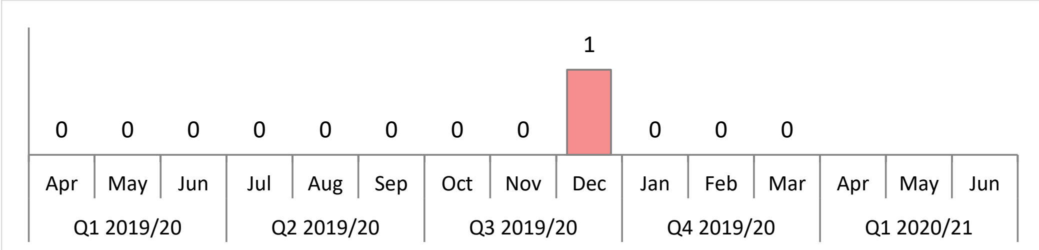
In total there has been 36 medical device related pressure ulcers reported against a target of 42, indicating that the 25% reduction target has been met



Mar-20	Pressure Ulcers: Device Related, Category 4
0	Total number of device-related category 4 pressure ulcers. Includes those from both a hospital and community setting.
Target <= 1 *	The Trust set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (March data) we have had no Category 4 MDRPU reported.

Actions

In total there has been 36 medical device related pressure ulcers reported against a target of 42, indicating that the 25% reduction target has been met



Indicator Detail

Mar-20	Safety Thermometer: Hospital
95.7%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	A decision was taken to suspend the collection of Safety Thermometer data following the outbreak of Covid-19. The point of prevalence snap shot audit data collected through this methodology is replicated and reported within other metrics.
>= 95%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		
Value	97.3%	96.7%	96.4%	97.0%	95.5%	94.6%	95.9%	94.8%	96.7%	96.9%	96.7%	95.7%			

Actions

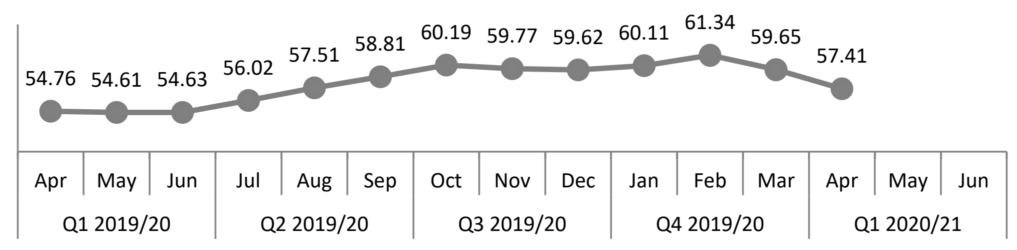
Mar-20	Safety Thermometer: Community
97.1%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	A decision was taken to suspend the collection of Safety Thermometer data following the outbreak of Covid-19. The point of prevalence snap shot audit data collected through this methodology is replicated and reported within other metrics.
>= 95%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		
Value	98.7%	98.0%	96.5%	97.0%	96.7%	96.7%	96.0%	96.5%	96.8%	96.1%	97.8%	97.1%			

Actions

Indicator Detail

Apr-20	Patient Safety Incident Rate
57.41	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The patient safety incident rate per 1000 bed days has dropped slightly this month.



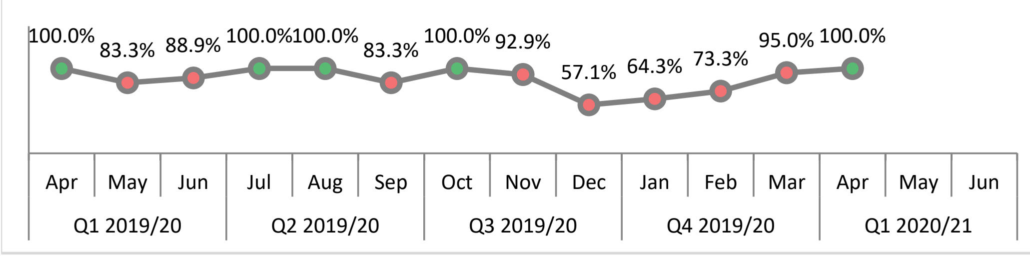
Actions

The response to the Covid -19 pandemic has resulted in the Trust providing services in a different way. Many staff are working in different areas, in different teams and with a different cohort of patients.

It is not clear, at this stage, whether the drop in reporting is a result of fewer incidents, or as a result of reduced reporting.

The trend is being monitored and instances where there is evidence of poor reporting, is being addressed at the time.

Apr-20	Patient Safety Alerts: Completion
100.0%	The percentage of Patient Safety Alerts that are completed within their due date.
Target >= 100%	In April 2020, all alerts were responded to and completed, within the expected timeframe.



Actions

There are 2 alerts that remain overdue:
- Anti-ligature alert

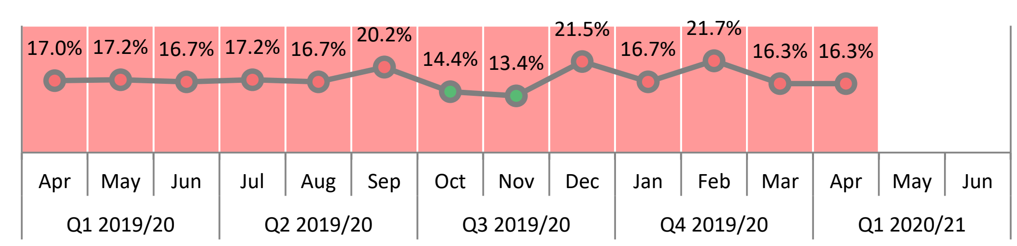
The policy has been drafted and risk assessments have been completed in all clinical areas. Ligature cutters have been placed on resus trollies and training is being rolled out as part of resuscitation training. Review of the assessment process is being undertaken with the support of our mental health partners, at which point the alert will be signed off.
- Professional use defibrillator/monitor: all HeartStart XL+ risk of failure to deliver therapy.

A Phillips engineer is required on site to update the software of the monitors. This has been delayed. Assurance has been given by the manufacturer that the devices are safe to use until the required software update is completed.

NHS Stockport NHS Foundation Trust

Indicator Detail

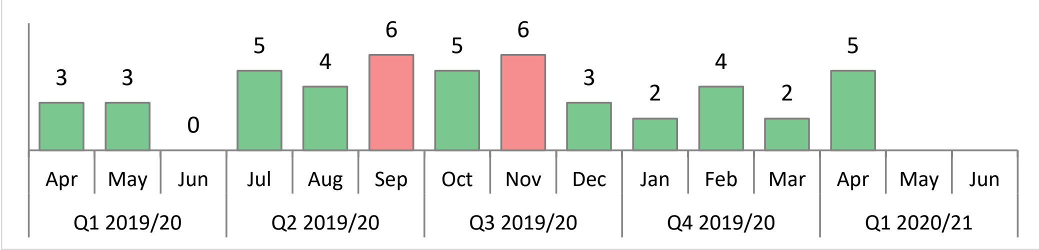
Apr-20	Emergency C-Section Rate
16.3%	The number of patients having an emergency c-section, as a percentage of all patients having registerable births.
Target	The percentage of women undergoing an emergency caesarean section has remained the same as March at 16.3% .
<= 15.4%	



Actions

The emergency caesarean section rate is monitored within the business group.
The emergency caesarean section rate needs to be taken into account alongside the increased complexities of women giving birth, compared to a few years ago, these women have a higher risk of emergency caesarean section and therefore as the percentage of these women increase, so will our Caesarean section rate.
As a result of this the business group will be reporting caesarean section overall, rather than elective and emergency rates (These rates will continue to be documented but for information only)

Apr-20	Term Babies Admitted to the Neonatal Unit
5	Number of term babies (greater than or equal to 37 weeks) admitted to SCBU/NICU, at birth, unexpectedly.
Target	In April, there were 5 babies admitted to the neonatal unit, in line with target.
<= 5	



Actions

Term babies admitted to the neonatal unit is monitored within the business group through the maternity dashboard.

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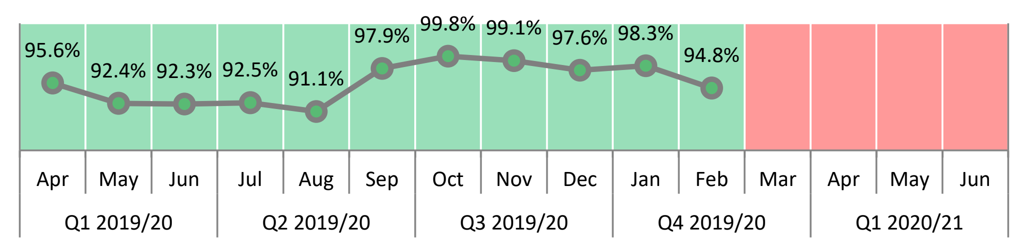
NHS Foundation Trust

Indicator Detail

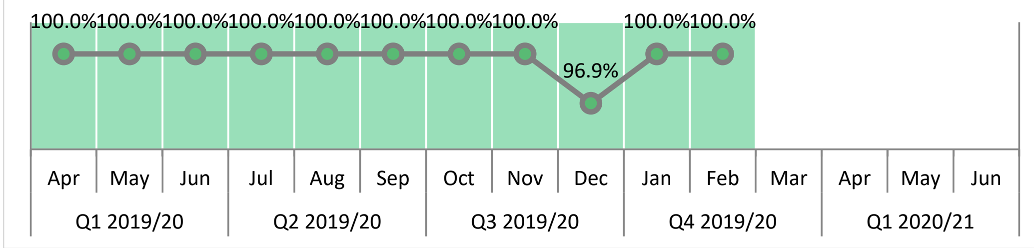
Feb-20	Dementia: Finding Question
94.8%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target is >90%.
>= 90%	



Actions

Dementia FAIRS monitoring has been suspended during the COVID 19 pandemic. During the suspension period, the care provided for patients living with dementia have continued.

Feb-20	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target is >90%.
>= 90%	

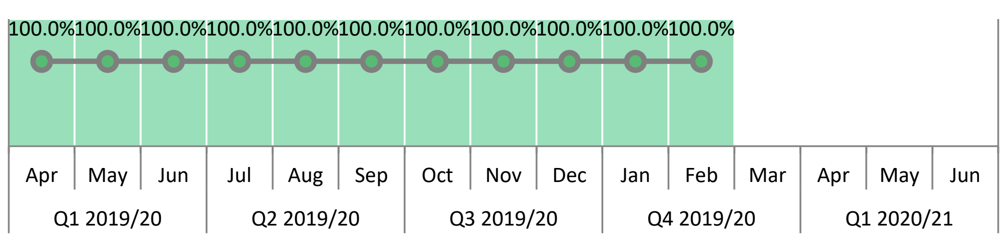


Actions

Dementia FAIRS monitoring has been suspended during the COVID 19 pandemic. During the suspension period, the care provided for patients living with dementia have continued.

Indicator Detail

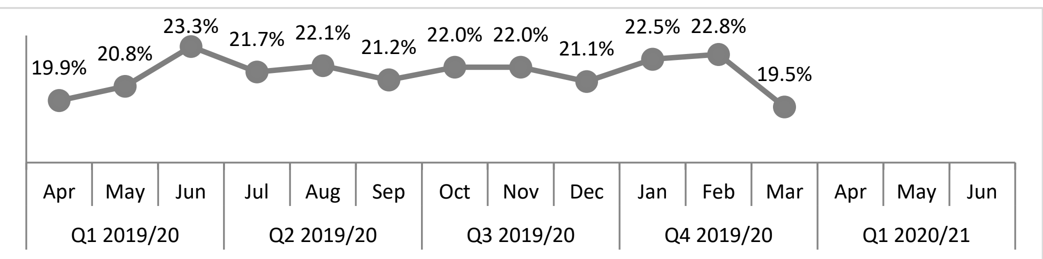
Feb-20	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target is 90%.
>= 90%	



Actions

Dementia FAIRS monitoring has been suspended during the COVID 19 pandemic. During the suspension period, the care provided for patients living with dementia have continued.

Mar-20	Friends & Family Test: Response Rate
19.5%	The percentage of eligible patients completing an FFT survey.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care. During the COVID-19 pandemic it was agreed nationally to limit contact to indirect communication only via SMS.



Actions

The top 3 positive themes were:

Staff attitude
Implementation of care
Environment

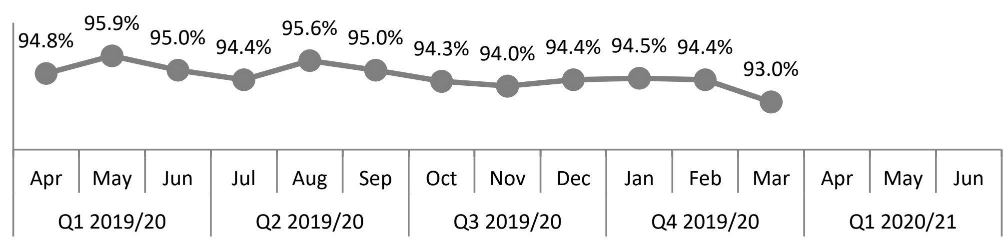
The top 3 negative themes were:

Staff attitude
Waiting time
Environment

The re launch scheduled for implementation in April has been postponed due to the COVID-A9 pandemic, date to be confirmed.

Indicator Detail

Mar-20		Friends & Family Test: Inpatient
	93.0%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target		The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.

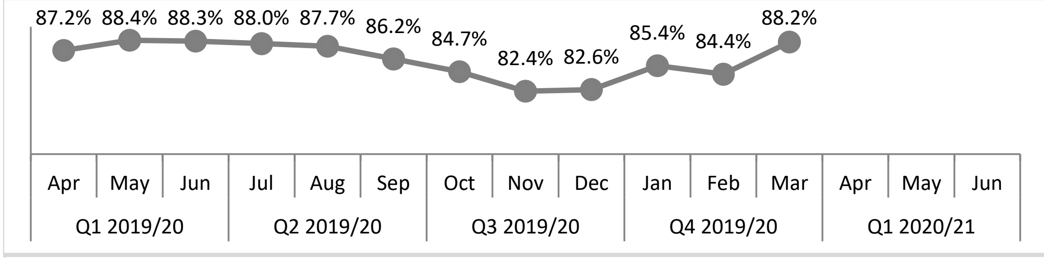


Actions

There were 210 inpatients who responded during the month of March.

The Patient Experience Group and Patient Experience Action Group monitor results on a regular basis.

Mar-20		Friends & Family Test: A&E
	88.2%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target		The percentage of surveyed patients attending the Emergency Department who are extremely likely or likely to recommend the Trust for care.



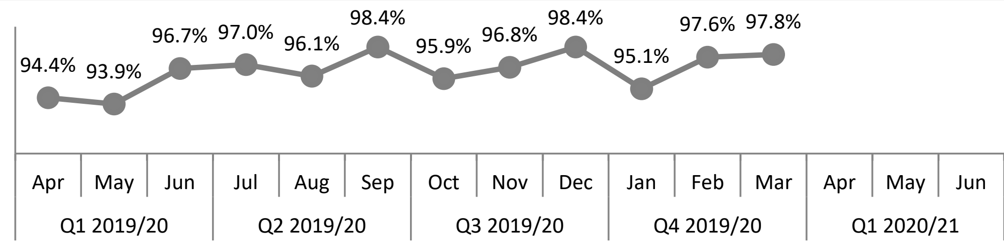
Actions

There were 779 patients who responded during the month of March.

The Patient Experience Group and Patient Experience Action Group monitor results on a regular basis.

Indicator Detail

Mar-20	Friends & Family Test: Maternity
97.8%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients attending Maternity services who are extremely likely or likely to recommend the Trust for care.

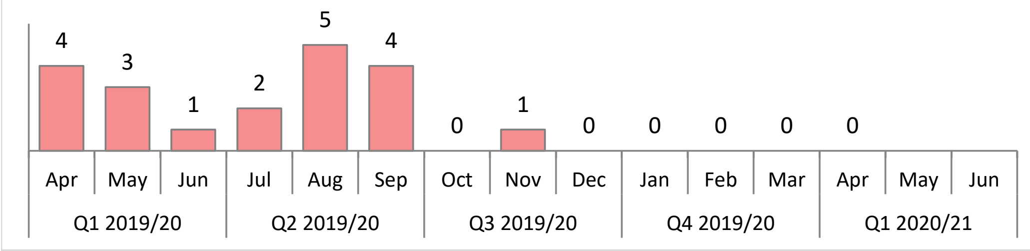


Actions

There were 73 patients who responded during the month of March.

The Patient Experience Group and Patient Experience Action Group monitor results on a regular basis.

Apr-20	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target <= 0	There were no patients affected by a mixed sex breach in the month of April.



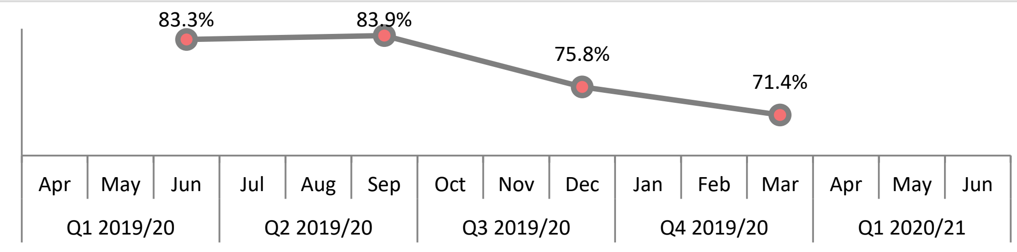
Actions

The delivering same sex accommodation policy is awaiting approval at the next patient experience group.

NHS Stockport NHS Foundation Trust

Indicator Detail

Mar-20		Learning Disability: Adjusted Care Plans
	71.4%	The number of inpatients with a learning disability who have a reasonable adjustment care plan in place, as a percentage of all patients with a learning disability.
Target		Performance against target slipped in Q4 to 71.4% from 75.8% in Q3. A review of the 10 patients for whom a RACP was not in place showed that all had an LD flag on Advantis, and the nursing notes for 8 of the 10 included a reference to the fact the patient had a learning disability.
>= 100%		

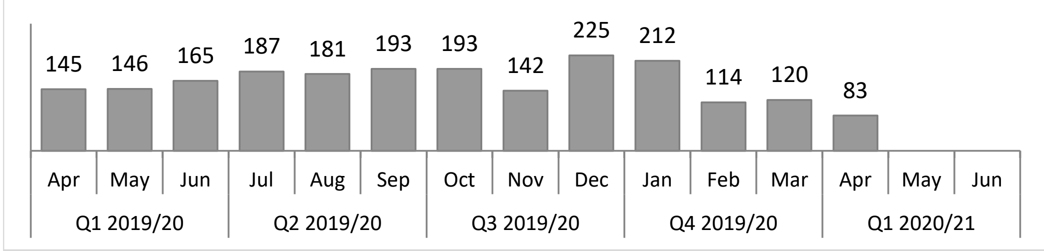


Actions

An incident report will be completed for each person that did not have an RACP.

The Named Nurse for Adult Safeguarding will discuss the actions required to improve compliance across the Trust.

Apr-20		Compliments
	83	Total number of compliments received.
Target		For April 2020, 83 compliments have been received by the Trust.



Actions

Business groups continue to work with staff and wards to ensure compliments are being captured on the Datix system. This will enable us to capture a wealth of information from thank you cards, letters, gifts and verbal feedback from service users and members of staff. The information is populated on a dashboard for each clinical area and their respective business group.

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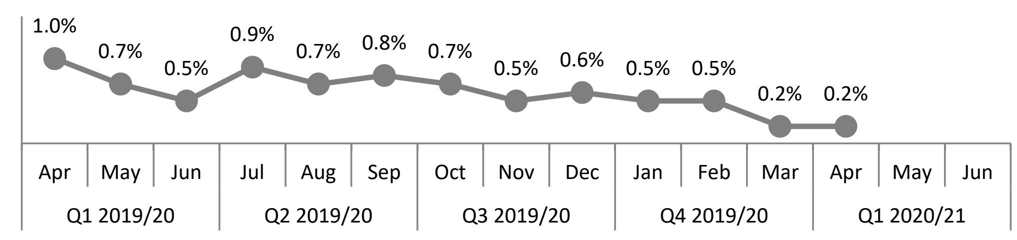
Indicator Detail

Apr-20	Complaints Rate
0.2%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	12 formal complaints were received in April 2020: Integrated Care = 1, Medicine = 8, Surgery = 2, WCDS = 1 and Estates & Facilities = 0

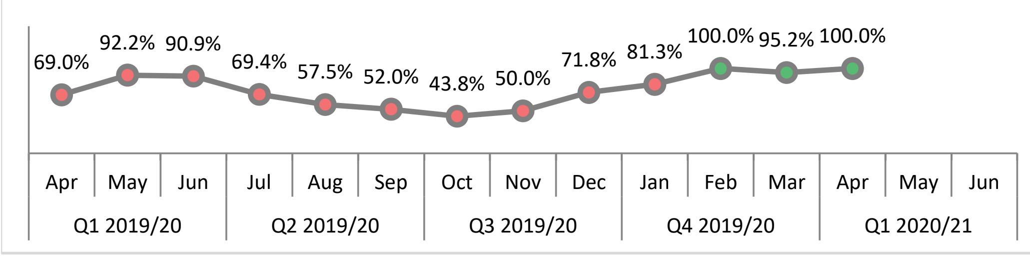


Actions

Due to the ongoing COVID19 pandemic NHS England and NHS Improvement are supporting a system wide “pause” of the NHS complaints process which would allow all health care providers in all sectors to concentrate their efforts on the front-line duties and responsiveness to COVID19. However, patients and the public are still able to raise concerns or make a complaint, but the expectation of an investigation and response is being managed. Complaints are still being acknowledged, logged and shared with business groups with immediate action being undertaken where necessary.

All complaints then remain open until further notice, unless an informal resolution can be achieved.

Apr-20	Complaints: Response Rate 45
100.0%	The percentage of formal complaints responded to within 45 days.
Target >= 95%	Of the 21 closed in April 2020, all were responded to on time resulting in a 100% response rate.



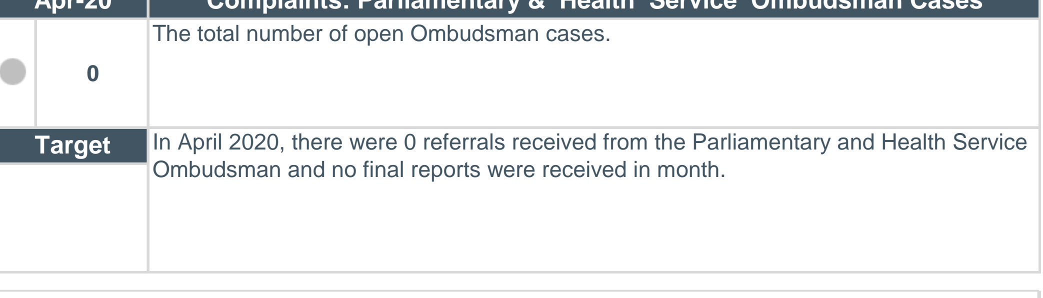
Actions

Work is still being undertaken on the cases received prior to the 'pause' in the formal complaints process. The patient and customer services team continue to liaise with the business groups and the executive team with the aim of maintaining the Trust complaints response rate above 95%.

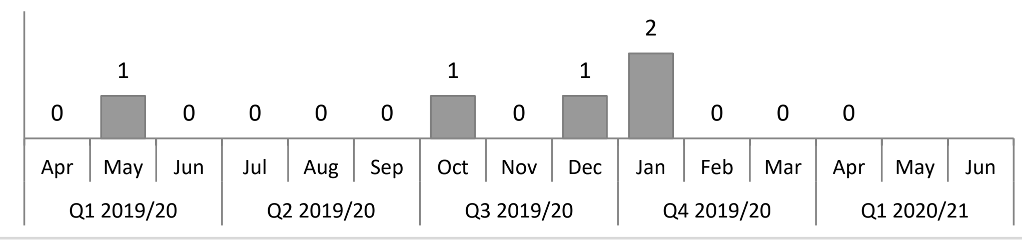
Complainants are kept informed of any delays that occur resulting in the Trust not being to respond in the agreed timeframe.

Tab 6.5 Performance Report

Indicator Detail

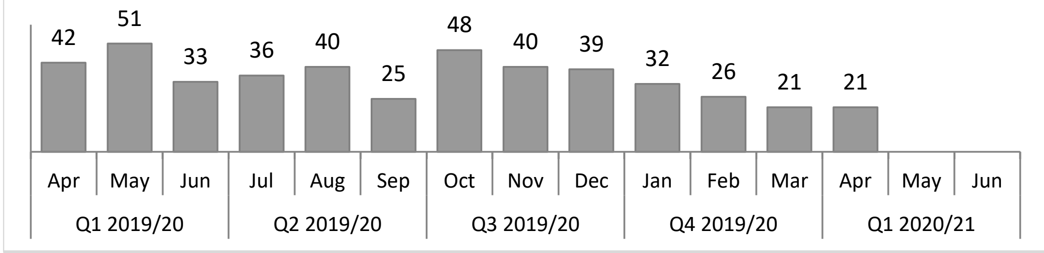


Apr-20	Complaints: Parliamentary & Health Service Ombudsman Cases
0	The total number of open Ombudsman cases.
Target	In April 2020, there were 0 referrals received from the Parliamentary and Health Service Ombudsman and no final reports were received in month.



Actions
Due to the ongoing COVID19 pandemic, from 26 March 2020, the Parliamentary and Health Service Ombudsman stopped accepting new NHS complaints and stopped work on all open cases. No date has been received on when they will resume.

Apr-20	Complaints Closed: Overall
21	The total number of formal complaints that have been closed.
Target	In the month of April 2019, 21 responses were sent in month: integrated care 6, medicine 4, surgery 7, women, children & diagnostic services 2 and corporate 1.

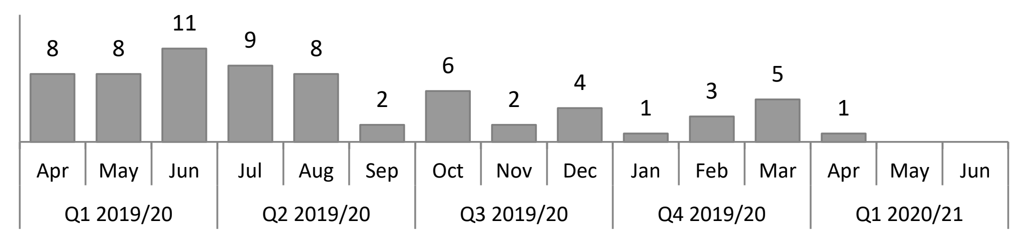


Actions
Work continues to ensure responses are sent in the timeframe initially agreed on the commencement of the investigation.

Public Board - 4 June 2020-04/06/20

Indicator Detail

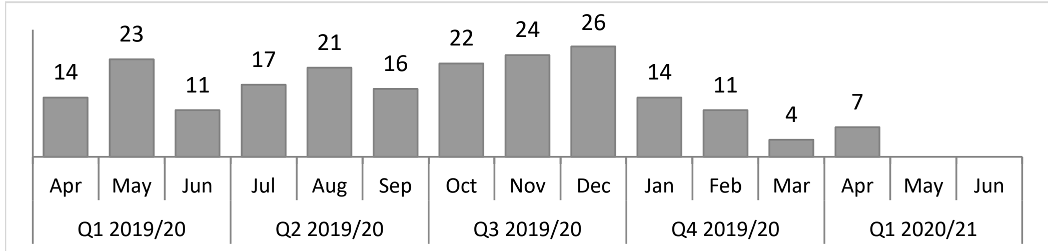
Apr-20	Complaints Closed: Upheld
1	The total number of upheld formal complaints that have been closed.
Target	For April 2020, 1 case was upheld out of the 21 closed.



Actions

All actions and learning identified as a result of complaint are shared with the complainant. Any actions or learning is then uploaded to Datix by the business group and assigned to staff. Datix will then monitor whether this has been completed.

Apr-20	Complaints Closed: Partially Upheld
7	The total number of partially upheld formal complaints that have been closed.
Target	In April 2020, 7 of the cases were partially upheld of the 21 closed.

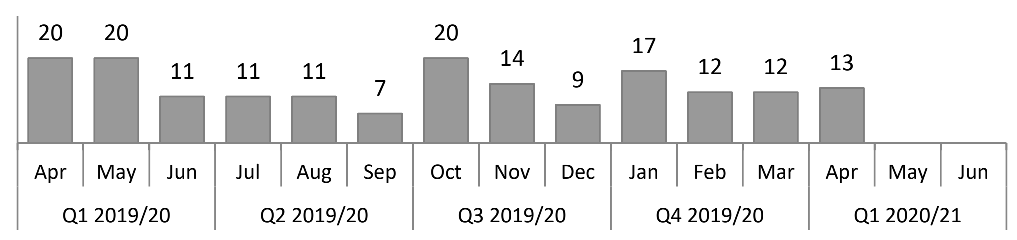


Actions

Where learning points are identified on a complaint that has been partially upheld, this will be reflected within the complaint response and shared with the complainant.

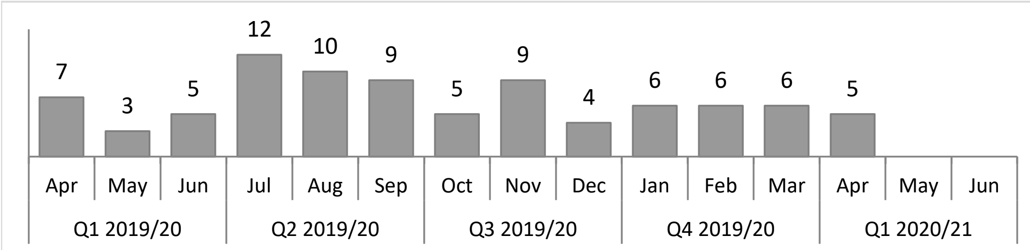
Indicator Detail

Apr-20		Complaints Closed: Not Upheld
	13	The total number of not upheld formal complaints that have been closed.
Apr-20		In April 2020, 13 of the cases were not upheld of the 21 closed.



Actions
Complaints that have not been upheld may still have learning points for staff to reflect on. If this is the case, this will be shared with the complainant and fed back to appropriate staff.

Apr-20		Litigation: Claims Opened
	5	Total number of claims opened in month.
Target		There were 5 new litigation claims opened in April 2020. 3 new claims were for medical negligence. 2 new claims were for employment liability.

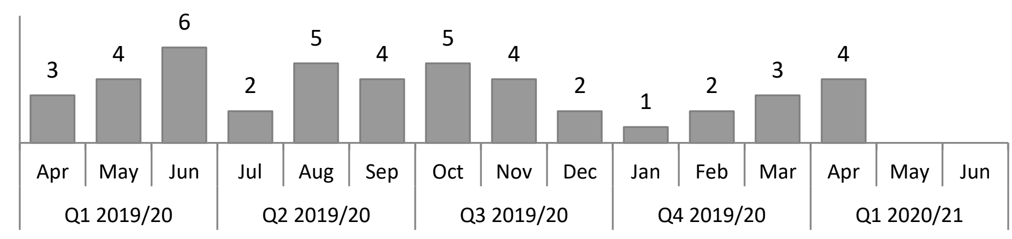


Actions
The process for investigating claims received has commenced in line with policies and procedures.

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20		Litigation: Claims Closed
	4	Total number of claims closed in month.
Target		There were 4 litigation claims closed in April 2020. The closed claims included; 2 for employment liability, 1 for medical negligence and 1 for public liability.

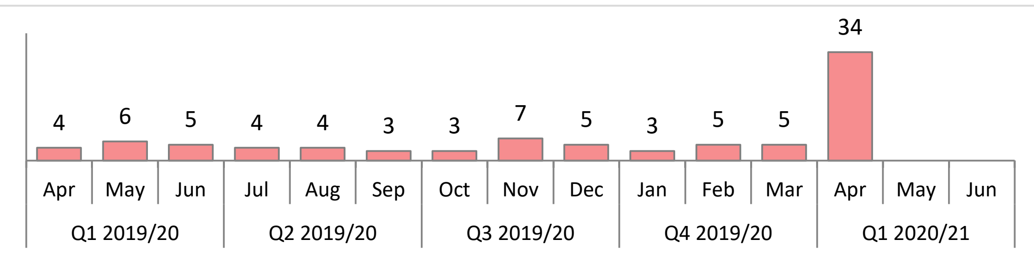


Actions

Two of the claims were successfully repudiated.

The remaining claims were settled out of court, based on the litigation risk.

Apr-20		Referral to Treatment: 52 Week Breaches
	34	The total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.
Target	<= 0	The Trust reported 34 52 week breaches at the end of April, compared to 5 in March. A contributory factor to all of the breaches was cancellation of non-urgent elective activity as a result of the covid-19 pandemic. The split by speciality is as follows: Oral Surgery x9, Gastroenterology x8, Urology x6, ENT x5, General Surgery x5, Ophthalmology x1

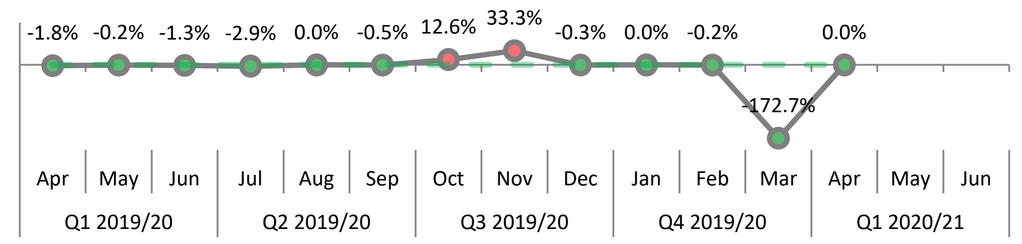


Actions

The number of patients breaching 52 weeks will continue to rise whilst the Trust is working towards fully restoring the elective programme, thus having reduced capacity to operate on and see non-urgent elective patients.
To help minimise clinical risk due to extended waits, clinicians are clinically reviewing the longest waiting patients to assess for any clinical harm.

Indicator Detail

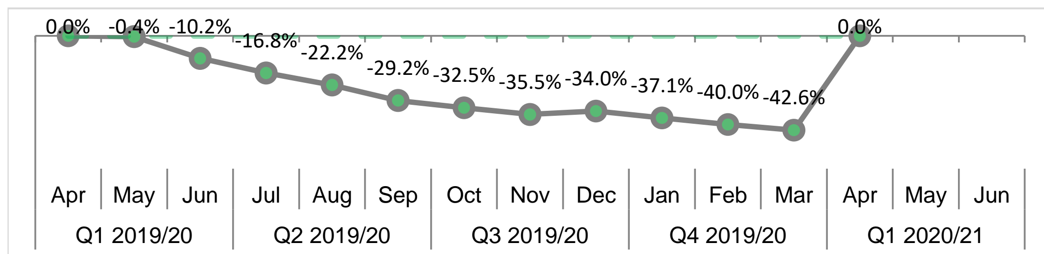
Apr-20		Financial Controls: I&E Position
●	0.0%	The percentage variance between planned financial position and the actual financial position.
Target		NHS Improvement expected all trusts to report a break even position in April 2020. This means that trusts that would otherwise be in deficit should accrue for additional income to bring the adjusted financial performance to overall zero.
<= 0%		



Actions

To deliver the required break even financial position in April the Trust has assume an additional £0.25m of "true-up" funding, in addition to the £22.2m block and £2.5m top-up already received in relation to April.

Apr-20		Cash
●	0.0%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target		The amended cash management arrangements for the period 1st April to 31st July 2020 should provide certainty of cash inflows to NHS organisations in conjunction with simplified transacting protocols. Key principles are to ensure that there is enough cash in the system for providers and suppliers.
<= 0%		

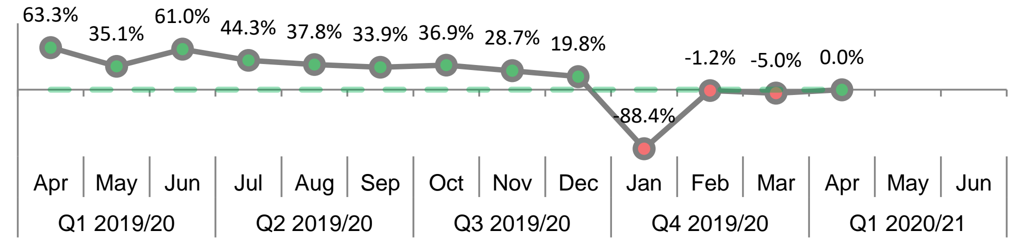


Actions

- All named commissioners paid full block contract values for April in advance on 1st April, and for May on 15th April.
- The June block contract is to be paid on 15th May and July block contract on 15th June.
- Cash in the bank on 30th April 2020 was £44.4m.

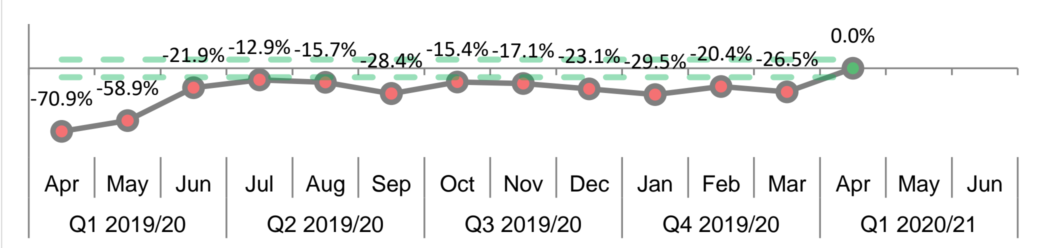
Indicator Detail

Apr-20	CIP Cumulative Achievement
0.0%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The block contract arrangements are intended to cover inflationary uplifts with no efficiency requirement factored in for the first 4 months of the financial year April to July 2020.
>= 0%	



Actions

Apr-20	Capital Expenditure
0.0%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	
+/- 10%	



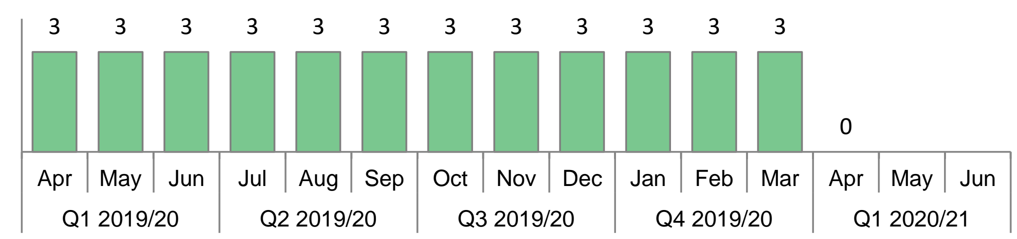
Actions

The Trust has plans in place for an internally funded capital programme of £9.7m plus further schemes including the £30.6m emergency campus development of which £1.6m will fall in 2020/21, and continues to plan for the release of Healthier Together additional funding. The total programme for 2020/21 is £22.1m.

NHS Stockport NHS Foundation Trust

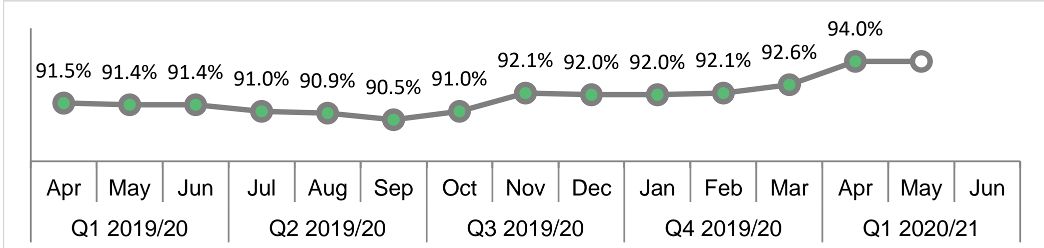
Indicator Detail

Apr-20		Financial Use of Resources
●	0	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target		The regulatory oversight framework is being reviewed in line with the overall reporting and administrative burden on the NHS, and as a result this metric has not been collated nationally for April.
<= 3		



Actions

May-20		Substantive Staff-in-Post
●	94.0%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target		The Trust staff in post figure for April 2020 is 94%. Actual FTE staff in post increased by 21.53 FTE Work continues to recruit to vacant post and reduce temporary staffing costs.
>= 90%		



Actions

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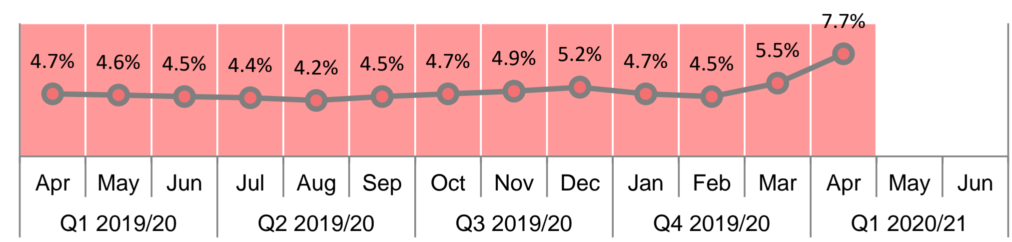
Indicator Detail

Apr-20		Sickness Absence: Monthly Rate (UoR)
●	7.7%	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.
Target		The in-month unadjusted sickness absence figure for April 2020 is 7.69%; an increase of 2.01% compared to the adjusted previous month's figure of 5.68%. The unadjusted cost of sickness absence in April 2020 is £1M; a increase of 282K from the unadjusted figure of £734K in the previous month. This does not include the cost to cover the absence.
<= 3.5%		

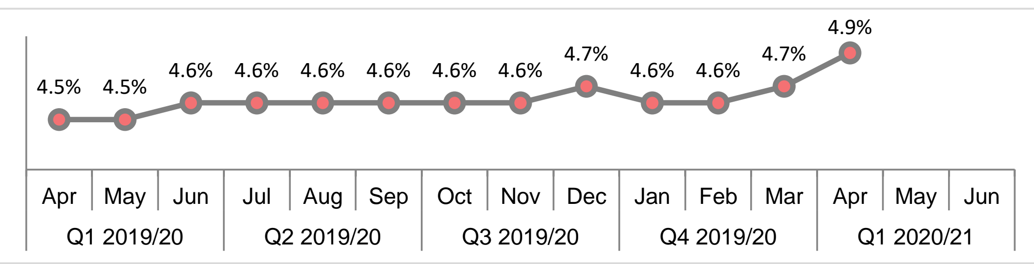


Actions

The highest reasons for sickness are;
Anxiety/Stress/Depression
Back/Musculoskeletal Problems including Injury/ Fracture
Gastrointestinal Problems
Infectious Diseases
Cough/Cold/Influenza

There were 6,159 FTE lost due to Infection Diseases, which is the reason we are using to record Covid-19 related sickness'. Sickness % for April 2020 excluding Covid-19 related absences would be 4.61%.

Apr-20		Sickness Absence: Rolling 12-Month Rate (UoR)
●	4.9%	The total number of staff on sickness absence, as a percentage of all staff-in-post whole time equivalent. Calculated as a 12-month rolling average.
Target		The in-month unadjusted sickness absence figure for April 2020 is 7.69%; an increase of 2.01% compared to the adjusted previous month's figure of 5.68%. The unadjusted cost of sickness absence in April 2020 is £1M; a increase of 282K from the unadjusted figure of £734K in the previous month. This does not include the cost to cover the absence.
<= 3.5%		



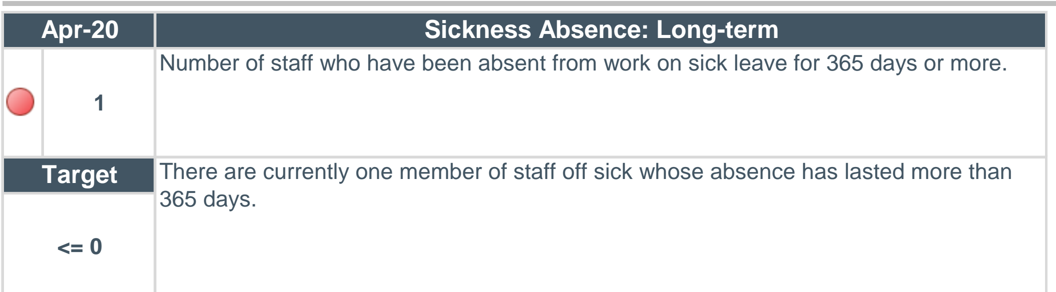
Actions

The highest reasons for sickness are;
Anxiety/Stress/Depression
Back/Musculoskeletal Problems including Injury/ Fracture
Gastrointestinal Problems
Infectious Diseases
Cough/Cold/Influenza

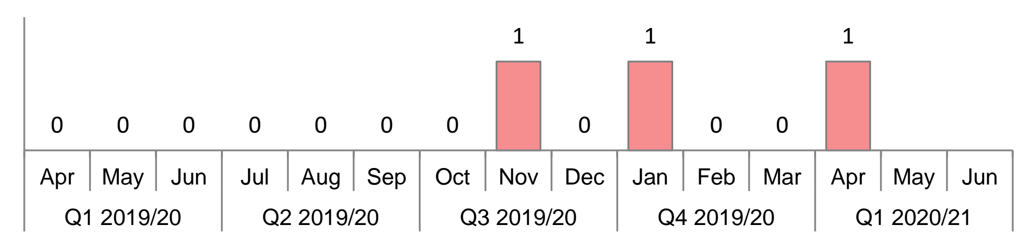
There were 6,159 FTE lost due to Infection Diseases, which is the reason we are using to record Covid-19 related sickness'. Sickness % for April 2020 excluding Covid-19 related absences would be 4.61%.

NHS Stockport NHS Foundation Trust

Indicator Detail

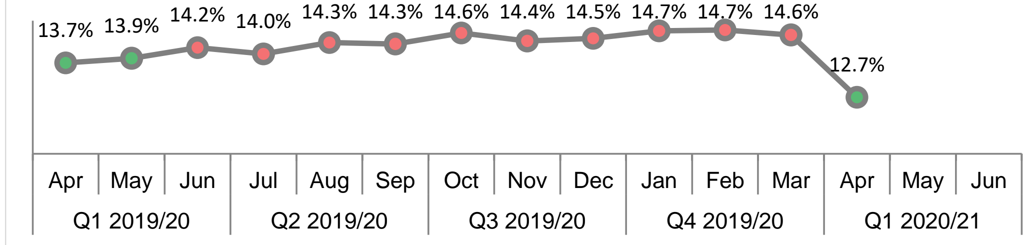


Apr-20	Sickness Absence: Long-term
1	Number of staff who have been absent from work on sick leave for 365 days or more.
Target <= 0	There are currently one member of staff off sick whose absence has lasted more than 365 days.



Actions

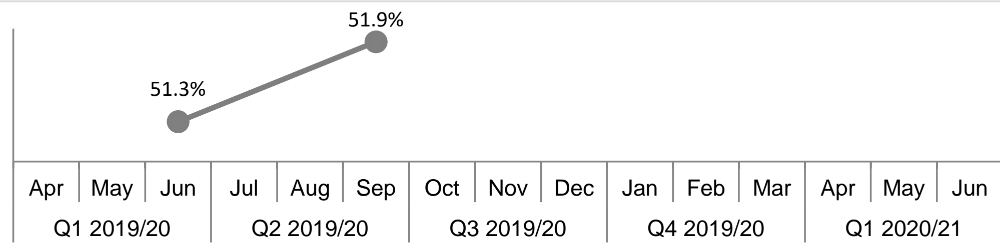
Apr-20	Workforce Turnover (UoR)
12.7%	The percentage of employees leaving the Trust and being replaced by new employees.
Target <= 13.94%	The rolling 12-month unadjusted permanent headcount turnover figure is 14.17%, (adjusted for flexi retirements and TUPE transfers, the figure is 12.66%). The top known leaving reasons are: Work Life Balance together with Dependents (19.68%), Relocation (14.91%), Retirement (10.27%), and Promotion (9.05%).



Actions

Indicator Detail

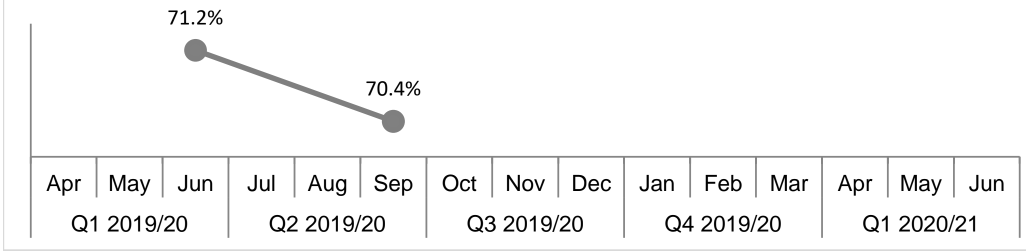
Sep-19	Staff Friends & Family Test: Recommend for Work
51.9%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust as a place of work.
Target	Due to Covid-19 this national data collation has been stood down for Quarters 4 and 1.



Actions

Staff survey actions will be taken forwards

Sep-19	Staff Friends & Family Test: Recommend for Care
70.4%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	Due to Covid-19 response national data collation for Quarters 4 and 1 has been stood down.

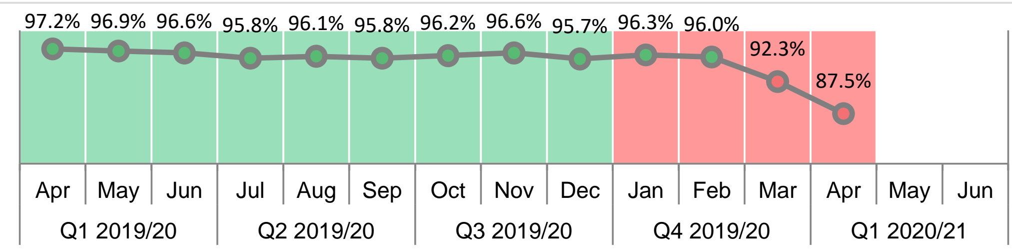


Actions

Staff survey actions will be taken forwards

Indicator Detail

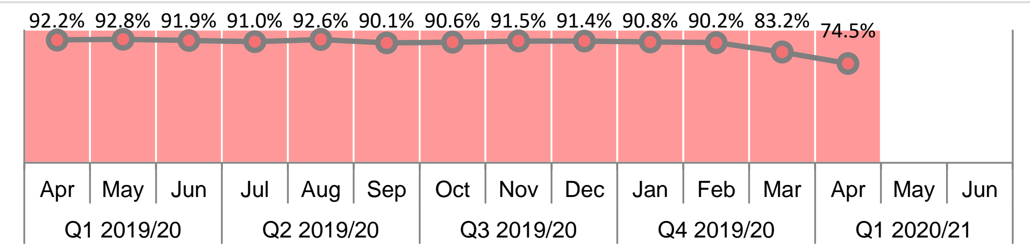
Apr-20	Appraisal Rate: Medical
87.5%	The percentage of medical staff that have been appraised within the last 15 months.
Target >= 95%	The medical appraisal rate has decreased by 4.78% to 87.50% in April below the Trust target of 95%. The Trust's total appraisal compliance for April is 74.50% which has decreased from last month 83.22% and remains below the Trust's target of 95%.



Actions

Continued support to managers to complete their appraisals is provided by the learning & development team.

Apr-20	Appraisal Rate: Non-medical
74.5%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target >= 95%	The Trust's total appraisal compliance for April is 74.50% which has decreased from last month 83.22% and remains below the Trust's target of 95%. Currently all Business Groups are under the Trust target of 95%



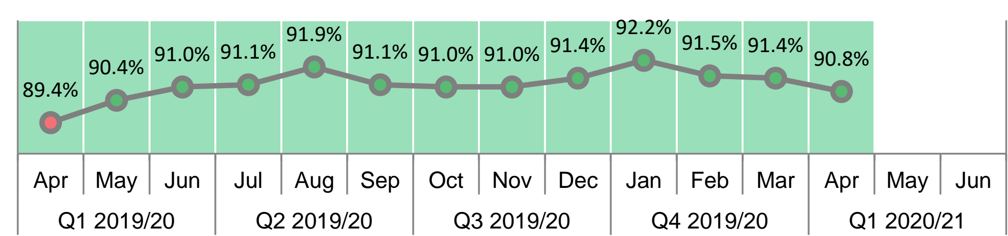
Actions

Continued support to managers to complete their appraisals is provided by the learning & development team.

NHS Stockport NHS Foundation Trust

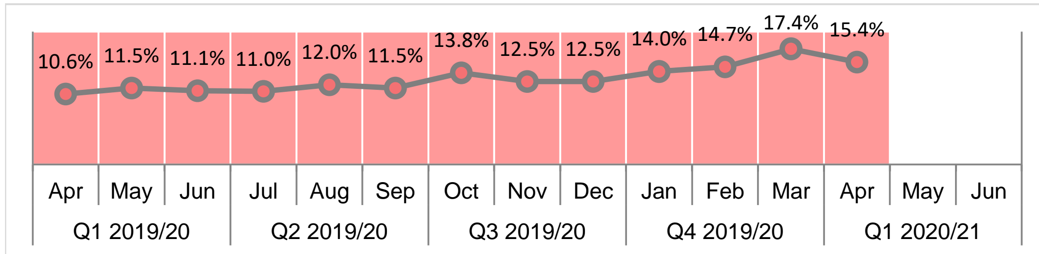
Indicator Detail

Apr-20	Statutory & Mandatory Training
90.8%	The percentage of statutory & mandatory training modules showing as compliant.
Target >= 90%	Statutory and Mandatory training has decreased from 91.42% in March to 90.78% in April but continues to be above the Trust compliance target of 90%.



Actions

Apr-20	Bank & Agency Costs
15.4%	The total bank & agency cost as percentage of the total pay costs
Target <= 5%	The total bank and agency spend in April was £3.2M, which represents 15.42% of the total pay bill within the month. The business groups with the highest bank & agency spend in April were M&CS & Surgical both (£812K



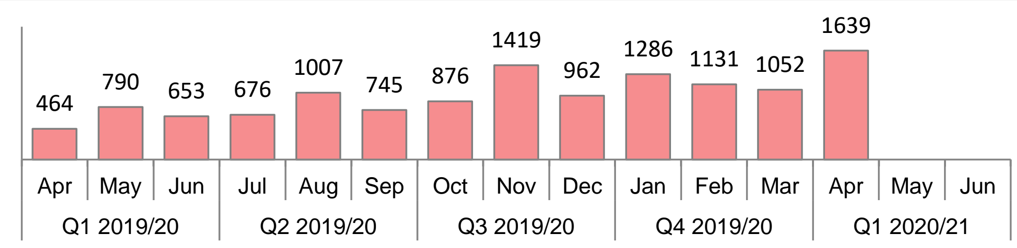
Actions

Winter incentive scheme for substantive staff including extension of increased rates for RNs to 31st May.
Improvement rota management,
Implementing and improving electronic rostering for all the workforce
Enhanced controls on temporary staffing requests and approval
Flexible working options
Use of technology to ensure more staff are able to access and volunteer to work extra shifts
Successful substantive recruitment from within the UK and overseas, for key medical and nursing vacancy hotspots
Significant growth of the medical bank to reduce the reliance on agencies and avoid the commission payments
Introduction of new roles, such as the Physician Associate
Return to practice and conversion courses to registered practice

NHS Stockport NHS Foundation Trust

Indicator Detail

Apr-20	Agency Shifts Above Capped Rates
1639	Number of agency shifts above above the provider spend cap.
Target <= 0	There were a total of 1,639 agency shifts paid above the NHSI cap rate during the 5 week period from 30th March to 3rd May 2020. This equates to an average of 328 shifts per week, which is an increase of 65 shifts per week compared to March's figures and also an increase compared to the 116 shifts per week in April 2019.

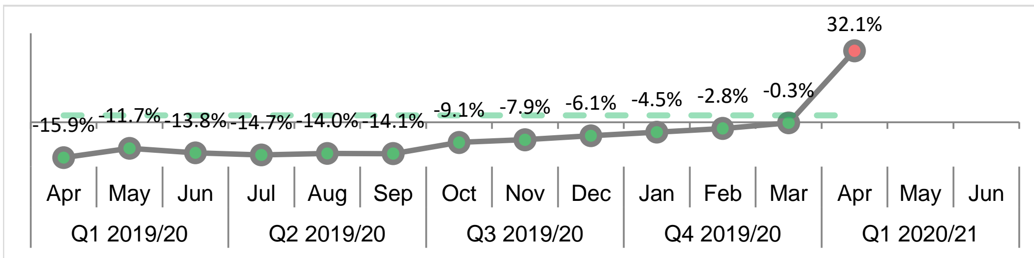


Actions

Due to actions taken around COVID-19, there were 79 registered nursing shifts above cap that are not allocated to any business group through NHSP as they were booked as "Allocate on Arrival". For the shifts that were booked directly to departments, the highest number of agency breaches were in M&CS, Surgery and Integrated Care with an average of 102, 99 and 94 shifts respectively, including medical and AHP shifts. Within this period there were 461 cap breaches relating to non-framework agencies - Robinsons (106) and Thornberry (355).

The total number of agency shifts worked in this period, including shifts under cap, was 2,503 – an average of 501 per week. This is an average increase of 20 shifts per week compared to March.

Apr-20	Agency Spend: Distance From Ceiling (UoR)
32.1%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target <= 3%	



Actions

Indicator Detail

Apr-20		Staff Suspensions
●	0	Number of staff who have been suspended from work for 90 days or more.
Target		There is currently no members of staff who has been suspended for more than 90 days.
<= 0		

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Staff Suspensions	0	1	1	1	0	0	0	0	0	0	0	1	0		
Quarter	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		

Actions

		Recruitment Lead Time
●	16.49	Average waiting time between issuing of a conditional offer to issuing an unconditional offer across all staff groups
Target		The Trust average time to hire is currently 15.94 weeks. The average time to hire within the following clinical staff groups is as follows, Nursing & Midwifery Registered – 14.98 weeks; Allied Health Professionals – 15.92 weeks; Additional Clinical Services – 19.71 weeks; Medics – 25.2 weeks.
<= 20		

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Recruitment Lead Time	22.93	23.15	22.69	20.31	20.60	24.54	21.77	22.34	21.81	20.30	21.89	21.51	16.49		
Quarter	Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		

Actions

Indicator Detail

Mar-20	Flu Vacination Uptake
80.0%	The percentage of staff receiving the flu vaccination.
Target	The Trust achieved its target of 80% of frontline staff vaccinated, releasing the associated CQUIN payment.
>= 80%	

60.4%	70.4%	75.6%	75.4%	77.2%	80.0%

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21		

Actions
No Actions

Safer Staffing Report - April 2020

The usual safe staffing report completed from data-sourced from the Unify (NHS Digital) submissions has been suspended nationally in month due to Covid situation a number of wards have been closed and surgical wards have been reallocated.

Nursing & Midwifery	Establishment FTE	NHSP Nurse FTE	Total Establishment	Sum of FTE Actual	NHSP Nurse FTE	Total Actual FTE	Sum of FTE Variance	Variance from Establishment %	Post Recruited to in TRAC FTE	Grand Total Variance from Establishment FTE
Corporate Services	65.69	0.00	65.69	64.51	0.00	64.51	1.18	1.79%	28.96	-27.78
Emergency Department	119.04	2.56	121.60	89.47	2.56	92.03	29.57	24.32%	0.00	29.57
Integrated Care	350.14	7.85	357.99	292.45	7.85	300.3	57.69	16.12%	34.24	23.45
Medicine & Clinical Support	311.47	7.99	319.46	264.65	7.99	272.64	46.82	14.66%	3.00	43.82
Surgery GI & Critical Care	426.21	12.28	438.49	360.23	12.28	372.51	65.98	15.05%	6.00	59.98
Women, Children & Diagnostics	354.6	3.16	357.76	348.32	3.16	351.48	6.28	1.76%	14.00	-7.72
Grand Total	**1627.15**	**33.84**	**1660.99**	**1419.63**	**33.84**	**1453.47**	**207.52**	**12.49%**	**86.20**	**121.32**

Additional Clinical Services	FTE Budgeted	FTE Actual	Variance From Establishment FTE	Variance From Establishment %
	794.00	818.09	-24.09	-3.03%
Grand Total	**794.00**	**818.09**	**-24.09**	**-3.03%**

DESCRIPTION	AGGREGATE POSITION	TREND	PERFORMANCE AGAINST PREVIOUS MONTH
RN safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	April RN rates indicate 222.3 WTE filled	Of the RN 222.3 WTE (Demand 324.9 WTE) The fill rate overall is 68.2% of the shifts requested. 40.6% are NHSP and agency 28.2%
Non-registered safe staffing levels are supported by temporary staff (NHSP Bank).	This is reported as demand versus NHSP and agency fills compared to substantive vacancies.	April non-registered rates indicate 149 WTE filled	Of the non-registered 149 WTE (Demand 242.6 WTE) the fill rate is 73.1%.

During April 2020 sickness levels increased combined with staff who were required to “shield” from patient facing duties due to Covid, impacted on staffing levels.

In order to ensure safe staffing levels in March 2020 a Staffing Hub, led by Corporate Nursing, was initiated covering 07:00–21:00 seven days a week. Business group matrons commenced a 7 day working pattern to support areas during the Covid impact.

Due to the sickness levels and shielding of temporary NHSP and 1st tier agency workers there were insufficient workers to fill the demand requested. Therefore authorisation was requested and approved to book “allocate on arrival” tier two agency RNs, and if necessary off-framework agency RNs to secure safe staffing for both the wards and Emergency Department. Insufficient cover was being provided by NHSP for non-registered support staff and authorisation was sought to cascade shifts during the Covid pandemic impact for non-registered agency staff.

In April the Trust received 68 applications from student nurses and midwives to work as a Band 3s and 4s. Approximately 30 have completed their induction and have been deployed into clinical areas. The Learning and Development Team are fast-tracking the remaining students.

Medical students have also been deployed working as non-registered support staff assisting in supporting safe staffing.

Shielded RNs are working in the Trust in non-patient facing roles such as Fit Testing and patient liaison roles.

In the Staffing Hub a “Heatmap” has been developed and is now fully operational providing clarity and assurance regarding staffing levels for all clinical wards, ED, ICU and Theatres. The nursing RAG rating is generated by reviewing established RN, Band 4 and non-registered staffing levels versus actual levels. The data also captures patient numbers and enables a professional over-ride RAG rating facilitated by matrons and Hub shift leaders to enable acuity factors to be considered.

The Hub has a ‘CommShare’ system to enable a retrospective clearly documented review of decisions made in relation to safe staffing. The Heatmap data is available to ensure the Board have daily access to up-to-date staffing levels.

CQUIN Report

Mar-20

Background

The national Commissioning for Quality and Innovation (CQUIN) payment framework allows Commissioners to reward excellence, by linking a proportion of a healthcare Providers' income to the achievement of quality improvement goals and innovations.

The Trust is required to provide its commissioning bodies with quarterly evidence submissions for each CQUIN indicator. This evidence demonstrates how the Trust has performed against the milestones set out within each CQUIN indicator.

Monthly meetings are held with the Medical Director and CQUIN Leads to review progress and provide assurance. CQUIN updates are provided quarterly to the Quality & Safety Improvement Strategy Group (QSISG) and Quality Governance Group (QGG).

This report provides a summary of the confirmed achievement for Qtr 3 2019-20.

KEY: **Green** = Achieved / Full Payment **Amber** = Part Payment **Red** = Not Achieved / No Payment

	CQUIN Indicator	Quarter 3				
		Target	Result	Value	Value Secured	
1	**Antimicrobial Resistance -** Lower Urinary Tract Infections in Older People	90%	38%	£96,968	0%	£0
2	**Antimicrobial Resistance -** Antibiotic Prophylaxis in Colorectal Surgery	90%	48%	£72,726	0%	£0
3	**Frontline Staff Flu Vaccinations**	N/A	N/A	N/A	NA	N/A
4	**Alcohol and Tobacco** – Screening	80%	98%	£48,484	100%	£48,484
5	**Alcohol and Tobacco** – Tobacco Brief Advice	90%	67%	£48,484	43%	£20,848
6	**Alcohol and Tobacco** – Alcohol Brief Advice	90%	0%	£48,484	0%	£0
7	**Three High Impact Actions To Prevent Hospital Falls**	80%	50%	£193,936	45%	£87,271
8	**Same Day Emergency Care** – Pulmonary Embolus	75%	97%	£48,484	100%	£48,484
9	**Same Day Emergency Care** – Tachycardia with Atrial Fibrillation	75%	75%	£48,484	100%	£48,484
10	**Same Day Emergency Care**– Community Acquired Pneumonia	75%	82%	£64,645	100%	£62,059
11	**Medicines Optimisation**	N/A	PASS	£9,062	100%	£9,062
12	**National Dose Banding for Adult Intravenous Anticancer Therapy (SACT)**	95%	100%	£7,720	100%	£7,720
	Total	-	-	**£687,477**	**49%**	**£332,412**

Board of Directors' Key Issues Report

Report Date: 04/06/2020		**Report of:** Audit and Risk Committee		
Date of last meeting: 21/5/2020		**Membership Numbers:** Quorate (by Webex)		
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit progress report • Draft HOIA opinion • Draft 2020/21 Internal Audit Plan • Anti-fraud Annual Report and 2020/21 Plan • External audit – Mazars audit strategy and update • Accounting Policies, Waivers, Losses and compensation • Key issues for the 2020/21 Accounts		
	Alert	• Two Internal Audit reports, Fit and Proper Persons, and Conflicts of Interest gave only limited assurance		
	Assurance	• Draft HOIA opinion provides substantial assurance that there is a good system of internal control		
	Advise	• The draft Internal audit plan for 2020/21 would be revisited to reflect the changed operating environment and priorities • Anti-fraud annual report and 2020/21 plan were approved • Deadlines for the 2020/21 accounts should be met – there will not be an audit of the Quality Accounts • Accounting Policies were approved for recommendation to the Board • Key issues for the 2020/21 accounts were discussed noted		
2.	Risks Identified	With the exception of risks noted in the Trust Risk Register, no further risks were identified.		
3.	Actions to be considered at other Committees	Nil		
4.	Report Compiled by	David Hopewell, Chair	Minutes available from:	Committee Secretary

Board of Directors' Key Issues Report

6.6

<table>
<tr><td colspan="2">Report Date:
04/06/2020</td><td>Report of: Quality Committee</td></tr>
<tr><td colspan="2">Date of last meeting:
26/05/2020</td><td>Membership Numbers: Quorate</td></tr>
<tr><td>1.</td><td>Agenda</td><td>The Committee considered an agenda which included the following:
• MRSA Bacteraemia presentation
• Prevention of Future Death Report
• Covid-19 Quality Impact Assessment
• Covid-19 Quality Update
• Committee Work Plan
• IPR – Quality Metrics
• CQC
- CQC Warning Notice
- CQC Report
• CNST Standards Assurance
• Cancer Covid-19 Report
• Maternity Dashboard
• Patient Safety & Experience
- Quality Improvement Plan
- Quality Improvement Initiatives
• Learning from Experience
• Key Issues Reports
- Safeguarding Group
- Infection Prevention and Control Group
- Quality Governance Group</td></tr>
<tr><td></td><td>Alert</td><td>The Committee wish to alert the Board to the following:
• There are 670 patients on the Patient Tracking List (PTL) on the GP 2-week wait referral pathway. Approximately 40% of these patients are marked as deferred or awaiting diagnostics or surgical intervention.</td></tr>
<tr><td></td><td>Assurance</td><td>The Committee received assurance that:
• Significant progress has been made with regards to improvements in relation to the CQC Warning Notice. The Committee received Level 2 assurance that areas of concern have been addressed. Work continues to obtain additional evidence and in the testing of new systems and processes.</td></tr>
<tr><td></td><td>Advise</td><td>The Committee wish to advise the Board on the following:
• Quality Impact Assessments will now be carried out on decisions made by the Clinical Advisory Group (CAG) in relation to the Trust's response to the</td></tr>
</table>

		Covid-19 healthcare emergency.		
2.	Risks Identified	The Committee agreed/identified that there was a risk • In relation the number of patients awaiting endoscopy procedures due to limited capacity. The Trust is developing plans to increase capacity in this area. • To patients due to Covid-19 related disruption of the local cancer system resulting in delays to diagnosis and treatment. The Trust is currently unable to quantify the impact of this. • As public confidence grows, non elective presentations will increase. The pre-existing unfilled posts (150), current staff absence through covid (304 absent), compounded by those unable to manage front line duties presents a significant capacity risk for the coming months. • Due to a number of metrics being paused due to the Covid-19 emergency and therefore the committee has does not have visibility of key quality indicators. The scale of the some the issues is therefore an 'unknown'		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*			
4.	Report Compiled by	Dr M Logan-Ward	Minutes available from:	Committee Secretary

6.6

Board of Directors

Report to:	Board of Directors	**Date of Meeting:**	04 June 2020
Subject:	**Risk Report**		
Report of:	Interim Director Governance & Risk	**Prepared by:**	Interim Director Governance & Risk

6.7

Report for Assurance

Corporate objective ref:	All	This report: • updates the Board of Directors on the progress to review existing risk registers and preparations for introducing a Risk management Committee; • outlines to the Board an aggregate account of significant risk exposures valid at the time of writing; • gives an indication to the Board of potential future risk considerations. The Board are invited to consider the report and: • Note the aggregated significant risk exposures as outlined; • Note the initial thinking to develop an emergent risk horizon; and • Advise on any further actions required ahead of the Risk Management Committee meeting.
Board Assurance Framework ref:	n/a	
CQC Registration Standards ref:	Well-led Domain	
Equality Impact Assessment:	☐ Completed ☒ Not required	

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

Risk Report

1. Purpose

1.1 The Purpose of this report is to:

(i) update the Board of Directors on the progress to review existing risk registers and preparations for introducing a Risk management Committee;
(ii) outline to the Board an aggregate account of significant risk exposures valid at the time of writing;
(iii) give an indication to the Board of potential future risk considerations.

2. Review of Risk Registers

2.1 The Board supported the recommendation of the Interim Director of Governance & Risk Assurance to temporarily pause existing risk registers held on Datix ® to enable a review to take place with accounting officers responsible for business groups and major corporate functions.

2.2 During May 2020, these reviews have taken place and changes are being made to risk registers at the time of report ahead of formal review by the Risk Management Committee (RMC) in June. At the time of writing it was understood that some business groups and major corporate functions intended to develop their risk profiles using the time available up to and including 31st May. The Board are therefore advised that whilst every effort have been taken to faithfully report the significant risks in this document, leaders of business groups and major corporate functions intended to make changes which will alter some of the risks reported in this paper.

2.3 Steps have been taken to introduce a simplified risk grading matrix as agreed by the Board of Directors in April. This simplified matrix is being used to underpin risk register reviews taking place presently.

2.4 Preparations for the first RMC have been made. The RMC is scheduled to hold its inaugural meeting on 17th June 2020. Terms of reference and an annual programme of scheduled business has been developed for approval. The annual cycle of business includes the sequencing of formal reviews of 'reportable risks' from each business group and major corporate function at several points throughout the year ahead.

2.5 Good Governance Masterclasses, led by the Interim Director of Governance & Risk Assurance, have been held with Women's, Children's & Diagnostics and Surgery Business Groups in May. Invitations have been extended to others and there appears to be an appetite from amongst senior leaders to attend.

3. Significant Risk Exposures (valid as at 28/05/2020)

3.1 At the time of writing there are 453 live risks on the Trust's risk register. Using impact and likelihood markers, these risks are distributed as follows:

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain	Total
1 - Negligible	5	3	1	0	2	11
2 - Minor	7	27	15	13	16	78
3 - Moderate	18	55	69	66	8	216
4 - Major	29	38	48	17	7	139
5 - Catastrophic	3	4	1	1	0	9
Total	62	127	134	97	33	453

3.2 On the spectrum of possible residual risk scores, the distribution of risk exposure is as follows:

20.97%					41.94%			37.09%					
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	10	19	56	5	70	51	69	20	114	9	17	8	0

3.3 A significant risk is understood as a risk where the exposure [after risk treatment] is rated 15 or more using the Trust's grading matrix. 7.5% of all live risks are currently rated as significant. At the time of writing the aggregate profile of current significant risks is as follows:

Nature of Risk Exposure	Count of Grouping	Risk Identified
Clinical Safety	11	Glucometer Machine Use; Ligature Risk; Spirometry on Wards; Eating disorder care; Access to MDT; Fax Machine withdrawal; POCT on Wards; Mental Health Support (CYP); Radiology Reporting Times
Staffing Levels	6	Nursing Staffing; Medical Staffing
Access Standards	5	4-Hour ED Target; 62-Day Cancer Target; Waiting List Expansion (Respiratory); Access to Critical Bed for elective surgery; 18-week RTT
Compliance	4	Clinical correspondence; Blood traceability; Pharmacy standards; Regulatory Reform (Fire Safety) Order
Staff Safety	2	Interruptions to supply of PPE; Manual handling regulations
Demand Exceeds Capacity	2	Unable to meet demands of winter across health system; Endoscopy services
Critical IT System Failure	1	Telepath system outage
Unserviceable Clinical Estate	1	Inability to service backlog maintenance
Staff Engagement & Morale	1	
Equipment Replacement	1	CT Scanner Replacement
Total	34	

3.4 At face value these risks are not yet under prudent control in accordance with the Board's appetite for taking risk. A challenge has been made to each risk with the relevant risk owner and director. It is anticipated, following this challenge, that a full review will be undertaken by risk owners, in advance of presentation to the Risk Management Committee. This will: (i) help to validate

the degree of exposure; (ii) define more directly (in some cases) what is at risk; and (iii) apply greater emphasis to the description of risk treatment strategies so that the RMC and Board of Directors can better understand any gaps in internal control.

3.5 As there are no new significant risks to report, it was decided to enable the Board to have an understanding of the significant risks as they appear in the register on the understanding the Board have previously reviewed controls for these risks. This includes the most recent addition concerning supply, distribution and use of PPE during the Covid-19 response which was added to the register and reviewed in detail by the Board in May 2020. Changes are currently being made to risk records ahead of consideration by the Risk Management Committee in June 2020. Future reports will set out the details of how each significant risk is being mitigated.

4. Emergent Risk Horizon

4.1 In this section an attempt has been made to give an indication of potential future risk. This is an area where the Board has expressed a preference for further identification and analysis. An understanding of potential future risk is evolving, associated with a high degree of uncertainty during the unfolding Covid-19 response. However, it is possible to capture emergent risk for the purposes of promoting discussion, analysis and informing the Board strategic considerations. The Board are advised that the risks outlined in this initial horizon scan are not exhaustive and will require more detailed discussion, analysis and debate before the Board could be confident in the assessment. However, it is anticipated that as the emergent risk horizon develops, it may help the Board envision risk, consider potential strategic impacts and determine assurance requirements going forward.

Building The Risk Profile

External

Risks beyond the Trust's direct control, but may impact on delivery.

We adapt to these risks using contingencies or risk transfer strategies.

Anticipated future risks beyond direct control of the Trust.

There may be strategic benefit from taking risk in this arena.

Core External Risk

Emergent Risk Areas

Current

SFT

Future 1-5 Year Horizon

Core Operational Risk

Business Evolution Risk

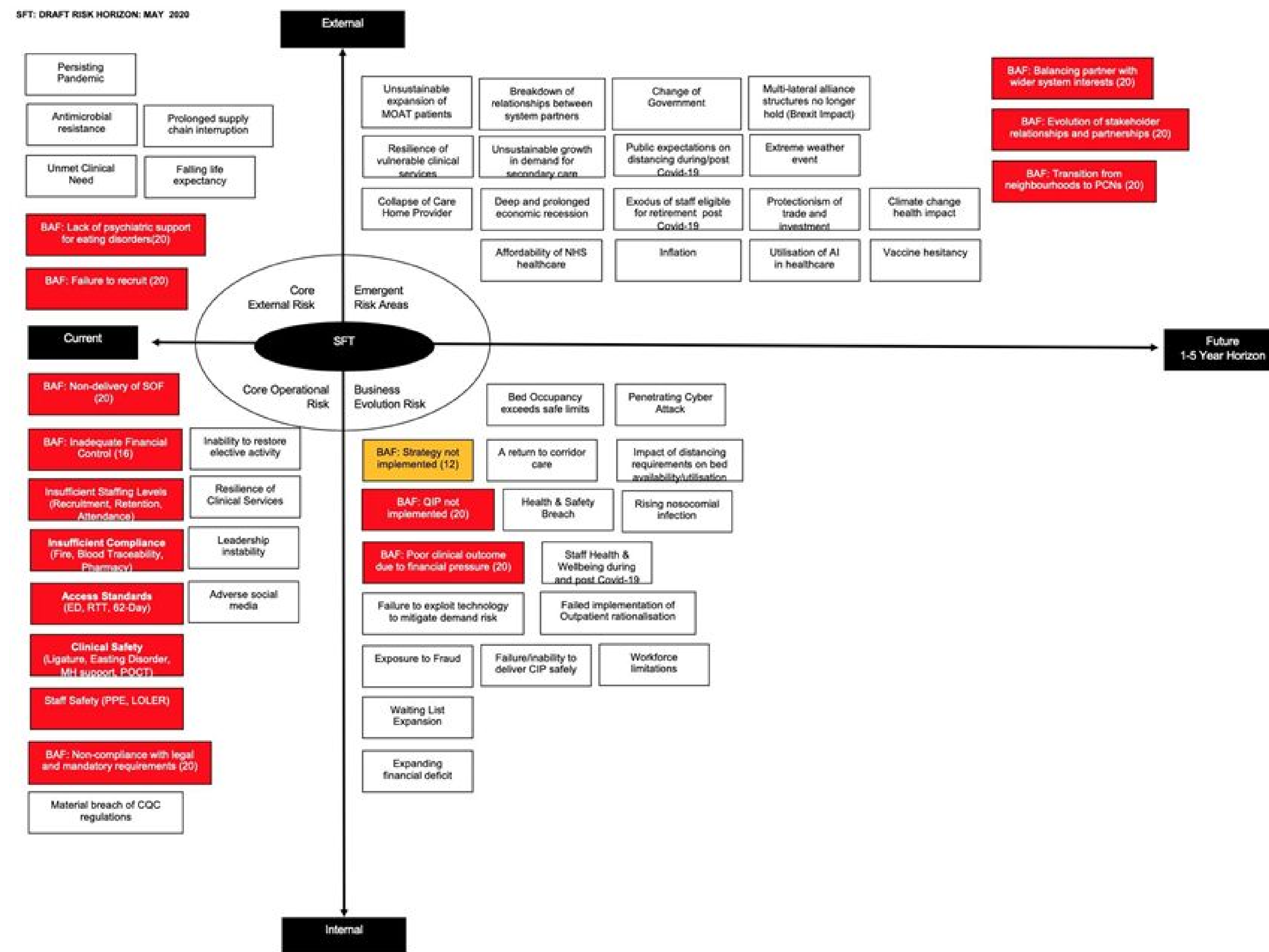
Day-to-day operational risk relating to safety, quality, compliance, patient experience, financial control.

There is no strategic benefit from being over-exposed to these risks.

Anticipated future risks, which are amenable to internal control.

There may be strategic benefit from taking risk in this arena.

Internal


SFT: DRAFT RISK HORIZON: MAY 2020
External
Persisting Pandemic
Antimicrobial resistance
Prolonged supply chain interruption
Unmet Clinical Need
Falling life expectancy
BAF: Lack of psychiatric support for eating disorders(20)
BAF: Failure to recruit (20)
Unsustainable expansion of MOAT patients
Breakdown of relationships between system partners
Change of Government
Multi-lateral alliance structures no longer hold (Brexit Impact)
Resilience of vulnerable clinical services
Unsustainable growth in demand for secondary care
Public expectations on distancing during/post Covid-19
Extreme weather event
Collapse of Care Home Provider
Deep and prolonged economic recession
Exodus of staff eligible for retirement post Covid-19
Protectionism of trade and investment
Climate change health impact
Affordability of NHS healthcare
Inflation
Utilisation of AI in healthcare
Vaccine hesitancy
BAF: Balancing partner with wider system interests (20)
BAF: Evolution of stakeholder relationships and partnerships (20)
BAF: Transition from neighbourhoods to PCNs (20)
Core External Risk
Emergent Risk Areas
Current
SFT
Future 1-5 Year Horizon
Core Operational Risk
Business Evolution Risk
BAF: Non-delivery of SOF (20)
BAF: Inadequate Financial Control (16)
Inability to restore elective activity
Insufficient Staffing Levels (Recruitment, Retention, Attendance)
Resilience of Clinical Services
Insufficient Compliance (Fire, Blood Traceability, Pharmacy)
Leadership instability
Access Standards (ED, RTT, 62-Day)
Adverse social media
Clinical Safety (Ligature, Easting Disorder, MH support, POCT)
Staff Safety (PPE, LOLER)
BAF: Non-compliance with legal and mandatory requirements (20)
Material breach of CQC regulations
Bed Occupancy exceeds safe limits
Penetrating Cyber Attack
BAF: Strategy not implemented (12)
A return to corridor care
Impact of distancing requirements on bed availability/utilisation
BAF: QIP not implemented (20)
Health & Safety Breach
Rising nosocomial infection
BAF: Poor clinical outcome due to financial pressure (20)
Staff Health & Wellbeing during and post Covid-19
Failure to exploit technology to mitigate demand risk
Failed implementation of Outpatient rationalisation
Exposure to Fraud
Failure/inability to deliver CIP safely
Workforce limitations
Waiting List Expansion
Expanding financial deficit
Internal

5. Recommendation

5.1 It is recommended that Board continue to allow further development of both the risk register and emergent risk horizon, both of which will be examined by the Risk Management Committee later in the month.

6. Action/Decision Required

6.1 The Board are invited to consider the report and:

(i) Note the aggregated significant risk exposures as outlined;
(ii) Note the initial thinking to develop an emergent risk horizon; and
(iii) Advise on any further actions required ahead of the Risk Management Committee meeting.

Interim Director of Governance & Risk Assurance
28/05/2020

Report to:	Board of Directors	**Date:**	5 June 2020
Subject:	Annual governance declarations		
Report of:	Director of Communications & Corporate Affairs	**Prepared by:**	Mrs C Parnell

REPORT FOR DECISION

<table>
<tr><td>Corporate objective ref:</td><td>N/A</td><td rowspan="4">Summary of Report

Each year the Board of Directors is required to make a number of governance declarations and retain copies of those declarationS should they be the subject of an audit by NHS England/NHS Improvement (NHSE/I).

Those declarations relate to the NHS Provider Licence:

• General Condition 6,
• Continuity of Services Condition 7,
• Corporate Governance statement FT4,

And governor training.

The Board of Directors is asked to make a series of statements indicating whether it considers the organisation to be compliant or non-compliant, with space on the templates for some narrative.</td></tr>
<tr><td>Board Assurance Framework ref:</td><td>N/A</td></tr>
<tr><td>CQC Registration Standards ref:</td><td>17</td></tr>
<tr><td>Equality Impact Assessment:</td><td>☐ Completed

X Not required</td></tr>
</table>

Attachments:	

<table>
<tr><td>This subject has previously been reported to:</td><td>☐ Board of Directors
☐ Council of Governors
☐ Audit Committee
☐ Executive Team
☐ Exec Management Group
☐ Quality Committee
☐ F&P Committee</td><td>☐ PP Committee
☐ Charitable Funds Committee
☐ Nominations Committee
☐ Remuneration Committee
☐ Joint Negotiating Council
☐ Other</td></tr>
</table>

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1. PURPOSE OF THE REPORT

Each year the Board of Directors is required to make a number of governance declarations, and retain copies of those declarations should they be the subject of an audit by NHS England/NHS Improvement (NHSE/I).

Those declarations relate to the NHS Provider Licence:

- General Condition 6,
- Continuity of Services Condition 7,
- Corporate Governance statement FT4,

and governors' training.

This report aims to assist the Board of Directors in deciding on a series of statements indicating whether it considers the organisation to be compliant or non-compliant, with space on the templates for some narrative.

2. DECLARATIONS

2.1 General Condition 6 – systems for compliance with licence conditions and related obligations

The Board of Directors is asked to consider whether it is compliant or non compliant with the following:

> "that in 2019-20 the Licensee took all such precautions as were necessary as to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

The nature of the declaration is both retrospective, in terms of arrangements in 2019-20, and prospective, in terms of continuation to meet the relevant criteria. The Boards of NHS Foundation Trusts are required to take all reasonable precautions against the risk of failure to comply with:

- the conditions of its licence,
- any requirements imposed on it under the NHS Acts, and
- the requirements to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

Those steps include:

- the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
- regular review of whether those processes and systems have been implemented, and of their effectiveness.

In considering compliance the Board of Directors should take into account the effectiveness of the Trust's risk management policy, risk registers and Board Assurance Framework as key components of the risk management system. It should note the outcome of the Head of Audit Opinion received at the Audit Committee held on 21 May 2020, which concluded that the organisation has "a good

system of internal controls designed to meeting the organisations objectives, which are generally being applied consistently."

The Board should also consider whether there have been, or there are planned to be, any changes to internal control arrangements that have the potential to impair the Trust's continuation of meeting the criteria for holding a licence.

During 2019-20 the Board of Directors recognised the need to improve the organisation's current governance and risk systems and process, and approached NHE/I to carry out a full governance review. It has also received feedback from a number of external reviews focusing on quality and safety. While these reviews are recommending areas for improvement it is expected that changes will enhance the ability of the organisation to continue to meet the conditions of its licence to operate as an NHS Foundation Trust.

2.2 Continuity of Services 7 – availability of resources

NHS Foundation Trust are required to act at all times in a manner calculated to secure that it has, or has access to, the required resources.

The self-certification for this declaration is a forward-look at the availability of resources or not, during 2020-21. The Board of Director must select one of the three options for certification as detailed below and provide a statement of the factors taken into account in making the relevant declaration.

The three statement options are:

(a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Or

(b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Or

(c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

In considering an appropriate declaration, Board members should note that 'Required Resources' are defined as follows:

- management resources,
- financial resources and facilities,
- personnel,
- physical and other assets

Factors to take into account as part of the self-certification include:

- the Trust's contract arrangements for 2020-21,
- the Going Concern assessment agreed by the Board,
- the External Auditor's report and opinion on both the financial statements and Going Concern,
- the likelihood of a requirement for external revenue funding during 2020-21,
- the implications of any planned or potential services changes in the context of resource availability to accommodate/service such changes,
- the likelihood of any unplanned changes emerging during financial year 2020 -21.

Due to the pandemic, the Trust's contract arrangements have rolled over from 2019-20. This position will continue to at least the end of June and is expected to be in place for a significant period of time as the NHS moves into a post-pandemic recovery phase.

The Board of Directors agreed its going concern assessment at its May 2020 meeting, but the external auditor's opinion has been delayed due to the pandemic and changes to the national timetable for the production of the annual report and accounts.

2.3 Corporate Governance Statement FT4

In considering responses to the various elements, the Board would usually consider the points set out in 2.1 in relation to risk assurance, as well as:

- External Audit reports on audit of the 2019- 20 Financial Statements and Annual Quality Report,
- Head of Internal Audit Opinion 2019-20,
- Compliance declarations in relation to the NHS Foundation Trust Code of Governance,
- Annual Governance Statement 2020-19.

Due to changes to the national timetable for the production of the annual report and accounts for 2019-20 the Audit Committee has not yet received the annual governance statement or external audit reports on the audit of financial statements. An external audit of the annual quality report is not required for 2019-20 due to the pandemic.

However, the Board of Directors did consider that it was compliant with all statements for 2018-19 (see appendix 2).

2.3 Training of governors

The Board of Directors is required to determine whether during 2019-20 it provided the necessary training to governors to ensure they are equipped with the knowledge and skills to undertake their roles.

In July 2019 the Council of Governor approved a new development and training programme, which included a revised induction programme and development opportunities built into the Council meetings. This was in addition to improvements to the Council agenda to ensure all governors received information about performance in relation to quality, safety, workforce and finance standards with which to hold the Board to account.

3. RECOMMENDATIONS

The Board of Directors is asked to:

- Determine whether it is compliant or non compliant with the statement set out in 2.1,
- Select one of the three statement options set out in 2.2,
- Determine whether it is compliant or non compliant with the statements set out in appendix 2 and the reasons on which it has based its decisions,
- Determine whether during 2019-20 it provided governors with the necessary training and skills to undertake their roles.

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

Self-Certification Template - Conditions G6 and CoS7

Stockport NHS Foundation Trust

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

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

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

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — Please Respond

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

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

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

7.1

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

Self-Certification Template - Condition FT4

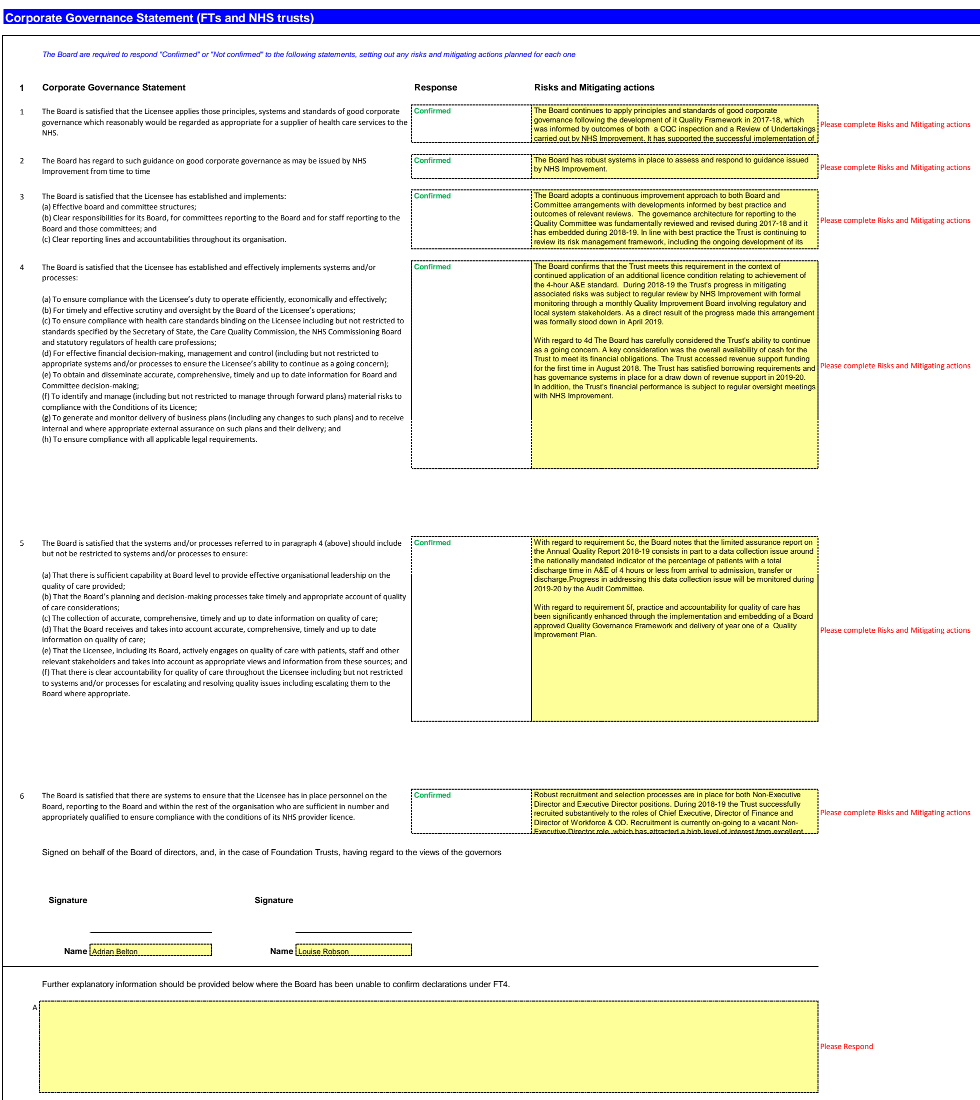
Stockport NHS Foundation Trust

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

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

These self-certifications are set out in this template.

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



Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

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

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board continues to apply principles and standards of good corporate governance following the development of it Quality Framework in 2017-18, which was informed by outcomes of both a CQC inspection and a Review of Undertakings carried out by NHS Improvement. It has supported the successful implementation of	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board has robust systems in place to assess and respond to guidance issued by NHS Improvement.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board adopts a continuous improvement approach to both Board and Committee arrangements with developments informed by best practice and outcomes of relevant reviews. The governance architecture for reporting to the Quality Committee was fundamentally reviewed and revised during 2017-18 and it has embedded during 2018-19. In line with best practice the Trust is continuing to review its risk management framework, including the ongoing development of its	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board confirms that the Trust meets this requirement in the context of continued application of an additional licence condition relating to achievement of the 4-hour A&E standard. During 2018-19 the Trust's progress in mitigating associated risks was subject to regular review by NHS Improvement with formal monitoring through a monthly Quality Improvement Board involving regulatory and local system stakeholders. As a direct result of the progress made this arrangement was formally stood down in April 2019. With regard to 4d The Board has carefully considered the Trust's ability to continue as a going concern. A key consideration was the overall availability of cash for the Trust to meet its financial obligations. The Trust accessed revenue support funding for the first time in August 2018. The Trust has satisfied borrowing requirements and has governance systems in place for a draw down of revenue support in 2019-20. In addition, the Trust's financial performance is subject to regular oversight meetings with NHS Improvement.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	With regard to requirement 5c, the Board notes that the limited assurance report on the Annual Quality Report 2018-19 consists in part to a data collection issue around the nationally mandated indicator of the percentage of patients with a total discharge time in A&E of 4 hours or less from arrival to admission, transfer or discharge.Progress in addressing this data collection issue will be monitored during 2019-20 by the Audit Committee. With regard to requirement 5f, practice and accountability for quality of care has been significantly enhanced through the implementation and embedding of a Board approved Quality Governance Framework and delivery of year one of a Quality Improvement Plan.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Robust recruitment and selection processes are in place for both Non-Executive Director and Executive Director positions. During 2018-19 the Trust successfully recruited substantively to the roles of Chief Executive, Director of Finance and Director of Workforce & OD. Recruitment is currently on-going to a vacant Non-Executive Director role, which has attracted a high level of interest from excellent	Please complete Risks and Mitigating actions

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

Signature		Signature	
Name	Adrian Belton	**Name**	Louise Robson

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

A

Please Respond

7.1

Worksheet "Training of governors"

Certification on training of governors (FTs only)

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

2 Training of Governors

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

Confirmed

OK

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

Signature		**Signature**	
Name	Adrian Belton	**Name**	Louise Robson
Capacity	Chair	**Capacity**	Chief Executive
Date	27 June 2019	**Date**	27 June 2019

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

A