Public Board meeting

Thu 01 August 2024, 09:30 - 13:00

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for Absence (Verbal)

09:30 - 09:30
0 min

2. Declaration of Interests (Verbal)

09:30 - 09:35
5 min

3. Patient Story (Verbal)

Information *Nicola Firth*

09:35 - 09:40
5 min

4. Minutes of Previous Meeting - held on 6 June 2024 (Paper)

Decision *Marisa Logan-Ward*

04 - Public Board Minutes - 6 June 2024.pdf (12 pages)

09:40 - 09:40
0 min

5. Action Log (Paper)

Information *Marisa Logan-Ward*

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

09:40 - 09:50
10 min

6. Chair's Report (Paper)

Discussion *Marisa Logan-Ward*

06 - Chairs Report - August 2024.pdf (5 pages)

09:50 - 10:00
10 min

7. Chief Executive's Report (Paper)

Discussion *John Graham*

07 - Chief Executive Report - August 2024.pdf (6 pages)

PLANNING

10:00 - 10:10
10 min

8. Final Operational Plan (Paper)

Discussion *Paul Buckley*

08 - Final Operational Plans 2024-25.pdf (6 pages)

10:10 - 10:10
0 min

9. Opening Budgets 2024/25 (Paper)

Decision *John Graham*

09 - Opening Budget 2024-25.pdf (7 pages)

PERFORMANCE

10:10 - 10:40
30 min

10. Integrated Performance Report (Paper)

Discussion *John Graham / Executive Directors*

- Quality
- Operational Performance
- Workforce
- Finance

10a - Integrated Performance Report - Front Sheet June 2024.pdf (2 pages)
10b - Integrated Performance Report - July 2024.pdf (19 pages)

10:40 - 10:50
10 min

11. Finance Report - Financial Position Month 3 (Paper)

Discussion *John Graham*

11a - Financial Position Report Month 3 2024-25 Front Sheet.pdf (3 pages)
11b - Financial Position Month 3 2024-25.pdf (14 pages)

STRATEGY

10:50 - 11:00
10 min

12. Digital Strategy Progress Report (Paper)

Discussion *Peter Nuttall*

12a - Digital Strategy Progress Report - Front Sheet.pdf (4 pages)
12b - Digital Strategy Progress Report.pdf (14 pages)

11:00 - 11:10
10 min

COMFORT BREAK

PEOPLE

11:10 - 11:20
10 min

13. People & Organisational Development Plan Progress Report (Paper)

Discussion *Amanda Bromley*

13 - People & Organisational Development Plan Progress Report.pdf (9 pages)

11:20 - 11:25
5 min

14. Wellbeing Guardian Report (Verbal)

Discussion *Marisa Logan-Ward*

11:25 - 11:35
10 min

15. Safer Care (Staffing) Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

- 15a - Safe Staffing Report - Front Sheet.pdf (2 pages)
- 15b - Safe Staffing Report.pdf (26 pages)

QUALITY

11:35 - 11:45
10 min

16. Annual Safeguarding Report (Paper)

Discussion *Nicola Firth*

- 16a - Annual Safeguarding Report 2023-24 Front Sheet.pdf (2 pages)
- 16b - Annual Safeguarding Report Summary.pdf (9 pages)
- 16c - Annual Safeguarding Report 2023-24.pdf (45 pages)

11:45 - 11:55
10 min

17. Annual Research, Innovation & Development Strategy Progress Report (Paper)

Discussion *Andrew Loughney*

- 17 - Joint Research Development & Innovation Annual Report 2023-24.pdf (43 pages)

11:55 - 12:05
10 min

18. Annual Learning from Deaths Report (Paper)

Discussion *Andrew Loughney*

- 18 - Annual Learning from Deaths Report 2023-24.pdf (7 pages)

GOVERNANCE

12:05 - 12:15
10 min

19. Risk Management Strategy and Policy (Paper)

Discussion *Nicola Firth*

- 19a - Risk Management Strategy & Policy - Front Sheet.pdf (2 pages)
- 19b - Risk Management Strategy and Policy - July 2024.pdf (25 pages)

12:15 - 12:25
10 min

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

Decision *John Graham*

- 20a - Opening-Q1 Board Assurance Framework 2024-25 - August 2024.pdf (8 pages)
- 20b - Appendix 1 - Board Assurance Framework 2024-2025.pdf (21 pages)
- 20c - Appendix 2 - Significant Risk Register - June 2024.pdf (2 pages)

STANDING COMMITTEE REPORTS

12:25 - 12:25
0 min

21. Board Committees - Key Issues Reports:

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

21.1. People Performance Committee (Paper)

Information *Beatrice Fraenkel*

21a - People Performance Committee Key Issues Report - July 2024.pdf (3 pages)

21.2. Finance & Performance Committee (Paper)

Information *Anthony Bell*

21b - Finance & Performance Committee Key Issues Report - June 2024.pdf (3 pages)
21c - Finance & Performance Committee Key Issues Report - July 2024.pdf (3 pages)

21.3. Quality Committee (Paper)

Information *Mary Moore*

21d - Quality Committee Key Issues Report.pdf (6 pages)

21.4. Audit Committee - including Annual Review 2023/24 (Paper)

Decision *David Hopewell*

21e.1 - Audit Committee Key Issues Report - July 2024.pdf (3 pages)
21e.2 - Appendix 1 - Audit Committee Annual Review 2023-24.pdf (18 pages)

CLOSING MATTERS

12:25 - 12:25
0 min

22. Any Other Business (Verbal)

12:25 - 12:25
0 min

23. Board Work Plan & Attendance - For information (Paper)

Information

23a - Board of Directors Annual Workplan 2024-25.pdf (4 pages)
23b - Board of Directors 2024-25 Attendance.pdf (1 pages)

DATE, TIME & VENUE OF NEXT MEETING

12:25 - 12:25
0 min

24. Thursday, 3 October 2024, 9.30am, Pinewood House Education Centre

12:25 - 12:25
0 min

25. Resolution:

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

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 6 June 2024, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

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

In attendance:

Mrs Rebecca McCarthy	Trust Secretary
Mr Paul Featherstone	Director of Estates & Facilities *(for Item 64/24)*
Ms Laura Swann	Sustainability Manager *(for Item 64/24)*
Ms Hannah Silcock	Assistant Director of Transformation *(for Item 71/24)*

Apologies:

Mr Anthony Bell	Non-Executive Director

** indicates a non-voting member*

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

Quorate: Yes

REF No/Yr.	ITEM	ACTION OWNER
53/24	**Apologies for Absence** The Interim Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
54/24	**Declarations of Interest** There were no declarations of interest.	
55/24	**Patient Story** The Board of Directors watched a video regarding the development of a Mental Health Passport in partnership with Pennine Care NHS Foundation Trust. **The Board of Directors received and noted the Patient Story.**	

56/24	**Minutes of Previous Meeting** The minutes of the previous meeting held on 4 April 2024 were agreed as a true and accurate record.	
57/24	**Action Log** The action log was reviewed and annotated accordingly.	
58/24	**Chair's Report** The Interim Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Board of Directors received an update on the following: - Operational and financial pressures - External partnerships - Trust activities - Strengthening Board oversight The Board of Directors remembered the contribution of the forces and acknowledged the Veteran's Passport in place at the Trust, which had been recognised nationally. In response to a question from Dr Samira Anane, Non-Executive, regarding communication of the Joint Chair appointment, the Chief Executive confirmed that staff and key stakeholders had received communication regarding the decision to appoint a Joint Chair. Dr Louise Sell, Non-Executive Director/Senior Independent Director, advised that the first Joint Nominations Committee for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust would be held on 10 June 2024 to consider the appointment process. **The Board of Directors received and noted the Chair's Report.**	
59/24	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: - Updated CQC Guidance for Well Led & CQC Cabinet Office Review - Consultation on the updated NHS England Oversight and Assessment Framework - GM System - Trust Operational Pressures - Success & Celebrations **The Board of Directors received and noted the Chief Executive's Report.**	
60/24	**Corporate Objectives: Review of Outcome Measures 2023/24** The Director of Strategy & Partnerships presented a report providing a year-end position against the Trust's Objectives and Outcome Measures for 2023/24, noting that the reports considered at meetings of the Board and its Committees were aligned with the corporate objectives and key outcome measures. In response to a comment from Dr Louise Sell, Non-Executive Director, regarding the subjectivity of Red/Amber/Green (RAG) ratings, the Chief Executive acknowledged the report narrative was key to determining	

	achievements of the objectives. The Interim Chair recognised the hard work and contribution of colleagues in delivering the majority of objectives, given the challenging operating environment. **The Board of Directors received and noted the Corporate Objectives: Review of Outcome Measures 2023/24.**	
61/24	**Corporate Objectives: Draft Outcome Measures 2024/25** The Director of Strategy & Partnerships presented the draft outcome measures aligned to the agreed Corporate Objectives 2024/25. In response to comments from Non-Executive Directors regarding the specificity of outcome measures, the Board of Directors acknowledged the potential to further develop and strengthen the outcome measures, and that this would also form part of the development of the refreshed Trust Strategy. **The Board of Directors received and noted the report and endorsed the draft outcome measures aligned to the Corporate Objectives for 2024/25.**	
62/24	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Operations** The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, No Criteria to Reside (NCTR), diagnostics, Referral to Treatment (RTT), outpatient efficiency, and theatre efficiency metrics due to under-achievement in month. The Board of Directors heard that performance against ED 4-hour and 12-hour metrics showed some signs of improvement, albeit performance was still outside the target thresholds. The Director of Operations advised that the Trust would receive support from the Emergency Care Improvement Support Team (ECIST), with action plans in development to support the new national 4-hour ED target of 78% by March 2025. The Director of Operations advised that the diagnostic position continued to be challenged due to the loss of independent MR capacity. The Board of Directors heard that significant improvements had been made to the Trust's RTT position in 52, 65, and 78-week waits. It was noted that the Trust was performing well against trajectory plan to have zero 65+ week waits by September 2024. The Director of Operations reported positive performance against all cancer metrics in month, highlighting a continued improvement to the 28-day faster diagnosis performance. The Director of Operations commended all teams for the levels of activity delivered, particularly considering the closure of Outpatients B and	

disruptions to theatres from the Emergency & Urgent Care Campus building works. The Board of Directors thanked colleagues for maximising all opportunities to treat patients, whilst recognising the suboptimal conditions for staff and patients.

In response to a question from Mrs Mary Moore, Non-Executive Director, regarding action taken to support patients whose appointments cancelled due to the disruptions to theatres, the Director of Operations confirmed that approximately 20% patients had taken up the opportunity for mutual aid offered, with other patients rebooked. She advised that the Get if Right First Time (GIRFT) team were supporting the Trust with a view to improving the take up of mutual aid. In response to a question from Dr Samira Anane, Non-Executive Director, querying barriers to accessing mutual aid, the Director of Operations advised that a transport offer had been in place since Covid, and this continued to be offered to patients. She commented that one of the reasons patients did not take up the offer of mutual aid is due was patients choosing to stay with a specific clinician. The Chief Executive briefed the Board of Directors on an improved GM approach to mutual aid, which would commence at the beginning of the patient pathway.

Quality
The Chief Nurse and Medical Director presented the quality section of the IPR and highlighted challenges and mitigating actions regarding sepsis, infection prevention & control, incidents, pressure ulcers, complaints and maternity due to under-achievement in month.

The Board of Directors noted positive performance against SHMI and HSMR mortality rates. The Medical Director advised that the Trust continued to perform well against the timely recognition of sepsis metric, however antibiotic administration within the necessary timescales continued to be challenging. Mrs Mary Moore, Non-Executive Director, commented that the Quality Committee would remain abreast of the potential impact of new NICE guidance for sepsis. In response to a question from the Interim Chair querying how the Trust was addressing the issues around timely administration of antibiotics, the Medical Director acknowledged progress had been stubborn, with improvement opportunities being explored through engagement with AQuA, including opportunity for benchmarking.

The Chief Nurse reported increased infection rates for C.diff, noting that new internal targets for reducing infection rates had been set for 2024/25. The Board of Directors noted an increased trend for written complaints and patient safety incidents, including mitigating actions.

People
The Director of People & Organisational Development (OD) presented the people section of the IPR and advised that exception reports related to performance against appraisal rates only, with other people related metrics performing within target thresholds. She briefed the Board of Directors on mitigating actions, including a deep dive and a launch of a new toolkit to support appraisals.

Finance
The Chief Finance Officer presented the finance section of the IPR, noting that more detailed financial information was provided under a separate

	agenda item. **The Board of Directors received and noted the Integrated Performance Report.**	
63/24	**Finance Report** The Chief Finance Officer presented a report providing an update on year-end 2023/24 financial position and financial performance for Month 1 2024/25. The Board heard that the Trust had delivered the planned deficit of £32.2m in 2023/24, pending external audit approval. The Interim Chair commended achievement of the financial plan, albeit recognising the significant deficit. The Chief Finance Officer advised that the Trust has a planned system deficit of £46.1m in 2024/25, pending final approval by the Greater Manchester Integrated Care Board (GM ICB). The Chief Finance Officer reported that, subject to known risks as agreed within the GM ICB, the Trust was forecasting to: - deliver its financial plan for 2024/25 - deliver its capital plan for 2024/25 - deliver its savings plan for 2024/25 - require further cash borrowing, which is subject to national approval. The Board of Directors heard that that the Trust had strengthened its financial governance with a series of grip and control actions to support delivery of the financial plan for 2023/24, including review of all vacancies, focused action on reduction in agency costs and reconciliation of budgeted posts, and that this would continue in 2024/25. In response to a question from Mr David Hopewell, Non-Executive Director, the Chief Finance Officer confirmed that the deadline for the next plan submission was 12 June 2024 and highlighted significant challenges around the capital programme. **The Board of Directors received and noted the Finance Report.**	
64/24	**Green Plan Annual Report 2023/24** The Sustainability Manager presented a report providing an update on progress made against the Green Plan, including current challenges and future opportunities. She highlighted plans to establish a joint Green Plan Group for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust, and a joint Green Plan from January 2025. In response to a question from Dr Louise Sell, Non-Executive Director, about future reporting of projects, including significant building projects, the Sustainability Manager confirmed intention to develop reporting going forward, with focus on monitoring the impact of areas that were within the Trust's gift to control and those that were more difficult to control. In response to a question from Dr Louise Sell, Non-Executive Director, querying links with groups in the community, the Sustainability Manager noted	

	the importance of linking in with the local community, including community groups, noting she had previous experience of this working with the Local Authority. Mrs Beatrice Fraenkel, Non-Executive Director, reflected on the link between the Green Plan, design of clinical environment, procurement opportunities and the transport approach across the GM, noting the importance of all areas in the delivery of future healthcare. In response to a question from Mrs Mary Moore, Non-Executive Director, the Sustainability Manager briefed the Board of Directors on plans in relation to the Greater Manchester (GM) Combined Authority energy obligation requirements. The Chief Nurse recognised a link between the Green Plan and the Health & Wellbeing Strategy and suggested that it would be helpful for future reports to provide further detail on the utilisation of the increased bicycle spaces across the Trust site. The Director of People & Organisational Development (OD) reaffirmed the overlap between the Green Plan and the Health & Wellbeing Strategy, noting current work regarding green spaces on site. Furthermore, she highlighted the importance of raising awareness of the green agenda through the Trust's communication channels. The Interim Chair noted the need for further clarity to determine if a Non-Executive Director lead was required for the Green Group. **The Board of Directors received and noted the Green Plan Annual Report 2023/24**	
65/24	**Workforce Equality, Diversion & Inclusion (EDI) Strategy Report** The Director of People & OD presented a report providing progress against each of the targets set out within the EDI Strategy relating to workforce, culture, assurance and compliance and health inequalities. The Director of People & OD confirmed all statutory reporting had been completed for 2023/24, including submission of data relating to the annual Workforce Race Equality Standard (WRES) Report, annual Workforce Disability Equality Standard (WDES) Report, the annual Gender Pay Gap Report and the NHS National Staff Survey Results Report. In response to a question from Dr Louise Sell, Non-Executive Director, seeking further information and progress with the reverse mentoring scheme, the Director of People & OD recognised that further work was required to encourage colleagues to take part in the scheme, noting that staff networks could also be used to promote this. Dr Louise Sell, Non-Executive Director, suggested that it might be helpful to have films introducing Board members and Mrs Beatrice Fraenkel, Non-Executive Director, stressed the need for prospective reverse mentors to understand the role and expectations. Noting the 3 year EDI Strategy ran until 2025, the Director of Strategy & Partnerships noted opportunity to work jointly with Tameside & Glossop Integrated Care NHS Foundation Trust on the next iteration. In response to a question from the Interim Chair about capturing feedback	

	from agency staff, the Director of People & OD advised that avenues for communicating feedback were outlined as part of induction. **The Board of Directors received the Workforce Equality, Diversion & Inclusion (EDI) Strategy Report and noted progress of the Trust's EDI Strategy 2022-25 and associated consolidated action plan.**	
66/24	**Freedom to Speak Up Report** The Director of People & OD presented a report providing an overview of the Freedom to Speak Up Guardian's activities since the previous report. She briefed the Board on the content of the report and provided an update on: • Freedom to Speak Up role activities • National Guardian Office guidance and webinars • Contact with Guardians • Staff Survey results • Case contacts • Update on open cases • Themes and trends • Community resolution • Addressing perceived racial elements • Cultural awareness and understanding • Addressing inappropriate behaviour • Clarity of reporting systems and understanding differences • Routes to speaking up • Capacity The Board of Directors heard that there had been an increasing trend in Freedom to Speak Up (FTSU) contacts in Quarter 4 2023/24, reflecting an increased awareness and willingness among staff to raise concerns. The Board acknowledged themes and trends observed, including perceived detriment and barriers to speaking up, highlighting the need for clear guidelines and fostering a culture of accountability and transparency. Noting the increasing trend in contacts, Dr Samira Anane, Non-Executive Director, sought further information regarding this. The Director of People & OD provided further contextual information regarding, noting that the increase, in part, came from colleagues contacting the FTSU Guardian tended when they had not received a satisfactory response from management or were unsure who else to contact regarding certain matters. Mrs Mary Moore, Non-Executive Director, commented that FTSU had been one of the recommendations arising from the Francis Report regarding patient safety, but noted that there seemed to have been a shift, with more behavioural issues highlighted. The Director of People & OD and Chief Nurse acknowledged this comment and the shift in the role, however welcomed the balanced approach of the FTSU Guardian, which encouraged people to come forward. In response to a question from the Director of Strategy & Partnerships regarding FTSU capacity, the Director of People & OD stated that the FTSU Guardian worked across the two Trusts, responding to workload in a flexible manner. She commented that work was ongoing to identify more FTSU champions to assist the guardian in her role. Mrs Beatrice Fraenkel, Non-Executive Director, noted that she was in regular contact with the FTSU	

	Guardian, in her role as the Non-Executive Lead in this area, and welcomed the efforts of the FTSU Guardian in raising the profile of FTSU across the organisation. **The Board of Directors received and noted the Freedom to Speak Up Report.**	
67/24	**Safe Care (Staffing) Report** The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Board of Directors acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Board heard that robust staffing has been implement ensuring that the Trust is safely staffed and able to provide high quality patient care throughout the industrial action. **The Board received and noted the Safe Care (Staffing) Report.**	
68/24	**CQC Maternity Services Inspection Report** The Chief Nurse presented the inspection report from the CQC announced inspection of maternity services covering the domains of safe and well led as part of the national maternity inspection programme. She confirmed the report published on 10 May 2024 rated the service as 'requires improvement' in both safe and effective, meaning that rating remained unchanged. The Chief Nurse confirmed the report included 3 'must do' actions, and 4 'should do' actions and presented an action plan in response to these recommendations, which was to be submitted to the CQC by no later than 7 June 2024. The Board of Directors heard that the report and action plan had also been considered by the Quality Committee. In response to a question from the Interim Chair regarding the potential changes taking place at the CQC, the Chief Nurse noted that previous outcome inspections were unlikely to change irrespective of any changes at CQC. She advised, however, that the Trust had fed back to the CQC regarding the process, particularly with respect to challenges associated with the final report. **The Board of Directors:** • **Received the Maternity Services CQC Inspection Report published in May 2024, following inspection in September 2023.** • **Received assurance in relation to the action plan created following receipt of the report.**	

	• **As recommended by Quality Committee, approved the action plan to be submitted to the CQC by 7 June 2024.**	
69/24	**Annual Quality Strategy Report 2023/24 and Objectives 2024/25** The Chief Nurse presented a year end update against the Trust Quality Strategy (2021-2024). She confirmed the RAG score applied reflected progress since the implementation of the Quality Strategy in 2021 to end of 2023/24, with most objectives rated as 'green'. In addition, the Chief Nurse presented the objective measures for 2024/25, recognising that specific metrics had been included for certain objectives, with programmes of work highlighted for others. It was noted that the next iteration of the Quality Strategy would be developed through the Quality Committee. **The Board of Directors reviewed the progress made to date against the Quality Strategy 2021 – 2024 and noted the Objective Measures set for 2024/25.**	
70/24	**Annual Health & Safety Report 2023/24** The Chief Nurse presented a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within the Trust during 2023/24. She confirmed the data within the annual report brought together data reported to the Quality Committee throughout the year. In response to a question from the Interim Chair querying whether staff side representation was still a requirement at the Health & Safety Joint Consultative Group and if this had improved, the Chief Nurse confirmed that this remained an expectation, albeit noting challenges in this area regarding capacity. **The Board of Directors received and confirmed the Annual Health & Safety Report, which has been reviewed and recommended by Quality Committee, in line with key issues reported to Quality Committee throughout 2023/24.**	
71/24	**Transformation Annual Report 2023/24** The Assistant Director of Transformation presented a report providing an update on service transformation programmes across this Trust and Tameside & Glossop Integrated Care NHS Foundation Trust to facilitate joint learning opportunities. She highlighted a number of service transformation initiatives that had led to, or were leading to, improvements whilst continuing to build and nurture a culture of continuous improvement. It was noted several of these have also contributed to supporting wider organisational effectiveness that is often difficult to capture. The Board of Directors heard that service transformation programmes were monitored through a monthly Service Improvement Group chaired by the Chief Executive. In response to questions from Non-Executive Directors regarding measurement of the impact of the schemes, the Assistant Director of Transformation confirmed that key performance indicators and outcome measures were considered through the monthly Service Improvement Group, noting that further work was required to strengthen the financial elements and	

	ensure alignment with system and national metrics. The Chief Executive stated that schemes were prioritised to support the Trust Strategy and Corporate Objectives, with further information to be incorporated in future iterations of the report. In response to a question from the Interim Chair regarding aligned communications, the Assistant Director of Transformation confirmed that the Transformation Team worked with the Communications Team to ensure joined up and effective communications. **The Board of Directors are asked to reviewed and confirmed the Transformation Annual Report 2023/24.**	
72/24	**Annual Self Certification: Continuity of Services 7 – Availability of Resources** The Board considered the self-certification declaration for Licence Condition 'Continuity of Services 7 – Availability of Resources'. The Trust Secretary advised that the requirement for self-certification, previously in relation to the General Condition 6 and Corporate Governance Statement FT4 of the licence, had been removed from the new licence to reduce duplication with other reporting mechanisms, such as the NHS Oversight Framework, Annual Report and Annual Governance Statement. She noted, however, that with respect to the 'Continuity of Services 7 – Availability of Resources' the self-certification requirement remained in place and was to be approved by a resolution of the Board of Directors. **The Board of Directors approved the self-certification and declaration for Licence Condition – Continuity of Services 7: Availability of Resources, as reviewed and recommended by Audit Committee as follows:** *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 have access to the required resources:* - *Risk associated with planning guidance assumption on prescribed activity growth levels, noting the Trust's continued growth position particularly in Emergency Care.* - *Potential risk to income should elective activity projections not be achieved across the GM system and within the Trust, following on from industrial action disruptions seen in the previous year as well as risk on the condition of the Trust's estate.* - *Lack of capital availability across the ICS in order to deliver a balanced capital plan and where the risk to disruption to service is high given the condition of the estate and the level of backlog*	

	maintenance required. - *Uncertainty around financing arrangements within the GM system for 2024/25 and the mechanisms for cash support for capital schemes.* - *The implications on revenue on the shortage of capital funding for 2024/25 given the age and condition of the estate.*	
73/24	**Going Concern Declaration** The Board of Directors considered a report asking the Board to approve the recommendation from Audit Committee, and support the declaration that, in accordance with International Accounting Standard 1 and the NHS Foundation Trust Annual Reporting Manual (ARM) 2023/24, the Directors of the Trust have a reasonable expectation of the continued provision of Stockport NHS Foundation Trust's services and, for this reason, the Directors should continue to adopt the going concern basis in preparing the accounts for 2023/24. **The Board of Directors approved the declaration that the Trust continued to adopt the going concern basis in the preparation of the accounts.**	
74/24	**Board Committees – Key Issues Reports** **People Performance Committee** The Acting Chair of People Performance Committee (Mrs Mary Moore, Non-Executive Director) presented the key issues report from the People Performance Committee meeting held on 9 May 2024. She briefed the Board on the content of the report and detailed key people related issues considered. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues report from the Finance & Performance Committee meeting held on 16 May 2024. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Chair of Quality Committee (Mrs Mary Moore, Non-Executive Director) presented the key issues report from the Quality Committee meetings held on 23 April 2024 and 28 May 2024. She briefed the Board on the content of the report and detailed key quality related issues considered. **The Board of Directors reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.** **Audit Committee**	

	The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the key issues report from the Audit Committee meeting held on 21 May 2024. He briefed the Board on the content of the report and detailed key issues considered, and confirmed the name change of the Trust's External Auditors to Forvis Mazars. **The Board of Directors reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.**	
75/24	**Board Work Plan & Attendance** The Board of Directors noted the Board Work Plan and Attendance for 2024/25.	
76/24	**Date and Time of Next Meeting** Thursday, 1 August 2024, 9.30am, Pinewood House Education Centre.	
77/24	**Resolution** *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
				No open actions.		

On agenda
Not due
Overdue
Closed

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

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	6
Meeting	Board of Directors				
Report Title	Chair's Report				
Presented by	Dr Marisa Logan-Ward, Interim Chair	**Author**	Dr Marisa Logan-Ward, Interim Chair		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

1. Purpose of the Report

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

2. Operational and Financial Pressures

Since my last report operational pressures persist across the Trust and this has been exacerbated by further deterioration of the estate on the hospital site. Poor condition of the estate now regularly impacts our services and has an adverse effect on patient and staff experience. Together with system partners, GM ICB and healthcare leaders are working through options to address the immediate and long-term future of our Trust estate.

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

The NHS in Greater Manchester has significant financial and operational challenges. GM ICS is now working more closely with NHS England to deliver a set of formalised agreed actions under one single improvement plan (the 'Enforcements Undertakings').

Despite the challenges, the Trust is starting to see significant progress in addressing long waits for treatment. With 78 weeks almost eliminated the focus is now 65 week wait.

Thank you to all our colleagues and partner organisations who work hard to maintain the quality of our services and enhance patient, carer, and staff experience.

3. External Partnerships

I attended the Stockport Social Value Roundtable – a multi-agency networking event bringing together senior officers from across the borough to explore opportunities to increased Social Value.

I met with Michael Cullen, the newly appointed Chief Executive of Stockport Council, where we discussed some of the key issue facing health & care across the borough. We reflected on the impact of partnership working at place on hospital discharge and community support, progress made on the health prevention agenda and continued focus on delivering the One Stockport Plan.

4. Trust Activities

As part of the financial turnaround programme of NHS Greater Manchester ICB, supported by PwC, I have attended the Financial Plan Support meeting for Trust Chairs.

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

4. Governors

I attended another excellent Members Event which was well attended by members, governors and the public. This month the topic was 'Ageing Well' with presentations from the Transformation Team and colleagues from KOKU Health Ltd: a spinout from The University of Manchester established to deploy a digital health app for falls prevention and health literacy to older adults.

Council of Governors changes

The following governors have recently confirmed their intention to step down from the Council of Governors:

- Thomas Lowe, Public Governor, High Peak & Dales
- Janet Browning, Public Governor, High Peak & Dales
- Gillian Roberts, Public Governor, Tame Valley & Werneth

On behalf of the Council of Governors and the Board of Directors, I would like to thank them for their contribution to the work of the Council of Governors and wish them the very best for the future.

The vacancies will be picked up as part of the forthcoming governor elections to be held this summer/autumn.

5. Strengthening Board Oversight

Our board development session in July focussed upon the Independent Review into the failings in care and treatment provided to patients at Greater Manchester Mental Health NHS FT (GMMH). We were by Professor Oliver Shandley OBE, who led the review[1], and worked through the findings and recommendations in the context of Stockport NHS FT.

The board also received an update on the implementation of the CQC's new Single Assessment Framework.

6. Other activities

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

- Chaired Consultant Interview panels (Obstetrics & Gynaecology, Radiology (Urology & Musculo-skeletal), Gastroenterologist, Anaesthesia/ICU.
- Informal meetings with Joint Chair: Dorset Healthcare and Dorset County Hospital, and Joint Chair of North Bristol and University Hospital Bristol & Weston.
- Regular discussions with Non-Executive Directors, Executive Directors, Chief Executive, and the Deputy Chief Executive, Chair of Tameside & Glossop NHS FT.
- Meetings with:

[1] Independent Review into Greater Manchester Mental Health NHS FT (2024). *NHS England*.

    - Stockport Locality Chairs
    - GM Trust Chairs
    - Lead Governor
- Board sub-committee member: Charitable Funds.
- Chair - Council of Governors meeting (formal and informal meetings).

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	7
Meeting	Board of Directors				
Report Title	Chief Executive's Report				
Presented by	Karen James, Chief Executive	Author	Rebecca McCarthy, Company Secretary Helen O'Brien, Head of Communications		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	2.1 – 2.2
Sustainability (including environmental impacts)	N/A

Executive Summary

The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments including:

- Outcome of General Election
- Shaping Better Services for Children and Young People'
- Cyber Security
- Covid-19 Inquiry
- Greater Manchester System
- Trust Operational Pressures
- Industrial action by junior doctors
- Estates Issues
- Success & Celebrations

1. Purpose of the Report

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

2. National

2.1 Outcome of General Election

Following conclusion of the General Election at the beginning of July, Sir Keir Starmer announced his cabinet and ministerial appointments. Wes Streeting, Member of Parliament (MP), has been appointed as the new Secretary of State for Health and Social Care, along with two other members who have previously held shadow positions - Karin Smith was appointed as Minister of Health (Secondary Care) and Andrew Gwynne as Parliamentary Under Secretary of State for Public Health and Prevention.

Mr Streeting has announced plans for an independent investigation into NHS performance in England, with Professor Lord Darzi, an NHS surgeon and former health minister, appointed by the new government to lead the investigation. Lord Darzi will lead a rapid assessment of the issues facing the NHS. The audit will provide a starting point for the development of a 10-year plan for health which will be led by Sally Warren, former Director of Policy at the Kings Fund, with support from teams at the Department of Health & Social Care and NHS England.

2.2 'Forgotten Generation: Shaping Better Services for Children and Young People'

NHS Providers have recently published their report 'Forgotten Generation: Shaping Better Services for Children and Young People', informed by a survey of NHS Trusts. The report highlights the challenges faced by children and young people in accessing timely care, with nearly all respondents reporting that demand for children and young people's services has increased since the Covid-19 pandemic. The report highlights the top three policy changes respondents would like to see national government make to support improvements in services: -

- Increasing investment in prevention and early intervention.
- Accepting a cross-government approach to improve the health and wellbeing of children and young people.
- Increasing investment in targeted early years support.

2.3 Cyber Security

Following the cyber-attack on the pathology system in South East London, strategic discussions are taking place with the ICB Chief Executives around ensuring cyber security and resilience in NHS systems in the face of global threats.

2.4 Covid-19 Inquiry

The first publication of the recommendations by the Covid-19 Inquiry, covering the 'resilience and preparedness' (Module 1) of the government for the pandemic will be released at the end of July. Work will take place to examine the recommendations for future action.

3. Greater Manchester

Following discussion with Greater Manchester (GM) system leaders and NHS England, GM NHS resubmitted its Operational Plan for 2024/25, covering activity, finance and workforce, to NHS England (NHSE) within the required timeframe.

NHS England (NHSE) have now published the Enforcement Undertakings that set out the improvements required by the GM Integrated Care Board (GM ICB), which cover four themes; Leadership and Governance; Quality; Financial Sustainability; Performance and Assurance. The Enforcement Undertakings were presented to the GM ICB on 17th July. Alongside this, a Single Improvement Plan has been developed by the ICB that will set out the planned improvements.

The GM ICB are to launch a public engagement exercise under the umbrella title 'An NHS Fit for the Future', which will run until autumn. This programme will engage with the public with a focus on the work to improve population health, performance and finances; to understand what the public feel is important and areas of priority, and to increase awareness and understanding of the challenges we face.

4. Trust

4.1 Operational Pressures

Pressures in our urgent and emergency care services remain steady, and we continue to see high numbers of patients attending our Emergency Department. This year we have seen an average of 305 attends per day, which is above our ambition of 270 per day. Such high numbers do have an impact on our performance, which is currently below national access standards and trajectories for non-elective care.

We continue to work closely with our partner organisations to support patient flow and help us achieve our goals around timely discharge. In June, alongside Age UK, Mastercall, Stockport Metropolitan Borough Council, and Stockport Locality Integrated Care Board (ICB) colleagues, our Health & Social Care Collaborative event highlighted the vast array of services that can support hospital flow and deliver excellent patient centred care in the community.

We have started to see significant progress in our long waits for treatment, with just nine people waiting for treatment longer than 78 weeks in June and plans to eliminate this altogether. We are now focusing on those patients waiting >65 weeks and again have already started to see a significant drop in numbers.

4.2 Industrial action by junior doctors

Our junior doctors took part in national planned industrial action, 27th June – 2nd July. This was a dispute between union members and the government. As ever, whilst we support our staff's right to strike, our focus remained on patient safety during this time.

4.3 Estates Issues

Our ageing estate, particularly on the hospital site, continues to impact on our services, patients and staff. Over recent months we have experienced several challenging estates incidents, and we are likely to experience more business

continuity issues as the result of our ageing buildings. As previously reported to the Board of Directors, whilst we still have ambitions to build a new hospital for the people of Stockport and continue to evaluate medium-term solutions, we also must be realistic about the amount of capital funding that is likely to be available in 2024/25 to maintain the current hospital buildings, and are undertaking a wholistic review of the current estate and the associated increasing risks which will be presented to the Board of Directors in due course.

In more positive news however, we recently opened the new staff facilities as part of our Emergency and Urgent Care campus. The facilities provide bigger workspaces, new rest areas, lockers, showers and changing facilities. This takes us one step closer to the completion of our £30m facility.

We have also now completed the demolition of our Outpatient B building and broken ground on a new patient facility at the other side of our campus, with work continuing to re-establish outpatient services across our hospital site.

4.4 Successes & Celebrations

4.4.1 **Safety First: Trust shortlisted five times in the HSJ Patient Safety Awards**
The Trust has been shortlisted five times in the Health Service Journal Patient Safety Awards, each one for a different project to enhance safety.

The paediatrics team have been shortlisted in the 'Patient Safety Education and Training' category for their project to improve staff skill and confidence when caring for children and young people experiencing a mental health crisis.

The surgical theatre team are finalists for the 'Patient Safety in Elective Recovery' award, for their scheme to improve theatre productivity, and ensure patients have timely access to surgery.

The urology team are also finalists in the 'Patient Safety in Elective Recovery Patient Safety in Elective Recovery Award' category, for their project of ensuring faster outpatient appointments for patients by working with colleagues in primary care.

The endoscopy team have been shortlisted in the 'Quality Improvement Initiative of the Year' category for their various measures to improve efficiency, productivity and patient experience while reducing their backlog of procedures.

And finally, the Trust's people directorate has been shortlisted for the 'Staff Health and Wellbeing Initiative of the Year' award for their joint venture between the occupational health department, and our gynaecology services to provide more support for colleagues who are experiencing the menopause.

These initiatives showcase the innovative action taking place across our many different services to ensure the best possible standards of patient safety. The winners of the awards will be announced at a ceremony in Manchester on 16th September 2024.

4.4.2 **New fluoroscopy equipment providing enhanced scanning for patients at Stepping Hill Hospital**

New fluoroscopy equipment is now in use at Stepping Hill Hospital's radiography department, using the latest technology to provide improved and more accurate image quality. Digital imaging requires less maintenance and reduces the time taken for examination, making the process easier for both staff and patients. It also minimises the dosage of x-ray radiation the patient is exposed to during these examinations, meaning the procedure is now safer too.

4.4.3 **Greener Communities Fund Award**

Stockport NHS Charity is one of eight charities across the UK to be awarded a Greener Communities Fund grant to create and enhance green spaces and improve access to nature for its staff and patients.

The charity will use the £68,000 grant to fund a new Acute Frailty Unit Therapy Garden at Stepping Hill Hospital. The project will see the transformation of a neglected courtyard area into a tranquil relaxing garden space where patients with long-term health conditions, dementia or mobility issues can engage in structured outdoor activities to aid their physical and mental recovery.

4.4.4 **Learning Disability Awareness Week (17th June – 23rd June)**

We were proud to celebrate Learning Disability Week in June, highlighted by a very special performance by the Vivo Makaton Choir in our restaurant as part of the celebrations and awareness drive.

During the week, the Trust's Safeguarding and Patient Experience Teams highlighted the support they offer for people with learning disabilities and demonstrated the ambition to transform the delivery of healthcare through further working with partner agencies to develop and strengthen wider system working to ensure that all patients, regardless of their individual needs and circumstances, can access the care they require.

4.4.5 **Armed Forces Week (24th June – 29th June)**

Armed Forces Week and Reserves Day gave us the opportunity to celebrate the support we give to both our reservist and veteran staff. Extra days leave in place for training, and supportive HR policies in place, as well for as the spouses and partners of those serving in the Armed Forces.

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	8
Meeting	Board of Directors				
Report Title	Operational Plan 2024-25				
Director Lead	Paul Buckley, Director of Strategy & Partnerships	**Author**	Andy Bailey, Deputy Director of Strategy & Partnerships		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note the final Operational Plans submitted to Greater Manchester Integrated Care Board.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
x	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
x	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan

Where issues are addressed in the paper

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

Executive Summary

The attached paper provides an overview of the Trust's final Operational Plans for 2024/25, submitted by the Trust to Greater Manchester (GM) Integrated Care Board (ICB) in June 2024.

National planning guidance set a range of performance standards:

- 78% performance against 4hr Accident and Emergency (A&E) standard
- 70% performance against the 62-day cancer standard
- 77% performance against the 28-day Faster Diagnosis Standard (FDS)
- 95% of diagnostics within 6 weeks of referral
- Elimination of 65 week waits by September 2024
- Increased elective activity on 2023/24 – 103% value-weighted activity compared to 2019/20
- Reduce staff absences and improve retention
- Reduction in agency spend
- Delivery of a balanced net financial position.

As previously reported to the Board through draft iterations, the Trust's plans are based on work with Divisions to determine activity, workforce and finance plans, including detailed efficiency and cost improvement schemes. Executive Team reviewed detailed elements of the draft plan, setting targets for performance standards.

The final plan assumes a £43.8m deficit. This includes a range of financial pressures highlighted by Divisions and approved by the Executive Team.

Risks to delivery include:

- Sustained growth in A&E attendances and non-elective admissions
- Significant growth in 2-week-wait cancer referrals
- Change in elective case mix to day-case may impact cost-weighted activity and ERF funding
- Potential impact of Industrial Action
- Ability to live within a £18.5m capital expenditure limit (CDEL)
- Ability to achieve a cost improvement plan (CIP) of 5%.

The Trust's performance against the plan will be reported monthly to Board through integrated performance reports.

Operational Plans 2024-25

1. National Planning Guidance

National planning guidance for 2024/25 was published on the 27th March 2024. For the most part, the guidance reflects the ongoing delivery of the NHS Long Term Plan, with a focus on the following areas:

	**Workforce**	• Reduction in whole time equivalent (WTE) and no unplanned growth. • Reduce agency staffing (3.2%) and improve sickness absence.
	**Urgent Care**	• Improve performance against the A&E 4hr target to 78%.
	**Electives**	• Increase elective activity beyond 23/24 and reduce 65 week waits to 0.
	**Diagnostics**	• Increase access and improve 6 week waits
	**Cancer**	• 70% performance against the 62-day cancer standard • 77% performance against the 28-day Faster Diagnosis Standard (FDS)
	**Finance**	• Delivery of a balanced position across the system.

2. Trust's Plans

2.1 Activity Plan

The Trust's activity plan is based on 2023/24 actual outturn.

Activity is planned to increase across all points of delivery, both admitted and non-admitted, planned and urgent care. There are 4 more working days and 1 less calendar day in 2024/25 (compared to 2023/24) and includes:

- **17k additional Outpatient Appointments**
  - 13k additional new appointments
  - 4k additional follow up appointments
- **2k additional Elective Inpatients**
  - 1.5k additional daycases
  - 0.5k additional electives
- **1k additional A&E attendances** (1% growth added to plan).
  - 2% growth was seen in 2023/24
  - Attendances are now 13% higher than 2019/20
- **9k additional Diagnostic Tests**

The elective plan includes activity sent to the Independent Sector last year. This was previously delivered through a GM-wide contract, which has now been passed back to providers to manage.

The diagnostic plan includes additional activity from the summer 2024 when the Community Diagnostics Centre (CDC) is due to open.

The table below shows the change between draft and final plan along with the variance to both 2019/20 and 2023/24 (adjusted for working/calendar days). The final 2024/25 plans include the restoration of outpatient services and additional activity to achieve zero 65+ week waiters by September 2024.

TRUST	Draft 2024/25 Plan	Final 2024/25 Plan	Variance to draft plan	Final 24/25 Plan variance to :	
				2019/20	2023/24
A&E	**113,777**	**114,339**	**562**	113%	101%
Non Elective Spells	**43,552**	**43,151**	**-401**	101%	101%
NEL 0 Length of Stay (LoS)	16,768	16,727	-41	97%	101%
NEL 1+ LoS	26,784	26,424	-360	104%	101%
Total Outpatients	**338,876**	**350,447**	**11,571**	103%	103%
New	129,538	136,405	6,867	119%	109%
Follow-up	209,339	214,042	4,703	95%	100%
Electives Total	**38,917**	**39,967**	**1,050**	104%	104%
Day Case	33,537	34,257	720	106%	104%
Elective Inpatient	5,380	5,710	330	93%	108%
Diagnostics Total	**159,633**	**162,527**	**2,894**	114%	104%
Endoscopy	10,435	10,861	426	103%	96%
Imaging	134,879	135,779	900	120%	104%
Echo	11,235	12,512	1,277	112%	120%
Audiology	3,084	3,375	291	45%	109%

Delivery of this activity plan will support the Trust to meet the majority of performance standards set out in the national planning guidance detailed below.

Standard	Assumption	Submission Jan-24	Draft Plan Mar-24	Final Plan Apr-24
65week waits (ww)	Zero by Sep 2024	No	No	Yes
52ww	Zero by end March 2025	No	No	Yes
A&E 4hrs	78% by end March 2025	No	Yes	Yes
Bed Occupancy	92% Apr 24 to Mar 2025	No	No	No
Diagnostics 6ww	Increase % pts seen in 2023/24	Yes	Yes	Yes
Cancer FDS	77% by end March 2025	Yes	Yes	Yes
Cancer 62 day waits	70% by end March 2025	No	Yes	Yes
Cancer backlog	Backlog should not increase beyond end Mar 24 position	Yes	Yes	Yes

Strategic oversight will be maintained at the Trust's Board via the monthly integrated performance reports, as well as weekly updates to the Executive Team.

2.2 Workforce Plan

The workforce plan is based on 2023/24 outturn. Planning assumptions and projections are cross referenced to funding assumptions and whole time equivalent (WTE) staff. Workforce, CIP & activity plans have been triangulated as part of the operational planning process. Plans aim to improve performance on sickness and maintain current turnover rates.

The following assumptions form part of our plan:

- No unplanned growth.
- No industrial action.
- Recruitment and retention improvement rates continue.
- Performance & demand continue in line with the plan.
- Sickness absence improvement plans are realised.

- Shortage/speciality posts are recruited to.
- Assumes Independent sector income has no WTE impact.

Our workforce priorities focus on addressing supply and retention challenges (substantive and temporary staffing), reducing the reliance of premium rates of pay, progressing digital and workforce transformation and improving staff experience, morale and addressing wellbeing challenges.

Our recruitment plan includes increasing the number of apprenticeships, degree apprenticeships and career pathways to continue expanding domestic recruitment pipelines, including 'pathways into employment' and 'grow our own' initiatives. We will continue to provide Cadets and internships schemes with support from the local college. International recruitment and domestic recruitment events will continue for difficult to recruit posts.

Our Health & Wellbeing (H&WB) programme provides aims to support retention of staff through a wide range of programmes. We also have a clinical psychologist team providing enhanced support & trauma response interventions. We will focus on leadership development to ensure inclusive leadership, supported by the Civility Saves Lives programme to create the conditions required continue to deliver the actions set out in our Organisational Development Plan. Flexible working and flexible retirement arrangements are in place and available to staff to support them with their work life balance and working longer as appropriate.

During 2024/25, we will continue our plan of reducing agency usage by maximising our partnership with NHS Professionals and Liaison for the supply of temporary workers. To reduce our overall use of temporary workers and to ensure grip and control of spend, temporary staff usage is regularly scrutinised, rostering compliance is reported through monthly meetings and, where possible, we will move regular temporary workers to substantive posts.

Strategic oversight will be maintained at the Trust's People Performance Committee and the monthly Finance Improvement Board, where workforce numbers will be reviewed to ensure compliance against the plan throughout 2024/25 and any deviations will be challenged accordingly. The weekly Staffing Approval Group, chaired by the Trust's Director of People & OD, will continue to review all temporary staffing requests and ensure all recruitment is aligned to the workforce plan. In addition to our Workforce Efficiency Group, also chaired by our Director of People & OD, focusing on our workforce priorities.

2.3 Financial Plan

The Trust's financial plan for 2024/25 includes a deficit position of £43.8m. This includes a range of financial pressures highlighted by Divisions and approved by the Executive Team.

As part of GM's drive towards financial balance the Trust's planned deficit had improved for system reporting purposes from the draft plan by £2.3m.

The Trust has a challenging CIP of £24.6m, which is split evenly between recurrent and non-recurrent savings.

The Trust will require revenue support from April 2024, broadly in line with deficit plan. A cash application has already been submitted to NHS England.

A full breakdown of the financial plan can be found in the finance papers to Board. Performance will be scrutinised through the Finance & Performance Committee and reported monthly to Board.

2.4 Capital Plan

The Trust's capital departmental expenditure limit (CDEL) allocation for 2024/25 is £13.2m.

The Trust's draft submission in March 2024 was a plan of £39m. To support a compliant GM system capital plan, the Trust's final plan totals £18.2m (£13.2m CDEL and £5m Public Dividend Capital related to the GM Pharmacy Aseptic scheme).

We will continue to pursue support for our draft plan of £39m. However, there is no route to access cash to support the capital plan presented, this will require GM / NHSE support in the first instance. If this is not supported, the Trust will need to consider all other unpalatable options which may not determine value for money. Examples include – disposal of assets, managed equipment and / or other mitigations as necessary to mitigate significant safety risk.

The Trust is in active dialogue with GM ICB and Northwest regional finance team regarding financial support for a new outpatient's facility required because of the closure and resulting demolition of Outpatients B.

Strategic oversight will be maintained at the Trust's Board via the monthly Finance reports.

3. Next Steps

The Trust will be monitored on the delivery of the plans by the GM ICB. Regular updates to the Board of Directors will be scrutinised in detail by the relevant Board committees.

A Sustainability Plan is being developed by the ICB to address the challenges across finance, quality, performance and population health. Within this, the system must demonstrate how it will return to run rate balance by the end of 2025-26 as per NHS England's requirement. A key element of the Sustainability Plan will therefore be financial modelling. The Trust will ensure that it participates in this work and its delivery thereafter.

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	**X**	**Agenda No.**	9
Meeting	Board of Directors				
Report Title	Opening Budgets 2024/25				
Director Lead	John Graham, CFO/Deputy CEO	**Author**	Kay Wiss, Director of Finance		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors are asked to approve the opening budgets for 2024/25, which reflect the current submitted financial plan, which may be subject to change.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust has set an income and expenditure financial plan with a deficit of £43.8m for 2024/25 aligned with the activity and workforce plans.

In accordance with the Standing Financial Instructions the Board of Directors are asked to approve the opening budgets for 2024/25 and this paper will set out:

- The assumptions made in the plan
- The key areas for investment to deliver the plan
- Risks to delivery of the plan

The Trust has a compliant capital plan of £29.1m for 2024/25.

1. Purpose

1.1 The Trust has been working on its financial plan in accordance with national guidance and as part of the Greater Manchester Integrated Care System.

1.2 The final financial template submission was submitted on the 12th June 2024 and this paper is prepared in accordance with the Standing Financial Instructions (SFIs) as set out in section 3.1 to propose for approval a budget for 2024/25.

2. Background and Links to Assurance Committees

2.1 The Finance & Performance Committee have been appraised on a monthly basis of progress of the annual planning process and the principles that have been applied.

2.2 An extended version of this paper was presented and discussed at the Finance & Performance Committee on the 18th May 2024, with an update provided on 20th June 2024.

3. Budget plan for 2023/24

3.1 The financial plan for a deficit of £43.8m was submitted on the 12th June 2024 and was agreed in accordance with Greater Manchester Integrated Care System (GMICS). This can be summarised in Table 1 and the full Income and Expenditure table is shown in Appendix 1.

Table 1

Income & Expenditure position Plan 2024/25	£m
Total Income	428.7
Substantive	(283.4)
Bank	(34.7)
Agency	(12.8)
Pay Costs	(331.0)
Drugs	(23.5)
Clinical supplies & services	(31.6)
Other non-pay	(57.3)
Below the line	(29.3)
Total Expenditure	(472.8)
TRUST PLAN 2024/25	(44.0)
Add back donated asset	0.2
TRUST PLAN FOR SYSTEM REPORTING 2024/25	(43.8)

3.2 The plan has been aligned to the activity and workforce plan and a summary of the key assumptions within the plan are covered in the following points:

3.3 **Income –** The NHS Payment Scheme continues from 1st April 2023, with Aligned Payment and Incentive (API) continuing a blended payment mechanism. Contracts include a fixed element agreed locally for acute, community and maternity services (referred to as the block). The GM approach has been to align all the providers within the ICS through values in block contracts and this is the main basis of the income plan. The Trust has also set income targets for system funding notified from GM.

3.4 An exercise continues under the heading Future Funding Flows across the GM system to review the system funding and elements of the contract allocations that have taken place during the Covid years. This work continues but at the start of 2024/25 no decision has been taken to reallocate funds across GM trusts.

3.5 Similar to Payment by Results [PbR] the Trust is also paid variable income linked to activity for inpatient elective, day case and out-patient first attends under the Elective Recovery Fund (ERF). However individual Trusts cannot deliver additional activity and assume payment, as target and performance thresholds are linked at GM level. There is a potential risk in the plan if the Trust does not deliver activity targets; however as this has not been finally agreed all Trusts within GM have assumed full income and the risk will be managed at an ICS level.

3.6 **Pay –** The Trust continues to use bank and agency staffing to provide a safe level of cover. In order to plan for this level of costs an adjustment has been made to the financial position at Trust level to recognise that there will be bank and agency costs; without amending the structure of the Divisional budgets. This will assist with monitoring the plan at GM and NHSE level.

3.7 **Pay award –** Contingency has been made for a 2.1% pay award in accordance with planning principles for 2024/25, though actual costs could be in excess of this. The annual cost of consultant Clinical Excellence Awards (CEAs) has also been provided for; however in this year this will be subsumed into the main pay award and not allocated separately. Any further increases in pay award above the prescribed in planning guidance should be subject to additional funding from NHSE.

3.8 **Industrial action** – There were significant costs and impacts in activity from industrial action in 2023/24; these are not planned for in 2024/25.

3.9 **Drugs –** The Trust has assessed the activity and cost profile for drugs for the coming year including estimates for the cost and related income for high-cost drugs and devices; under national payment rules these are chargeable on an actuals basis. During 2023/24 GM managed risk regarding variable drugs charges at an ICS level and current expectations are that this will continue in 2024/25. Specialist commissioners will continue to pay this on a variable basis.

3.10 **Clinical Supplies and Services –** An assessment of the clinical cost of delivering elective activity has been made and set within budgets.

3.11 **Other non-pay** – This includes the increasing costs of inflation for energy, supplies and external contracts. This also covers increased maintenance costs for the capital purchases made in 2022/23 and 2023/24 according to the warranty schedules. Inflation funding will be a key area of focus and will only be released into divisional budgets once actual costs are known and price increases from suppliers have been appropriately challenged.

3.12 **Below the line** – Technical changes have been made in accordance with the changes for IFRS16 and for increased depreciation associated with the capital programme in 2023/24.

3.13 The **CIP plan** of is 2.5% £12.3m recurrent and 2.5% £12.3m non-recurrent has been agreed and for the purposes of the plan submission the breakdown according to the areas where the savings are planned to be released are in Table

3.14 **Capital plan** – The Trust has resubmitted the capital plan for 2024-25, and now has a compliant plan totalling £29.1m including:

- £13.2m internally funded
- £12.1m PDC
- £0.26m contribution from the Trust Charity towards the Emergency & Urgent Care Campus (EUCC)
- £3.5m IFRS16 impact of leased assets

4. Areas of Risk

4.1 The position across the GM remains a concern as the system plans submitted by GM ICS are still subject to agreement with y NHS England. The planning guidance set an expectation that systems should breakeven for 2024/25 and each system has a collective statutory duty to meet this. The out-turn for GM ICS for 2023/24 was £180m and there is a deficit plan for 2024/25. Review with NHS England continues and there is a risk of regulatory interventions of systems/ providers, additional controls and continued oversight meetings.

4.2 Inflation and the cost of living crisis is an on-going risk for all Trusts. System inflation funding/ cost uplift factor (CUF) was limited to 0.9% (2.0% inflation including consultant pay award increase less 1.1% assumed efficiency), but the Trust's expected impact is in excess of this. Further cost increases, both direct to the Trust and those passed on through our supply chains, are a risk to the Trust financial position.

4.3 The effect of inflation and hardship on staff may also present a further risk to staffing and associated costs. Whilst industrial action was seen from medical staffing both senior and junior in 2023/24 creating financial pressure in paying increased premium rates to Trust staff working additional hours to allow their colleagues to strike; there remains the risk of further action in 2024/25.

4.4 As there is limited capital available to the Trust and the age and condition of the site is poor that there is a transferred increase in costs of revenue, either from additional failure of equipment or loss of productivity.

4.5 The activity pressures to deliver national priorities will be challenging for the Trust, particularly:

- 77% of emergency department (ED) patients seen within 4 hours by March 2025 – currently below 70% at March 2024
- Reduce bed occupancy to 92% or below – currently 94.2% Q4 23/24
- Eliminate 65 week waits by end of September 2024 – 679 at March 2024
- Reduction of bank and agency staff to 3.7% of total pay bill – 4.8% 2023/24

Together with additional ED staffing to support growth in attendances, reliance on premium rate staffing to support on-going escalation beds and lack of community capacity, this presents a significant risk to the cost base of the organisation.

4.6 The national expectation is to recover elective activity to 107% of 2019/20 levels, however the GM ICB target for 2023/24 was 103% and this target will continue in 2024/25. Individual targets have been issued for individual Trusts but does not take account of the impact of transferring the responsibility of the Independent Sector. Whilst improvement was shown in the second half of 2023/24 there remains a risk depending on capacity available that the target will not be achieved. GM Trusts have been asked to plan for full income achievement within their plans.

4.7 The Trust drew down revenue support in Q4 2023/24 of £5m. The Trust will continue to require revenue support in 2024/25 and this is estimated at £44m. There is a requirement for the Board of Directors to sign off the borrowing applications and provide evidence of financial control in order to access revenue support. The current capital plan will also require cash support and this is being discussed with the ICB.

5. Recommendations

5.1 The Board of Directors are asked to approve the opening budget plan for 2024/25.

Appendix 1

Category	Annual £000s
Block Contract / System Envelope	389,465
Other Non NHS Clinical Income	6,418
Clinical Income from Patient Care Activities	**395,883**
Research & Development	1,034
Education & Training	11,395
Pharmacy Trading Units Income	6,587
Other Income	15,709
Other Income	**34,724**
TOTAL INCOME	**430,607**
Pay Costs	(332,400)
Substantive Staff	*(284,460)*
Bank Staff	*(34,490)*
Agency Staff	*(13,451)*
Drugs	(23,468)
Clinical Supplies & Services	(31,345)
Other Non Pay Costs	(58,264)
TOTAL COSTS	**(445,477)**
EBITDA	**(14,870)**
Depreciation	(21,756)
Interest Receivable	555
Interest Payable	(731)
Unwinding of Discount	(30)
Profit/(Loss) on disposal of fixed assets	11
PDC Dividend	(7,212)
Total Below the Line	**(29,162)**
TRUST SURPLUS / (DEFICIT)	**(44,032)**

NHS
Stockport
NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	10
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to review and discuss performance against the reported metrics including any mitigating actions to improve performance that are described in the exception reports.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
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x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
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x	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust

x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
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	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

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

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

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

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

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting period

June 2024

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

Quality Highlight

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

- SHMI Mortality rates continue to be low, with Stockport reported with the lowest rates across GM.
- The Trust continued to perform well against the timely recognition metric, with 100% reported in-month for June. Antibiotic administration performance continues to be challenging, although an improving trend in compliance is apparent over the last several months.
- Reported infection rates for C.diff continue to be higher than projected and Stockport ranks 5th of 7 GM trusts. E.coli rates are showing strong improvement in trends.
- We continue to perform well against all Stroke and Falls metrics.
- All pressure ulcers across all categories and settings are showing increasing trends. There have been an unusually high number of category 3 & 4 pressure ulcers reported in the hospital setting.
- Written complaint rates have remained high over the last 6 months. Timely response to complaints is recovering and an improving trend can be seen since March 2024.
- Smoking during pregnancy performance has not changed significantly, but new targets introduced for 2024/25 mean performance has been above the target threshold since April, with a significant increase for June.

Operations Highlight

Exception reports included this month relate to performance against Emergency Department, No Criteria to Reside, Diagnostics, Outpatient Efficiencies, and Theatres.

- Performance against the ED 4-hour and 12-hour metrics do show some signs of improvement, although still outside the target thresholds. Action plans in development to support the new national ambition of 78% by March 2025.
- The number of patients with no criteria to reside continues to improve. New targets set for 2024/25 mean April performance continues to show as under-performance.
- The diagnostic position continues to be challenged due to backlogs in MR, Echo, and Audiology. Although improving trends can be seen in backlogs for MR and Echo, Audiology remains a concern.
- In performance against the cancer standards, strong improvements can be seen in the trends for 62-day performance. 28-day FDS continues to perform well above local projections as well as the national target.
- Significant improvements seen in our RTT position on the number of 52+, 65+, and 78+ week waits. The Trust is performing well against the trajectory plan to have 0 65+ waits by September 2024.
- Outpatient efficiencies in DNA and Clinic Utilisation have shown deterioration in performance across May and June. Reviews of the process are ongoing and is providing assurance that all booking and reminder systems are operating as planned.
- The Trust continues to be one of the best performing Trusts in GM for theatre touch-time utilisation. New transformation work-streams have begun, with a focus on key areas known to be negatively affecting performance.

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

Workforce Highlight

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

- Performance against the substantive staff-in-post metric has dropped slightly for June, but continues to be well above target threshold.
- Monthly sickness absence rates have risen for May and June, but remain in line with the average reported over the last 12 months. Anxiety, stress and depression is the main cause, with a 3rd of all absence episodes reported.
- Agency costs continue to show strong improvement compared to total PAY costs and are reported below the target threshold for the last several months.
- Workforce turnover shows a strong improvement in performance trend since August 2023, with the last 3 months reported below the target threshold.
- Appraisal rates across all staff groups shows an improving trend, although all divisions are still reported below the 95% target threshold.
- Mandatory training rates have seen strong improvement over the last several months and have been above the 95% target since April 2024.

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Finance Highlight

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

At month 3 2024-25 the Trust position is adverse to plan by £0.1m – a deficit of £13.4m. The adverse position is due to the cost of industrial action offset by an overachievement of CIP.

The Cost Improvement (STEP) programme is profiled on a stepped basis with an increased requirement in the second half of the year. The STEP target has overachieved in month 3 by £0.3m and to date full year savings of £8.1m have been actioned of which £1.6m is recurrent.

The Trust maintained sufficient cash in June, however an application for revenue support for July of £1.7m has been made and has been approved.

The Trusts capital plan is £29.1m. The plan is now compliant, but this will present challenges with cash as the forecast expenditure is £49.9m and continues to be discussed with NHSE.

Integrated Performance Report
Scorecard

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: HSMR	Apr-23 to Mar-24	≤ 100		↑	101	●	●
Mortality: SHMI	Mar-23 to Feb-24	≤ 100		↑	92	●	●
Sepsis: Antibiotic administration	Jul-23 to Jun-24	≥ 90%		↗	76.4%	▲	▲
Sepsis: Timely recognition	Jul-23 to Jun-24	≥ 90%		↑	98.2%	●	●
C.diff infection rate	Jul-23 to Jun-24	≤ 32.75		→	37.37	▲	▲
Covid-19 infection rate	Jul-23 to Jun-24			→	1.11		
E. coli infection rate	Jul-23 to Jun-24	≤ 31.41		↗	32.03	▲	▲
MRSA infection rate	Jul-23 to Jun-24	≤ 0		→	0.44	▲	▲
Stroke: Overall SSNAP Level	Mar-24	≥ C		→	A	●	●
Falls causing moderate+ harm	Jun-24	≤ 22	2	→	1	●	●
Falls due to lapses in care	Jun-24	≤ 425	47	→	15	●	●
Falls rate	Jun-24	≤ 3.51	2.71	↘	3.12	●	●
Pressure Ulcers: Community, Cat 2	Jun-24	≤ 114	35	↘	15	▲	▲
Pressure Ulcers: Community, Cat 3&4	Jun-24	≤ 38	17	↘	6	▲	▲
Pressure Ulcers: Hospital, Cat 2	Jun-24	≤ 79	19	↘	9	▲	●
Pressure Ulcers: Hospital, Cat 3&4	Jun-24	≤ 8	7	↘	2	▲	▲
Complaints: Timely response	Jun-24	≥ 95%	97.9%	↗	100%	●	●
Complaints: Written Complaints Rate	Jun-24	≤ 7.9	9.63	→	8.43	▲	▲
Never Event Incidence	Jun-24	≤ 0	1	↓	1	▲	▲
Patient Safety Alerts	Jun-24	≤ 0	8	→	2	▲	▲
Patient Safety Incident Investigatio..	Jun-24		8	→	2		
Patient Safety Incident Rate	Jan-24 to Jun-24			↓	86.78		
Early Neonatal Deaths	Jun-24	≤ 0	0	→	0	●	●
Maternity Diverts	Jun-24	≤ 0	0	→	0	●	●
Registrable Stillbirth Rate	Jun-24	≤ 0	4.23	→	9.52	▲	▲
Registrable Stillbirths	Jun-24	≤ 0	3	→	2	▲	▲
Smoking In Pregnancy	Jun-24	≤ 4%	5.9%	→	8%	▲	▲

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
Ambulance handover delays	Mar-23	≤ 5%	23%	→	22.6%	▲	▲
4hr Standard	Jun-24	≥ 78%	63.5%	↗	65.6%	▲	▲
Patients in department over 12 hrs	Jun-24	≤ 2%	10.5%	↗	8.9%	▲	▲
No criteria to reside (NCTR)	Jun-24	≤ 61	221	↗	75	▲	▲
Discharge ready	Jun-24	≥ 85%	84.3%	↑	84.3%	▲	●
Delayed discharges	Jun-24	≤ 4%	3.9%	→	3.7%	●	●
Diagnostics: 6 Week Standard	Jun-24	≤ 5%	20.3%	→	19.3%	▲	▲
62-day standard	Jun-24	≥ 70%	69.1%	↑	64.6%	▲	▲
28-day standard (FDS)	Jun-24	≥ 77%	81%	↗	82.9%	●	●
14-day standard (2WW)	Jun-24	≥ 93%	97.7%	→	96.1%	●	●
Incomplete pathways 18-week %	Jun-24	≥ 92%		→	52.5%	▲	▲
52-week breaches	Jun-24	≤ 3783		↑	2208	●	●
65-week breaches	Jun-24	≤ 0		↑	478	▲	▲
Outpatient DNA rate	Jun-24	≤ 6.3%	8%	↘	8.6%	▲	▲
Outpatient clinic utilisation	Jun-24	≥ 90%	92.8%	↘	90.1%	●	▲
Patient initiated follow up (PIFU)	Jun-24	≥ 5%	4.5%	↗	4.7%	▲	▲
Capped Touch Time Utilisation	Jun-24	≥ 85%	78.2%	→	77.1%	▲	▲
Average cases per 4-hour session	Jun-24	≥ 2.8	2.75	→	2.62	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Jun-24	≥ 90%	94%	→	93.2%	●	●
Sickness Absence: Monthly Rate	Jun-24	≤ 5.5%	5.7%	↘	5.8%	▲	▲
Workforce Turnover	Jun-24	≤ 12.7%	12.4%	↑	12.5%	●	●
Staff Retention Rate	Jun-24		99.1%	↗	99.1%		
Appraisal Rate: Overall	Jun-24	≥ 95%	91.2%	↗	90.6%	▲	▲
Mandatory Training	Jun-24	≥ 95%	95.3%	↑	95.4%	●	●
Agency Costs %	Jun-24	≤ 3.2%	3.1%	↑	3%	●	●
Finance Scorecard							
Capital Expenditure	Jun-24	≤ 10%		↗	-57.7%	●	●
Cash Balance	Jun-24			↘	13.2		
CIP Cumulative Achievement	Jun-24	≥ 0%		→	8.1%	●	●
Financial Controls: I&E Position	Jun-24	≤ 0%		↑	1.1%	▲	▲

Legend

1-month Forecast

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

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

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

Quality **Sepsis**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	98.2%	↑	● ● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	76.4%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

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

Timely Recognition

- 100% timely recognition in June.
- 12 month rolling figure 98%, ahead of trust target.

Please note that quality measures for sepsis require review in line with revised NG51.

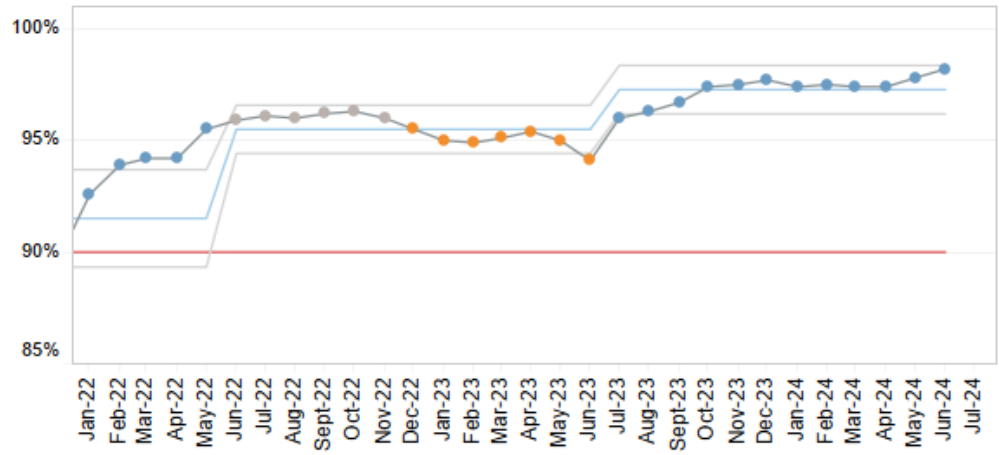
Antibiotic Administration

- June compliance 79%.
- 12 months rolling figure now 76% below trust target.
- 19/24 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- 4/5 fails occurred Out of Hours. 2222 utilised for 2/4 fails.
- All fails were red flag triggers.
- 2 fails in medical division, 3 fails in surgical division.
- Delays: 21 mins, 25 mins, 25 mins, 69 mins, 249 mins (average = 77.8mins)
- Identified themes: Delay in administration (3 fails), delayed prescribing (4 fails), unavailability of antibiotics (1 fail) and short staffing (1 fail)
- Time due to administration: 1 min, 23 min, 58 min, 77 min, 155 min (average= 63 min)
- Sepsis6 completed by clinician in 1/5 incident.
- Sepsis6 compliance 24%.

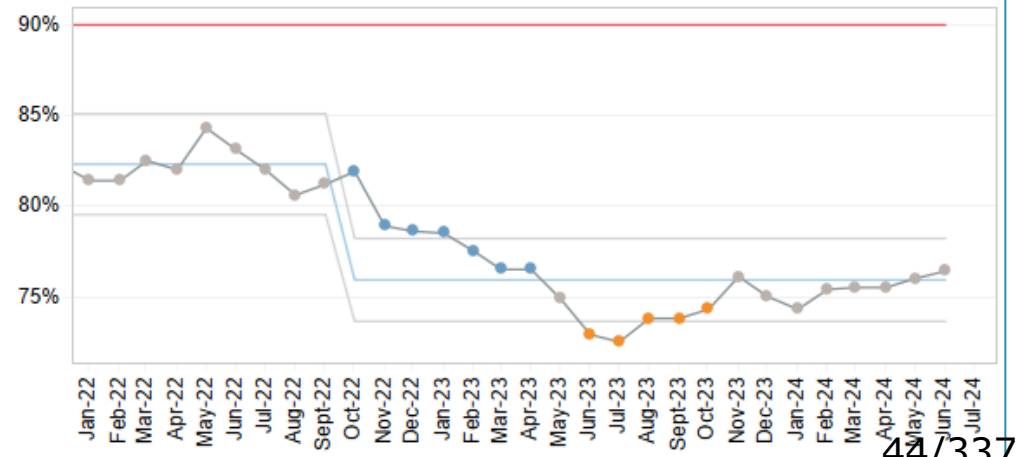
Sepsis star certificate awarded to D2. Ongoing work by Sepsis Steering Group to identify support required to implement revised NG51. Transformation request in progress. Presenting AQUA data/ revised NG51 at Patient Safety Group July.

An improving trend in compliance is apparent over the last twelve months.

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Update provided by	Emily Abdy
Executive Lead	Andrew Loughney

Quality **Infection Prevention & Control**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 32.75	37.37	→	▲ ▲ ▲ ▲ ▲ ▲	▲
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 31.41	32.03	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	0.44	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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

C.Diff

- There were 4 HOHA and 2 COHA cases in June, totalling 27 YTD. The Trust is over the projected threshold of 18.25 for the end of June.
- 25 cases have been presented to the HCAI Panel and 2 cases await panel review in July. The most common themes for learning are ensuring appropriate antibiotics are prescribed, reviewed and stopped in a timely manner and ensuring handwashing, PPE and commode cleaning are embedded practices across the trust.
- The latest National figures (April 2024) rates Stockport fifth out of the seven GM Trusts which is an increase from the previous month. Out of the forty two ICB's across the UK, GM is ranked thirty eighth which is an increase from the previous month.

MRSA

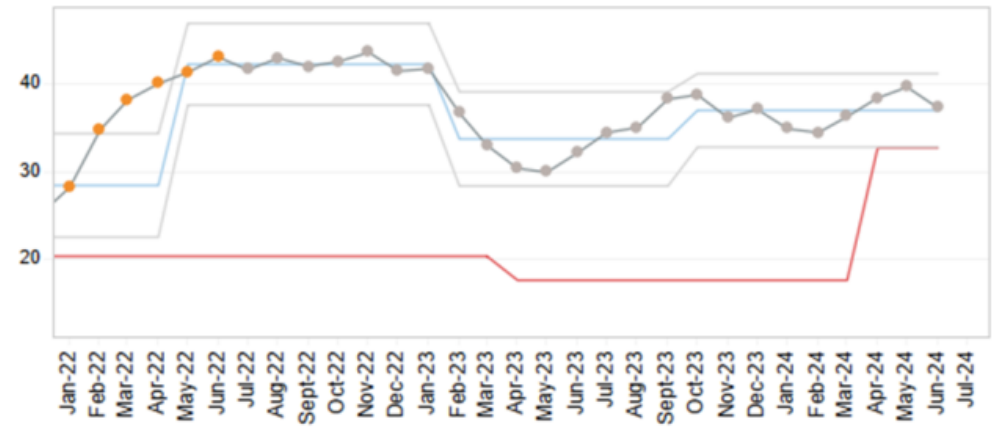
- The Trust had 0 cases of MRSA Bacteraemia in June against a zero-tolerance threshold.
- The latest National figures (April 2024) rates Stockport second out of the seven GM Trusts which is the same as the previous month.

E.Coli

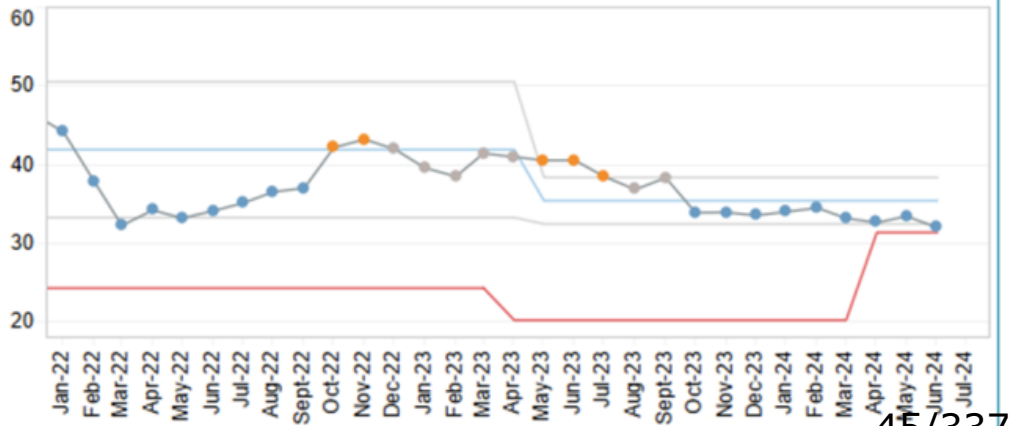
- There were 4 HOHA and 1 COHA case in June totalling 16 cases YTD. The Trust is under the projected threshold of 17.5 for the end of June.
- The latest National figures (April 2024) rates Stockport third out of the seven GM Trusts which is a decrease from the previous month.
- The task and finish group continues to review documentation around the care and management of urinary catheters to support practice.

Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

Performance for C.diff infection rate



Performance for E. coli infection rate



Quality **Pressure Ulcers**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	9			
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	3			
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	15			
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	6			

Hospital Acquired

- There have been 9 category 2 pressure ulcers reported in June 2024, including 5 incidents as a result of a medical device.
- Of the 9 incidents reported 1 was as a result of a lapse in care (LIC) and 2 showed no lapses in care (NLIC), however 6 incidents still require the investigation to be finalised.
- Thematic review of the outcome of incidents will be undertaken both at divisional level and by Tissue Viability Service, across the organisation to highlight areas where support or training is required to improve practice.
- The launch of our risk assessment tool and associated documentation on patient track is now planned to 'go live' at the end of July

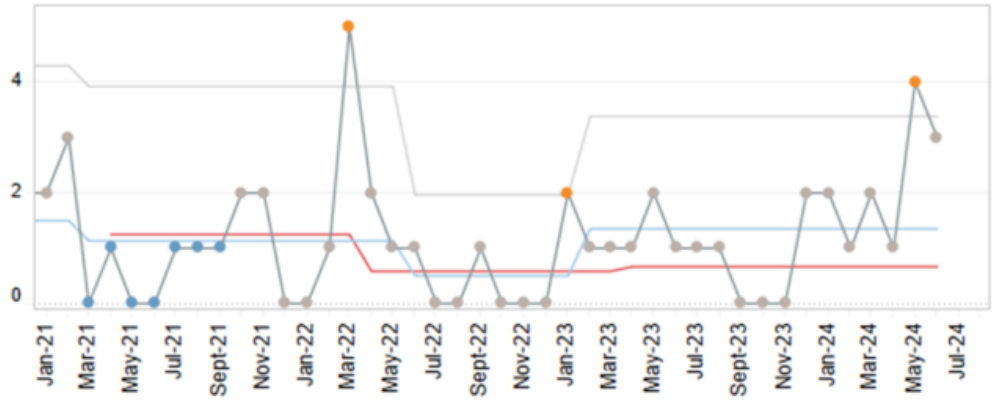
- There have been 3 category 3 and 4 pressure ulcers reported in June 2024.
- Of the 3 incidents, 2 cases had no lapses in care found; one incident where areas of learning were found has been progressed to a patient safety incident investigation.

Community Acquired

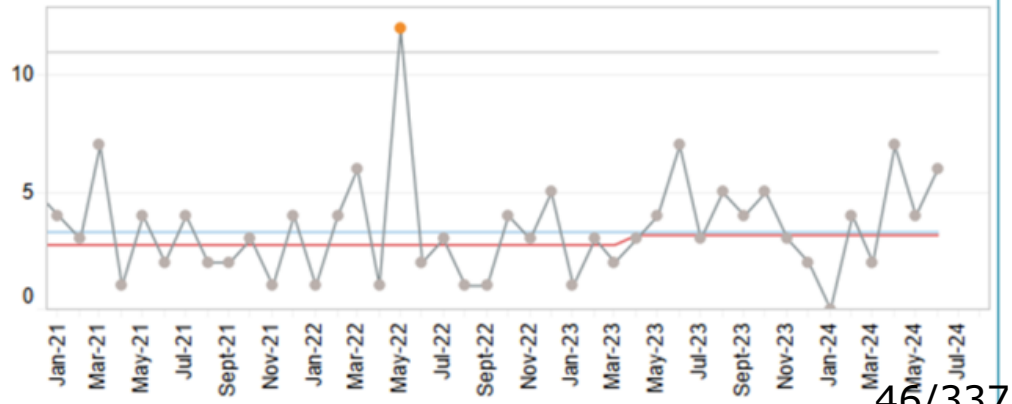
- There have been 15 category 2 pressure ulcers reported in June 2024.
- Of the 15 incidents 4 have had the investigation completed and found no lapses in care.
- There are still 11 incidents awaiting the outcome of the investigation, and improvement is required within the community setting for our investigation time frame target.

- There have been 6 Category 3 pressure ulcers reported in June 2024.
- Each incident of a category 3 or 4 pressure ulcer is investigated and reviewed to identify any learning or lapses in care. All the incidents have been reviewed at PSIRG and found no lapses in care.
- A thematic MDT review has been completed to understand the trends and identify any areas of learning or action for community even though no direct lapses in care contributed to the incidents.

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Update provided by	Lisa Gough
Executive Lead	Nic Firth

Quality **Complaints**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	100%	↗	● ● ▲ ● ● ●	●
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 7.9	8.41	→	▲ ▲ ▲ ▲ ▲ ▲	▲

Complaints Rate

- 46 formal complaints were received in June 2024 - Clinical Support Services = 3, Integrated Care = 4, Medicine & ED = 18, Surgery = 12, Women & Children = 9, Corporate = 0, Estates & Facilities = 0
- The PALS & Complaints team continue to receive a high number of contacts each month. 546 new contacts were received in June 2024 (formal complaints, informal concerns, PALS enquiries, compliments, MP enquiries) with 525 cases being closed in month.
- Communication from staff on the wards and delays in providing appointments are the two highest areas of concern.

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

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

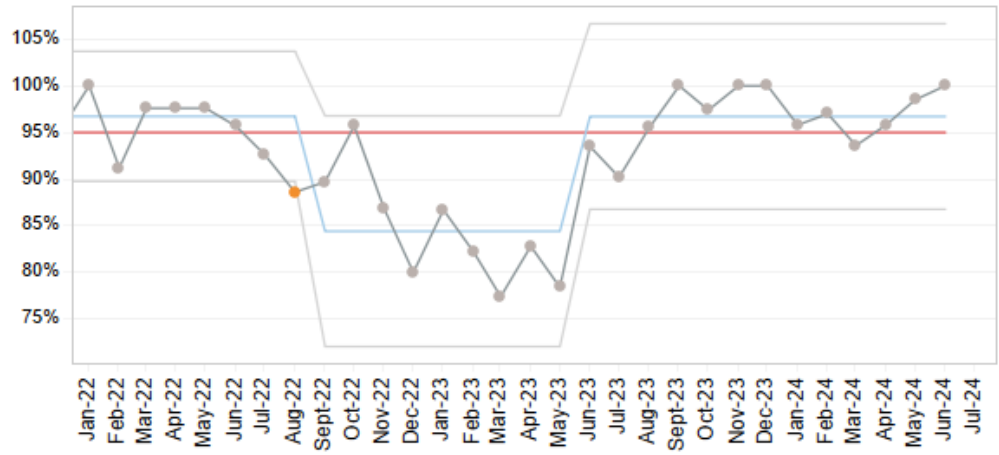
Top five themes for informal concerns in June 2024 was as follows:

1. Appointments
2. Communication
3. Waiting time
4. Admin procedures & record management
5. Patient care

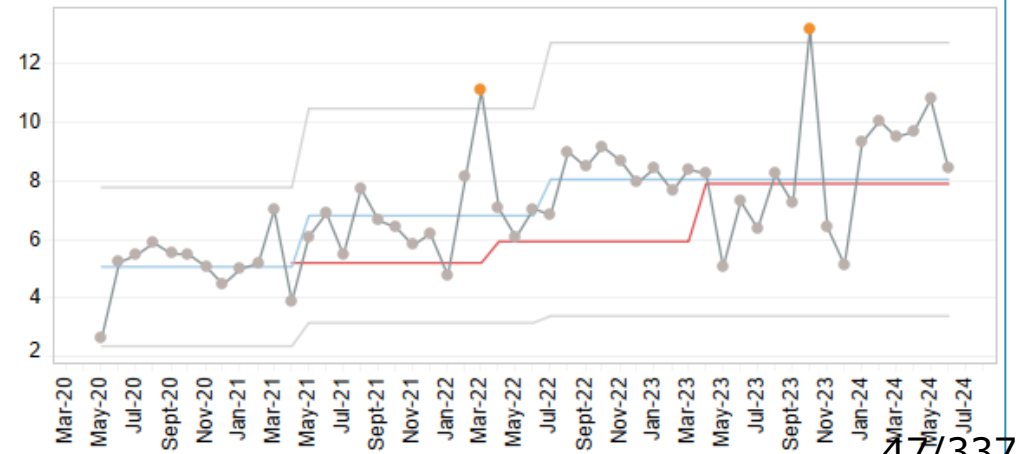
Timely Response

- 29 formal complaint responses were sent out in June 2024. All of the 29 responses sent within the agreed timeframe, resulting in a 100% response rate.
- This is a significant achievement considering the high volume of work, ongoing pressures at the Trust, staff leave and industrial action.

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Update provided by	Rebecca Harrison
Executive Lead	Nic Firth

Quality **Incidents & Risk**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Never Event Incidence	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur.	<= 0	1	↓	● ▲ ● ● ● ▲	▲
Patient Safety Alerts	The number of national patient safety alerts not completed to deadline.	<= 0	2	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient Safety Incident Investigations	A count of the patient safety incident investigations (PSII) that have been declared in month.		2	→		
Patient Safety Incident Rate	The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.		86.78	↓	▲ ▲ ▲	

Patient Safety Incident rate

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

Patient Safety Alerts

- There were two National Patient Safety Alerts with completion deadlines in June 2024, both were completed by their deadline date.
- There are two National Patient Safety Alerts with completion deadlines from previous months where the Trust remains non-compliant.
  - SHOT/2022/001 - Preventing transfusion delays in bleeding and critically anaemic patients.
  - NatPSA/2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.

Patient Safety Incident Investigations (PSII)

- There were 2 Patient Safety Incident Investigations declared in June2024:
  - One was declared under 'Local Priority 2: Pressure Ulcers'
  - One was declared under 'National Priority: Incident meeting the Never Event criteria 2018 or its replacement'

Never Events

- There was 1 never event reported in June 2024.
  - Wrong Site Surgery; Wrong Site Block. A fascia iliac block intended for a right hip was performed on a left hip in the Emergency Department.

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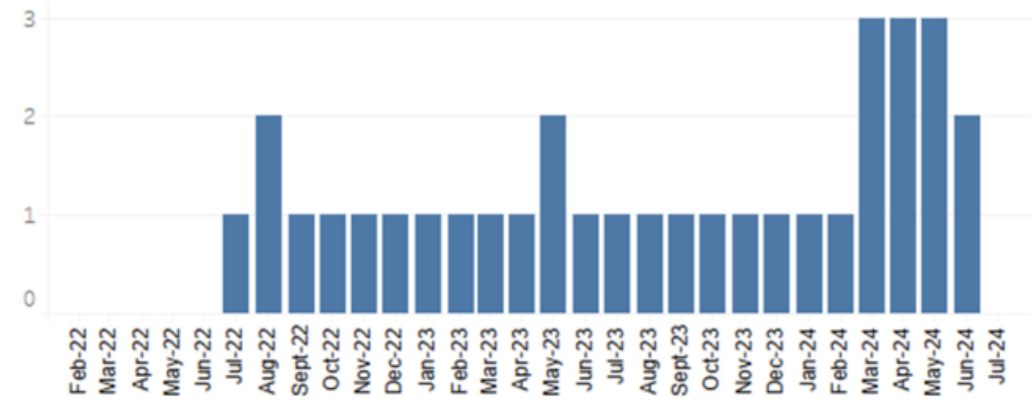
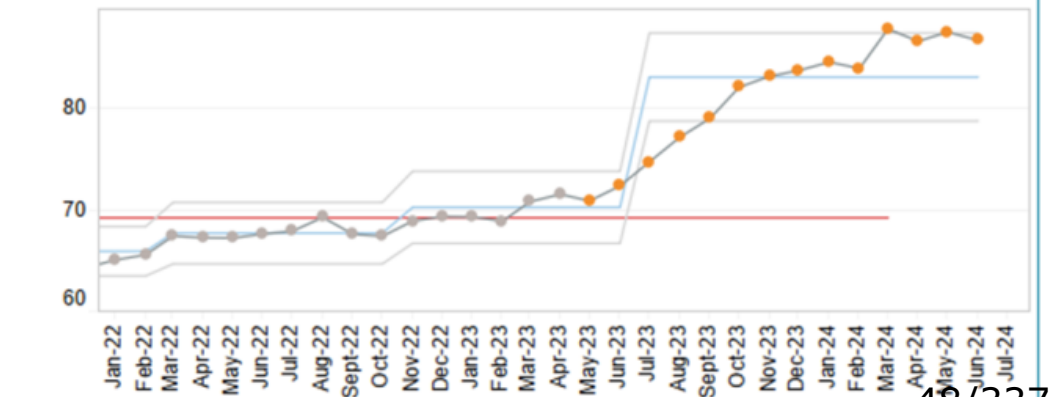
Showing number of Patient Safety Alerts



Performance for Patient Safety Incident Rate



Update provided by	Jane Carpenter
Executive Lead	Nic Firth

Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	0	→	▲ ● ● ● ● ●	●
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	2	→	▲ ● ▲ ▲ ● ▲	▲
Registrable Stillbirth Rate	Calculated as a rate per 1000 registrable births.	<= 0	9.52	→	▲ ● ▲ ▲ ● ▲	▲
Smoking In Pregnancy	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 4%	8%	→	● ● ● ▲ ▲ ▲	▲
Maternity Diverts	The total number of occasions the maternity unit has been unable to admit women during the reporting period.	<= 0	0	→	▲ ● ▲ ● ● ●	●

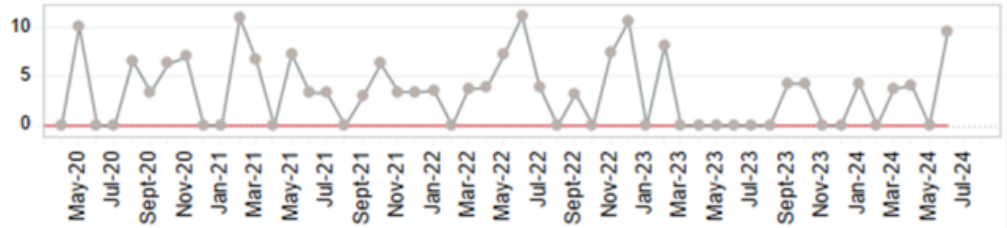
Smoking in Pregnancy: This metric excludes women whose smoking status was not known at the time of delivery, and only includes women initially booked with us who then delivered with us. Women known to be smokers at the time of delivery are defined as pregnant women who self-reported that they were smokers.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

- The percentage of women smoking at the time of delivery (SATOD) in June was 8% against a national target of <6% and GMEC target of <4% by 2026
- This is a significant increase in percentage for June.
- This appears to be due to a both significant decrease in number of deliveries in June at the same time as a slight increase in those smoking at time of delivery compared to the past 2 of months.
- We have also had an increase in number of women smoking at time of booking (April: 16, May: 14, then June: 25) – but the differences between numbers smoking at booking to SATOD has actually improved (difference in April: 4, May: 3, then June: 10).
- National dashboards look at the regional/post code data so we cannot compare this Napier figure to that percentage, as this is a complex transfer of data between Trusts quarterly and calculated via post code, not from those delivered with us at Stockport.
- Across GM FOR 23/24 the SATOD rate has fallen for the 6th consecutive year to 7.7%, all providers have seen a drop in 23/24 with Stockport, achieving 4.5% in Q4 and 5.8% for the year

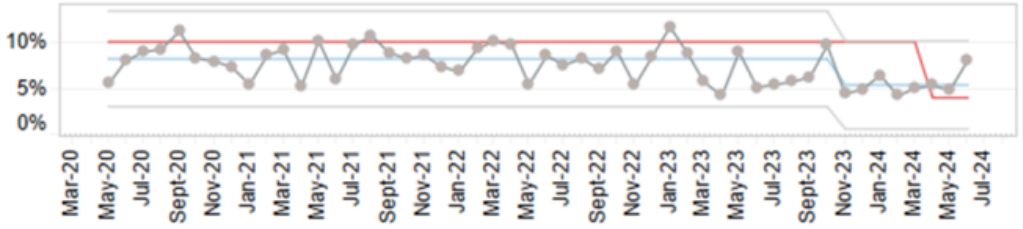
Registrable Stillbirths

- There were 2 registerable stillbirths in June, 1 35+3 weeks attended Triage with reduced fetal movements and 1 36+5 weeks attended Triage with reduced fetal movements both confirmed Fetal death in utero.
- Both cases will be reviewed using the Perinatal Mortality Review tool using an MDT approach.
- Rapid Reviews undertaken initially with no immediate learning identified.

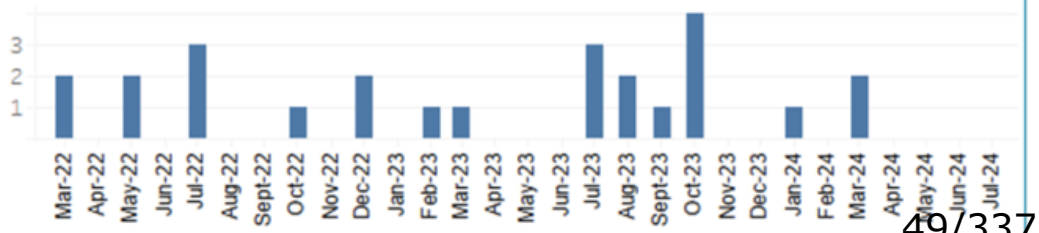
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Signed off by	Sharon Hyde
Executive Lead	Nic Firth

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Emergency Department**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 78%	65.6%			
Patients in department over 12 hrs	The number of patients spending 12 hours or more in department, as a percentage of all patients attending the emergency department.	<= 2%	8.9%			

June Summary

- June 2024 performance against the UEC 4hr standard saw an increase from 61.9% in May 2024 to 65.6%
- Daily attendances marginally decreased to 311 in June 2024 vs 314 in June 2023
- Admissions to hospital from ED remained static at 86 per day, 26% conversion rate
- June saw a decrease in 12 hour waits in ED to 270 compared to 325 in May 2024. Robust processes for managing, reviewing and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service.

Key actions

- Weekly Trust ED performance meetings to enable flow from each service to support performance against clinical standards
- Work streams Identified to improve performance against clinical standards:
  - Front door streaming/Triage
  - Diagnostic pathways
  - Overnight breaches
  - Medical workforce to support twilight hours
  - Zero tolerance for paediatrics & minors breaches
  - Introduced 2am doctor huddle
  - NWAS collaborative working to support handover times

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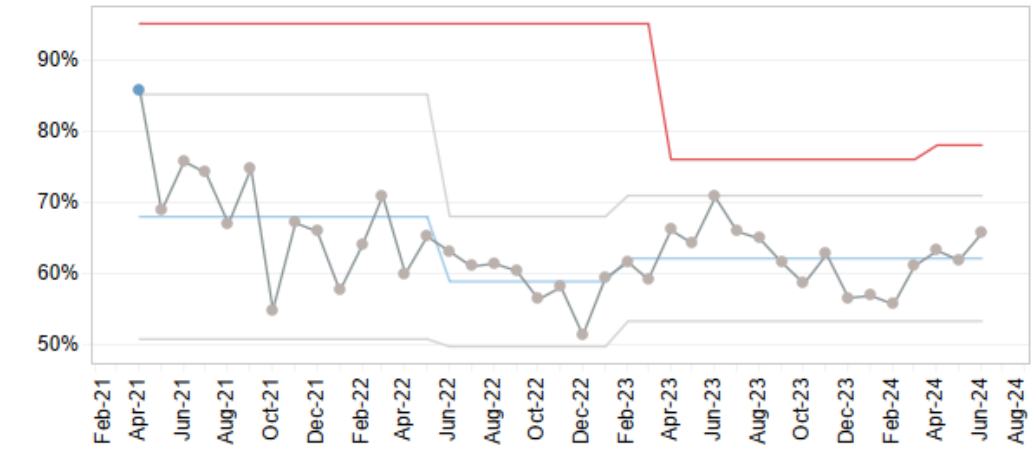
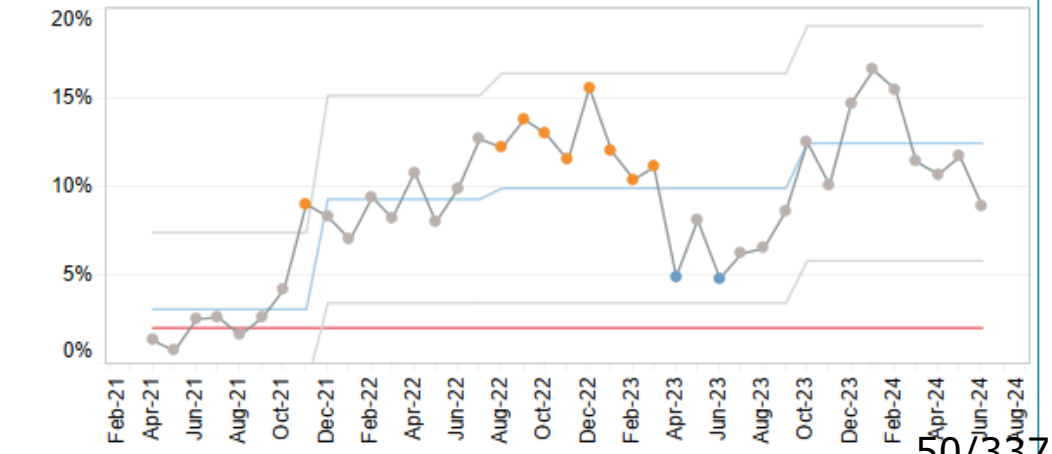
Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Signed off by	Catherine Cotton
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Patient Flow** NCTR

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 61	75			

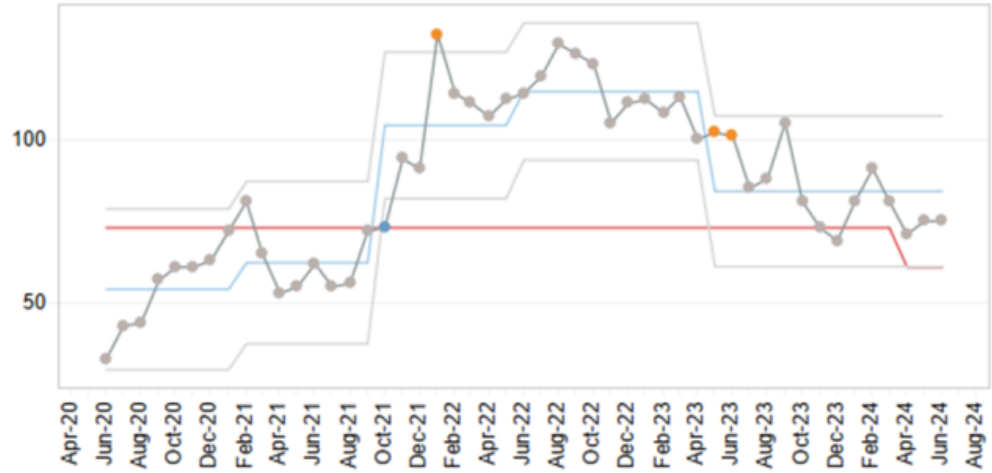
June Summary

- The number of patients with no criteria to reside (NCtR) remained unchanged in month.
- Marked improved NCtR position re Derbyshire though numbers have increased slightly.
- Number of East Cheshire patients with NCtR has reduced somewhat in month.
- Spot purchasing of community beds continues; however, this is causing delays as the private care home providers can be selective regarding the cohort of patients they accept and cannot meet patient need; therefore Pathway 2 numbers remain high.
- Improved Pathway 1 discharges taking place by utilising Reablement team from Adult Social Care. Target is a minimum of 5 patients to be discharged daily by this route, currently not meeting 5 daily.
- Trusted Assessor link nurse role in place for 3-month period to reduce need for care homes to attend the Trust to assess patients .
- Challenges with admissions to D2A beds in Bramhall Manor from 25th June due to the closure of some beds due to Norovirus (reopening 3rd July).
- Bramhall Manor (BM) and system partners complete a review and additional resource to increase minimum number of assistance x 2 from 8 patient to 12 to increase utilisation.
- Derbyshire team visited Stockport to understand Transfer of Care Hub functionality and Trust challenges for Derbyshire discharges. Derbyshire have now commenced a pilot of a central hub to triage SFT discharge referrals.

Key Actions

- Programme of Flow Work continues to be embedded
- Discharge to Assess services operating a proof of concept in supporting a small number of patients i.e. 3 at any one time, of carefully selected patients to return to the community as an alternative to a bed -based service, with 24 hour wrap around care. Early patient outcomes appear positive.
- Plans for D2A to extend the 'Tuck Up and Make Safe' provision to support the ASC Reablement team to achieve the minimum number of 5 daily discharges
- NCtR dashboard now live which gives visibility of all patients with a NCtR within the Acute Trust and tracks progress of the D2A process.
- Electronic Transfer of Care referral form live on Advantis – ongoing, but shows reduced duplication .
- Care home dedicated individual within D2A; working with care homes to reduce length of stay in returning patients who are residents in care homes
- Daily escalation to system partners taking place of any patient over 24 hours for Pathway 1 and Fast Tracks and 48 hour for Pathway 2 and 3.
- Spot purchase process in place however system review of community beds being undertaken..
- 6-week review continues of the Transfer of Care Hub model and associated Health and Social Care workforce. Increased presence from ASC commences in July with team manager in post.
- System Safe and Timely discharge meetings continue with full programme of work

Performance for No criteria to reside (NCTR)



Update provided by	Jane Ankrett
Executive Lead	Jackie McShane

Integrated Performance Report
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BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Diagnostics**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: 6 Week Standard	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	19.3%			

Echo

June Summary

- June validated position is 482 breaches which is a decrease of 114 breaches and below our trajectory by 184 breaches.
- This positive position is supported by:
  - An increased uptake in WLIs from substantive staff
  - Locum Weekend working for STRESS ECHO
  - Additional agency capacity provided by SET Agency
  - CDC Programme

Actions/Mitigations:

- Secured additional lists via SET Agency, Locum for STRESS ECHO and WLI's for substantive staff for July performance.
- Completed Mutual Aid documentation and submitted, waiting outcome

MR

June Summary

- The MR position worsened during June peaking at 640 patients waiting over 6 weeks. This has subsequently improved to 467 breaches at month end.
- The backlog is on a downward trajectory following the implementation of the mobile MR scanner at Wythenshawe.

Actions/Mitigations:

- Agreement reached with Alliance and Wythenshawe to continue the mobile MR scanner until end of July.
- CDC capacity will be utilised from August and options are being explored to maintain additional capacity on the Stockport site if required.

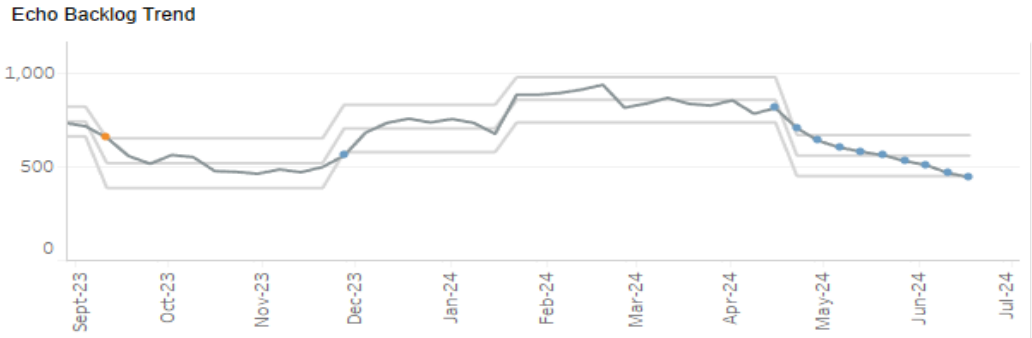
Audiology

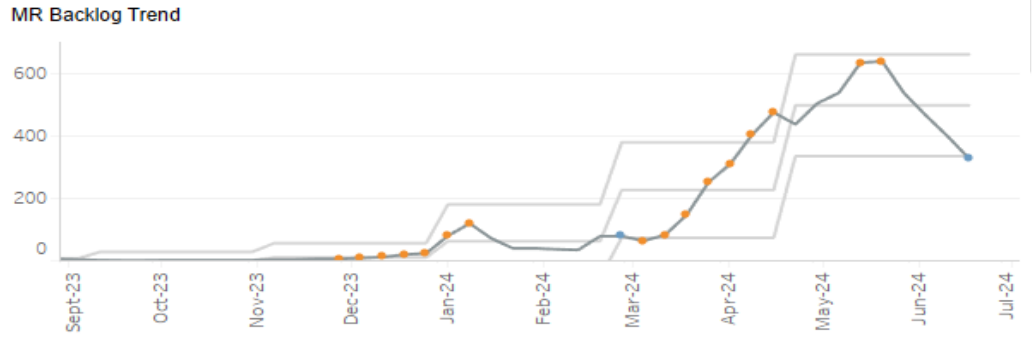
June Summary

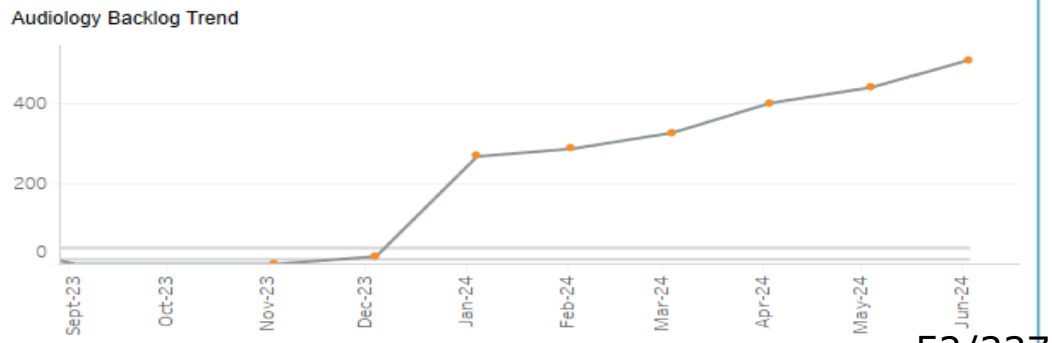
- Senior Audiologist Sickness has come to an end and clinics are back to full capacity
- Staff burnout, limited uptake for additional sessions
- Reduced capacity due to paediatrics requiring band 5 and Band 6 audiologist for consultation as per peer review
- Conflicting priorities - Peer review actions v Performance - limited resources in clinic

Actions/Mitigations:

- Medinet candidates need to be UKAS and IQIPS accredited, no suitable CVs at present
- Audiology clinic slots to change from 45 to 30 minutes to allow more patients to be seen in clinic
- Continuing to monitor and validate DNAs – identify trends, remove patients from waiting list by following the access policy







Updates provided by	Mike Allison / Angela Barrett / Fiona Humphreys
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Cancer**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on any type of cancer pathway that have received their first treatment within 62 days of upgrade or GP referral. Includes two-we..	>= 70%	64.6%	↑	▲ ▲ ▲ ● ▲ ▲	▲
28-day standard (FDS)	The percentage of patients that are notified whether or not they have cancer within 28 days from the date of referral.	>= 77%	82.9%	↗	▲ ● ● ● ● ●	●
14-day standard (2WW)	The percentage of patients on a cancer pathway that have attended their first outpatient appointment within 14 days of their GP referral.	>= 93%	96.1%	→	▲ ● ● ● ● ●	●

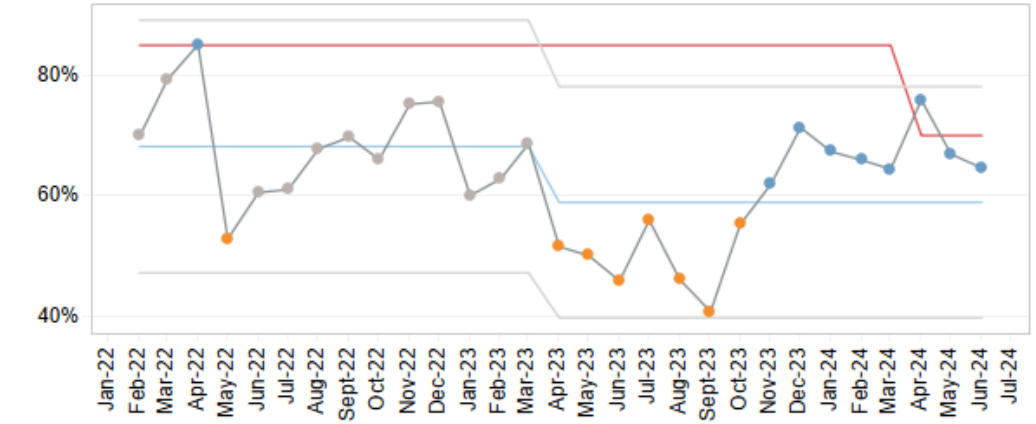
June summary

- The final 62 day performance for May is 66.9% , slightly below the trajectory target of 67.2%. The key driver of this position is the high number of non-compliances in the Lung pathway which has been adversely affected by the regional capacity for PET scans. This should begin to improve now that this issue has been resolved.
- The Trust continues to perform well against the 28 day FDS target, achieving 80.6% in May.
- The 63+ backlog has reduced again this month to 32.

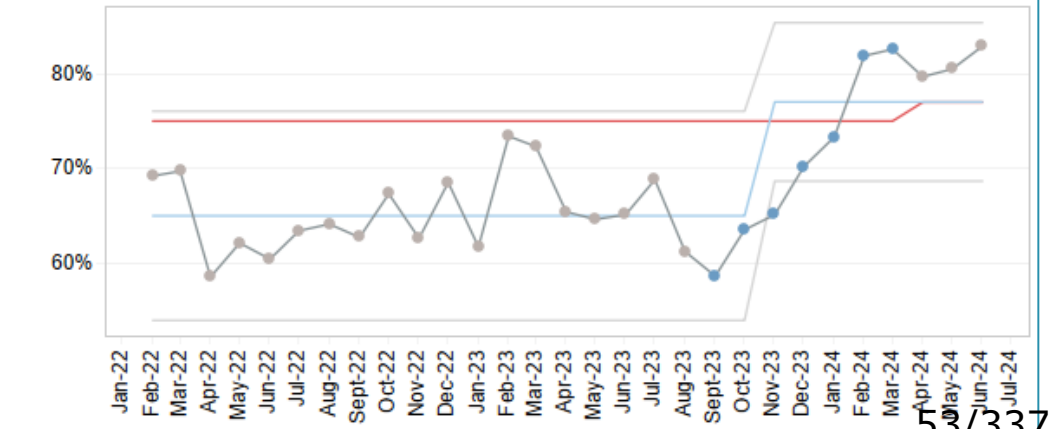
Key actions and risks

- The Lung upgrade form has been redesigned with input from both the MDT and referrers. This will support appropriate referrals and improve the quality of information to enable more effective clinical triage.
- A Haematology workshop has been scheduled for 9th July to look at improving the 28 day FDS pathway.
- Haematology have secured a locum Consultant to provide increased flexibility and clinic capacity.
- The Urology team are working collaboratively with GM Cancer to scope out the possibility of a Single Queue approach for LATP biopsies.
- Lead Bladder Consultant hosted GM workshop on improving the bladder pathway, focus is on producing guidance for prioritisation of TURBTs and risk stratification
- The level of provision for Urology Oncology clinics is uncertain from July following departure of one of the Christie Consultants. Possible risk of extended waiting times.
- Risks remain around sustained delivery of performance once temporary funding of key posts supported by GM Alliance come to an end.
- Continued Industrial Action may also have a negative impact on waiting times and subsequent performance.

Performance for 62-day standard



Performance for 28-day standard (FDS)



Update provided by	Jo Pemrick
Executive Lead	Jackie McShane

Integrated Performance Report
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BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Outpatient Efficiencies**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	8.6%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	90.1%	↘	▲ ▲ ● ● ● ●	▲
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 5%	4.7%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

June Summary

Clinic Utilisation

- Overall utilisation is at 90%. Once the exclusion have been removed, the overall utilisation improves to 91% and is at target.
- The centralised booking team performance was again at 91% in June , with non central booking team clinics at 92% which is a slight reduction fall from May's position of 94%.

DNA

- The DNA rate has risen again in June to 8.5% compared to a target of 6.3%. This is the second consecutive month were the rate is over 8% and the highest it has been since December 22. A review of the process is ongoing and is providing assurance that all booking and reminder systems are operating as planned.

PIFU

- June is 4.7% (Stockport continues to be ranked 1st in GM for PIFU) .

Key Actions

Clinic utilisation

- A deep dive into June's processes is to be completed for the central booking team. The utilisation report now updated daily to allow in month monitoring.

DNA's

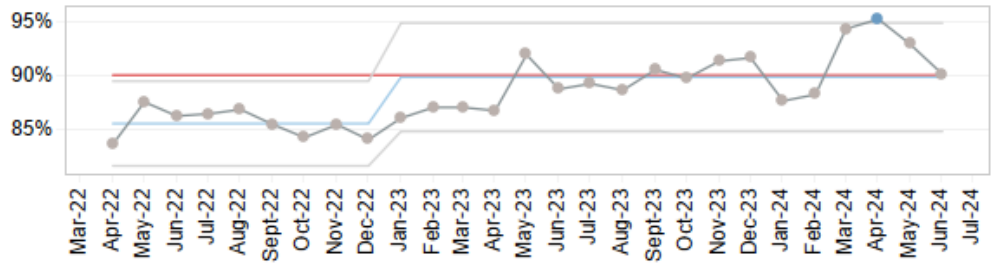
- The DNA action plan work is ongoing . Work on the DNA report to allow daily monitoring has begun in July.

PIFU

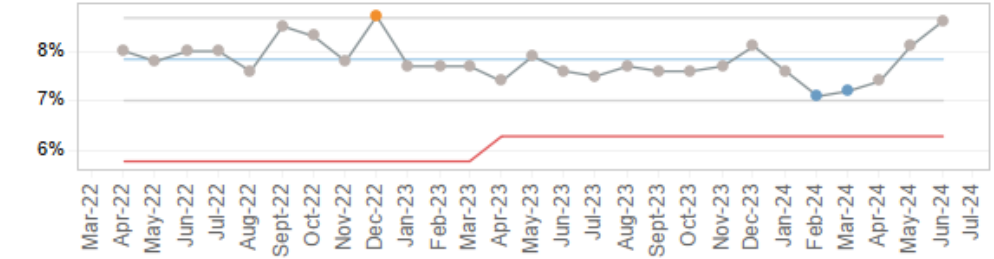
- Specialties are engaging well with the GIRFT Further Faster initiative. The ongoing work is helping teams look at opportunities to increase the use of PIFU in their specialities and this is showing an improving position . This work continues to being led by the Medical Director.

Signed off by	Mike Allison
Executive Lead	Jackie McShane

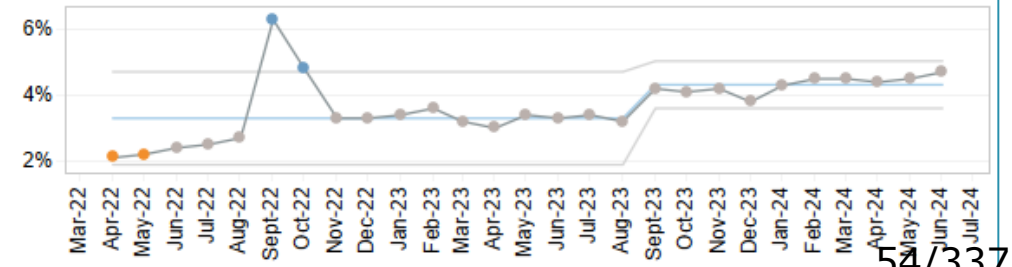
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



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BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Theatres**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded.	>= 85%	77.1%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Average cases per 4-hour session	The total number of completed cases, calculated as a rate per 4-hour session equivalent. Excludes emergency and trauma sessions.	>= 2.8	2.62	→	● ▲ ▲ ● ● ▲	▲

June 2024 Summary

- The latest (16/06/24 refresh) Model Health CTTU Trust performance data is 76.8% - below Peer (79.5%) and National (78.8%). However, Trust performance is still reporting as 2nd best in GM.
- Trust tableau data for Jun24 shows week to week movement between 75% and 80% - average is 77%. CTTU was 79% in Feb24 and Mar24, 78% in Apr24, and 79% in May24.
- Main Theatres is averaging 82%.

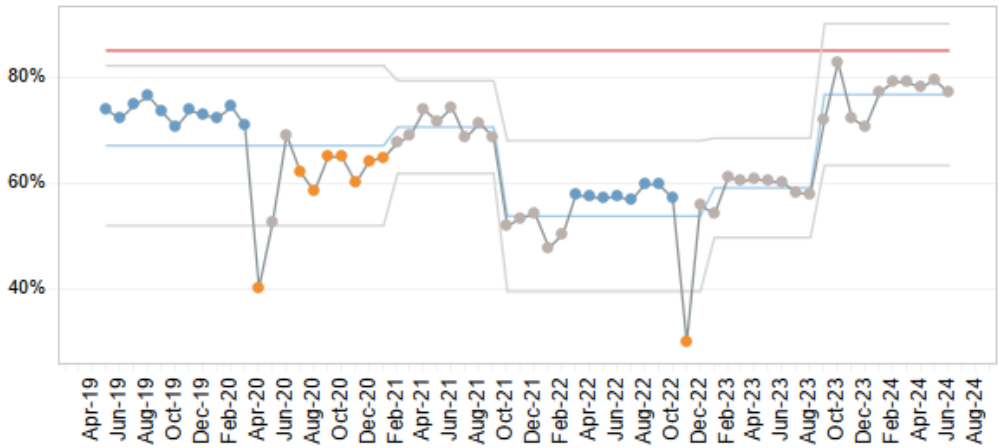
Key Issues

- Productivity has been affected by a planned shutdown of Main Theatres 8-11 in Apr24-May24, annual leave over half-term, and Junior Doctors' Industrial Action in Jun24.
- By location, the Trust average CTTU is negatively skewed by less favourable performance by SEC averaging 65%, and Maple averaging 61%.
- By specialty, the Trust average CTTU is negatively skewed by less favourable performance for Ophthalmology at 64%, Oral Surgery at 61% and Pain at 58%.
- Ophthalmology had 58 sessions in Jun24 – 16% (9 sessions) had a late start, and 71% (41 sessions) finished early.
- Oral Surgery had 30 sessions in Jun24 – 50% (15 sessions) had a late start, and 40% (12 sessions) finished early.
- Pain had 6 sessions in Jun24 - 3 sessions had a late start, and 1 session finished early.
- As well as the location and specialties listed above, the key theme contributing to CTTU underperformance across all specialties is early finishes.

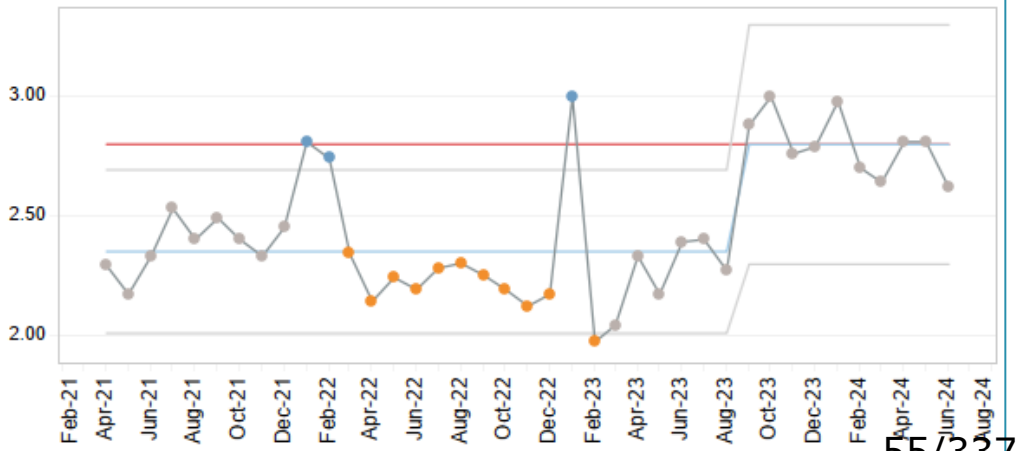
Key Actions

- DMs to review Theatre Performance Highlight on tableau, and feedback themes of late starts, inter-case downtime, and early finishes by specialty and by consultant to their specialties on a regular basis.
- Theatre Performance Operational Group – cross divisional group which scrutinises relevant performance data, delivers the programme of work set by the strategic group, initiates and oversee actions to improve performance, and ensures accountability and responsibility.
- Theatre Improvement transformation programme - restarted and re-defined key workstreams to focus on specific areas know to be skewing CTTU performance, including: SEC Productivity, Maple Suite Productivity, and Procedure Time.
- Transfer of Oral Surgery and Ophthalmology to Division of Surgery

Performance for Capped Touch Time Utilisation



Performance for Average cases per 4-hour session



Update provided by	James Thomson
Executive Lead	Jackie McShane

Workforce **Sickness Absence**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate — The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 5.5%	5.8%	↘	▲ ▲ ● ● ▲ ▲	▲

The in-month sickness rate in June 2024 has increased to 5.76% from 5.87% in May. Our rolling 12-month absence figure is 5.80%, above our new operational plan target of 5.5%.

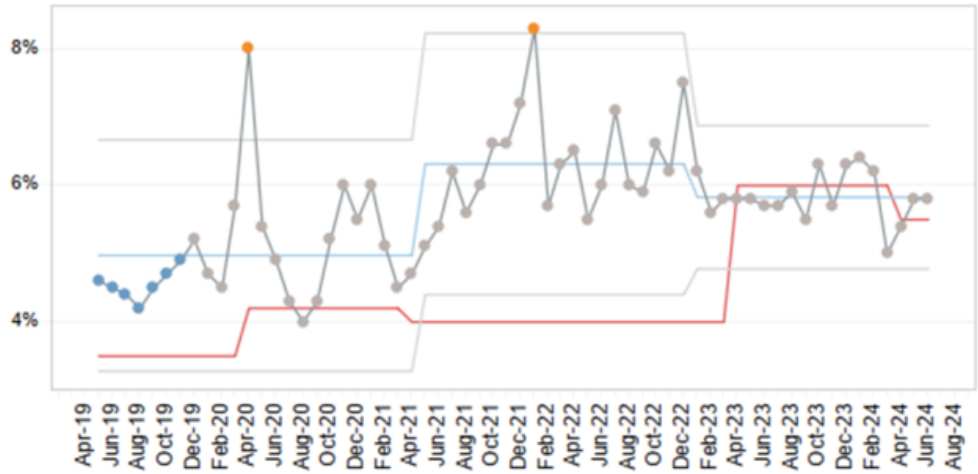
The main reason for absence is anxiety, stress and depression which accounts for 33.1% of all sickness. This is followed by Gastro at 9.2% of sickness and MSK 9.1%. In Month we have seen an increase of 0.48% in our short-term absence cases, to 2.38% in June, impacted by outbreaks of norovirus. Our long-term sickness absence rates, however, have seen improvement following the ongoing support provided by the Deputy Director of People and OD; reducing in month by 0.52% to 3.38%

In a way to support our staff, there is a physiotherapy service that staff can self-refer to within our Occupational health department. There is also the menopause clinic which is well attended where staff are supported and signposted for treatment. SPAWS continues to support staff who are struggling with their mental health.

The HR department is ensuring that risk assessments are carried out timelier, this includes stress risk assessments and pregnancy risk assessments after a slight increase as pregnancy as a reason for absence.

We have introduced a new Occupational health system which supports the referral and reminder for staff appointments and enables managers to access the information required directly, shortening referral wait times and improving access to information to support with the management of attendance.

Performance for Sickness Absence: Monthly Rate



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Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Workforce **Appraisal Rates**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	90.6%			

The consolidated appraisal compliance currently stands at 90.64% which is a drop from June when we reported 91.89%. Clinical Support and Women and Children are the only divisions above target.

We launched the new Let's Talk Appraisal toolkit on the 1st June 24, and we are trailing a self-submission process for colleagues to input the recording of their own appraisals via the Self Service element of ESR. This is being implemented alongside the normal reporting process for now.

The OD Team continue to provide a monthly Appraisal training session to support colleagues who need to undertake appraisals in their team, this training has been updated to reflect the new processes.

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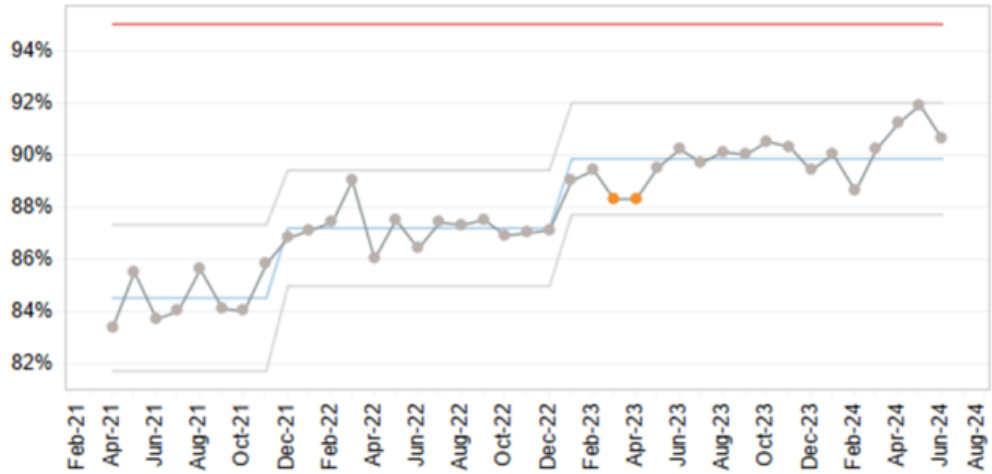
Performance for Appraisal Rate: Overall



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

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NHS Stockport NHS Foundation Trust

Finance

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-57.7%	↗	● ● ● ● ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		13.2	↘		
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	8.1%	→	● ● ● ● ● ●	●
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	1.1%	↑	▲ ▲ ▲ ● ● ▲	▲

Risks

Cash remains one of the biggest risks for 2024-25 with the cash risk increased on the Trust Risk register to 25. Revenue support has been received at short notice in July and further applications will be made in Q2; however discussions continue with GM ICB about a more sustainable position.

Capital - Continuing to progress schemes that were part of the original non-compliant plan will now result in a gap of £20.8m between funding and expenditure.

The estimated pay award in line with national guidance has been set at 2.1%. If the national pay bodies recommend a higher percentage this will cause an additional financial pressure.

Additional costs and loss of activity due to industrial action has not been included in the planning process. Any further industrial action taken by junior doctors will further impact on activity, expenditure, and cash.

The STEP target for 2024-25 has been set at 5% (£24.6m). Delivery of this level of savings is challenging for the Trust in year; however, all schemes considered continue to be assessed through the Quality and Equality Assessment process.

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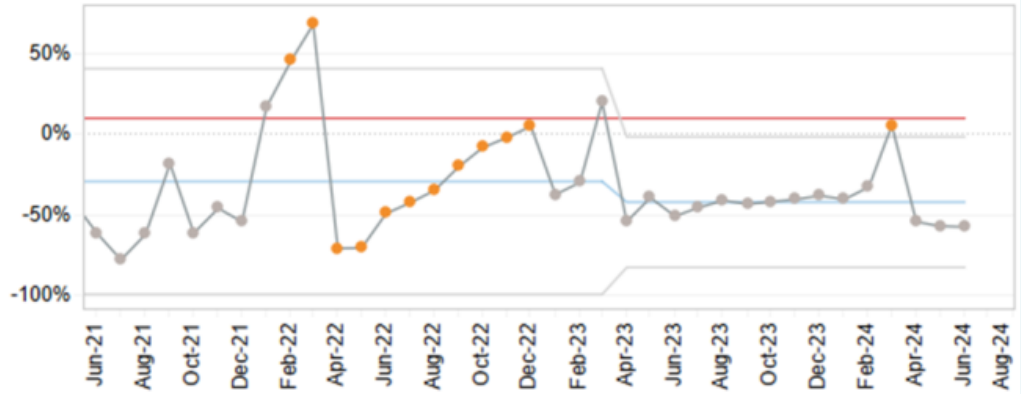
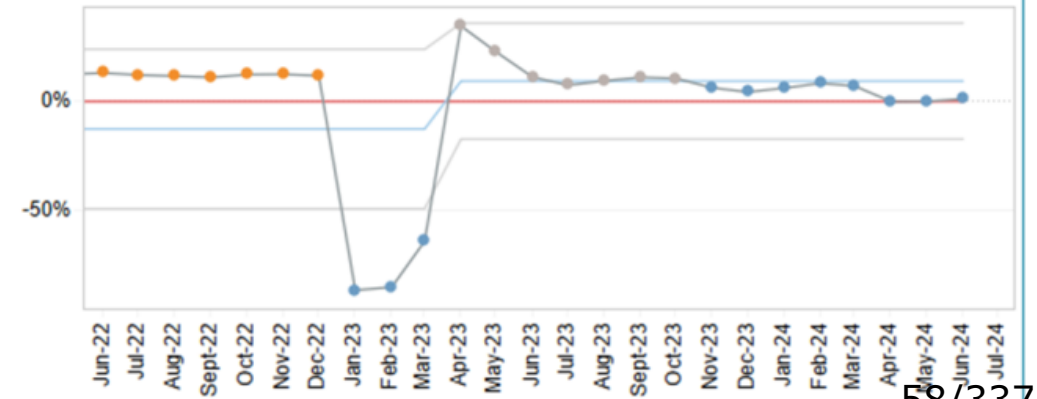
Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Update provided by	Tracy Coburn
Executive Lead	John Graham

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	11
Meeting	Board of Directors				
Report Title	Finance Report Month 3 2024/25				
Director Lead	John Graham Chief Finance Officer	**Author**	Kay Wiss Director of Finance		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to receive the Financial Position Report for Month 3 2024/25, to update on the current financial position in support of the Integrated Performance Report.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust has a deficit of £13.4m at Month 3 (June) 2024/25, which is an adverse variance of £0.1m to plan. A detailed finance paper was presented to the Finance & Performance Committee on the 18th July 2024 and this paper is the summarised key extracts from that paper. The key driver of the variance are unfunded industrial action costs.

The Trust has delivered savings of £3.3m at Month 3 which is £0.3m ahead of plan; the savings plan for the year is weighted towards the second half of the financial year and focus remains on delivering recurrent savings. The total plan for 2024/25 is £24.6m.

At this early stage in the financial year the forecast remains to deliver the financial plan for 2024/25 subject to risks highlighted within the paper

The Trust cash position remains at 25 on the significant risk register and the Trust's application for cash borrowing in June was not approved; however an application for July of £1.7m has been approved.

Progress continues with reducing reliance on temporary staffing costs via an agency and the Trust continues to be below the 3.2% target. In June additional costs of £0.4m have been incurred in bank costs

which relates to cover for industrial action, an equivalent of an additional 10 wte.

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

NHS
Stockport
NHS Foundation Trust

Board of Directors

1st August 2024

Financial Performance

John Graham
Chief Finance Officer

Contents

NHS Stockport NHS Foundation Trust

1. Overall Financial Position M3 2024-25

NHS Stockport NHS Foundation Trust

	In-Month			Year to date			Forecast		
Income & expenditure Position	**Budget £m**	**Actual £m**	**Variance £m**	**Budget £m**	**Actual £m**	**Variance £m**	**Budget £m**	**Actual £m**	**Variance £m**
Total Income	**36.3**	**36.5**	**0.2**	**107.2**	**108.0**	**0.9**	**430.6**	**430.3**	**(0.3)**
Substantive Staff	(24.9)	(24.9)	(0.0)	(73.7)	(74.0)	(0.4)	(284.5)	(291.4)	(6.9)
Bank Staff	(2.8)	(2.9)	(0.1)	(8.5)	(8.1)	0.4	(34.5)	(31.1)	3.4
Agency Staff	(1.3)	(0.8)	0.4	(3.5)	(2.6)	0.9	(13.5)	(9.6)	3.8
Pay Costs	(29.0)	(28.7)	0.3	(85.6)	(84.8)	0.9	(332.4)	(332.1)	0.3
Drugs	(1.9)	(1.8)	0.1	(5.8)	(6.0)	(0.2)	(23.5)	(23.4)	0.1
Clinical Supplies & Services	(2.5)	(3.1)	(0.5)	(7.8)	(8.5)	(0.7)	(31.3)	(31.2)	0.1
Other Non Pay Costs	(5.4)	(5.7)	(0.3)	(14.4)	(15.4)	(1.0)	(58.3)	(58.4)	(0.1)
Below the Line	(2.3)	(2.3)	0.0	(6.8)	(6.8)	0.0	(29.2)	(29.1)	0.0
Total Expenditure	**(41.2)**	**(41.5)**	**(0.4)**	**(120.5)**	**(121.5)**	**(1.0)**	**(474.6)**	**(474.3)**	**0.3**
TRUST SURPLUS / (DEFICIT)	**(4.9)**	**(5.0)**	**(0.2)**	**(13.3)**	**(13.5)**	**(0.2)**	**(44.0)**	**(44.0)**	**0.0**
Pharmacy Shop	-	-	-	-	-	-	-	-	-
Add back Fixed Asset Impairment	-	-	-	-	-	-	-	-	-
Add back Reversal of Fixed Asset Impairment	-	-	-	-	-	-	-	-	-
Remove capital donations/grants/peppercorn lease I&E impact	0.0	0.0	0.0	0.1	0.1	0.0	0.2	0.2	0.0
Remove PFI revenue costs on an IFRS 16 basis	0.0	0.0	(0.0)	0.4	0.4	(0.0)	1.7	1.8	0.1
Add back PFI revenue costs on a UK GAAP basis	(0.0)	0.0	0.0	(0.4)	(0.4)	0.0	(1.7)	(1.7)	(0.1)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(4.9)**	**(5.0)**	**(0.1)**	**(13.2)**	**(13.4)**	**(0.1)**	**(43.8)**	**(43.8)**	**0.0**

1. Overall Financial Position

NHS Stockport NHS Foundation Trust

- The Trust has a deficit of £5.0m in month and £13.4m year to date which is adverse to plan by £0.1m. This is due to the cost of industrial action in June 2024 offset by an overachievement in delivery against the STEP target at month 3.

- The Trust forecast position at month 3 is in line with the annual plan that has been submitted to GM and nationally – a year end deficit of £43.8m.

- The STEP target at month 3 is £3.0m of which 50% is recurrent. The STEP target has overachieved in month 3 by £0.3m however, at this point most of the savings are non-recurrent. This is the key financial focus for the Divisions.

2. Forecast

NHS Stockport NHS Foundation Trust

A forecast is required as part of the NHSE reporting pack at M03, and at this stage of the financial year the forecast will be reported in line with plan.

Current high-level risks to the forecast are:

- The estimated pay award in line with national guidance has been set at 2.1%. If the national pay bodies recommend a higher percentage this will cause an additional financial pressure.

- Additional costs and loss of activity due to industrial action has not been included in the planning process. As the junior doctors have voted for a mandate to take industrial action this would impact on activity, expenditure and cash. It is not clear if funding will be made available nationally to cover any of the costs. Whilst the cost of the action in June has been included, the forecast does not include any further costs as per NHSE instruction.

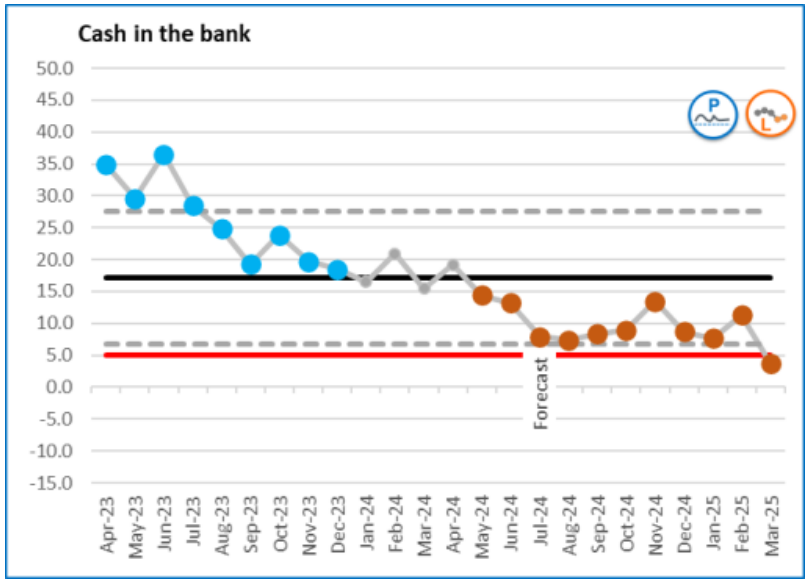
- The STEP target for 2024-25 has been set at 5% (£24.6m). Delivery of this level of savings will be a challenge for the Trust in year; however at this stage full delivery is planned.

- The risk of non-delivery of activity in accordance with ERF is still unclear and whilst an indicative target has been given, the phasing of the plan continues to be discussed.

3. Cash

a. Cash Position

Stockport NHS Foundation Trust



Cash at the end of June was £13.2m a reduction from £14.4m in May.

Capital Creditors at the end of June were £8.3m.

An application for revenue support for July has been made for £1.7m to bring total revenue support by Month 4 at £7.1m.

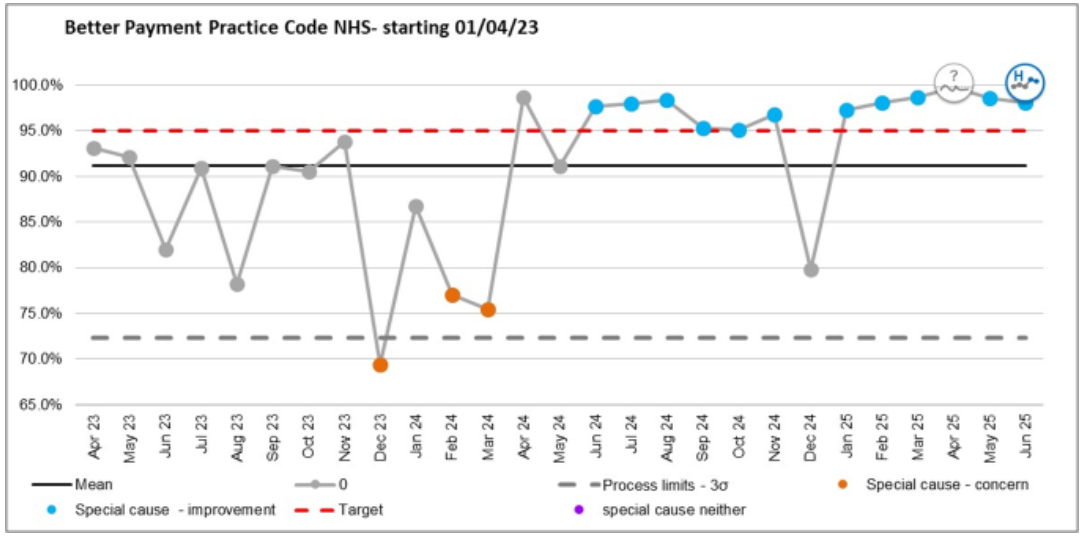
Revenue support requests for the remainder of the year are subject to the confirmation of additional system funding from GM, however further applications for revenue support over the remainder of the year up to the Trust annual deficit of £44m are included in the forecast shown.

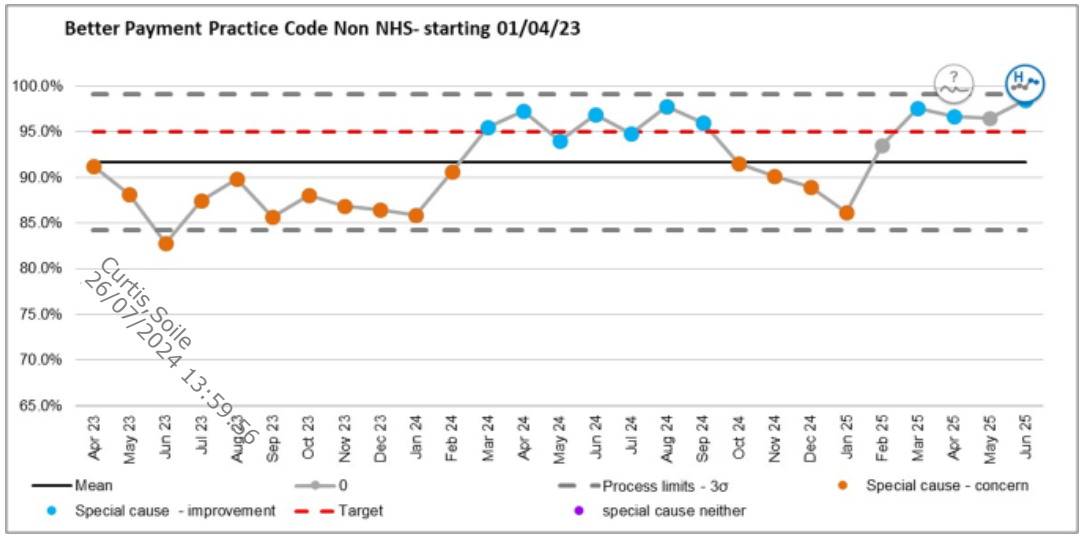
Cash Balances will continue to be monitored by the Cash Monitoring Group including the management of weekly BACS payments in order to protect the cash position to ensure payroll can be paid.

At the current time the cash risk remains at a score of 25 on the significant risk register

4. Cash

b. Better Payment Practice Code





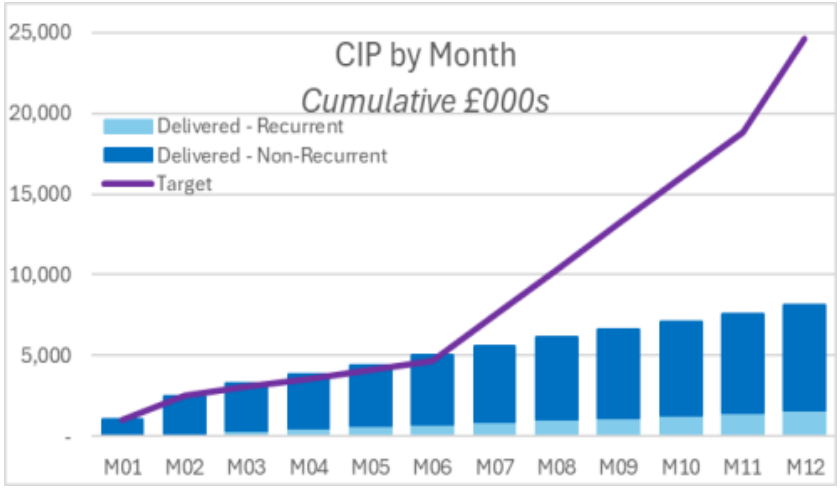
The Better Payment Practice Codes (BPPC) sets the target for 95% of all valid invoices to be paid within the agreed timeframe.

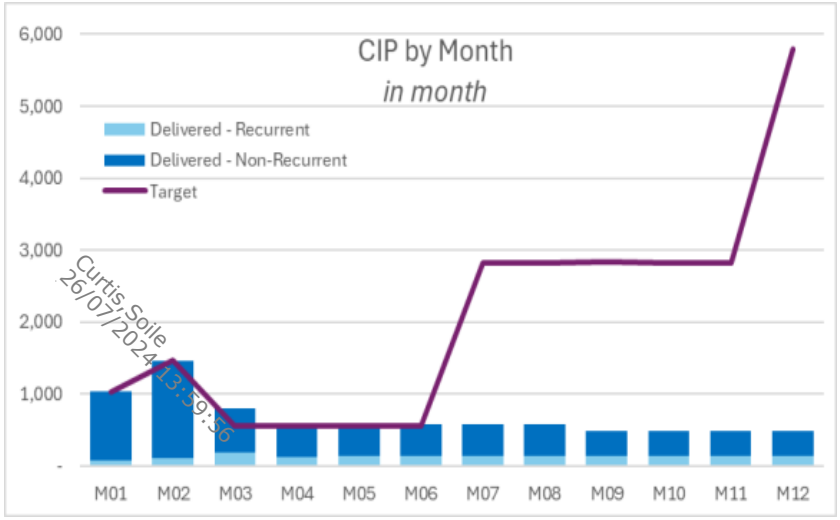
Performance against the standard is reported for both NHS and non-NHS invoices, as shown in the charts.

Performance continued to be above the target in June; however in future months depending on the cash position this could deteriorate depending on the level of payments held or delayed.

5. Key Drivers of the Financial Position

a. STEP (Stockport Trust Efficiency Programme)





The Trust STEP target for 2024-25 is £24.6m. This is split evenly between recurrent and non-recurrent savings.

The target is split £19m across the divisions with £5.6m technical.

The target to month 3 is £3.0m of which 50% is recurrent.

To date the Trust has delivered the £3.2m savings however, only11% is recurrent.

The total actioned full year is £8.1m of which £1.6m (19.5%) is recurrent.

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

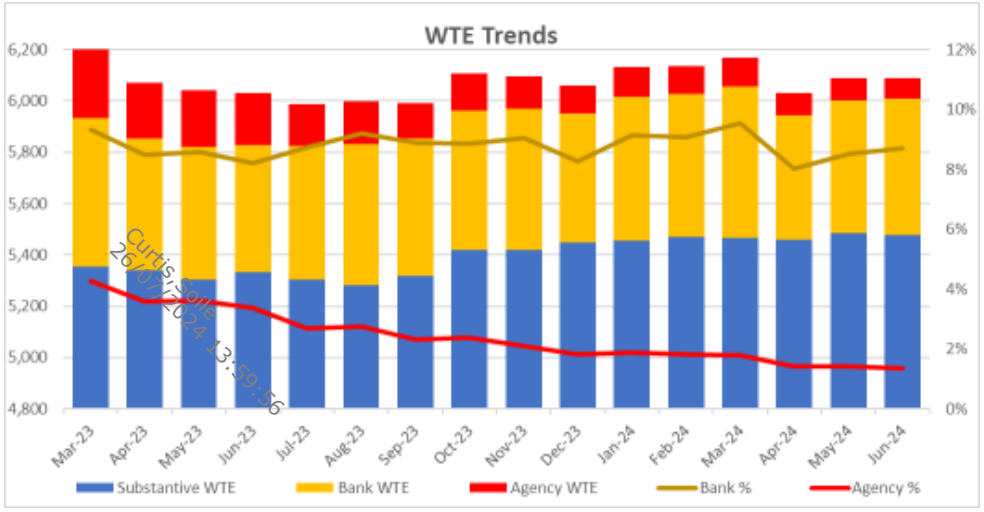
Deep dive quarterly sessions continue across Divisions

5. Key Drivers of the Financial Position

b. Staff and WTE reconciliation - WTE

Stockport NHS Foundation Trust

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



As can be seen in the charts there has been a slight increase in wte in June compared to May, but both still represent a reduction from March 2024.

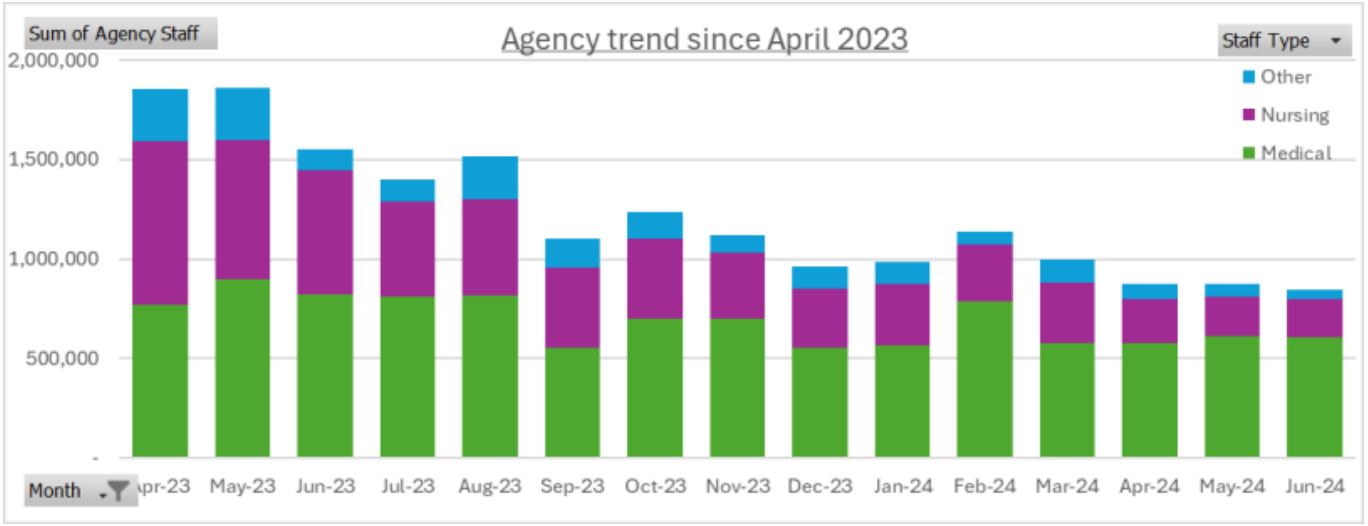
The increase in substantive staff relates partly to successful recruitment, and also to posts which have previously been capitalised in 2023/24, particularly the Digital & Informatics and Estates Team, but are no longer affordable within the capital envelope for 2024/25.

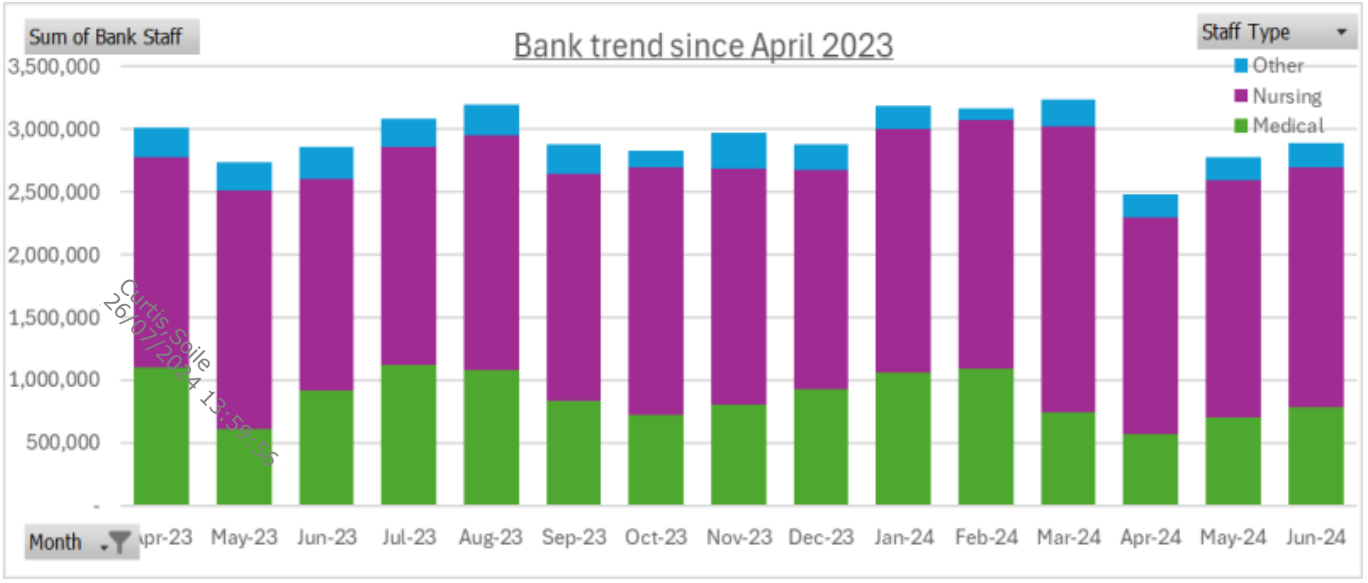
The positive trend in reduced agency usage has continued. Agency staff WTE as a percentage of total staff has reduced from 4.3% in March 2023 to 1.4% in June 2024.

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

5. Key Drivers of the Financial Position

b. Staff and WTE reconciliation - £





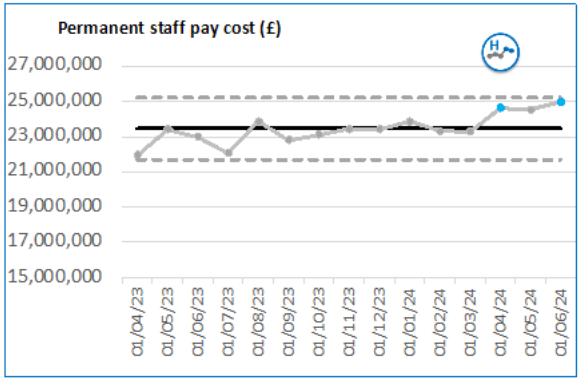
These graphs show that agency costs have reduced in line WTE over the past year and are now less than £1.0m per month, with month 3 being the lowest in the period. Costs remain predominantly for medical staff, though there are also costs for nursing and other staff groups.

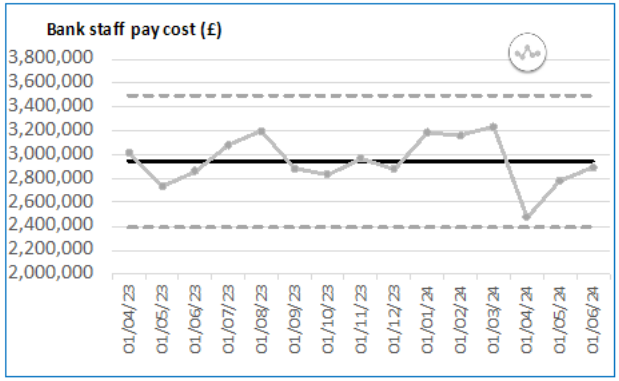
Bank costs have remained under £3.0m per month for quarter 1 2024-25, with the reduction mainly falling in nursing.

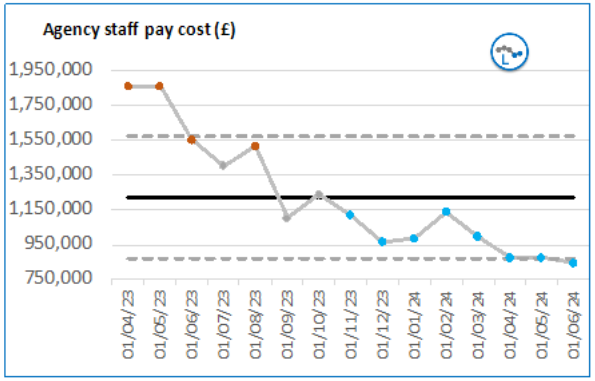
This supports the data shown in the SPC charts on the following slides.

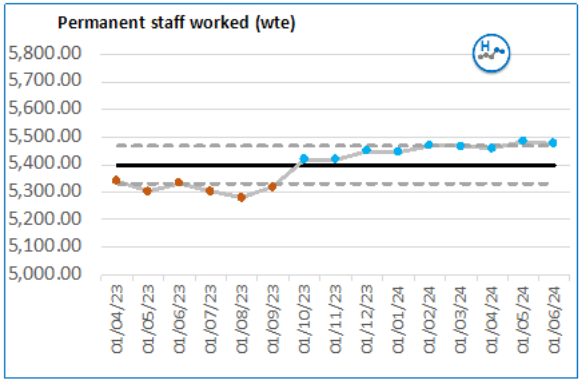
5. Key Drivers of the Financial Position

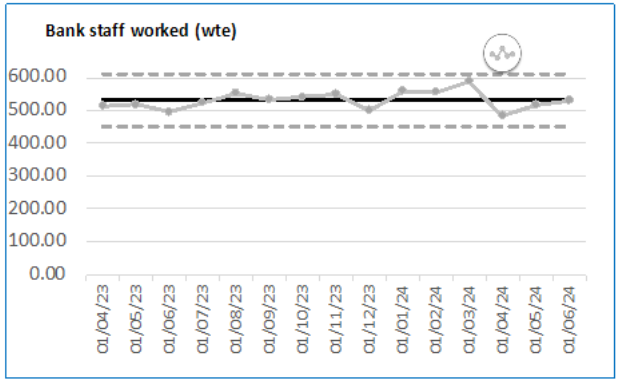
c. Temporary Staffing – All staff groups

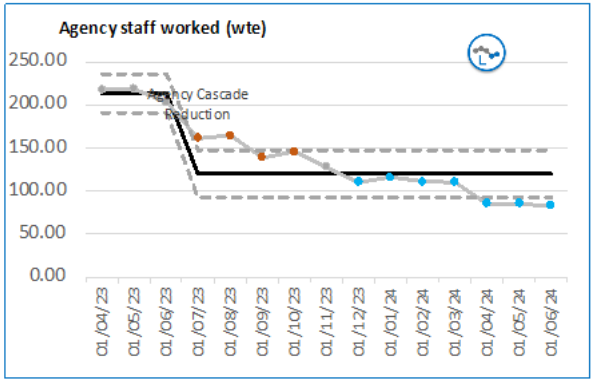












Month 2 includes the 2023-24 actual pay costs for the consultants. 2.1% has also been included to month 3 for the 2024-25 pay award in line with planning assumptions.

Month 3 includes costs and WTE covering the industrial action which took place on the 27th – 30th June 2024, £384k – 10.39 wte and is predominantly medical staffing costs

5. Key Drivers of the Financial Position

c. Temporary Staffing

NHS Stockport NHS Foundation Trust

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

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

- Continued scrutiny at the Staffing Approval Group to challenge agency requests, including rates and the use of alternative agency providers. Since month 3, all agency and recruitment requests are subject to additional scrutiny and approval via the ICB.

- Engagement with NHSP Gateway Service has commenced, engagement with the divisions has identified an appetite for supporting CESR opportunities in Microbiology, Radiology, General Medicine (including Geriatrics & Stroke), the available candidates are being explored.

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

- Focussed work continues through the Workforce Efficiency Group on reducing temporary staffing costs

6. Capital

Description	Month 3			Year To Date M3			2024-25		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Estates	1.5	1.2	(0.3)	4.3	3.5	(0.8)	20.9	39.9	19.0
Equipment	-	-	-	-	-	-	-	-	-
IFRS16	-	-	-	-	-	-	3.5	3.5	-
IT	-	0.2	0.2	-	0.6	0.6	4.7	6.5	1.8
Total	**1.5**	**1.4**	**(0.1)**	**4.3**	**4.1**	**(0.2)**	**29.1**	**49.9**	**20.8**

The Trust has resubmitted the capital plan for 2024-25, and now has a compliant plan totalling £29.1m including £3.5m for IFRS16.

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

Discussions continue with NHSE about additional support for schemes to support key projects.

7. Recommendations

Stockport NHS Foundation Trust

The Board of Directors is asked to:

- Note the financial position of the Trust to M03 and the key drivers within the position
- Acknowledge the cash and capital risks for 2024/25 and beyond

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	12
Meeting	Board of Directors				
Report Title	Digital Strategy 2021-26 Progress Report				
Presented by	Peter Nuttall, Director of Informatics	**Author**	Digital and Informatics Team. Peter Nuttall.		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to review the content of the report and confirm progress against the Digital Strategy 2021-26.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains.

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

This paper relates to the following Board Assurance Framework risks.

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

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

Where issues are addressed in the paper

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

Executive Summary

This is the fourth update report on the delivery of Trust's Digital Strategy (2021-2026). The Strategy was approved by the Trust Board of Directors in December 2022 and four update reports have been generated in October 2022, May 2023, November 2024, and May 2024 (this report). The report is structured around the seven key ambitions of the strategy (see diagram below) and provides an update on the actions listed against each of the ambitions in the strategy document and includes outcomes resulting from the work (blue italics).

1. Introduction

1.1 The aim of this report is to update the Board with work that has been undertaken in the last six months to deliver the Trust's Digital Strategy. Detailed below are the key highlights from the report.

2. DIGITISE patient care

2.1 The Digital Nursing Team has delivered advanced functionality within PatienTrack, including Sepsis 6 risk assessment and personalised data dashboards, to support clinical observations and provide visibility of patient acuity. Outcomes resulting from this work are reported (in blue italics) in the paper.

3. EMPOWER our patients

3.1 Comprehensive patient- portal functionality will be procured as part of an acute EPR solution; however, using a current Trust system supplier, a basic patient portal has been established allowing patients to read their outpatient appointment letters and receive messages to confirm their requirement for an appointment if there are long wait times. In addition, a proof- of- value exercise is underway to ascertain whether the costs of sending clinical letters to patients via the Trust portal/NHSApp is a more cost-effective approach than via post.

4. SUPPORT our staff

4.1 E- learning training continues to be revised to split training into smaller modules to allow flexibility when completing digital training. The team has delivered digital training packages for the new blood- tracking solution (Haemonetics) and Solus Cardiology, alongside the delivery of PatientCentre Outpatients e learning, to allow users of the old green screen solution to move onto the more modern interface.

5 INVEST in our infrastructure

5.1 The vast majority of the new wireless infrastructure / cabinet upgrades have been completed. There remain several cabinets that are deemed complex due to significant building/movement works. The programme will fully conclude by end of August 2024.

6. ENGAGE our clinical leaders to improve quality

6.1 Accurate and complete clinical coding of activity is important to ensure patient safety, accurate benchmarking, and appropriate reimbursement, under the block payment regime, for the services we provide. The Clinical Coding Team now has access to the Greater Manchester Care Record to view patients' comorbidities as recorded on primary care systems. Use of this system, together with the implementation of ClearView, a clinically driven digital coding validation and audit system, has helped to improve the quality and depth of clinical coding.

7. ENHANCE our performance

7.1 Work continues on transitioning community data into a single Trust data warehouse, developing the underlying reporting structure, and rebuilding national reporting. Re-development of local reporting from the data warehouse has started. The review process for operational reporting requirements with the community service teams has also commenced.

8 COLLABORATION with our partners

8.1 Stockport & Tameside digital teams continue to work on the preparation activities for the formal procurement and implementation of a joint EPR solution. A joint Outline Business Case was supported by both Trust Boards in Jan/Feb 2023. The Boards recognised the affordability gap in the case, but wished to see progression to the formal procurement stage where exact costs would be finalised. This position was supported by GM ICS and the case was submitted to the Regional Team in May 2023. There has been significant remodelling on the financial schedules

to improve the Trusts' positions. Unfortunately, the Trust has yet to get national approval for the business case and continues to work with the Frontline Digitisation Team, ICS, and National Capital and Cash team. It is hoped that approval will be granted in Q2 2024-25 to allow the formal procurement to commence.

9 Recommendations

The Board is asked to note the content of this paper and supporting Digital Strategy; Delivery Update Report.

Digital & Informatics Team

NHS Stockport NHS Foundation Trust

Digital Strategy

2021-2026

Delivery Update: No 4

Trust Board of Directors

May 2024

CONTENTS

1. INTRODUCTION

This is the fourth update report on the delivery of Trust's Digital Strategy (2021-2026). The Strategy was approved by the Trust Board of Directors in December 2022 and three update reports have been received in October 2022, May 2023, and November 2024.

The delivery of the strategy is the responsibility of the Digital and Informatics Teams, with oversight from the Digital & Informatics Group. This Group meets on a bi-monthly basis and is chaired by the Director of Informatics. Key Issues & Assurance Reports are presented to the Finance and Performance Committee.

2. REVIEW OF AMBITIONS

The report is structured around the seven key ambitions of the strategy (see diagram below) and provides an update on the actions listed against each of the ambitions in the strategy document.

3 FUNDING OPPORTUNITIES

The digital and informatics department have been successful in securing additional external capital funding including £9.9 million in 2021/22, and £8 million 2022/23. This has enabled investment in a new LIMS solution, ophthalmology EPR, blood tracking system, improved digital dictation, mobile devices for acute/community and significant investment a replacement acute wireless solution and supporting network cabinet refresh programme.

4 OVERALL PROGRESS ON DELIVERY

In the past 6 months, the teams have continued to progress with the delivery of the digital strategy in parallel with managing all BAU activities.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Acute EPR (Electronic Patient Record).

Stockport & Tameside digital teams continue to work on the preparation activities for the formal procurement and implementation of a joint EPR solution. A joint Outline Business Case was supported by both Trust Boards in Jan/Feb 2023. The Boards recognised the affordability gap in the case, but wished to see progression to the formal procurement stage where exact costs would be finalised. This position was supported by GM ICS and the case was submitted to the Regional Team in May 2023. There has been significant remodelling on the financial schedules to improve the Trusts' positions. Unfortunately, the Trust has yet to get national approval for the business case and continues to work with the Frontline Digitisation Team, ICS, and National Capital and Cash team. It is hoped approval will be granted in Q2 2024-25 to allow the formal procurement to commence.

Laboratory Information Management System (LIMS).

The LIMS (Telepath replacement) programme is progressing and is now planned to go live in October 2024, in a sequence of go lives with Bolton, NCA, and Tameside. For Stockport, the LIMS programme forms part of a bigger Pathology Digital Programme which also includes the implementation of GM digital pathology, which is technically live, but operationally delayed, as a result of pressures and vacancies in cellular pathology.

Optimising existing systems and maximise capabilities.

The Digital Nursing Team has delivered advanced functionality within PatienTrack, including Sepsis 6 risk assessment and personalised data dashboards, to support clinical observations and provide visibility of patient acuity. This work not only has an impact on patient safety, but also enables more accurate BI reporting on patient acuity and nursing intervention. The team continues to develop the system as requested to support key patient safety initiatives and plan to introduce falls/bed- rail assessment modules, Purpose T skin integrity assessments and Paediatric Early Warning Score assessments in this financial year.

Outcome: Delivery of SEPSIS 6 Screening in Patientrack supports the assessment, identification and management of sepsis and informs antibiotic requirements. Total rolling 12-month position of timely recognition of sepsis is at 98.2%, enabled by electronic assessment tool and automated alerting of patients with amber and red risk markers.

Outcome: Following delivery of MUST electronic nutrition and hydration risk assessment in Patientrack in November 2022, the percentage of new patients assessed within six hours of admission has increased from 44% in December 2022 to 86.4% in July 2024.

Advantis Ward developed to include bespoke 'No Criteria to Reside' and delayed discharged assessments to support operational planning and patient flow.

Maximising the benefits of Community EPR.

New pipeline developments in the community EPR solution include the introduction of the use of Accurx to support direct patient communication via text, which automatically records in the patient's record, and the provision of electronic pathology ordering to support streamlined workflows and operational efficiencies in the Pathology department.

Expanded system integration and data sharing.

Working with Stockport Locality and GMSS colleagues, we have undertaken a review of access profiles within the Greater Manchester Care Record (GMCR) for Trust staff to facilitate a relaunch of Electronic Palliative Care Coordination Systems (EPaCCS). EPaCCS is used to record and share an individual's care preferences and key details about their care at the end of life. An earlier planned launch in November 2023 was not achieved due to factors outside the Digital Team's control, and the teams are now working on a releaunch in Q1 2024-25.

Explore use of AI/VR & NLP.

Enhanced digital dictation allows the clinician to dictate their letters but instead of providing medical secretaries with voice files from which to type the associated letter, a text file is provided for the secretary to review and then send. Following a successful pilot, enhanced digital dictation has been implemented across all clinical specialities apart from Obstetrics and Gynaecology. Date for go live still to be confirmed. The benefits of this solution are reduction in turnaround times for letters being sent to GPs. During the next 12 months, the team will be going out to procurement for a replacement solution as the current system is no longer supported and will include opportunities as part of this procurement to explore more advanced solutions such as ambient dictations to support workflows and administrative efficiencies.

'AI' functionality to be introduced into radiology PACS system to provide clinical decision support to diagnostic radiographers.

Digital Clinical Safety.

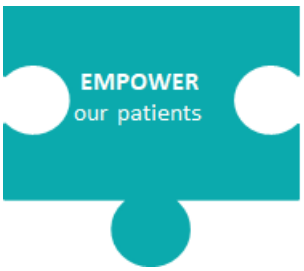
A robust governance structure and process have been implemented to track and progress the organisation's compliance with DCB standards to ensure the clinical safety of digital systems is assured prior to implementation. A Digital Clinical Safety Group has been established with multi-disciplinary representation and a series of templates and support packages established to enable project teams to achieve compliance. A network of Clinical Safety Officers is being established.

COMPLETED PROJECTS:

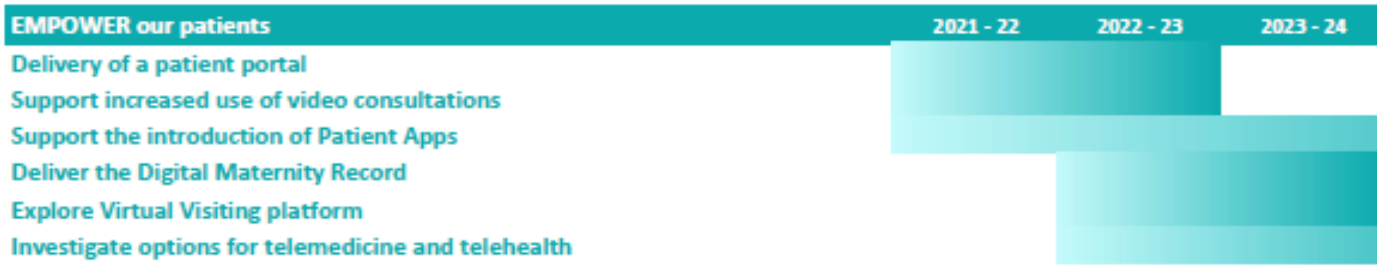
Haemonetics BloodTrack;
MASEY Colposcopy;
Infoflex;
Rhapsody integration engine;
Telepath integration with Greater Manchester Care Record.
Outcome: Masey Colposcopy – Compressed a 6–9-month project into 16 weeks to support a recurring Divisional STEP of £17k per annum.

NEW PROJECTS COMMENCED:

CLIO – E clinical outcome forms (in- house development to replace green paper RTT forms) to improve data quality and patient tracking for patients on RTT pathways.
E-Patch;
E-Triage;
Solus Endoscopy;
Solus Cardiology;
Evolve upgrade;
Advantis EDT – document sending system.



OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Delivery of a patient portal.
Comprehensive patient- portal functionality will be procured as part of an acute EPR solution; however, using a current Trust system supplier, a basic patient portal has been established allowing patients to read their outpatient appointment letters and receive messages to confirm their requirement for an appointment if there are long wait times. Having secured £75K from the national Wayfinder programme, work has been completed on the Trust's portal to the NHS App link to enable patients to view their appointment. In addition, a proof- of- value exercise is underway to ascertain whether the costs of sending clinical letters to patients via the Trust portal/NHSApp is a more cost-effective approach than via post.

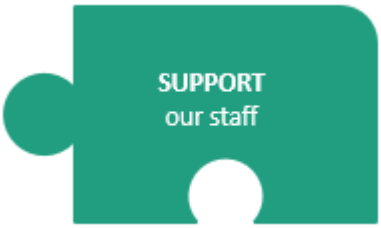
Support increased use of video consultation.
The team has procured a new contract with Attend Anywhere to allow the Trust to continue to offer video consultations to our patients, with operational teams responsible for the uptake and wider use of the functionality.
Outcome: reprocured video consultation functionality, supporting clinical care, at a significant price reduction from the centralised GM contract through efficient negotiations (£20k saving per annum on GM centralised costs).

Support introduction of patient applications.
As part of a GM Elective Recovery Programme, the Trust piloted the 'My Recovery' application. This supports patients cared for by Trauma & Orthopaedics in completing questionnaires to enable the team to track pre- and post- operative patients.

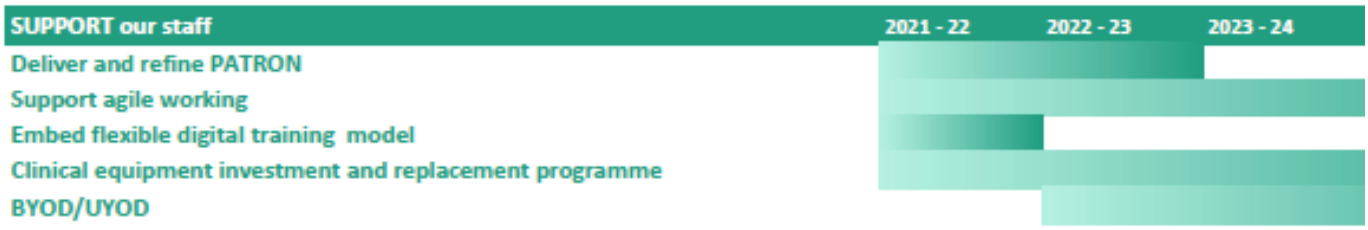
Delivery of the digital maternity record.
Progress in building system enhancements into Euroking has been slow due to ongoing supplier capacity issues. This has been exacerbated by a national issue with Euroking that has caused clinical risk in some Trusts but only data-quality issues at Stockport. A detailed internal investigation was held, and all mitigations put in place. Work continues to ensure actions outlined in the National Patient Safety Alert, published 7th December 2023, are completed. A second digital midwife has now been appointed.

Explore virtual visiting platform.
No updates.

Investigate options for telemedicine and telehealth.
No updates.



OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Embed flexible digital training model.
E- learning training continues to be revised to split training into smaller modules to allow flexibility when completing digital training. The team has delivered digital training packages for the new blood- tracking solution (Haemonetics) and Solus Cardiology, alongside the delivery of PatientCentre Outpatients e learning, to allow users of the old green screen solution to move onto the more modern interface. Work is also underway to refresh Community EPR modules. The Digital Skills Team and Digital Nursing Team also have a standing session at the new Staff Induction Programme to support new members of staff with the use of Trust clinical digital systems.
Outcome: Over the past 6 months 6,684 'e learning' courses have been completed by staff to support provision of appropriate access to clinical systems.

Clinical equipment investment and replacement programme.
Digital Clinical Ward Rounds continue Trust wide, with representation from IT and the Digital Nursing Team, to ensure digital equipment in clinical areas continues to enable care as required and that staff have the equipment which they need to fulfil their clinical roles and responsibilities. The Team is continuing to roll out new devices including ePMA trolleys, dual- screen ward- round trollies, and single screen desktops on wheels, across all clinical areas, to support changes in ways of working and care delivery. There are approx. thirty devices left to be distributed. Work has also been undertaken to remind staff in clinical areas how to report issues with broken IT equipment to ensure that they can be fixed as soon as possible.

BOYD/UYOD (Bring/ Use Your Own Devices).
No updates.

COMPLETED PROJECTS:
Support agile working;
Deliver and refine PATRON clinical portal.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Optimisation of Unified Communications (UC) Programme.
Initial programme deployment was completed in Sept 2022. More agile elements of the programme were not delivered due to the speed and nature of the initial deployment due to the COVID-19 pandemic. The Digital Technology & Support team has begun a major handset rationalisation programme to further realise the benefits of the new UC solution. Significant numbers of software (softphone) phone licences have been deployed, reducing the need for physical handsets, and allowing for re-deployment of those handsets to those areas that need them.

Implementation of Vocera Communications System.
Investments in hardware have been made but the programme is on hold pending completion of the wireless/cabinets programme. A business case for the restart of Vocera will be presented through the Trust's governance processes.

Introduction of Virtual Desktop Infrastructure (VDI).
Following completion of rollout of the new VDI solution across all community locations, the acute rollout has now commenced but will be aligned with the mandatory deployment of Windows 11.

Windows 11.
Significant preparatory works, including the introduction of automatic deployment options, have been completed, ahead of the commencement of the Windows 11 upgrade programme. This will upgrade the Trust's 4,500+ Windows- 10 based laptops and PCs with a newer, more efficient, and secure operating system ahead of the end of support date for Windows 10 (14th October 2025).

Office 365 / Microsoft Teams.
Most staff have been 'onboarded' to Office 365, with less than 8% of the total target staff groups remaining. This programme will be completed by quarter 2 of 2024-25, after which a programme to migrate all Cisco Webex users to Microsoft Teams will commence, with planned completion in quarter of 2024-25.

Review and rationalise/optimisation of all end-user devices.
Once the VDI programme is complete, a full end-user device rationalisation programme (tablets, PCs, and laptops) will commence. Piloting of new, more capable, Microsoft-surface- hybrid laptops is underway in Community. The devices will replace the Samsung tablets.

Replacement of Beech House data centre.
Due to significant challenges with the current 'end of life' cooling systems in the Beech House server room and the overall deterioration of the Beech House building, a programme has commenced in conjunction with Estates & Facilities to look at all options, including a data centre "pod". Architects have been appointed and have produced several options for consideration. A further, more comprehensive, assessment of the Beech House building is pending and will help inform the options.

Review external partners IT support arrangements.
GM Shared Services provide our connectivity to community sites and the wider HSCN network. A three-year extension to this contract was put in place in 2023-24, which avoided any annual increase in the cost. An options appraisal is planned for quarter 4 of 2024-25 and this will determine what the approach will be for connectivity requirements at the end of this contract. A migration to alternative connectivity will take in the region of 12 months.

Digital equipment tracking system.
Investments have been made, but the programme is on hold pending completion of the wireless/cabinets programme that is a prerequisite for this.

Review patient 'infotainment' system.
No updates.

Centralised printing solution.
A fully- managed print solution has been deployed across all Trust departments/divisions, including community, which provides for scanning and locked/secure print. This comes with significant reporting/intelligence on the type of printing being undertaken. Whilst this programme represented a c£45k cost saving over the previous printing arrangements, further opportunities are available to make significant savings and the Digital Technology & Support team has already flagged this with senior management.
Outcome: New metric to be monitored- reduction in colour printing as a percentage of the total volume (target volume of around 10% of the total). Colour printing accounts for around 20 – 25% of our total monthly print volume and 75% – 80% of the cost. Halving the monthly colour print volumes, could save anywhere between £30k - £90k recurrently). Latest data: 23.9% of printing done in colour.

Maintain security against cyber- attacks.
Significant progress in regular software updating/patching has been made, backed by robust and structured change control processes. Palo Alto cyber- security capabilities have been deployed, providing threat detection and remediation for our network (referred to as East to West- type traffic).

A Business Case was fully approved for investment in next-generation firewalls, providing for the best possible perimeter security. These will be fully deployed by quarter 2 of 2024-25 ahead of the existing firewalls' end- of-support date.

Major improvements/governance changes are planned for cyber security including the introduction of a five- year Cyber- Security Strategy, the formation of a Security Operations Centre (SOC), and the production of an overarching business case for consideration to address our people-centric cyber- security deficiencies.

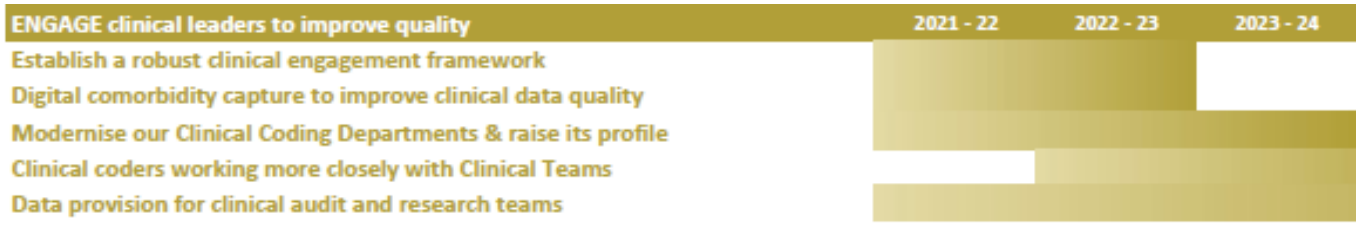
Replace acute wireless infrastructure.
The vast majority of the new wireless infrastructure / cabinet upgrades have been completed. There remain several cabinets that are deemed complex due to significant building/movement works. The programme will fully conclude by August 2024.

Infrastructure replacement/enhancement 5-year Investment Plan.
A five- year Infrastructure upgrade/replacement roadmap and plan is being produced that will outline the technical priorities for the next five years.
Outcome: Core Infrastructure Uptime Target of 99.999% (excludes planned downtime/maintenance). Latest data: June 99.999%.

Deliver an effective information governance framework and maintain accreditations and certifications that demonstrate information security best practice.

Outcome: Achieving "Standards Met" for all mandatory requirements of the Data Security and Protection Toolkit Assessment 2023/24. Maintaining ISO 27001 (Information Security Standard). Maintaining accreditation to the Secure Email Standard (DCB 1596), which allows the Trust to send secure (encrypted) email to other accredited organisations.

OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Establish a robust clinical engagement framework.

Work is currently underway to engage clinical teams across both the acute and community sites in preparation for the procurement of an EPR. Clinical teams have been engaged through workshops, forums, and 1:1 discussions to inform creation of demonstration scripts. Once the EPR programme is confirmed, the foundation building work completed to date will inform the establishment of an engagement framework that will underpin digital clinical safety, IT development prioritisation, and EPR procurement/implementation. Efforts are currently underway to design a Trust Digital Champion Programme that will increase the presence and impact of digitally- enthused clinicians across the organisation to promote pipeline projects and to garner momentum and interest in the digital and informatics specialties.

Digital comorbidity to capture to improve clinical data quality.

This development is currently on hold due to staffing pressures in the Trust's Digital Development & Integration Team. A review of the need for this application, given the recent implementation of ClearView coding software, is to be undertaken.

Accurate and complete clinical coding of activity is important to ensure patient safety, accurate benchmarking, and appropriate reimbursement, under the block payment regime, for the services we provide. The Clinical Coding Team now has access to the Greater Manchester Care Record to view patients' comorbidities as recorded on primary care systems. Use of this system, together with the implementation of ClearView, a clinically driven digital coding validation and audit system, has helped to improve the quality and depth of clinical coding.
Outcome: The benefits of the implementation of ClearView can be seen with a 10% increase in net tariffs per patient spell (+£1.1m across 12 months) and an increase in the average co-morbidity per spell (SHMI) from 4.53 to 5.17 (the national mean is 4.66).

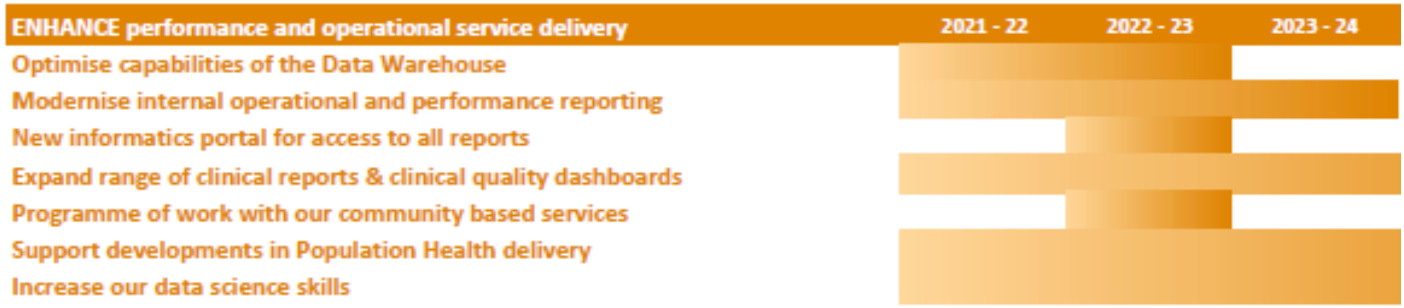
Modernise our clinical coding department and raise its profile.

Clinical coding is a highly skilled task that requires considerable training and extensive knowledge. The coding team has undergone a reorganisation, with the establishment of a new management team, including a joint Head of Clinical Coding, working collaboratively across Stockport and Tameside. A cross-organisational training team is in the process of being established, with the recruitment of a new trainer to support staff development and professionalism. The management team attends regular clinical meetings including Clinical Effectiveness, Clinical Directors' Forum, Mortality Review Group, the Palliative and End of Life Care Steering Group, and the Haematology Improvement Project Board. Clinical Coding presentations are delivered to new junior doctors and, once fully established, the new Clinical Coding Improvement Lead post will continue to help deliver the department's improvement and engagement programme, linking in more closely with divisional clinical leads.

Clinical coders working more closely with clinical teams.
See previous point.

Data provision for clinical audit and research teams.
To support improved access to data for clinical audit and research in the future, the following detail has been included in the draft EPR output- based specification and will be a requirement of a future EPR supplier.
'*The EPR solution must also allow for effective clinical audit by providing functionality to easily identify cohorts of patients, and subsequently supply a standard set of information and ad hoc reports to assess clinical practice. A combination of specific clinical audit reports and alerts are expected to be provided by the bidder to support the clinical audit function for each discipline.'*

OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Optimise capabilities of the data warehouse.

The Trust's Data Warehouse centralises data from seventeen different clinical and administrative digital systems. Having data in one central place makes reporting, analytics, and external data submissions easier and more comprehensive. SQL data warehouse consolidation work continues, refining the underlying data models and developing new reporting layers in order to decommission legacy reporting tables, supporting the move to a "single version of the truth." Data from the Trust warehouse feeds into high profile NHS England improvement programmes, including Model Hospital, GIRFT and Faster Data Flows, as well as to the Integrated Care System supporting their System Control Centre, the new OPEL framework, and locality board reporting. This data is driving decision-making so particular attention is played to data quality with an established Trust Data Quality Review Group providing assurance and recommending improvements to ensure that data quality remains consistently high.

Modernise internal operational and performance reporting.

The Business Intelligence (BI) team continues to work closely with operational and transformation teams to develop and improve internal reporting. A significant focus recently has been supporting the theatres improvement project with a review of the underlying SQL databases and reporting datasets to ensure methodologies for calculating local reporting measures match those being used by Model Hospital and the national team. This review has also included a focus on data quality to ensure national data flows are accurate, fully validated, and contain the relevant theatre records. A new daily theatre flash report tool has been developed to allow operational teams see the performance of each individual theatre session each day, monitoring late starts, early finishes, overruns, on-the-day cancellations, booking utilisation, and much more. This tool, in combination with daily review meetings, has led to improvement in 'touch-time' utilisation. Several new Tableau theatre dashboards have also been developed, including a new scorecard that summarises performance and ranks specialty and consultant on highest to lowest theatre utilisation. These scorecards are being used by services to celebrate good performance and to highlight areas for improvement.

New informatics portal for access to all reports.

The BI team has started to develop centralised menus within Tableau for access to groups of similar reports.

Expand range of clinical reports and clinical quality dashboards.

As part of the transformation project to maximise perioperative patient opioid management pathways, in line with national guidelines, the BI team has developed a dashboard to monitor the opioid usage for hip- and- knee surgery patients on admission and during their hospital stay. BI continues to support the deteriorating patient group with data and dashboards and the Palliative and End of Life Care Group has recently been supported with an updated comfort-observations dashboard to monitor any issues in the process and outcomes of the observations made specifically for

end of life care, including missed observations, median duration time for patients on comfort observations, and assessment of patients with moderate/severe pain/agitation/sore mouth during last 24 hours of life.

Programme of work with our community- based services.

Work continues on transitioning community data into a single Trust data warehouse, developing the underlying reporting structure, and rebuilding national reporting. Re-development of local reporting from the data warehouse has started. The review process for operational reporting requirements with the community service teams has also commenced.

Support developments in population- health delivery.

The BI team continues to support the work of the Integrated Care System with the development of risk stratification tools that aid the locality's population- health and health- inequalities agendas.

Increase data- science skills.

No updates.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Link closely with Tameside digital teams.

Where opportunities have arisen, the teams continue to work closely together, including the use of resource from Tameside to support current interfacing requirements, and establishing a collaborative clinical coding organisational structure. Stockport and Tameside continue to work closely on a joint EPR Programme.

Digitally support the joint clinical strategy with East Cheshire.

No update.

Explore options for joint digital working

As part of the EPR Programme, the intention is to streamline support for the system and as such a single joint implementation team and helpdesk/support function has been scoped and included in the OBC. This will support the Trusts in leveraging their joint workforce to ensure the single EPR solution is a success.

Review internal and external technical interoperability capabilities.

No updates.

Alignment of ambitions with Stockport and Greater Manchester.

The Trust's Chief Information Officer (CIO) and Chief Clinical Information Officer (CCIO) attend the Stockport Digital Leaders' Meeting on a monthly basis. Currently primary care and the Trust are working together to finalise plans for a go live of 'Tquest Radiology' on 19th November. This solution will allow GPs to order radiology examinations electronically using the same system they currently use for pathology requesting.

The CIO also attends the weekly meeting of GM Provider CIOs. Both forums ensure that Stockport's ambitions and delivery plans are aligned to external plans.

SUMMARY

Delivery of the Digital Strategy is continuing to progress well, supported by the significant external investment that the team managed to secure. In addition, the Trust's major digital ambition of a new EPR solution is also progressing, which is a positive step for the Trust, although there are delays in the external approval processes due to issues with affordability. The team is, however, working hard to keep procurement and preparedness activities on track and ensure close collaboration with Tameside. It should also be acknowledged that the Digital and Informatics Team continues to deliver the day- to- day activities highlighted in the diagram below (e.g. answering helpdesk calls; maintaining, and enhancing, digital systems; securing clinical engagement; ensuring good data governance; and responding to ad hoc data requests).

NHS
Stockport
NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	13
Meeting	Board of Directors				
Report Title	People & OD Plan Update				
Director Lead	Amanda Bromley, Director of People & OD	**Author**	Emma Cain – Deputy Director of People & OD Lisa Gammack – Deputy Director of OD		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are requested to note the progress against the People & Organisational Development Plans, that support the detailed progress reports provided regarding each element to the People Performance Committee.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD plan. An update was previously reported to Board in January 2024.

We continue on our improvement journey, with ambitious aims and objectives for our organisation, operating in a challenging multifaceted context, whilst acknowledging this it is important that we measure the impact of our plans against our people key performance indicators. We have continued to see improvement and movement in a positive direction. We will continue to monitor our progress and ensure mitigations are in place should our performance change.

Our priority areas will continue to be our focus, looking to deliver an improved retention position, reducing turnover and supporting a 'grow our own' approach to our career progression and talent management. Working to continue our improvement journey in respect of our agency spend is a high priority and linked into our recruitment plans. We will continue to look for opportunities for collaboration, focussing on a joint approach to delivering our people priorities in line with the NHS Long Term Workforce Plan.

We will continue to deliver the People & OD priorities alongside the EDI Strategy 2022-25 and Health and Wellbeing Plan. We will build on the delivery achieved and will be developing our People & OD plan for 2025 onwards. We are committed to having a relentless focus on progressing our improvement journey to creating a more compassionate and inclusive culture.

The Board of Directors are requested to note the contents of this report.

1. Introduction

1.1 The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD plan. An update was previously reported to Board January 2024.

2. Priorities

2.1 In March 2023, People Performance Committee received and approved the People & OD 2023/24 priorities. This paper updates against these priorities.

3. Impact

3.1 We are on an improvement journey, with ambitious aims and objectives for our organisation, operating in a challenging multifaceted context, whilst acknowledging this it is important that we measure the impact of our plans against our people key performance indicators.

3.2 We have continued to see the 'green shoots' of improvement and movement in a positive direction. We will continue to monitor our progress and ensure mitigations are in place should our performance change.

People Key Performance Indicators:

- ✓ Annualised (adjusted) Turnover rate has continued to reduce from 11.36% (Jan 24) to 10.6% (Jun 24)
- ✓ Reduction in agency spend as a % of pay to 3% in June 2024, against the new target of 3.2%. We continue to achieve our no 'off framework' spend.
- ✓ Sickness Absence Rate remains challenging, in January 2024, at 6.51%, reducing to 5.73% in June. Our year-to-date position is 5.8%.
- ✓ We achieved our mandatory training compliance of 95% in November 2023, with a small dip below target in February and March, recovering to over 95% throughout Q1 of 2024/24.
- ✓ We achieved our role essential training compliance of 90% in January 2024 and have improved this compliance level to 93.7% in June 2024.

4. Progress Update

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

Priority	Key Area of Focus	Current Status
Organisational Development	Board & Executive Team Development	On-going (BAU)
	Trust-Wide Leadership & Management Development Offer	Behind plan (and on track to completion)
	Civility Saves Lives Programme	Behind plan (and on track to completion)
	Onboarding	On track
	Coaching & Mentoring	On track
	Talent Management & Succession Planning	Behind plan (more work required to get on track)
	Career Progression	Behind plan (more work required to get on track)
Place Based Programmes	Attracting the local population, partnership working as part of the One Stockport Programme.	On track

Collaboration	Continue to look at opportunities to collaborate e.g. Knowledge & Library Services (KLS), Resus Faculty, etc.	On track (BAU)
	Commence work with Payroll.	Complete
	Continue with Occupational Health collaboration programme of work.	Complete
Medical Staffing/ Agency Expenditure	Review opportunities for increased grip/control to reduce expenditure.	On track
Sickness Absence	Development and implementation of person-centred absence management and wellbeing policy & approach. Reduce sickness absence.	On track

4.1 **Organisational Development Plan**

The OD Service is a collaborative function, led by the Deputy Director of OD that supports both Stockport FT and Tameside and Glossop ICFT. Both Trusts have ambitious OD Plans and so we actively explore opportunities where we can do things once (where appropriate) and share learning for the benefit of both organisations. Delivering the OD Plan, continues to be challenging due to operational pressures and emerging priorities. On occasions this has led to the delay or cancellation of planned events and activities, sometimes at short notice.

Below is a high-level overview of the OD work that has been delivered to date against the key priorities.

4.1.2 **Leadership and Management Development** – The 1-day 'Introduction to Compassionate and Inclusive Leadership' course continues to be popular. To date 182 individuals have attended and 132 are booked to attend before March 2025. The participant evaluation is very positive, and many attendees have encouraged colleagues to attend which is brilliant to hear.

Following a robust contract tendering process, an external company called Enlighten were commissioned to deliver the new 1-day coaching skills course. The course aims to help managers to facilitate better conversations. To date 102 individuals have attended and a 141 are booked to attend before the end of the year. Again, participant evaluation is very positive.

We have designed a 'Managers Welcome Session' which all line managers (regardless of grade) that join the Trust will be invited to attend. This will complement the 'Trust Welcome Session' that all employees attend. The 2-3 hour session will focus on what we expect from line managers working in Stockport and the support available to help them be the best version of themselves. Sessions will be delivered by the OD Service on a bi-monthly basis and individuals will attend within the first 4-6 weeks of joining the Trust. We have delayed the launch of the sessions until Q3 2024-25 to align with the revised timing of the refreshed Trust Welcome Sessions (September 2023).

A 'Brilliant Basics Programme' for line managers is in development, this offer aims to cover the context managers operate in, generic technical skills, role and expectations of line managers, communication styles and having better conversations. Subject to approval and securing required funding and venues, we aim to launch the programme during Q3 2024-25.

Work has started on designing a multi-disciplinary leadership development programme with internal stakeholders. We aim to have a final proposal for EMT to consider in August 2024 and a central funding bid will be submitted. At this stage we anticipate the programme being launched during Q4 2024-25 onwards (earlier if possible).

To support the delivery of the Trust's EDI ambitions, we have commissioned a series of 1-day Inclusive Recruitment Courses for up to 250 recruiting managers across the Trust. Subject to securing a suitable venue the courses will take place from September 2024 onwards.

4.1.3 **Improved Working Relationships** – Our Civility Saves Lives Programme, delivered by Rambutan continues to be promoted and delivered. To date 16% of our workforce (1010 staff) has attended the

2¼ hour awareness session and 30% (1867 staff) are booked on a session before the end of October 2024 when the programme is due to end.

In May 2024 the sessions were classified as 'role essential' training on ESR, leading to a significant increase in the number of bookings. We are working closely with divisions to ensure that all available places are maximised and 'hotspot' areas are allocated places. The Head of Service is closely monitoring the programme utilisation data and acting where required.

The OD Service is currently leading on the refreshing the Trust's values and behaviours; initiated in response to our staff telling us via the NHS staff survey and other employee voice channels that we need to do more to create a compassionate and inclusive culture. In addition, it is recognised that the context we are working in has significantly changed over the last five years and so the values and behaviours need to better align with our strategic ambitions.

The project is running in parallel with Tameside and Glossop ICFT's values refresh project. We are using a variety of ways to gain staff feedback on the values and behaviours, including an online survey, listening sessions, attending team meetings and workplace visits. To date around 310 survey responses have been submitted, the closing date was 28 June 2024. A proposed set of values and behaviours will be presented to the Executive Management Team be end of July 2024 and subject to approval, launched in September 2024. This important piece of work has linkages with the timing of delivering some key actions within the OD Plan and the Trust's branding re-fresh work. For example, the timing of starting the new Trust Welcome sessions, as the session will include a section on bringing the values and behaviours to life for new staff.

4.1.4 **Onboarding** – The refreshed content and format of the Welcome Sessions is being finalised. The specific timing of switching over to the new approach will be aligned with the launch of the refreshed values and behaviours. We are working towards starting the new sessions from September 2024 onwards.

In addition, we are updating the content of the Doctors in Training Induction Session which will be held in August 2024. This is linked to the NHS measures to improve the working lives of doctors in training.

4.1.5 **Coaching and Mentoring** – Individuals, on an ad-hoc basis, continue to be supported to access free coaching via the NW Leadership Academy's Coaching Hub. We continue to maximise the executive coaching offer for Executive Directors available through our annual membership.

We have a small internal pool of qualified coaches who are providing 121 coaching support to individuals. To help increase the size of the internal pool, the apprenticeship levy is being used to support three individuals to complete the Level 5 Coaching Professional Qualification. A collaborative Coaching Network has been established to support internal coaches (qualified and trainee) within Stockport FT and Tameside & Glossop ICFT, with their ongoing development and supervision. The Network held its inaugural meeting in late April 2024 and will meet on a regular basis.

We have launched the new Reverse Mentoring Scheme initially involving BAME and disabled staff. Despite a relentless focus on promoting the scheme, it has been extremely challenging to encourage staff to put themselves forward to be a mentor. At present 2 employees have started a mentoring relationship with 2 Non-Executive Directors. Early feedback shows that the participants are finding the scheme insightful and beneficial. The OD Service will refresh the communication and promotion approach over the coming months to help encourage more employees to take part.

4.1.6 **Talent Management & Succession Planning** - Although some initial research into approaches and tools has been undertaken, this is an area of work that is significantly behind plan. This is a consequence of competing demands, emerging priorities and other OD work taking longer to complete than anticipated.

The Head of Service has explored the NHS Scope of Growth Career Conversation Tool which isn't widely used in its entirety or at all by some NHS organisations. The Head of Service sits on a Greater Manchester Talent Leadership and Culture Group where practice and learning around this agenda is shared with the purpose of us utilising this knowledge in developing our approach.

The Deputy Director of OD and Head of Service have devised a plan that will enable the OD Service to progress this key area of work at pace. This includes facilitating a series of listening sessions/curiosity cafes during July and August 2024 to help better understand individuals' lived experience. Plus, co-designing and implementing an initial suite of interventions with an on-going commitment to further improve our approach.

Alongside this, a talent management and succession planning approach will be designed and piloted in agreed areas, initially for divisional operational management. This work will be completed over a 4-to-6-month period.

4.1.7 **OD Consultancy** – Demand for OD consultancy support has increased, particularly since divisions/departments received their 2023 NHS staff survey results. The service has been supporting teams to enhance leadership capability/behaviours, culture, performance and colleague experience.

Since September 2023, we have designed and facilitated 7 team interventions involving 64 individuals. The teams involved include Finance, Clinical Audit and Clinical Coding, plus nursing teams within Surgery and Women & Children's Divisions. Most of the interventions have utilised the Lumina Spark psychometric assessment tool which enables individuals to gain a better understanding of their communication styles to support them to develop more effective working relationships. Other interventions have included activities and exercises designed to set team vision and goals, improve communication, trust and collaboration amongst team members as well as strategies for addressing any issues or conflicts that may impact the team's performance.

The OD Service continues to work collaboratively with the Human Resources Team and Transformation Team to triangulate information and identify areas where OD consultancy support would be most beneficial. We are also progressing plans to develop OD skills within the HR Team to further support strategic goals and create sustainable change.

4.2 Place Based Programmes

In support of attracting the local population, partnership working and engagement in the One Stockport Programme we have continued to strengthen our career pathways, which are included in the recruitment of these roles, for example pharmacy, nursing, allied health professionals. Our career development pathways are underpinned by apprenticeships, for example TNA / RDNA / AHPA / Assistant Therapist Apprenticeships.

We continue to work collaboratively with our system partners within the health and social care sector offering insights and experiences for all the potential career possibilities across our Borough. We focus on supporting young people from some of our most under-represented groups which is aligned to NHS England (NHSE) Widening Participation framework; and the strategic aims of our EDI strategy and consolidated action plan S1, S2, and NPAge3

4.2.1 **Registered Nurse Degree Apprentices** – We have 4 registered nurse degree apprentices (RNDAs) who have qualified and are in post, a further 4 are on track to qualify in September and have secured posts. A further 5 RNDAs have commenced on programme and will qualify in 2025 and we are in process of recruiting 10 RNDAs to commence in September 24 and February 25. The difference between starting dates for the cohorts depends on previous experience and qualifications.

4.2.2 **Registered Nursing Associate** – We have continued to support colleagues on their career pathway to become a Registered Nursing Associate. We aim to recruit a cohort of 10 TNAs onto the programme annually. This has not always been possible, and our current cohort only has seven successful candidates. Our recruitment process for this programme includes a joint interview with the University. Success rates have varied among our applicants, and we have reviewed why colleagues are failing to meet the entry requirements. Consequently, we have developed a supportive programme which aims to help all applicants demonstrate how they meet the requirements and ensure they have the pre-requisite qualifications for this course.

4.2.3 **Nursing Associates** – In February 2023 7 Nursing Associates qualified and sign the NMC register. Of these seven, one remains employed with us and is currently a Nursing Associate on a medical ward; four have left the Trust as they were not successful in their application for our RNDA programme and have self-funded their own top up degree to become registered nurses. Of those self-funding, three will be returning to placement and we hope to be able to attract them to apply for nursing roles here once qualified. Two Nursing Associates have left the Trust as they were unable to secure roles in their preferred area of practice (Theatres), and we are now able to support any future requests in Theatres. The next cohort of 10 TNAs will commence in September, and we are currently recruiting with our university partners.

4.2.4 **Degree Apprenticeship** – We are supporting Level 6, degree apprenticeships across Integrated Care Therapies. This was driven by staffing short fall and turnover, especially in Occupational Therapy and Podiatry. One OT student has left the programme due to personal issues, but the rest are progressing well. Currently on programme we have:

- 4 Apprentice Occupational Therapists
- 2 Apprentice Physiotherapists
- 1 Apprentice Dietitian
- 1 Apprentice Podiatrist

- Plans are in place to offer two Registered ODP in September 2024 and procurement of a suitable provider is underway.

- The Speech and Language Therapist programme is highly competitive with only three providers nationally (Exeter, Birmingham and Sheffield). All providers are oversubscribed and securing places is a challenge. We have, however, been successful in our application for September and have secured a place for a Speech and Language Apprenticeship partnering with Sheffield University.

- The development and retention of our AHP assistant healthcare workforce will be supported by providing 2 AHP Healthcare Practitioner apprenticeship programmes (1 at level 3 and 1 at level 5) which will commence in September 2024.

4.2.5 **Cadet Programme** – Our cadet programme, introduced in September 2022, has gone from strength to strength. We currently have 89 cadets on placement. These learners are from Stockport College (BTEC programme) and Manchester College (Transitional Level 2 and T Level programmes). It is anticipated that we will primarily support learners on the T Level programmes and transitional programmes (pre-T level to support with increased academic requirements for T level compared to BTEC programmes) from September 2024, but we will continue to support other health programmes to support future employment in entry level band positions.

We have identified placement opportunities particularly in sectors that are struggling to recruit and retain staff. We are working with our One Stockport partners to support the expansion of the cadet and pre-registration placement opportunities within place-based social care settings.

The PEF team have audited and opened up the scheme to two care homes and will be expanding placements for cadets in other areas (such as mental health, charities, and sexual health services). It is expected that as the number of placement opportunities increases, so will the demand for learners, including work experience, T-Level students, cadets, and pre-registration learners. We were able to share our Cadet Programme story along with our One Stockport partners at the Commissioned Care Providers Forum which focused on collaborative working. This has generated considerable interest, and we are currently linking with several social care partners to further expand the cadet programme across our locality.

4.2.6 **Care Leavers** – Our collaboration with Stockport MBC and the Leaving Care Team has enabled us to support 5 Young Care Leavers into supported pre-employment pathways. We had successfully appointed 2 of the 5 into employment with our Trust however within the last 3 months due to personal reasons they have now moved to other opportunities.

We have evaluated the current model with Stockport MBC and acknowledged that the young people who come through this programme often have experience of significant trauma. We have therefore redesigned and codesigned an improved pre-employment pathway which offers enhanced support and employability skills.

4.4 Collaboration

We have continued to explore opportunities for collaboration, our focus has been in line with the Trust strategic intention to work in collaboration with Tameside & Glossop Integrated NHS Foundation Trust. In line with this we have:

- We continue to strengthen our collaborative Knowledge and Library Service and strategy.
- Established the Resus Faculty across Stockport and Tameside. Our clinical skills teams, resus teams and AIM faculties are working collaboratively to support each site for the provision of training.
- Collaboration arrangements are in place for our Wellbeing & Occupational Health Service across both organisations. We are leading the OH workstream as part of the Scaling People Services GM programme.
- From April 2024 our payroll services have been provided by Tameside & Glossop Integrated Care NHS Foundation Trust.
- We have made a joint appointment to the Head of Strategic Workforce Transformation role, which will work across the collaboration, supporting the strategic workforce planning agenda to bring to life the ambitions within the People and OD Plan. It is anticipated that the post holder will commence by Q3.
- Within the directorate, we are working collaboratively, to ensure sharing of best practice, learning and reducing duplication across several areas, some examples of our joint approaches are:
  - Launch and implementation of an electronic ID-checking services to reduce time to hire.
  - We are working to align and be proactive in the collaboration of HR policies and procedures, including the introduction of the new national policies and initiatives, such as the sexual safety charter.
  - A Peer Review process has been introduced to review Employee Relation cases and share learning and good practice, as well as identifying any themes/trends of outcomes and minimising the 'no case to answer' conclusions.
  - We have commenced working together on the Statutory and Mandatory training programme, supporting alignment within the CSTF and ensuring consistency. Our ambition is to take this work further and align our role essential training too.
  - We are meeting as a senior team across both organisations to explore collaboration of functional areas.

4.5 Agency Expenditure

Our work to review opportunities to reduce our agency expenditure remains a significant priority and whilst good progress has been made, throughout Q1 of 2024/25 we have consistently achieved better than the target of 3.2% of pay spend, we know that there are more opportunities to improve this position. The introduction of our Workforce Efficiency Group (WEG) which meets monthly, chaired by the Director of People & OD, is working closely with operational and clinical leaders to set ambitious targets to reduce agency nursing expenditure to 0%. Whilst this is ambitious nursing agency has come down from circa 20% in 22/23 to 7.8% in 24/25

We know that there are some challenging areas which will require the support of agency, due to the shortage and specialist nature of their roles, such as clinical coders, consultants and some trainee doctors. We continue to look to support the reduction of agency spend by converting agency workers to bank, supporting recruitment campaigns, working with the NHS Gateway service and national Emeritus programme as alternatives. We continue to challenge the rates charged, including commission percentages and look to support the conversion of agency workers to the bank wherever possible.

4.6 **Sickness Absence**

In line with the NW Wellbeing Charter, we have been engaging with the development of person-centred absence management and wellbeing policy & approach. The introduction and implementation of the national absence management and wellbeing policy has been delayed however the approach of a person-centred policy is being embedded within our practices and culture. We continue to work with Tameside colleagues, who are an early adopter site, to address training and the approach for implementation once approved. We are already using this ethos in support of staff who have been absent from work.

The managing and supporting of staff who are off due to sickness remains an on-going priority. The Deputy Director of People & OD continues to attend monthly meetings with each of the Divisions, focusing on the most complex and longest absence cases, which has been well received and the benefits are being noted with a reduction in our long-term sickness absence from 3.91% in February to 3.38% in June 2024.

The menopause service continues to be well received and positively supports staff and managers. Our MSK Physiotherapist is now in post and supporting staff with musculoskeletal issues, which is having positive impact in addressing absence due to MSK issues. Stress-related absences remain the highest reason for sickness, and we continue to benefit with the support of our Staff Psychological Wellbeing Service, During Q1 we experienced outbreaks of norovirus on the wards which has had a negative impact on our short-term sickness.

We have introduced a new Occupational Health system which supports the referral and reminder for staff appointments and enables managers to access the information required directly, shortening referral wait times and improving access to information to support with the management of attendance.

5. Next Steps

5.1 Our priority areas will continue to be our focus, looking to deliver an improved retention position, continuing with a positive turnover position & reducing temporary staffing expenditure, in addition to supporting a ‘grow our own’ approach to our career progression and talent management.

5.2 We will continue to look for opportunities for collaboration, focussing on a joint approach to delivering our people priorities in line with the NHS Long Term Workforce Plan. Our next area of focus will be the implementation and benefits realisation of AI/digital enhancements.

5.4 We will continue to deliver the People & OD Plan alongside the EDI Strategy 2022-25 and our Health & Wellbeing Plan. We are committed to having a relentless focus on progressing our improvement journey to creating a more compassionate and inclusive culture.

5.5 We will build on the delivery achieved and will be developing our People & OD plan for 2025 onwards.

6. Recommendations

6.1 The Board of Directors are requested to note the contents of this report.

NHS
Stockport
NHS Foundation Trust

Meeting date	1st August 2024	**Public**		**Agenda No.**	15
Meeting	Board of Directors				
Report Title	Safer Care (Staffing) Report				
Director Lead	Nic Firth Chief Nurse	**Author**	Rebecca Cunliffe Matron for Workforce		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to review and note the assurances of this report.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

We continue to experience high levels of operational demand within the acute and community services which we are aware is having an impact on both patient and staff experience.

The demands within the Emergency Department remain significantly impacted on by large numbers of patients who do not require a hospital bed any longer. The high number of patients attending ED has also had a direct impact on maintaining bed flow and admitting patients to wards promptly. This demand is operationally managed by our senior teams and on call colleagues with a continual dynamic risk assessments being carried out.

Robust staffing has been implement ensuring that the Trust is safely staffed and able to provide high quality patient care throughout the doctors' strike.

Safe Staffing Report – July 2024

Report of: Nicola Firth
Chief Nurse

Contents

NHS Stockport NHS Foundation Trust

1. Introduction

NHS Stockport NHS Foundation Trust

The safe staffing report provides the Committee with an update on the following:

- Staffing assurances
- Current challenges regarding staffing levels and risk mitigations the actions being taken to mitigate risks and financial impacts identified
- Evidence-based decision-making on safe and effective staffing is a requirement for all NHS organisations.

The Committee are asked to note the contents of the paper, current performance and actions being taken to drive improvement.

The NHS has produced a comprehensive long term workforce plan, and it represents a once-in-a-generation opportunity to put staffing on a sustainable footing for the future. This is a collective workforce plan for the NHS and sets out a clear direction for the long term. The certainty of confirmed funding up to 2028 allows us to take the actions locally, regionally, and nationally to address the gaps we have in the current workforce and meet the challenge of a growing and ageing population.

1. Introduction

Stockport NHS Foundation Trust

Safe staffing is a fundamental part of getting care and support right for individuals. It is essential that there is the right number of skilled staff with the correct skills set to meet the needs of the service. Evidence based decision making on safe and effective staffing is a requirement for all NHS organisations. We continue to focus on patient safety and patient experience, in relation to safer staffing. Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls and pressure ulcer incidence, which can be linked to staffing and support benchmarking activities. This will assist in facilitating consistent nurse-to patient ratios in line with agreed standards across similar care settings in England.

Safer Nursing Care Tool (SNCT)

The SNCT is a NICE endorsed evidence based tool and can be used in the following settings:

- Adult inpatient wards in acute hospitals
- Adult acute assessment units
- Children and young people's inpatient wards in acute hospitals
- Mental health inpatient wards
- Emergency departments

Primarily used by Nursing Workforce the tool supports the Chief Nurse in determining optimal nurse staffing levels, assisting staff in measuring patient acuity and/or dependency to inform decision making on staffing and workforce.

SNCT can also deliver evidence based workforce plans to support existing services or to develop new services.

2. Healthroster

NHS Stockport NHS Foundation Trust

The Trust uses SNCT at the daily staffing meetings to review staffing levels in conjunction with acuity levels of patients. Processes for improving the Key Performance Indicator (KPI) are :

- The new Rostering dashboard, this will be used to evidence performance with roster management. It has been developed and tested; It will go live on the 15 July. The dashboard will contain trend data on all aspects of the KPIs. Key areas for improvement can be identified and shared with key stakeholders.
- Quality improvement work has been undertaken to increase the wards roster approval lead times. This month the average is 70.58 days in advance of the start of the roster. Work will now commence supporting other clinical areas with their approval lead times
- We have seen a decrease in the total unavailability % reduced from 23.3% to 21.8%
- The % of changes to rosters since approval has also decreased from 25% to 23.3%
- Further work continues focusing on the total number of unused contracted hours and the lead time for shifts being requested to NHSP

Roster period : 17 June – 14 July 2024								Roster period : 20 May – 16 June 2024	
Business Division	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Unused hours (4 week period)	Over contracted hours (4 week period)	Total Hours balance	Additional Duties in hours (Total Hours)	Safecare % compliance across 3 Census periods (average)
ED	7%	49.5	11.2%	20.4%	506	390.6	115.4	421.23	n/a
IC	14.1%	64.58	19.7%	27%	1,086.2	687.3	398.9	1,734.47	58.33%
Medicine	12.3%	61.9	22%	31.3%	1,545.05	1,269.6	275.5	5,100.87	66.03%
S&CC	12.9%	72.9	24.7%	37.2%	1,855.8	1,007.5	848.3	4,925.68	57.02%
W&C	15.4%	61.14	37%	23.5%	958.2	591.9	366.4	297	65.48%
CSS	12.3%	29.66	15.90%	0.25%	1,868.17	650.54	1,217.63	794.5	n/a
Total	12.3%	56.6	21.8%	23.3%	7,819	4,597	3,222	13,273.75	61.72%

Data provided by the Rostering Team

3. Vacancies

Stockport NHS Foundation Trust

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	58.64	1.65	8
Corporate Services	98.76	0.79	35
Emergency Department	104.24	-19.60	15
Integrated Care	357.37	-28.33	38
Medicine & Urgent Care	346.07	-43.04	22
Surgery & GI	436.86	-31.69	28
Women, Children & Diagnostics	402.95	-9.26	46
Grand Total	1804.89	-129.48	192

The above data covers the positions of registered nurses (RNs), registered midwives (RMs), nursing associates (NAs) and newly registered nurses and midwives awaiting PINs in May 2024. The Trust is recruiting to turn over hence the difference in the grand total.

The process for recruiting nursing students has been agreed by all the Divisional Nursing Directors (DNDs), Head of Learning & Education and Workforce. This process will ensure nursing students are supported throughout their interview and appointment, HR recruitment process, induction and as they transfer from learner to practitioner. This process will be led by the Pastoral Care Lead.

4. NHS Professionals & Agency Usage

NHS Stockport NHS Foundation Trust

All day and night shifts are now only visible to agencies at 24 hours, other than Theatres. Agency usage in May was 8.3% a decrease from 9.2% in April. June had a further decrease to 7.7%.
By increasing the NHSP shift fill rate the agency fill rate continues to reduce. As shown in the below graph.

Significant work is ongoing in the Surgical Division. They have the highest usage of agency nurses. Overtime has now ceased. By reducing the reliance on agency spend in Theatres alone there is a financial saving of over **£250,000**. Theatres have several staff currently undertaking training and new starters awaiting start dates following a successful recruitment event.

NHSP and agency shift fill rates for April and May 2024

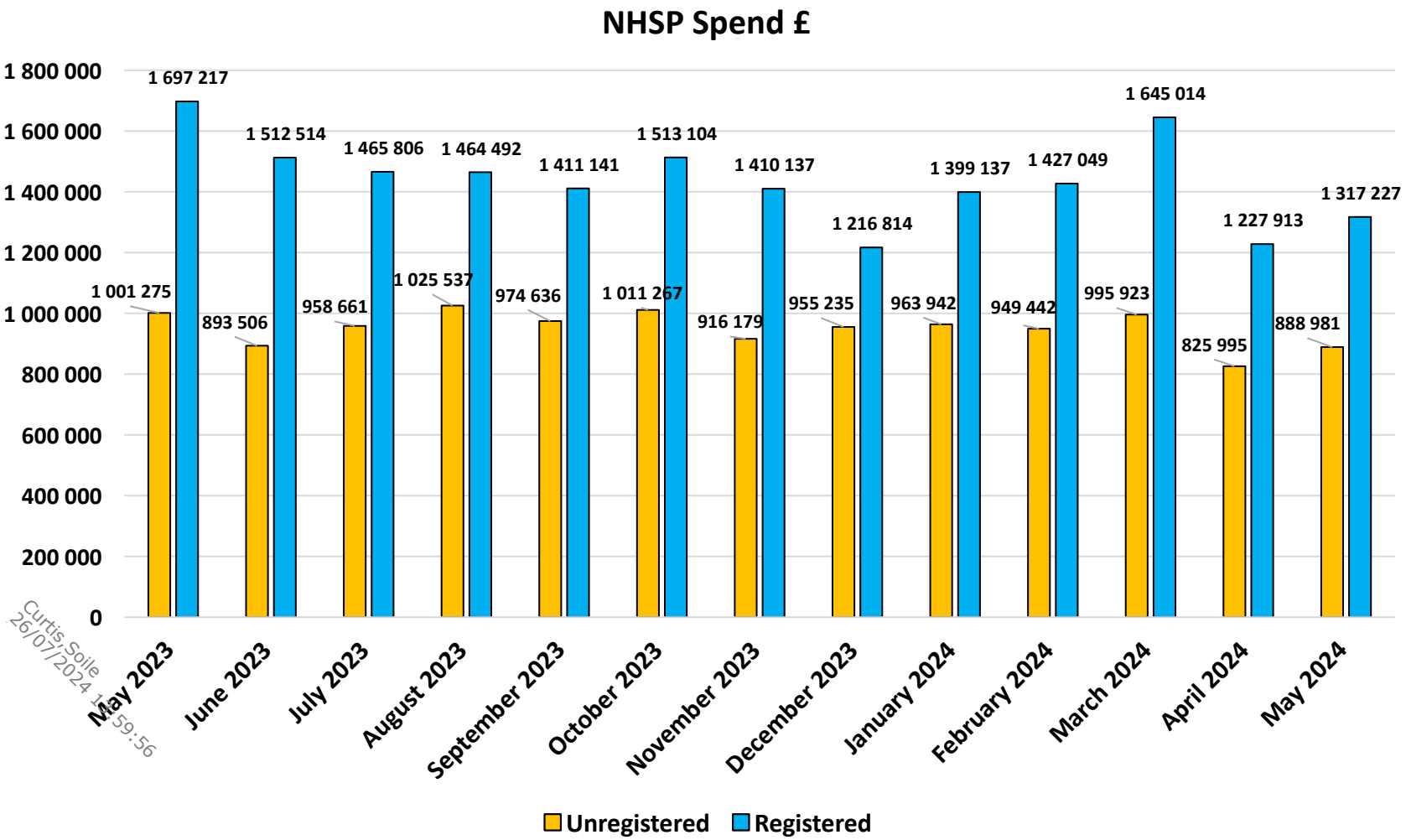
Nursing	April 2024				May 2024			
	Day	Nights	Saturday	Sunday & Bank Holiday	Day	Nights	Saturday	Sunday & Bank Holiday
Band 2	72.90%	99%	94.70%	97.70%	71.90%	98.40%	97.10%	97.20%
Band 3	80.90%	100%	92.60%	98.50%	88%	100%	92.20%	99%
Band 4 & 5	76.70%	95.50%	92.90%	95.70%	83.80%	95.10%	94.60%	96.50%
Band 6 & 7	88.80%	100%	97.70%	88.40%	95.90%	100%	94.10%	90.70%

Midwifery	April 2024				May 2024			
	Day	Nights	Saturday	Sunday & Bank Holiday	Day	Nights	Saturday	Sunday & Bank Holiday
Band 2	44.90%	95.40%	79.80%	100%	48.60%	100%	92.70%	90%
Band 3	75.30%	100%	100%	100%	45%	100%	70.60%	100%
Band 4 & 5	100%	0%	0%	0%	0%	0%	0%	0%
Band 6 & 7	38.10%	28.60%	57.30%	54.60%	44%	36.40%	37.30%	67%

Data provided by NHS Professionals

5. Nursing & Midwifery Temporary Staffing Spend

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

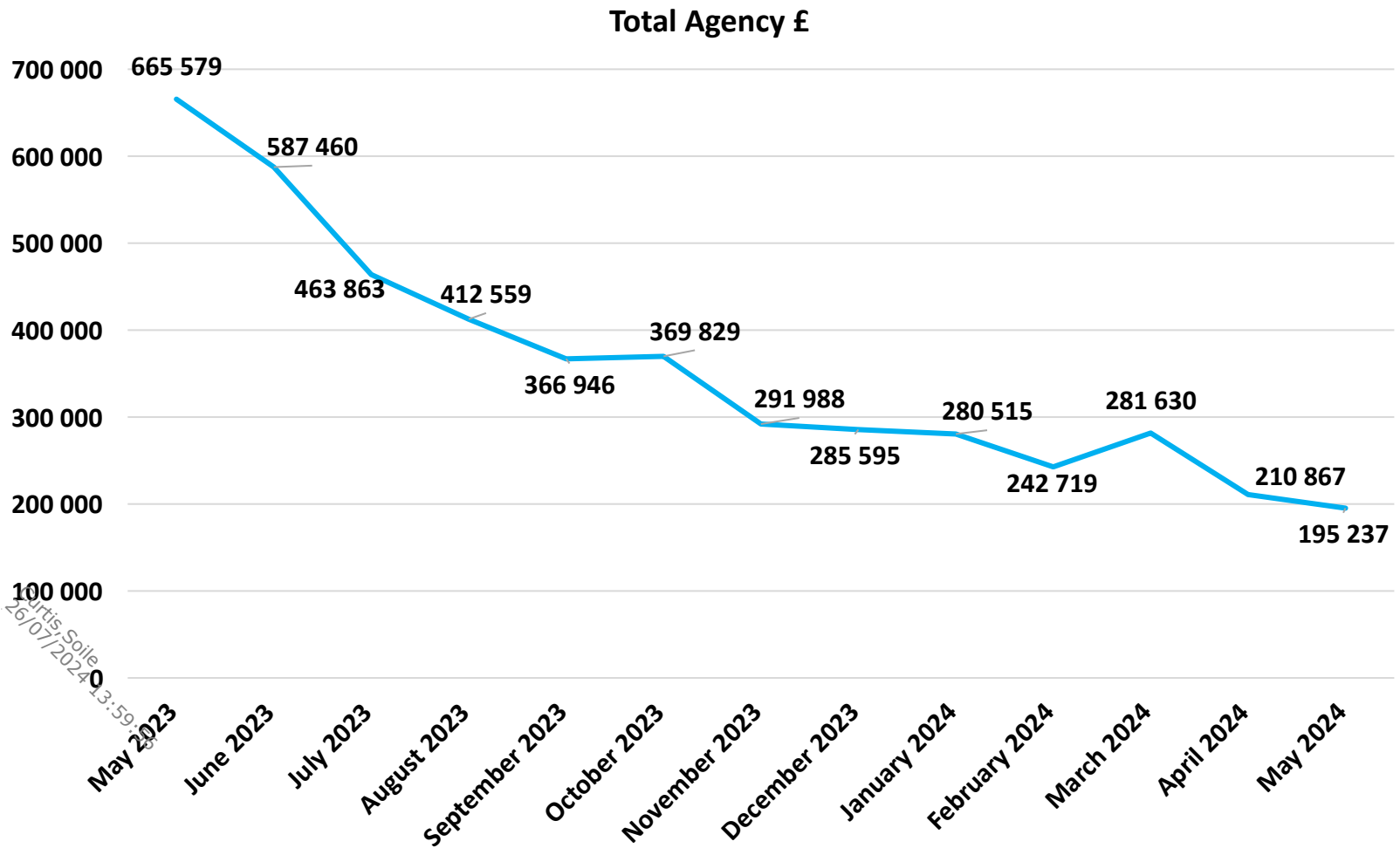


Data provided by People Analytics

5. Nursing & Midwifery Agency Spend

NHS Stockport NHS Foundation Trust

The information below illustrates the that as a result of the efficient working relationship between the NHSP and the Trust but agency usage has reduced from 9.2% in April to 8.3% in May.



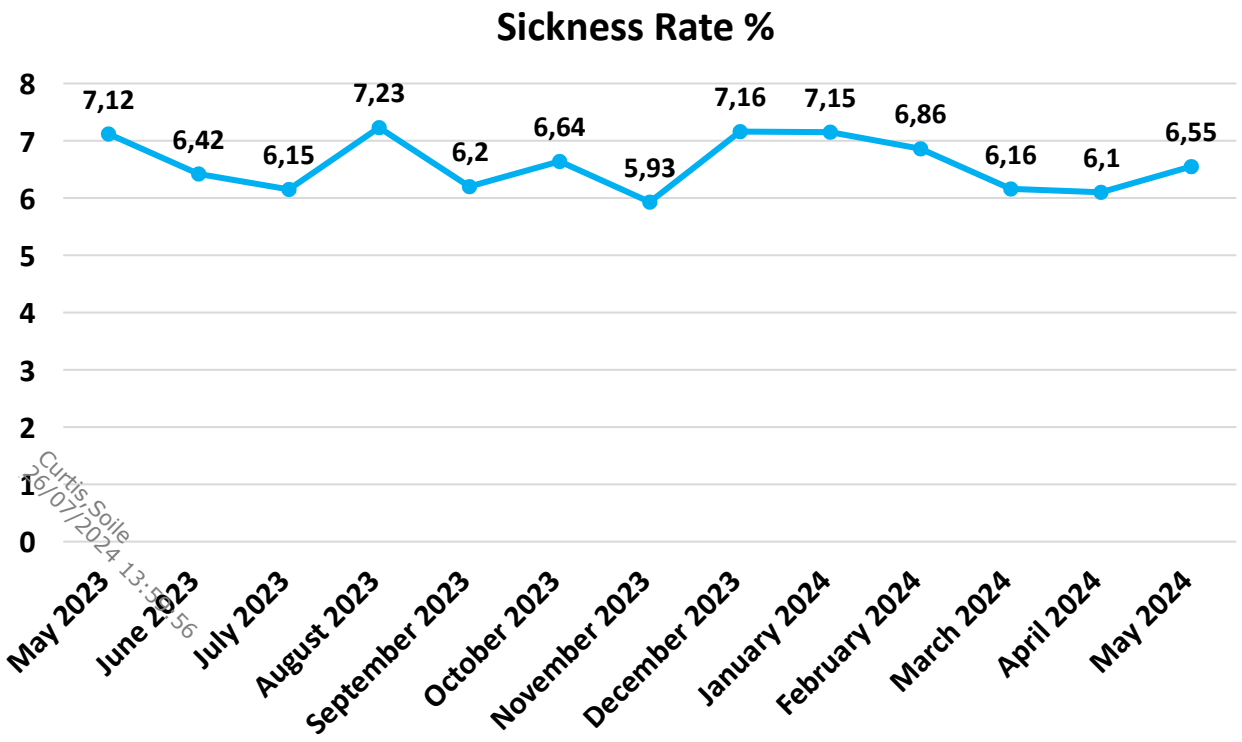
Data provided by NHSP

6. Nursing & Midwifery Absences

NHS Stockport NHS Foundation Trust

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

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



Role	Sickness %
AHPs	5.36%
RNs & RMs	6.49%

- The main reason for reported absence remains for Anxiety, Stress and Depression
- Managers work closely with Occupational Health and SPAWS in exploring alternative way of working to support the work life balance of our employees
- Professional Nurse Advocates (PNAs) on hand to provide coaching

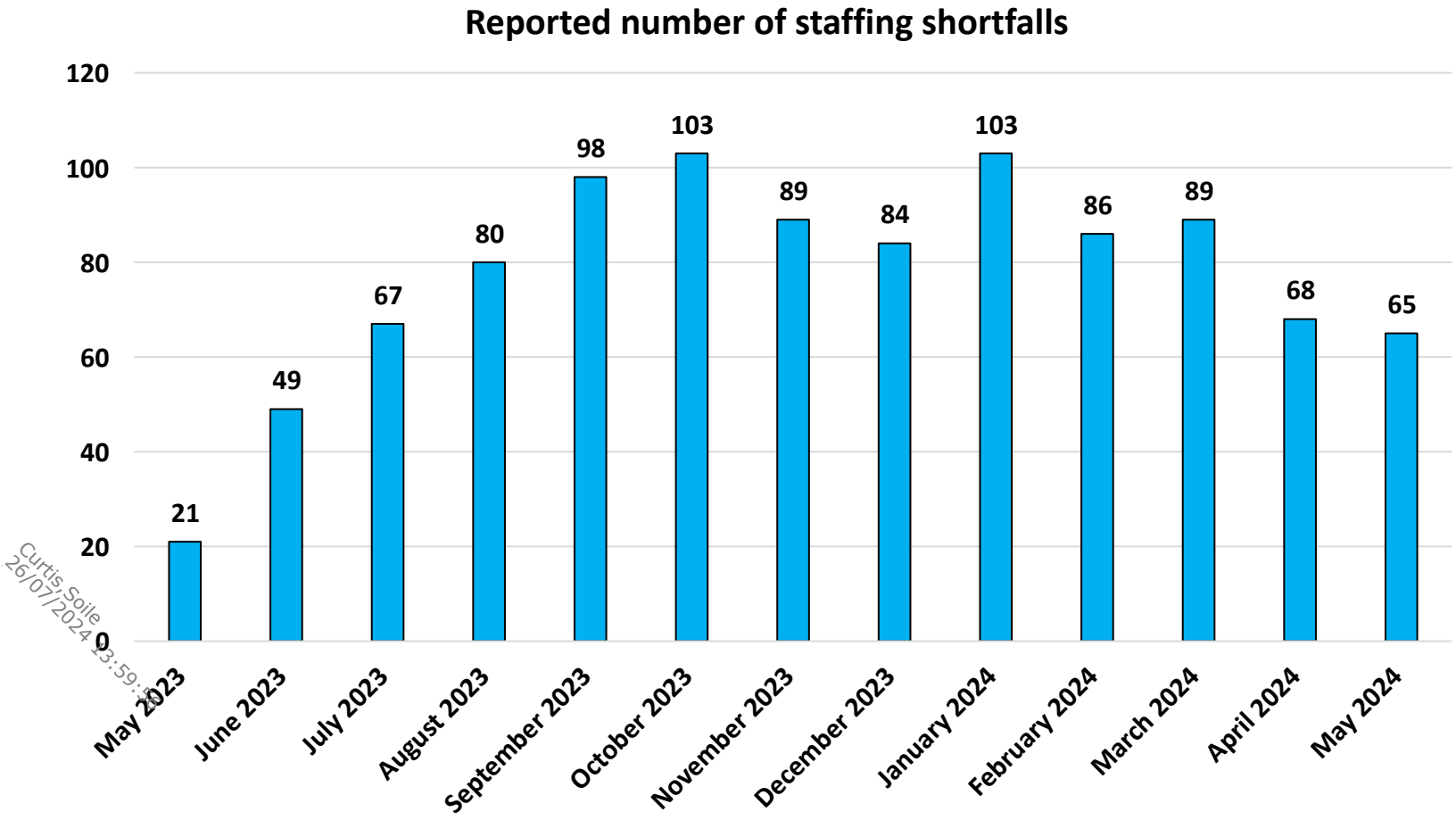
Data provided by People Analytics & Workforce

7. Nursing & Midwifery Risk Highlights

NHS Stockport NHS Foundation Trust

The Trust actively encourages all employees to report incidents of staffing shortfalls on Datix. There has been a slight decrease from the number recorded in April to May .

To ensure safe staffing during the doctors' strike a robust strategy has been implemented to maintain staff and patient safety.

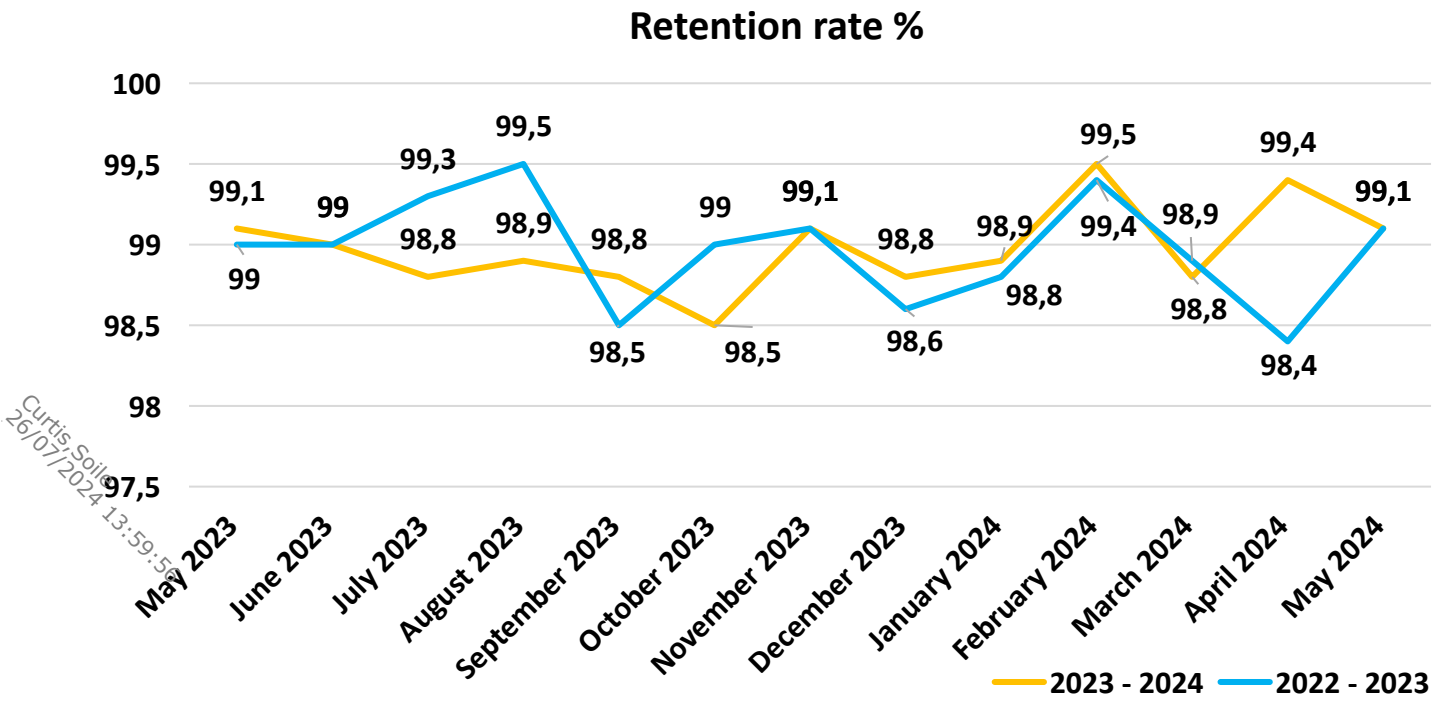


Data provided by Datix

8. Nursing & Midwifery Retention

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

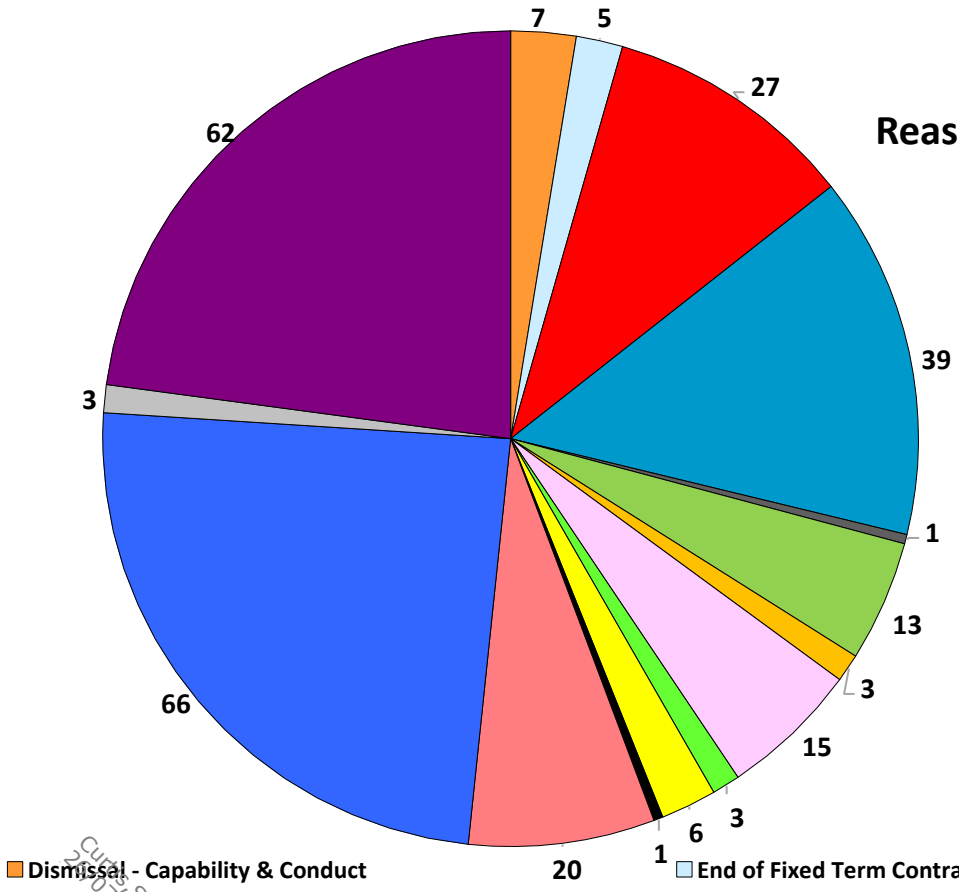
It is expected that the retention figures will continue to improve as the role of the Pastoral Care Lead will focus on supporting new starters from interview through the recruitment process, and their initiation on the wards. The Pastoral Care Lead role will manage the Grow & Retain our Workforce (GROW) pathway. GROW provides RNs with the opportunity to transfer internally and work in a different clinical environment exploring different specialities. The Trust values career development and invests in staff by providing training opportunities and supporting secondments to enhance career development. This plan, builds on the valuable work in both the NHS People Plan and the NHS People Promise.



Data provided by People Analytics

9. Nursing & Midwifery – Reasons for Leaving

Stockport NHS Foundation Trust



Reason for leaving the Trust May 2023 – May 2024

- Professional Nurse Advocates (PNAs) continue to have a positive impact on supporting staff.

Data provided by People Analytics

10. Nursing & Midwifery Recruitment

Stockport NHS Foundation Trust

- The Pastoral Care Lead when appointed will be supporting any recruitment event going forward along side the divisional workforce and education leads

- Divisions are running their own bespoke recruitment events, supported by Workforce and HR

12. Training Pathways

Stockport NHS Foundation Trust

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

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

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

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

Preceptorship Programme

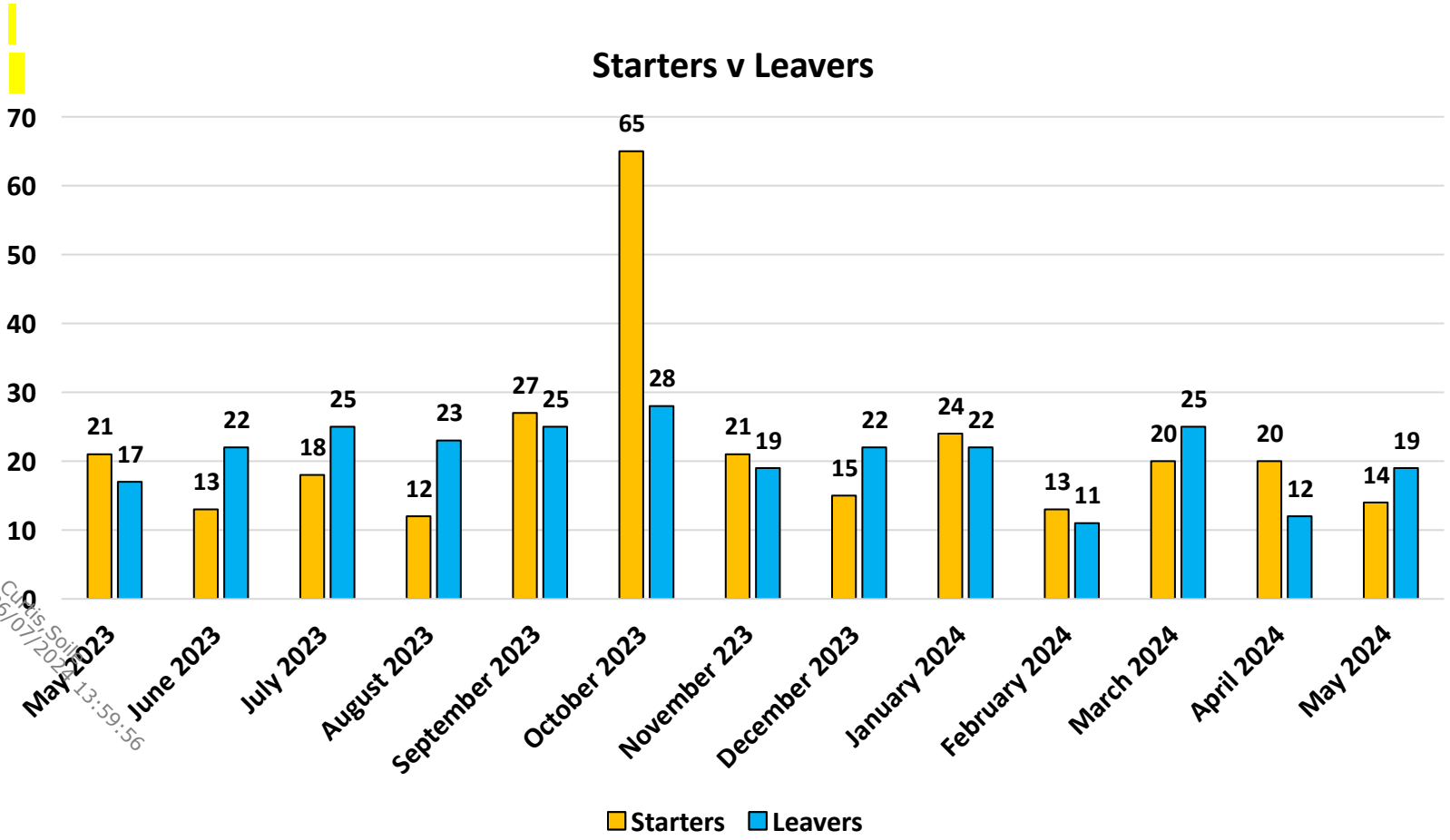
There are currently 351 staff showing active portfolios on the Preceptorship Programme; of these, 77 commenced between December and April 2024 and are within the 12 month period of Preceptorship, 6 have withdrawn from Programme,
3 left the Trust and 3 have been cancelled by their managers.

Work is on-going to support and encourage the 61 preceptees who were identified as disengaged, with visits to all areas being increased. The Legacy Mentor offers coaching, pastoral and practical support. Managers are informed when Preceptees become engaged.

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

13. Nursing & Midwifery Starters & Leavers

In May 2024 there were more leavers than new staff joining the Trust. The new role of Pastoral Care Lead will provide both practical and emotional support; with a focus on reducing the numbers of leavers. The Lead will engage with exit interviews and explore ways in retaining staff, and also identify the reason staff are leaving the Trust.



Data provided by People Analytics

14. Pathology

NHS Stockport NHS Foundation Trust

Laboratory Medical

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

Histology Laboratory

- **Biomedical Scientists (BMS)** Two additional Band 6 post on 12 month contracts have been interviewed, one was appointable but only willing to come for a substantive post, therefore no appointment was made. There are 3 team members recruited at Band 5 to fill Band 6 vacancies and training up to a Band 6 level, due to lack of Band 6 staff in the recruitment market. This will not affect skill mix and is good opportunity for career development.
- **Medical Laboratory Assistants (MLA)** – Cancer Tracker post is currently in the recruitment process.

14. Pathology

NHS Stockport NHS Foundation Trust

Blood sciences

- **Biomedical Scientists (BMS), Bands 5-8s** Have had good staffing stability for a number of years but there is now a significant level of turnover which especially affects the Biochemistry Team. Four staff have retired, handed in their resignation or been promoted into other roles. Permission to recruit to this turnover prior to leaving dates has been granted to maintain the stability of the service, 3 appropriate candidates have been offered roles and accepted to date.

- **Medical Laboratory Assistants (MLA), Bands 2-4** Supervisors role in Pathology Reception are being taken to job matching and this has caused a delay in recruiting to the role. There is a historically a high turnover for the MLA staff in the Pathology Reception and this is seen to be continuing. This is due to it being a stepping stone entry position within laboratory services.

Summary

Pathology has seen a rapid increase demand post-covid and the workload has past the point of saturation of the staffing resource. As such a business case has gone to executives for an increase in staffing. This has been agreed in principle but funding is yet to be sourced.

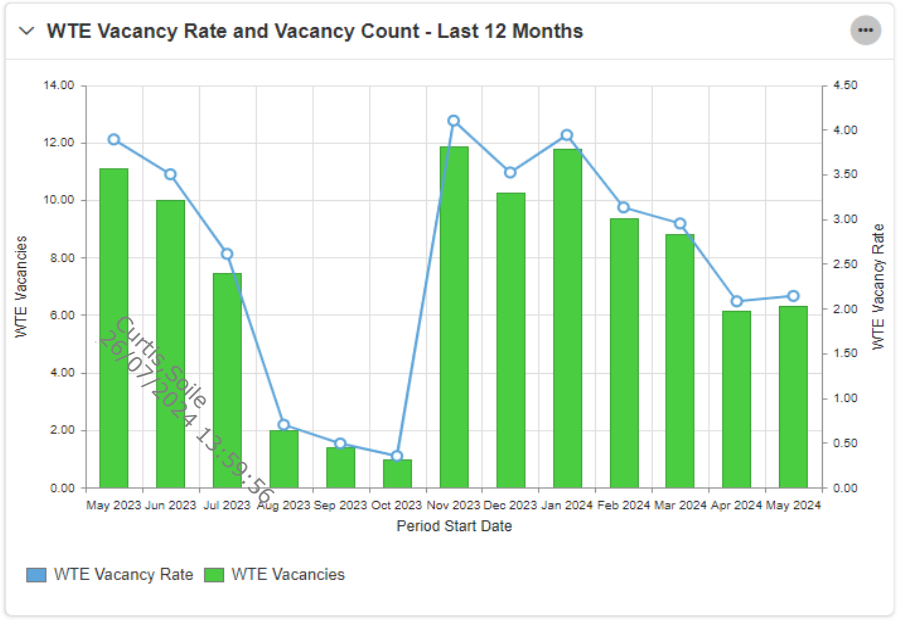
Recruitment remains an obstacle for experienced BMS staff and in-house training has been required to bring people to qualification and through their specialist portfolios.

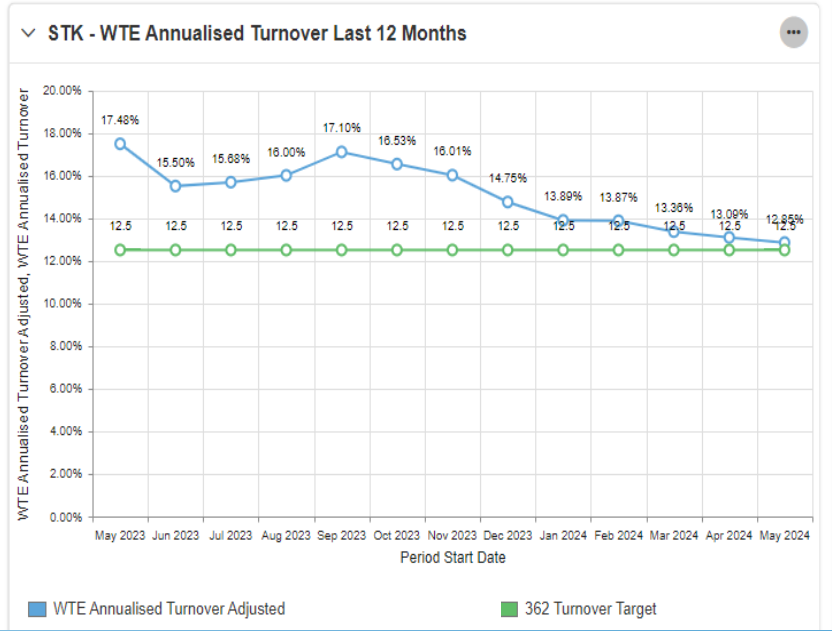
15. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

We have month on month been reporting the gains made with our **recruitment** and **turnover** and this is due to the huge efforts by our workforce and recruiting managers. It is right to acknowledge the significant progress they have made and the continued positive trends. Vacancies have reduced further to 6.32 WTE and turnover is the lowest it has been in over a year sitting just above the Trust target (12.5%) at 12.85%. Focused and consistent attention is being placed on staff wellbeing and satisfaction survey feedback to ensure we are being responsive to any factors within our control that can improve retention and general wellbeing in the work environment.

The first trial of a more **innovative & inclusive interview/recruitment strategy** has been piloted in Integrated Therapies with a hybrid approach of group/1:1, along with seen questions. The feedback from both the recruiting team and the candidates was incredibly encouraging, and we have shared this approach and feedback with recruitment as a positive and progressive opportunity for other areas which may benefit from different methods.





Data provided by Integrated Therapies & Boroughwide Services

15. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

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

Orthotics

Has faced sickness and the challenges of getting interim cover have been widely shared across the Trust. Having had minimal cover since October/November 2023 we were delighted to secure a number of days bank cover. This was significant in so far as Orthotists usually provide consultancy-based locum cover through the British Association of Prosthetics and Orthotists at premium rates. We were able to secure our cover through NHS Professionals as bank contracts, which was a huge achievement to ensure orthotics provision for our patients whilst also being cognisant of the financial impact.

In May 2024 bank Orthotist attended the local induction and started with the Trust. We are delighted to welcome them to Stockport and are hopeful we can now start reducing the waiting lists that have inevitably grown as a result of the gap. A service review is being undertaken to consider clinical pathways and evidence-based care, future service resilience with succession planning, and capacity/demand. We are learning from recent experience and working to future proof our Orthotics offer.

Speech and Language Therapy (SLT)

SLT remain another workforce with significant risk predominantly due to the large number of senior staff currently on maternity leave. The 3 staff we have been employied via agency have agreed to move onto NHSP and are currently working out their notice. It is expected that there will be no agency expenditure from 1st July 2024. We hope to see the staffing levels and skill mix stabilise between July and October when 2 Clinical Leads should return into post.

Data provided by Integrated Therapies & Boroughwide Services

15. Allied Health Professionals (AHPs) – Integrated Therapies

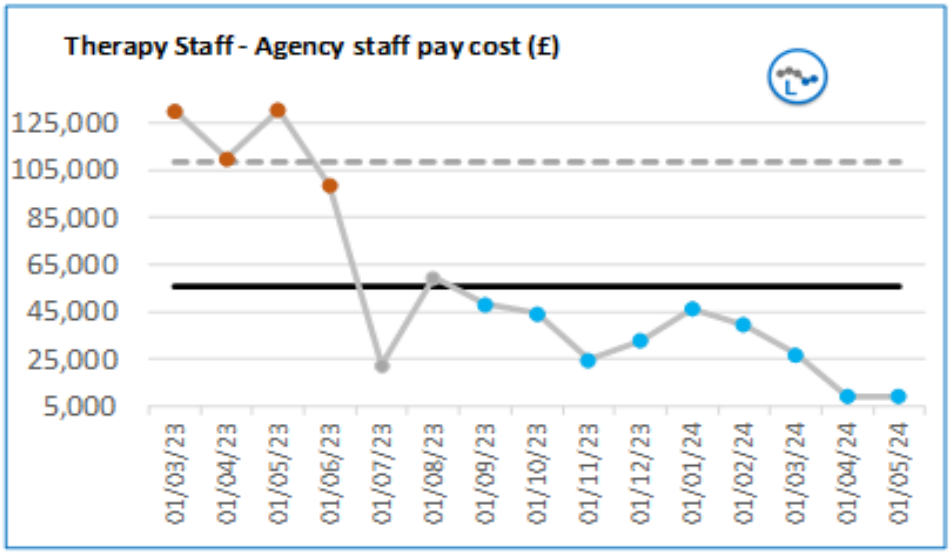
NHS Stockport NHS Foundation Trust

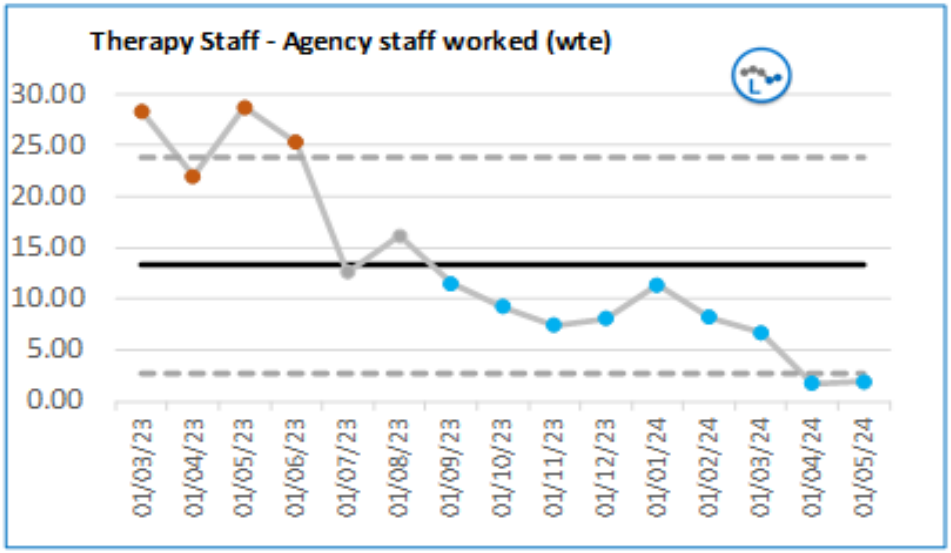
Agency Trajectory and Temporary Staffing

- The work to reduce agency expenditure in Integrated Therapies has been incredibly successful but we have now reached a plateau with the SLT (Speech and Language Therapist) locums who are reluctant to migrate over to NHSP.
- From 1st April 2024, it was only the SLT agency expenditure remaining.
- In May 2024, the SLTs agreed to move onto our bank and are currently working their agency notice.
- It is expected from 1st July 2024 that there will be no use of agency staff

Job Planning

- Job planning timelines have slipped slightly with a revised trajectory to be complete across the Directorate by the end of quarter two.
- However, initial feedback is positive and the concept is being well received across our therapy workforce.





Data provided by Integrated Therapies & Boroughwide Services

16. Midwifery Update

NHS Stockport NHS Foundation Trust

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

Registered Midwives		
WTE Actual	**WTE Vacancies**	**Post WTE Recruited to TRAC**
160.48	**Vacancies 4.8 Mat Leave 9.2**	**15.24**

Obstetrics cover

- 24/7 Consultant obstetric cover on delivery suite
- 2/day 7 day/week Consultant ward rounds in place
- Follow RCOG certificate of eligibility guidance for short term locums

Challenges

- Current registered vacancy inclusive of inpatient and outpatient areas 4.8 WTE, in addition to this there is currently a gap of 9.2 WTE on maternity leave. This equates to a total deficit of 14 WTE
- MSW 4.53 WTE vacancy and maternity leave 0.88 WTE. This equates to 5.41 WTE

Actions

- Weekly planned roster scrutiny meetings/E-roster training sessions - continue
- Recruitment event took place 20th April – 15.24 WTE job offers made
- Engage with trust pre-employment programme for health care workers

Assurance

- All shift co-ordinators have supernumerary status and monitored daily by MOD
- May showed achievement of 99.4% one to one care in labour (1 BBA)
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity Support Workers Framework Working Group
- Engaged with the International Educated Midwifery (IEM) recruitment programme. Four commenced in post, one requiring additional support having failed the OSCE
- Fully recruited to Ward Clerk and Housekeeper posts

Data provided by the Division of Women & Children's

17. Medical Staffing

NHS Stockport NHS Foundation Trust

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

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

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

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

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	253.71	225.59	28.11
Tier 2	123.82	106.28	13.92
Tier 1	113.42	156.6	26.18
Total	490.95	488.47	-2.48

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

Data provided by Medical Staffing

17. Medical Staffing

NHS Stockport NHS Foundation Trust

Consultant Recruitment

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

Medical Workforce Group (MWG)

- Senior Medical Recruitment is on the Annual Medical Workforce Plan. The group monitors this so that it can seek to assist divisions who for example have difficult to fill specialties and to ensure that all options are being explored.
- Senior Medical Locum Expenditure is also being monitored by the group so that it can actively seek to assist divisions in reducing costs to the Trust, whilst also focusing on ensuring ensure safe staffing levels and patient safety.

Data provided by Medical Staffing

18. Good news

Stockport NHS Foundation Trust

- The efficient working partnership between the Trust and NHSP has now resulted in successfully reducing bank and agency usage to an all-time low of 8.3%. The Current data for June is 7.7%

- Theatres are currently waiting for 10 new starters to join the department, and have only one vacancy

19. Going forward

NHS Stockport NHS Foundation Trust

- Following the success of the ‘Meet the Matron’ session at the University of Salford, the Matron for Workforce has now visited Manchester Metropolitan University to discuss delivering the session and contacted other universities.
- Chief Nurse Plans to attend Salford University in September 2024 to meet the Student Nurses.
- Working with NHSP a pathway has been created which enables NHSP HCAs to apply directly to vacancies within the Trust, this ensures a quick and streamline recruitment process
- Working with NHSP to reduce agency usage to under 7% for July. June finished at 7.7% agency usage. The lowest the Trust has ever been.

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	**X**	**Agenda No.**	16
Meeting	Board of Directors				
Report Title	Annual Safeguarding Report 2023/24				
Director Lead	Nic Firth, Chief Nurse	**Author**	Mags Deakin, Interim Head of Safeguarding		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to receive the assurance regarding compliance with statutory duties regarding safeguarding, as supported by the Quality Committee.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

This report covers the period from April 2023 to March 2024 and provides assurance that systems are in place to ensure that patients using Trust services are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise.

The annual report has been reviewed and supported by the Quality Committee.

Trust Annual Safeguarding Report 2023/24

Trust Board 1st August 2024

Purpose

Stockport NHS Foundation Trust (SNHSFT) is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

The Integrated Safeguarding Team supports SNHSFT in fulfilling its statutory duty and regulatory framework to safeguard all patients and staff.

The purpose of the annual report is to:

- Provide an overview of SNHSFT safeguarding activity in 2023/24
- Provide assurance that SNHSFT is compliant with its safeguarding duties
- Outline the key safeguarding priorities for 2024/25

Key Achievements and Challenges

- Following consultation with young people there has been a change to the language used with Children in Our Care.
- The Specialist Children in Our Care health team have seen a sustained increase in nursing activity with an increase of 22% in the numbers of statutory health assessments completed this year.
- There have continued to be challenges with the timeliness of receiving IHA requests which is having an impact meaning only 31.3% were seen within timescales in Q4. Along with the additional challenges in Q1 the overall performance for the year was 24%.
- There has been some further analysis into the impact of the delayed requests which has been shared with the local authority. Stockport NHS FT will continue to work in partnership in fulfilling the statutory health assessment and works proactively in trying to meet the challenging timescales.
- The hospital Independent Domestic Violence Advisor (IDVA) roles have been recruited to and are in post – funding for these posts ends in November 2024 and a business case is being drafted for additional funding to support this important service
- The Safeguarding Adults Policy was refreshed and relaunched within the Trust
- We have provided toolbox training to each of the clinical areas on MCA, Domestic Abuse, and DoLS and sessions remain on offer monthly.

Key Achievements and Challenges

- Reviewed MCA and DoLs policies and relaunched within the Trust
- Developed a Standard Operational Procedure (SOP) for safeguarding adult referrals in line with the Trust Safeguarding Adults at Risk policy
- Introduced the provision of a safeguarding adult link role within the Trust and monthly meetings for link nurses to obtain local and national learning to share within their networks
- The initiation of service transformation for safeguarding children and system upgrade to enable Health Visitor and School Nurse notifications to be sent directly from ED when there is a cause for concern
- Co-location of community and acute safeguarding children's teams providing an opportunity for skills to be shared, team building and peer support
- Introduction of psychological support for the safeguarding teams providing an opportunity for reflection and processing of complex situations they are faced with as their "everyday business"
- Building professional relationships with Healthwatch Stockport and independent care providers to improve communication across the health economy to improve patient experience when coming into hospital

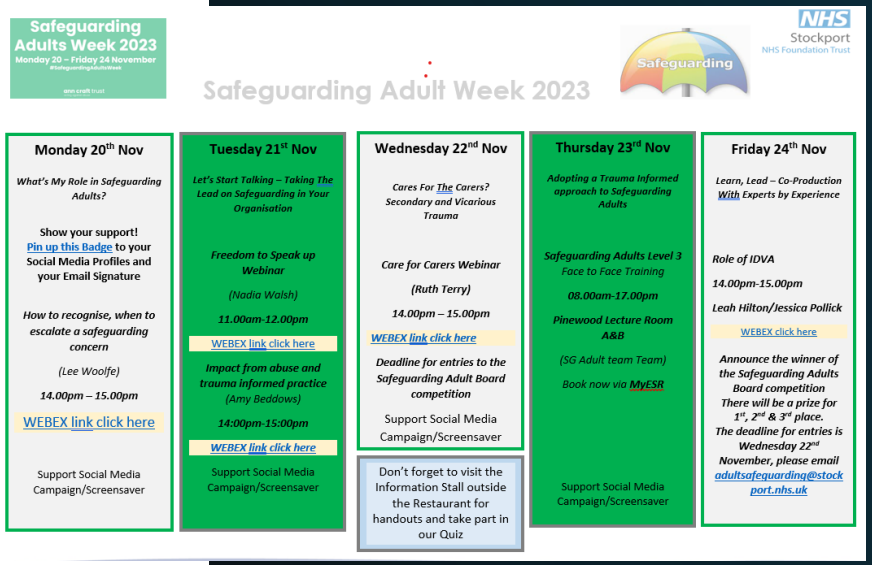
Highlights

National Safeguarding Adults Awareness Week 2023

The adult safeguarding team hosted a week of events and participated in Anne Crafts social media campaign to share the excellent work that was taking place within the Trust and the Partnership.

Key themes covered each day were

- What's my role in Safeguarding Adults?
- Let's Start Talking – Taking the lead on safeguarding in your organisation
- Cares for the Carers? Secondary and vicarious trauma
- Adopting a trauma informed approach to Safeguarding Adults
- Learn, Lead – co-production with Experts by Experience



Highlights

Safeguarding Newsletter

We launched the first of our quarterly Safeguarding newsletters in Autumn 2023 which provides an opportunity to keep staff up-to-date on developments within the safeguarding agenda, report on themes and trends, share learning and celebrate good practice.

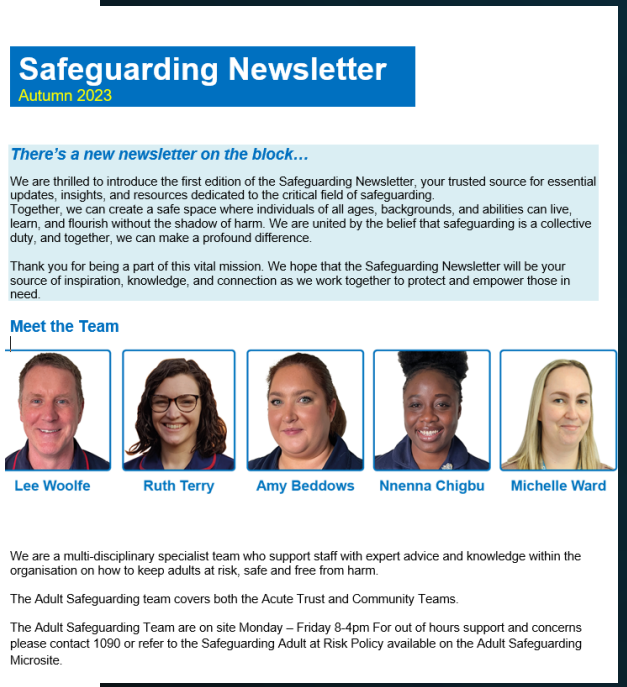
Training

Level 3 safeguarding adults training compliance is currently at 88% and continues on an upward trajectory

Level 3 safeguarding children training compliance has increased from 80% to 90%

Level 3 children in our care training compliance is currently 92%

The initiation of an electronic safeguarding platform to improve accessibility of key safeguarding information



Safeguarding Newsletter
Autumn 2023

There's a new newsletter on the block…

We are thrilled to introduce the first edition of the Safeguarding Newsletter, your trusted source for essential updates, insights, and resources dedicated to the critical field of safeguarding.
Together, we can create a safe space where individuals of all ages, backgrounds, and abilities can live, learn, and flourish without the shadow of harm. We are united by the belief that safeguarding is a collective duty, and together, we can make a profound difference.

Thank you for being a part of this vital mission. We hope that the Safeguarding Newsletter will be your source of inspiration, knowledge, and connection as we work together to protect and empower those in need.

Meet the Team

Lee Woolfe | Ruth Terry | Amy Beddows | Nnenna Chigbu | Michelle Ward

We are a multi-disciplinary specialist team who support staff with expert advice and knowledge within the organisation on how to keep adults at risk, safe and free from harm.

The Adult Safeguarding team covers both the Acute Trust and Community Teams.

The Adult Safeguarding Team are on site Monday – Friday 8-4pm For out of hours support and concerns please contact 1090 or refer to the Safeguarding Adult at Risk Policy available on the Adult Safeguarding Microsite.

Summary

This report demonstrates the commitment of the Trust to the safeguarding agenda and the progress made against priorities despite ongoing operational, system and partnership pressures, and how we have sustained and strengthened partnership working despite capacity challenges.

The safeguarding team has promoted the importance of safeguarding supervision and 'Think Family' being a standard operating process in all aspects of service delivery, and, has been reactive and visible in ensuring that staff are supported in delivering safe and effective care, with safeguarding as a golden thread woven throughout the patient journey.

We are proud of our achievements and welcome the challenges of the year ahead and would like to thank our colleagues at Stockport NHS Foundation Trust for their support and commitment to keeping the families in our locality safe from harm and abuse.

Ambitions for 2024/25

To achieve 95% compliance for Level 3 safeguarding adults training

To work collaboratively with all stakeholders to promote positive engagement with people with a learning disability and/or autism and their families and carers to improve patient experience and accessibility

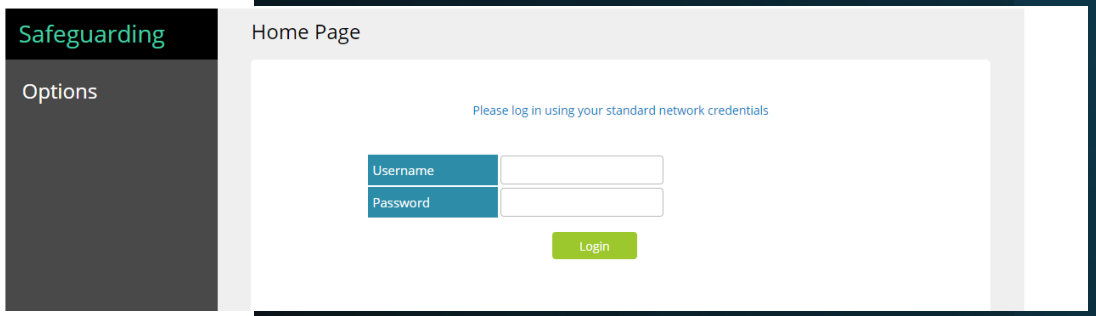
To work with partner agencies to improve the offer of support for families following the discharge of a baby into foster care at birth

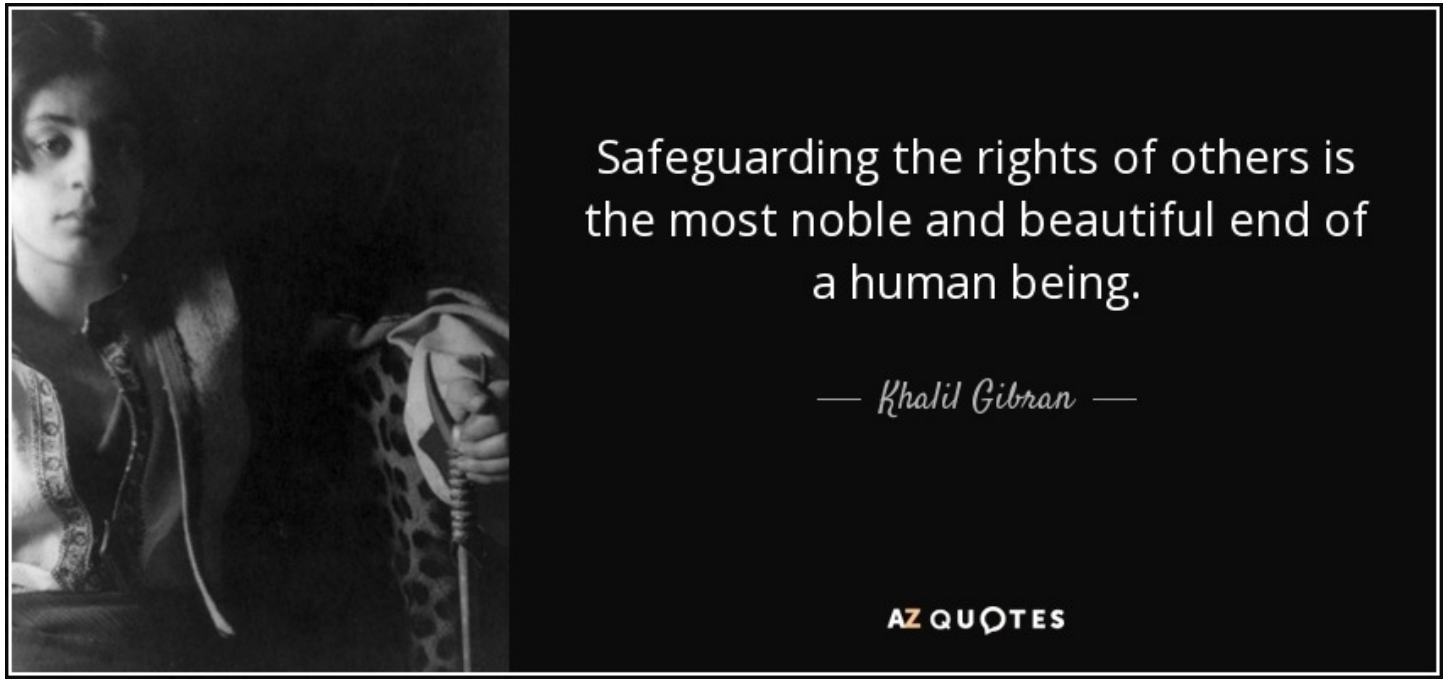
To improve the quality of safeguarding documentation and to launch the electronic safeguarding platform to assist staff in accessing key information regarding patients in their care

To support the ongoing work to reduce health inequalities for Children in Our Care

To increase visibility of the safeguarding teams across the divisions, supporting staff in increasing their knowledge and capacity

To launch the online safeguarding platform within timescale and embed into practice





Thank You

NHS
Stockport
NHS Foundation Trust

Stockport NHS Foundation Trust

Integrated Safeguarding

Annual Report 23/24

Making a difference every day

FOREWORD

As Chief Nurse and Executive Lead for Safeguarding along with the Head of Safeguarding, I am pleased and proud to introduce the Integrated Safeguarding Annual Report for 2023-2024, and I would like to begin by extending my thanks to all our staff for their commitment to safeguarding and their focus on keeping the families of Stockport safe during significant operational pressures and challenges.

Stockport NHS Foundation Trust is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

As an organisation we have a firm belief that every child and adult has the fundamental right to live a life free from harm or abuse. We have a large workforce, and it is a priority that all members of our organisation are fully engaged in the safeguarding agenda and can confidently advocate for the rights of patients in their care and recognise and respond to safeguarding needs.

Whilst the safeguarding frameworks for adults and children are managed separately, nationally they are often inter-linked, and practitioners are encouraged to 'Think Family' and the impact of adverse childhood experiences on health and life chances. The Trust reflects this in its local arrangements for safeguarding with close working between the adult and child safeguarding teams and a coordinated approach to safeguarding education for the workforce.

This annual report highlights the work undertaken by Stockport NHS Foundation Trust in respect of its commitment and responsibility to maintaining the safety and protection of children and adults at risk of abuse and neglect and provides us with an opportunity to celebrate our achievements and to focus on our priorities for the coming year.

Nic Firth
Chief Nurse/DIPC and
Executive Lead for Safeguarding

me, you, us
safeguarding is everyone's responsibility

CONTENTS

Introduction and purpose

The safeguarding of unborn babies, children and adults is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system. This requires all staff to be able to recognise their individual responsibility to safeguard and promote the welfare of adults and are equipped to fulfill this task, and the Trust is committed to supporting them in this. NHS Trusts must ensure that safeguarding adults and children is embedded at every level in their organisation.

Stockport NHS Foundation Trust responsibilities include ensuring staff have access to appropriate training, advice, support, and supervision in relation to The Care Act (2014), the Mental Capacity Act (2005) and the Prevention of Terrorism Act (2005).

This report covers the period from April 2023 to March 2024 and provides assurance that systems are in place to ensure that patients using Trust services are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise.

The adult and children's safeguarding teams support Stockport NHS Foundation Trust in fulfilling its statutory duty and regulatory frameworks to safeguard all patients and staff.

The purpose of this report is to:

- Provide an overview of Stockport NHS Foundation Trust safeguarding activity in 2023/24
- Provide assurance that Stockport NHS Foundation Trust is compliant with its safeguarding duties
- Outline the key safeguarding priorities for 2024/25

What is Safeguarding and why is it important to us?

Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.

Those most in need of protection include:

- Children and young people
- Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities.

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private, or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.

An adult is an individual aged over 18 years and over, theCare Act 2014 defines an adult at risk as:

- An adult who has care and support needs (whether the needs are met or not)
- Is experiencing or at risk of experiencing abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of, of the experience of, abuse or neglect

In England, a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached their 16th birthday and is

- Living independently
- In further education
- A member of the armed forces
- In hospital; or

- In custody in the secure estate

They are still legally children and should be given the same protection and entitlements as any other child (Department for Education, 2023).

Safeguarding Legislation and Regulatory Requirements.

The Trust has a statutory responsibility for ensuring that services provided by their organisation have safe and effective systems in place which safeguard adults, children and unborn babies at risk of abuse, neglect and exploitation.

Safeguarding responsibilities are enshrined in international and national legislation and our activity is underpinned by the legal frameworks outlined below.

<table>
<tr><th colspan="3">Legislation For All</th></tr>
<tr><td colspan="3">

Crime and Disorder Act 1998
Female Genital Mutilation Act 2003
Mental Capacity Act 2005
Convention on the Rights of Persons with Disabilities
Mental Health Act 2007
Children and Families Act 2014
Modern Slavery Act 2015
Serious Crime Act 2015
Domestic Abuse Act 2021
Health and Care Act 2022
The right to choose government guidance on forced marriage
Serious Violence Duty

</td></tr>
<tr><th>Safeguarding legislation specific to children</th><th>Safeguarding legislation specific to young people transitioning into adults, including children in care</th><th>Safeguarding legislation specific to adults</th></tr>
<tr><td colspan="2">

UN Convention on Rights of a Child
Children Act 1989 and Children Act 2004
Promoting the health and wellbeing of looked-after children
Children and Social Work Act 2017
Working together to safeguard children 2023: statutory guidance

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Care Act 2014
DH Care Guidance

</td></tr>
<tr><td colspan="2">

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
Looked After Children (LAC) – resources and guidance

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Adult Safeguarding: Roles and Competencies for Health Care Staff

</td></tr>
<tr><th colspan="3">Framework Specific to both Children and Adults</th></tr>
<tr><td colspan="3">

Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assurance 2022.
NHS Prevent training and competencies framework
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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External Safeguarding Governance and Partnership working

Stockport NHS Foundation Trust (SFT) continue to work with external safeguarding partners across the borough of Stockport andGreater Manchester.

The Safeguarding teams participate in several multi-agency meetings to support safeguarding arrangements. The Head of Safeguarding and Deputy Chief Nurse represent the Trust at the Local Safeguarding Adult Board and Executive meeting for the Local Safeguarding Children Partnership. Members of the safeguarding teams also attend subgroups of the respective boards and partnerships and these all share key information via internal reporting mechanisms.

A representative from safeguarding attends the following strategic and operational multiagency safeguarding meetings:

Adult	Children's	Joint
Stockport Local Safeguarding Adult Board	Children's Practice Improvement Partnership	Stockport Joint Safeguarding Adults Partnership Board & Safeguarding Children Partnership Executive Meeting
Adults Practice improvement partnership	Children's Quality Assurance Partnership	Domestic Abuse Partnership Board
Adults Quality assurance partnership	FGM Task and Finish Group	Domestic Abuse Operational Meeting
Multiagency adults at risk system (MAARS)	Integrated Looked after Children Board	Channel Panel & Prevent steering group
Safeguarding adult review (SAR) consideration and panel	Rapid review & Child safeguarding practice review panel and process	Domestic Homicide Review Consideration Panel
Hate crime partnership	Child Death Overview Panel	Complex safeguarding subgroup
		Training & Workforce development

The Trust continues to provide assurance to NHS Greater Manchester Integrated Care Board (ICB) (Stockport Locality) via the Greater Manchester Safeguarding Assurance Framework document that is populated by the safeguarding team each quarter and then is reviewed and scrutinised by Designated Professional and commissioning colleagues to monitor the Trust in its ability to safeguard individuals. This quarterly report is produced into an action plan whereby the safeguarding team and key leads from the trust and ICB meet to discuss. In addition to this an annual self-assessment of commissioning standards is completed for all aspects of safeguarding and sent as assurance to the ICB, this provides robust assurance in that the Trust is delivering its statutory duties, and this supports the section 11 audit that is required of all NHS Trust as directed by the Children Act 2004.

The contractual standards document identifies safeguarding standards reflecting our statutory responsibilities which healthcare providers are measured against. The audit tool comprises of 10 Key Lines of Enquiry.

- Organisational Governance
- Clinical Leadership in relation to safeguarding
- Safeguarding Processes
- Safeguarding Policies

- Supervision, training and development
- Looked After Children
- Adults at Risk
- Mental Capacity Act
- Child Death Review, and
- Lampard

There are **63 standards** in the 2023-2024 audit. SFT has achieved full compliance with **58 standards** and partial compliance with action plans in place to monitor progress against **5 standards**.

A summary of the self-assessment can be found in Appendix 1.

Governance and reporting Structure

The Trust has an Integrated Safeguarding Group which is chaired by the Chief Nurse/Executive Lead for Safeguarding whereby assurance is sought from named professionals, divisional colleagues and partnership updates are provided, this reports to the Board established Quality Committee in the form of a key issues report to provide robust assurance through to the Board of Directors. The Integrated Safeguarding Group is supported by operational groups for adults, children, and public health nursing, all these groups have a term of reference, action plans and business cycles. Further details of the governance structure for Safeguarding can be found in Appendix 3 of this report.

SFT have reporting structures in place for safeguarding across the Trust and work has continued to progress this year to support a think family approach to all safeguarding work.

Safeguarding incident reporting is managed through internal systems and processes which specialist practitioners support with providing advice, guidance, and support to Trust staff. The Trust has a mechanism of reporting safeguarding incidents using the Trust intranet and the Do it online form for Adult Safeguarding and via telephone contact, heath information sharing forms for children's safeguarding along with targeted referrals in maternity services. Staff can also refer directly to social care through the Multi Agency Safeguarding Support Hub (MASSH) and via the Adult Social Care referral form. Incidents that relate to the possible abuse and or neglect whilst in hospital and or concerns regarding patient safety will be discussed at other Trust meetings which include managing safeguarding allegations against staff.

Safeguarding structure / roles

SFT employs several highly skilled safeguarding specialists in a variety of roles both statutory and non-statutory to support the Trust in discharging its safeguardingduties.

The Chief Nurse is the Executive Lead for Safeguarding, the Deputy Chief Nurse (DCN) and the Head of Safeguarding (HoS) provide both strategic and operational support for all aspects of safeguarding and the wider agenda covering mental health, learning disability, autism, dementia, and delirium. Alongside the DCN and HoS, the Divisional Nurse Director and Divisional Director of Midwifery and Nursing for Women and Children support the safeguarding agenda with line management and professional support to named professionals.

The current safeguarding structure as of March 2024 can be found in Appendix 2 of this report.

Key Achievements and Celebrating Success

- The Hospital Independent Domestic Violence Advisor (IDVA) roles have been recruited and are now in post.
- The Specialist Children in Our Care health team have seen a sustained increase in nursing activity with an increase of 22% in the numbers of statutory health assessments completed this year.
- The Specialist Children in Our Care health team provide care and support to some of the most complex and vulnerable young people living in Stockport.
- Following consultation with young people there has been a change to the language used with Children in Our Care. Overwhelmingly children didn't like the use of abbreviations and the term LAC (Looked After Children) was considered particularly negative and offensive. Information has cascaded through the organisation with a particular emphasis on the power of language in both how it influences others and how it makes people feel.
- Profiling data questions are embedded within the assessment templates. Following learning from CSPR (Child Safeguarding Practice Reviews) There have been some additional elements added with a particular focus on the impact of previous childhood trauma and a wider look at neurodiversity.
- The L3 Children in Our Care safeguarding training module can now be reported through people analytics. The organisation is 92% compliant with an increase to 95% within Women and Children's division.
- The Specialist Children in Our Care team provides consistency to young people producing quality assessments, completed by a Specialist Nurse, in a venue of their choice. The Specialist team can prioritise and met their KPI requirements, but due to a sustained increase in demand and workload there is a direct impact on the ability of the team to meet the capacity and wider needs of young people in Stockport.
- We completed the Learning Disability Improvement Standards Year 6 Audit and shared findings with NHS England Benchmark. Findings will be published in Autumn 2024.
- The Safeguarding Adults Policy was refreshed and relaunched within the Trust.
- We have provided toolbox training to each of the clinical areas on MCA, Domestic Abuse, and DoLS and sessions remain on offer monthly.
- Standard Operational Procedure (SOP) has been produced to provide guidance to staff on the process of completing Dols applications and ensuring they meet compliance with local authorities.
- Annual audit cycles have been created by the safeguarding adult team to support the overall Safeguarding audit plan.
- Introduced an all age Quarterly Safeguarding Autumn Newsletter.
- Maintained a good trajectory of compliance in Safeguarding adult's level 3 training, currently at 88%.
- Safeguarding children level 3 training compliance has increased from 80% to 90%.
- Reviewed MCA & DoLS Policies and relaunched within the Trust.
- Continue to use the E-portfolio learning pathway to measure impact from Safeguarding adult level 3 training. Evaluations from learners are monitored and reviewed and feedback received helps the team to modify and improve future training sessions.
- Developed a standard operational procedure (SOP) for safeguarding adult referrals in line with the Trusts Safeguarding Adults at Risk Policy.
- Active participation at Stockport Safeguarding Partnership and Board and subgroup meetings.

- Introduced the provision of a Safeguarding adult link role within the Trust and monthly meetings for link nurses to obtain local and national learning to share wide within their networks.
- Built professional relationships with Healthwatch Stockport (HWS) and independent care providers to improve communication across the health economy to improve the patients experience when coming into hospital.
- The initiation of service transformation for safeguarding children and system upgrade to enable staff in ED to notify Health Visitor and School Nursing services directly with causes for concern for children who attend the department.
- Community and acute safeguarding children safeguarding children's teams are now co-located on site at the Trust, providing an opportunity for skills to be shared, vicarious support and team building.
- Safeguarding teams accessing regular support from the Trust Psychology and Wellbeing Service to enable opportunity for reflection and processing of complex situations they are faced with on a day-to-day basis.
- 100% annual appraisal compliance.
- 100% attendance at regular staff 1:1 sessions.

National Safeguarding Awareness Week 2023

The team hosted a week of events to mark Adult Safeguarding week. The team participated in Anne Crafts social media campaign to share excellent work that was taking place within the hospital, but also to share the excellent work within the partnership. The Team developed a wide-reaching selection of training programs to meet the needs of our patients and staff.

Safeguarding awareness week 2023 was a great success with great engagement across the Trust.

Key themes covered each day were:

- What's My Role in Safeguarding Adults?
- Let's Start Talking – Taking the Lead on Safeguarding in Your Organisation
- Cares For the Carers? Secondary and Vicarious Trauma.
- Adopting a Trauma Informed approach to Safeguarding Adults
- Learn, Lead – Co-Production with Experts by Experience

The week was a real celebration of how far the Trust has come in ensuring that patients are at the forefront of everything we do.

The Safeguarding adults team hosted a week of events including Level 3 Sg training to mark Adult Safeguarding week.

The team participated in Anne Crafts social media campaign to share excellent work that was taking place within the hospital, but also to share the excellent work within the partnership. The Team developed a wide-reaching selection of training programmes to meet the needs of our patients and staff.

SAFEGUARDING NEWSLETTER

A Safeguarding newsletter was published during this period. This newsletter provides national and local information about all aspects of children and adult safeguarding including PREVENT, Domestic Abuse and MCA/DoLS. It was distributed electronically via the Trust intranet site and is also used by Link Practitioners to support learning and practice. The newsletter supports the safeguarding training requirements of both the Adult and Children Intercollegiate Documents.

Congratulations to the winners of the safeguarding board competition:
Bluebell Ward: Most Engaging Board
Devonshire Centre: Most colourful Board
AMU: All Age & Think Family Board

Children in Our Care (formerly Looked After Children)

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

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

Stockport can and does provide care for Children in Our Care from outside the Local Authority due in part to the high number of private residential provisions. Placements here from other local authorities have a significant impact on the whole health economy.

Placements

In addition to Stockport's 153 mainstream foster carers there are 75 connected carers for Stockport children living in Stockport, in addition to this there are numerous different IFA (Independent Fostering Agency) carer's registered in Stockport. Stockport also has a large number of children who are looked after but continue to be placed at home with their parents.

The large number of children placed in Stockport by other areas are accommodated in a variety of settings, including private agency foster carers, residential homes, 16+ provision, therapeutic placements and specialist provisions. Currently Stockport has 57 homes providing approximately 250 places to children and young people.

Some of these placements provide accommodation for some of the most complex and vulnerable young people in Stockport, who access a variety of provision across the health economy. The Specialist Children in Our Care health team ensure that information is shared timely and appropriately to support access to services while here in Stockport.

Children in Our Care placed here from outside the Greater Manchester (GM) area face further challenges as they are not provided with any on-going therapy they may require. The current commissioning arrangements would mean that following assessment it would be up to the placing ICB to find and commission something privately.

There are currently 376 children from other local authorities placed in Stockport with a further 221 moving into the area during the year. For Stockport Local authority there were 504 Children in Our Care at the end of Q4 with an additional 236 starting their journey into care over the year.

Of the 374 children living here 266 were placed from the 9 GM areas with the remaining 108 placed by 45 other local authorities. There will be particular emphasis on these children as part of the new NHSE dataset.

Movements

Placements here from other local authorities have a significant impact on the whole health economy. It should be noted that the health assessment is only one part of the service provided. With the focus for reporting being purely based on this statutory element the complexity in working with these young people is often missed. There are large numbers of children and young people for which our services support who never have a health assessment in part due to placement moves and changes in legal status.

2023/2024	Q1	Q2	Q3	Q4
Placement Change	81	125	51	97
Movements in	34	50	42	60
Movements out	36	51	58	30
New into care	46	69	61	60

Specialist Children in Our Care health team activity.

The Specialist Children in Our Care health team provides a specialist resource to address the health needs of children and young people who are looked after by Stockport Local Authority, and young people who are living in Stockport who are looked after by other LAs. The delivery model for Children in Our Care is that services will primarily be delivered through existing primary and community services (such as health visitors, school nurses), with additional targeted support provided by the Specialist nursing team for those children and young people who either do not fall within the remit of, or find it difficult to access, local services. The team coordinate health assessment requests and provide support and guidance to professionals completing assessments. They also provide quality assurance for health assessments completed both in and out of area.

Most Stockport children that are placed out of area remain within Greater Manchester (GM) meaning many of the children living on the borders of Stockport remain on Stockport caseloads. The Specialist nursing team is currently working with a caseload of 190 young people, in addition to this the team coordinates the health requests for those children placed out of area and provides clinical oversight for those children with additional complexities and risk.

Information including safeguarding information, placement moves and requests for this year's 713 health assessments comes through the Specialist team, activity is captured through the quarterly activity reports and will need considering in terms of capacity, delivery and the commissioning of future service requirements.

Emotional Health and Wellbeing

There is a significant challenge for looked after children to access appropriate mental health provision, with the reduction of tier 2 services, Looked after young people are required to meet the threshold for tier 3 to receive specialist support. The health and wellbeing team commissioned by the LA are providing consultation to Social Workers and supporting carers and schools with interventions. There is hope in the future that they will be able to offer 1:1 work with young people. All children between the ages of 4-16 years have an SDQ (strengths and difficulties questionnaire) completed to inform the health assessment. Health professionals completing the review health assessment (RHA) also complete an age-appropriate assessment of emotional well-being; this provides a basis for discussion, support and on-going referral.

Children placed locally by other authorities outside of GM experience further challenge with emotional health support as currently Stockport CAMHS do not provide therapeutic support for these children.

Children in Our Care make up a small proportion of the child population (locally 79 per 10,000 (0.79%) which means they are significantly overrepresented in mental health presentations in ED (18%). Whilst there is recognition that following COVID 19 there has been an increase in demand in the general population, there needs to be consideration as to how services are experienced by young people and whether the provision is available and proportionate to need.

Key Performance Indicators (KPI) – Children in Our Care

Initial Health Assessments

SFT is commissioned to deliver to 52 clinics a year which has been the capacity required to meet the statutory requirement.

Initial Health Assessments	Total clinics	Stockport children seen	Other authority children seen	Total seen
April 2023	2	5	4	9
May 2023	4	13	4	17
June 2023	3	10	1	11
July 2023	4	14	4	18
August 2023	4	9	7	16
September 2023	5	14	5	19
October 2023	4	13	4	17
November 2023	5	13	4	17
December 2023	3	8	5	13
January 2024	4	15	2	17
February 2024	5	16	2	18
March 2024	4	8	5	13

There have continued to be challenges with the timeliness of receiving IHA requests which is having an impact meaning only 31.3% were seen within timescales in Q4. Along with the additional challenges in Q1 the overall performance for the year was 24%.

There has been some further analysis into the impact of the delayed requests which has been shared with the local authority. Stockport NHS FT will continue to work in partnership in fulfilling the statutory health assessment and works proactively in trying to meet the challenging timescales.

In Q4 we provided 13 clinics with 52 slots. There were 6 children not brought for appointment (all are offered a further appointment) and a further 4 who were either discharged or moved after an appointment had been offered.

The team have had a focus on the increased DNA/WNB rate and have identified a variety of factors. There needs to be a further planned review of the appointment letter stressing the importance of the appointment, alongside some planned communication out to placements and SWs to both support attendance and reduce the perceived flexibility and non-importance of these appointments.

Over the reporting year the Trust delivered 47 clinics which provided 199 appointment slots. There were 33 appointments not attended, all of which were offered another appointment. Of these 19 had a decliner pathway completed which included the offer of a home visit from the specialist nursing team.

Review Health Assessments

Review Health Assessments are completed by the caseload holder. In Stockport the Health Visitor completes the under 5's and the School Nurse would complete any 5-16's in mainstream education. Any 16 – 18-year-olds or young people in specialist educational provision would be completed by the Specialist Children in Our Care health team.

Number of RHA's completed by Health Visitors		School Nurses	Specialist Team
April 2023	6	14	15
May 2023	15	18	14
June 2023	8	30	6
July 2023	10	19	9
August 2023	21	13	11
September 2023	13	28	9
October 2023	10	24	9
November 2023	7	24	12
December 2023	10	12	4
January 2024	9	28	16
February 2024	10	26	6
March 2024	13	33	17

The challenges in meeting these KPI's are now monitored within a dashboard. This is providing greater oversight from managers and will feed into continuous service review.

The table below shows the comparison in completed assessments over the last 5 years.

Completed by	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
IHA	180	181	185	128	173	185
Specialist team	68	105	84	102	105	128
School Nursing	209	222	276	299	269	268
Health Visiting	96	96	113	133	154	132

Where there has been a consistent number of requests for most services, the Specialist Nursing team has seen a 22% increase. This needs to be considered within any service review and future resource planning.

Missing From Home

Children in Our Care make up a significant proportion of all children that go missing in Stockport. Ensuring that they have a multiagency plan for support is key when considering their safeguarding needs. For Stockport children there is a weekly staying safe panel for which there is health input too. There is currently a vacancy in the aspire nurse post meaning that the communication and sharing of information is even more important in the overall planning and support for the young person. A process is in place to ensure that the health professional is informed so that future support can be planned appropriately.

The team ensure that the appropriate professional receives the notification so they can review and support appropriately. This has a significant impact on the work of both the specialist health team alongside the wider health economy with 768 missing notifications processed during the reporting year.

Children's Safeguarding

The Trust has a specialist safeguarding children team which provides specialist advice, guidance and support to Stockport NHS Foundation Trust staff and other key agencies in the protection of children, unborn babies, and adults. They are supported by adult safeguarding, maternity safeguarding and looked after children's teams and work in collaboration to support the needs of individuals. The safeguarding children team attends internal and external strategy meetings, discharge planning meetings and other key safeguarding meetings to provide a safeguarding children perspective. The safeguarding children team ensure that any lessons learned from child safeguarding practice reviews are disseminated and embedded in Trust practice via safeguarding children training to ensure children continue to be safeguarded.

Health information Sharing Forms (HISF) & Children's Social Care Referrals

To ensure there is a clear review of the referral activity within the organisation the Safeguarding Children's Team review all child safeguarding referrals that are completed within the acute Trust and ensure that this is communicated in a timely manner to community health colleagues. Additional actions may be required to be completed such as follow-up referrals, escalating immediate concerns and ensuring the right practitioners are in receipt of the right guidance and support.

In addition to this function is the need to provide an element of quality assurance oversight to ensure all appropriate tasks have been completed and any outstanding actions are escalated accordingly within the relevant division or governance structure. The table below provides a breakdown of the total number of Health Information Sharing Forms and direct referrals to Children's Social Care (CSC) completed for the reporting year.

Health information Sharing Forms (HISF) & Children's Social Care Referrals.				
Month	**Total No. of HISF**	**HISF completed by the SGCT**	**Total No. of direct referrals to CSC**	**CSC ref completed by the SGCT**
April 2023	106	17	106	10
May 2023	120	27	145	21
June 2023	109	18	113	15
July 2023	113	27	113	13
August 2023	95	8	89	10
September2023	97	34	93	6
October 2023	113	30	115	13
November 2023	59	10	95	6
December 2023	60	14	80	1
January 2024	65	10	115	9
February 2024	90	13	98	4
March 2024	81	10	85	1
Year End 23/24	**1108**	**208**	**1247**	**109**
Year End 22/23	**1395**	**377**	**1568**	**279**

The referral activity remains high, particularly within the key hot spot areas such as the Emergency Department and the Tree House Children's Unit. Ensuring the safeguarding children's team provides direct support to the departments andwards has been pivotal in developing working relationships and guiding staff through the relevant process.

The safeguarding children team act as subject experts with regards to providing advice and oversite when required with Stockport NHS Foundation Trust staff; staff are empowered to complete MASSH referrals when concerns arise. The safeguarding children team will support escalating immediate concerns and ensuring the right practitioners are in receipt of the right guidance and support. How to complete a MASSH referral form is included in the training that the safeguarding children team delivers.

Comparison of year-end figures show a reduction overall in all sections for 2024 compared to 2023. No explanation can be offered for the reduction as Emergency Department (ED) attendances have remained consistent and it is typically Paediatric ED staff who generate the largest number of referrals to MASSH.

Mental Health Presentations

The data below demonstrates the referral activity in relation to children and young people who have presented due to concerns for their mental health and emotional wellbeing, and adult presentations where there have been safeguarding children concerns identified.
Whilst the data demonstrates that there has been a reduction in the number of presentations the complexity of these presentations continues to increase. The reduction of presentations also demonstrates that community support from external providers may be making a difference to acute presentations.

Month	CYP MH Presentations 0-15 2023/2024	CYP MH Presentations 16-17 2023/2024	Adult MH Presentations 2023/2024
April 2023	25	12	26
May 2023	49	20	24
June 2023	37	14	31
July 2023	34	10	29
August 2023	17	15	13
September 2023	24	05	16
October 2023	26	11	14
November 2023	32	12	18
December 2023	19	03	14
January 2024	28	13	28
February 2024	45	17	18
March 2024	28	13	12

Mental health presentation data has been collated by the business intelligence team for 2023 and 2024. As a result, the data is specific to a mental health diagnosis, resulting in a more accurate number of mental health presentations when compared to previous years data.

Paediatric Liaison Nurse Role

The traditional Paediatric Liaison Nurse function is an established role within the organisation. The role currently ensures that there is an effective communication pathway between hospitals and community services which enables children and their families to receive appropriate care and support. Within the organisation the Paediatric Liaison Nurse is based with the safeguarding children team, on the hospital site and reviews in detail all Emergency Department attendances of children and young people up to the age of 17years.This is to identify any potential concerns and to ensure that the appropriate community professionals and services are notified of the child or young person's presentation within a timely manner to ensure the families are in receipt of early intervention services.

Dependent on the need of the family further communications may be held with other multiagency partners such as children's social care, youth offending services, mental health services, and drug and alcohol services. The detail below captures the activity during April 2023 to March 2024, with the comparative data from the previous two years. The data shows a **1,503** reduction in 0–15-year-olds who attended Stepping Hill Emergency Department in April 2023 to April 2024, compared with April 2022 to April 2023.

Emergency Department Attendances 0 – 15yrs	2023/2024	2022/2023
April 2023	1740	1928
May 2023	1972	2278
June 2023	1819	2016
July 2023	1744	2074
August 2023	1376	1428
September 2023	1799	1724
October 2023	2097	2050
November 2023	2367	2436
December 2023	1904	2593
January 2024	1782	1625
February 2024	1783	1733
March 2024	2004	2005
Total	**22,387**	**23,890**

Emergency Department Attendances – 16–17 year old

Noted in the table below is a breakdown of the number of 16 and 17-year-olds who have presented to the Emergency Department during April 2023 to March 2024. The attendance is currently reviewed by the Paediatric Liaison Nurse and triaged for action.

Month	Total numberof attendees to ED aged 16-17 2023 / 2024	Total numberof attendees to ED aged 16-17 2022 / 2023
April 2023	161	186
May 2023	189	203
June 2023	184	181
July 2023	152	178
August 2023	158	143
September 2023	165	180
October 2023	172	184
November 2023	156	216
December 2023	146	152
January 2024	149	174
February 2024	201	162
March 2024	247	199
Total	2080	2158

Comparing the numbers year on year, shows a consistent number of 16 and 17 year-olds that attended Stepping Hill Emergency Department during the years of April 2022 to April 2024.

Paediatric Medical Reports

As part of a child protection enquiry a request for a child protection medical may be requested by Children Social Care and the Police as part of a Section 47 Investigation. This service is provided by Stockport Foundation Trust and the clinic is situated within the Treehouse Children Unit. Presented below is the data regarding the number of medicals completed during April 2023 to March 2024 with the comparative data from the previous year.

Paediatric Medical Reports (NAI)		
	2023/2024	2022/2023
April 2023	**8**	**9**
May 2023	**13**	**12**
June 2023	**10**	**1**
July 2023	**11**	**8**
August 2023	**15**	**13**
September 2023	**10**	**8**
October 2023	**3**	**8**
November 2023	**8**	**18**
December 2023	**6**	**1**
January 2024	**7**	**15**
February 2024	**6**	**11**
March 2024	**8**	**10**
End of Year Total	**105**	**114**

Where possible it is best practice to ensure sibling groups are seen together. This ensures that thechildren remain together as a sibling cohort, and it assists with continuity and the ability to reduce the need for multiple histories to be obtained if the children are reviewed by the same practitioner. This can however have a direct impact on the clinic's capacity and workload within the department which can result in time slots being extended to accommodate.

Child Death Overview Panel

Child Death Overview Panels (CDOPs) are a multi-disciplinary sub-group of Local Safeguarding Children Partnerships that work across Local Authority boundaries based on population numbers. CDOP reviews the deaths of all children aged from birth up to the age of 18 years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP area. There are 4 CDOPs across Greater Manchester, 3 of which function as a 'tri-partite' such as Stockport, Tameside and Trafford (STT). The table below details the Stockport child deaths during April 2023 to March 2024 within Stockport.

C.D.O.P			
Month	**Expected**	**Unexpected**	**Total**
April 2023	1	2	3
May 2023	0	0	0
June 2023	0	0	0
July 2023	0	1	0
August 2023	2	2	4
September 2023	1	0	1
October 2023	1	2	3
November 2023	0	0	0
December 2023	2	1	3
January 2024	0	0	0
February 2024	0	1	1
March 2024	1	2	3
End of Year Totals	**8**	**11**	**18**

Reporting a serious child safeguarding incident (working together 2018)

Local authorities in England must notify the National Child Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident. This is whereby a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –

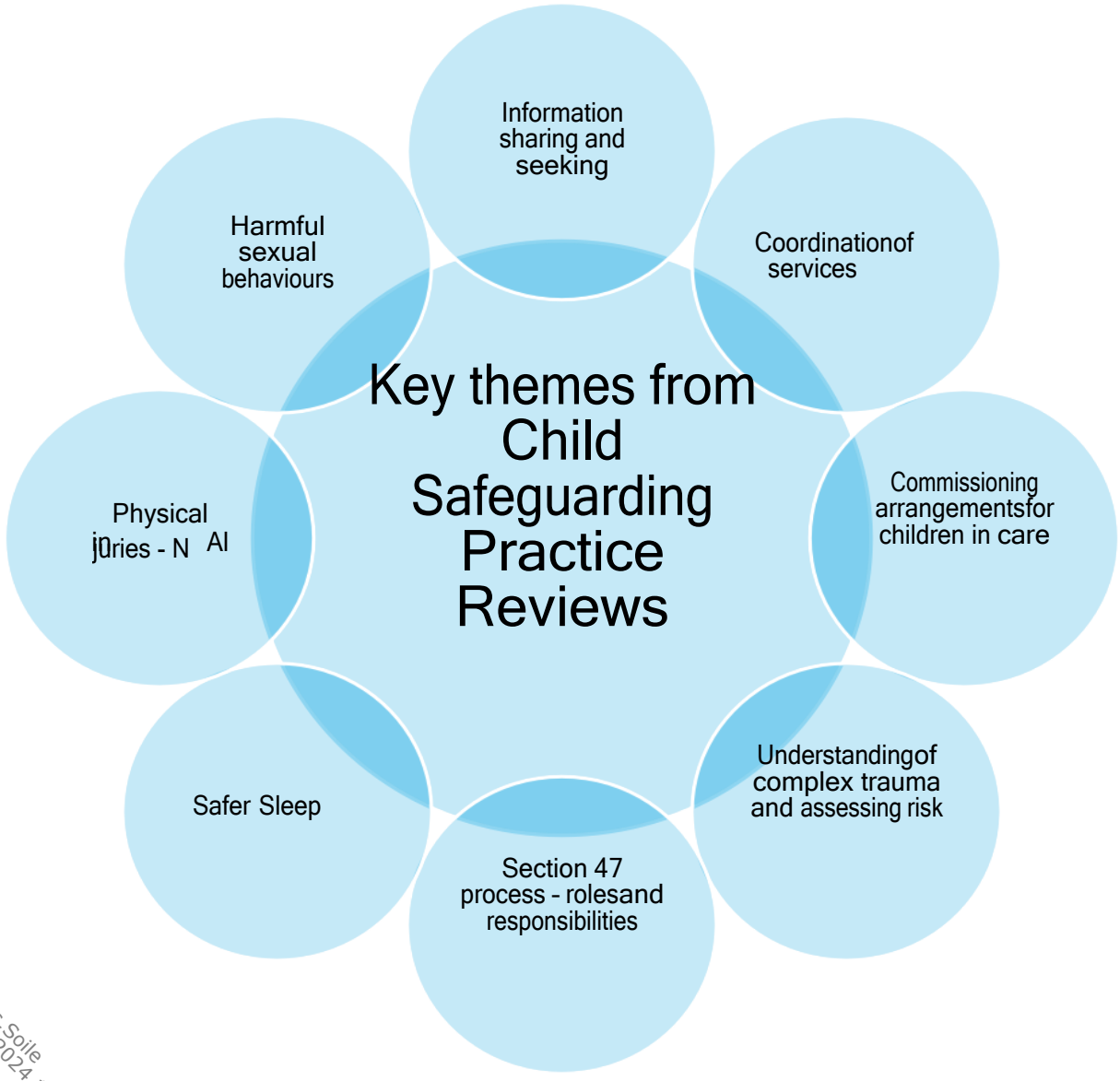
(a) the child dies or is seriously harmed in the local authority's area, or
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Safeguarding Partners must undertake a rapid review into all serious child safeguarding cases promptly and complete this within fifteen working days of becoming aware of the incident.

The table below demonstrates the number of agency check / rapid review responses submitted for children and young people who have died or have suffered significant / serious harm. The safeguarding children team have responded to all requests within the required time frame and submitted the evidence accordingly.

Child Safeguarding Practice Review / Learning ReviewAgency Report Submissions	
April 2023	**0**
May 2023	**2**
June 2023	**0**
July 2023	**1**
August 2023	**0**
September 2023	**1**
October 2023	0
November 2023	0
December 2023	1
January 2024	0
February 2024	1
March 2024	3

Overarching key themes from Child Safeguarding practice reviews Q1-Q4



Safeguarding Children's Supervision

Safeguarding children's supervision is offered widely across the Trust, acute and community services. The Trust Safeguarding Children Supervision Policy incorporates restorative ways of working to meet the needs of the workforce and demonstrate improvements with outcomes.

The compliance data has been separated below to include narrative surrounding the different cohorts of staff and their requirements.

Safeguarding Children Supervision in Health Visiting and School Nursing

Safeguarding Children's supervision in health visiting and school nursing has continued with the revised model of provision, with the aim to spend longer on those cases that are presenting the most difficulties for practitioners. This enables quality reflection, learning and development which are transferrable to other cases within their caseload.

The current safeguarding supervision compliance for health visitors and school nurses are noted below:

Health Visitor and School Nurse Supervision 2022 – 2023												
	April 2023	**May 2023**	**June 2023**	**July 2023**	**Aug 2023**	**Sept 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**
Staff requiring supervision (HV & SN)	20 HV 3 SN	19 HV 3 SN	17 HV 10 SN	23 HV 7 SN	14 HV 3 SN	14 HV 2 SN	24 HV 7 SN	15 HV 9 SN	16 HV 3 SN	22 HV 4 SN	14 HV 6 SN	16 HV 2 SN
No of staff supervised within timescale	**20 HV** **3 SN**	19 HV 3 SN	16 HV 10 SN	23 HV 7 SN	13 HV 2 SN	14 HV 1SN	24 HV 7 SN	15 HV 8 SN	13 HV 3 SN	12 HV 4 SN	14 HV 6 SN	16 HV 2 SN

Compliance remains high and of significant importance within the community provisions. To note, safeguarding supervision continued during the covid pandemic with amendments made to ensure that staff were seen prior to redeployment to ensure the caseloads had clear oversight.

The table presented below provides insight into the supervision and support activity which is delivered to several additional services across the organisation. This includes the detail of thetotal number of sessions completed across the community teams. The supervision sessions are completed in a variety of formats from individual sessions to group sessions and supervision regarding the production of chronologies and support with court reports and guidance through the child death rapid review process. This activity and demand for support remains high with the number of sessions delivered in all quarters as illustrated below.

Month	Total Number of SG Supervision Sessions Delivered by the Vulnerable Children's Team
April 2023	23
May 2023	22
June 2023	26
July 2023	30
August 2023	15
September 2023	15
October 2023	31
November 2023	23
December 2023	16
January 2024	16
February 2024	20
March 2024	18

Safeguarding Supervision within the Acute Services

The provision of supervision within the acute setting has been reviewed and a robust model has been implemented. The information below is in relation to practitioners who have specialist nursing roles and therapy roles as well as the practitioners within the main unit areas within paediatrics, neonates and the children's ED department.

Specialist Nursing Roles

Acute Safeguarding Children Supervision Provision – Acute Specialist Nursing Roles. Supervision (compliance collated on staff receiving supervision sessions every 12-14 weeks)												
	Q1			**Q2**			**Q3**			**Q4**		
	April 23	**May 23**	**June 23**	**July 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**	**Mar 24**
Children Learning Disability Team		**100%**		100%		100%		**100%**		100%		100%
Children Diabetes Team		**100%**		100%		100%		**100%**			100%	
Childr en Resp Team	100%	**100%**		100%		100%		100%		100%		100%
Children Epilepsy Team	100%	**100%**		100%	100%	100%			100%			100%

The monitoring and data collation regarding the specialist nursing groups remains on an individual compliance basis due to their case holding capacity. It is also noted that a number of the community teams hold dual roles and access supervision via the main community nursing forum.

Children's Therapy Services.

Therapies Safeguarding Children Supervision Provision – Non- Case Holding Practitioners. Supervision (compliance collated on staff receiving supervision sessions every 12-16 weeks) Supervisionis provided by Therapy Service Leads and Includes Paediatric Physiotherapy, Speech and Language Therapy and Orthoptist Department,												
	April 2023	**May 2023**	**June 2023**	**July 2023**	**Aug 2023**	**Sept 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 24**	**Feb 24**	**Mar 24**
Therapy Services	94%	**89%**	85%	95%	98%	98%	90%	87%	100%	86%	100%	100%
Therapy Leads	100%			100%			100%			100%		

The delivery of safeguarding children's supervision is provided by the Therapy Team Leads in group format. Several of the team leads have completed a safeguarding supervision course to support this function. The team leads then receive supervision facilitated by the Safeguarding Children's Team to provide aerial oversight of case management.

Main Paediatric Service Departments.

Acute Safeguarding Children Supervision Provision – Non-Case Holding Practitioners. Supervision (compliance collated on staff receiving supervision sessions every 12-14 weeks)												
	Q1			**Q2**			**Q3**			**Q4**		
	April 23	**May 23**	**June 23**	**July 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**	**Mar 24**
Children's CCNT			100%		100%			100%	100%			100%
Treehouse and Outpatient Department.	100%	100%			100%	100%	100%		100%	100%		100%
Neonates	100%		100%			100%	100%		100%			100%
Children's ED	100%			100%		100%		100%		100%		

The provision of safeguarding children's supervision to the acute staff is delivered in group format and the data collated demonstrates the sessions offered. This has been well received by the service leads and will be supported in the year ahead.

To assist with the delivery of this model there have been several practitioners within the women and children's division who have completed a safeguarding supervision course to support the service provision. This aim is to enhance the team experience by having one of the safeguarding children's team support the implementation and development of the supervisor skills and enhance the application of theory to practice.

Spontaneous supervision continues to be provided daily supporting current / active case management, some of which is delivered in a coaching method whereby the specialist nurse works directly alongside the member of staff to guide them through the process as well as telephone advice that results in a reflection and staff actions with regards to the case. Due to the increase in visibility across the Trust and the developments in working within other areas, there has been a noted increase in this activity, which has been extremely well received.

Safeguarding Children Training

SFT training compliance for Level 1 & 2 safeguarding children training remain above 90% and have continued to be monitored across the organisation. Level 3 safeguarding children training is offered to all Stockport NHS Foundation Trust staff working with children/families who contribute to assessing, planning, intervening, and evaluating the needs of a child/young person and their carers.

Focus has been placed to ensure practitioners have access to the required level of high-quality training through a blended approach alongside the Stockport Safeguarding Children's Partnership Multiagency Program and the safeguarding children team. The training provision from the safeguarding children team has been adapted to offer 8-hour, core, face to face Safeguarding Children Level 3 training which meets the competences outlined in the Intercollegiate document. The safeguarding children team have also developed more frequent and shorter sessions to increase the current offer for staff who find it difficult to be released from clinical settings. Training has evaluated extremely well; attendees report that they felt more confident about their involvement in safeguarding children, have benefited from the knowledge of outside speakers and the importance of having up to date knowledge around the more recent learning from Child Safeguarding Practice Reviews.

Level 3 compliance reporting has been reviewed with the Learning and Development Team. A revised Do It Online submission form is being produced to provide professionals with the ability to save the training that has been undertaken and submit the form once 8 hours of training has been accrued. In response to feedback from practitioners, there will be separate adult, and children Do It Online forms. The 8-hour core training sessions will be uploaded onto the Trust ESR system, without the need to complete a Do It Online form. The revised Do It Online form and the 8-hr face-to-face sessions will assist with accurate and consistent reporting and will support managers in accessing this information readily as part of their staff performance and monitoring processes. All safeguarding children training is now booked via ESR.

Children's Safeguarding Training	2023-2024			
	Q1	Q2	Q3	Q4
Level 1 (TARGET 85%)	97%	96%	97%	96%
Level 2 (TARGET: 85%)	93%	94%	94%	95%
Level 3 (TARGET: 85%)	80%	78%	87%	90%

The safeguarding children training targets above are set by Stockport Integrated Care Board, aligned to the Greater Manchester Safeguarding Assurance Audit Framework Tool directed from NHSE. The training compliance is now monitored and reported via People Analytics. This has provided more oversight and given the responsibility back to divisions to review and monitor compliance. To note SFT training target is 95% across all three levels.

Maternity Safeguarding

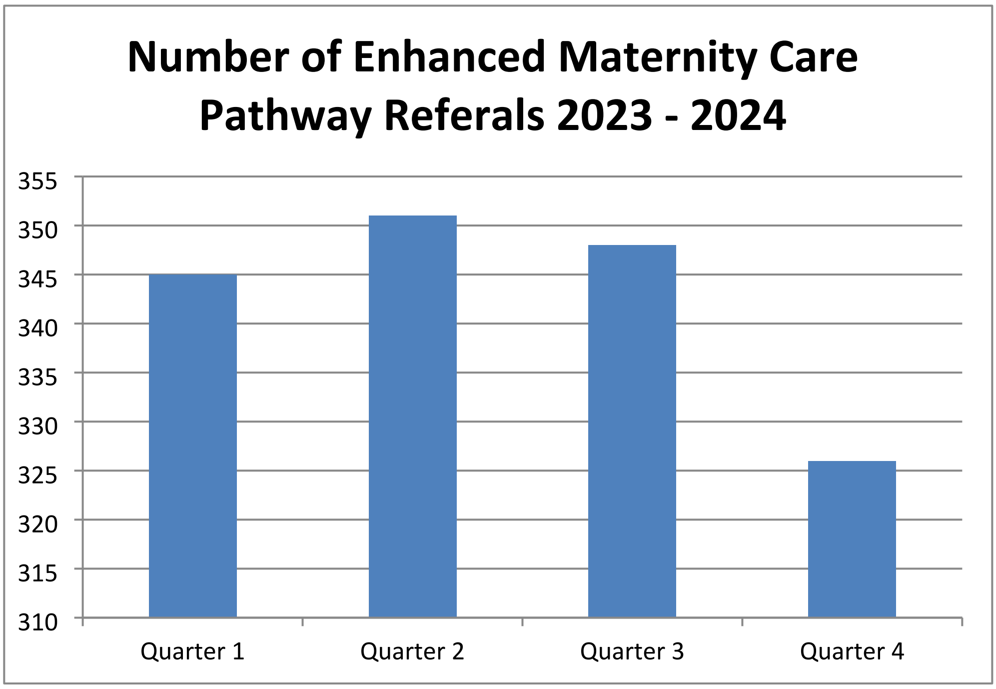
All staff working within Maternity Services at SFT have a role in identifying risk and ensuring unborn babies, new-born babies and adults at risk are protected from harm and abuse. Maternity staff are likely to have significant contact with families who may require support and interventions in relation to safeguarding children and adults.As part of the on-going developments in demonstrating the trustresponse to the protection of these at-risk groups, key systems and processes have been implemented to enhance the safe provision and care delivery to the patients in our care.

Maternity services at SFT provide antenatal, intrapartum, and postnatal care both within theacute environment of the acute Trust and across the Stockport and High peak footprint within children's centers and GP surgeries. In line with the choice agenda within maternity care, the organisation also provides antenatal and intrapartum care for out of area women who decided to access their antenatal and intrapartum care at SFT.

Within Maternity services, there are clear reporting structures to enable staff to escalate identified safeguarding concerns to any of the safeguarding teams as part of a think family approach to safeguarding. Most referrals are submitted directly to the maternity safeguarding team via an Enhanced Maternity Care pathway referral. Staff can also refer directly to Children's and Adult social care as necessary to protect the most at risk.

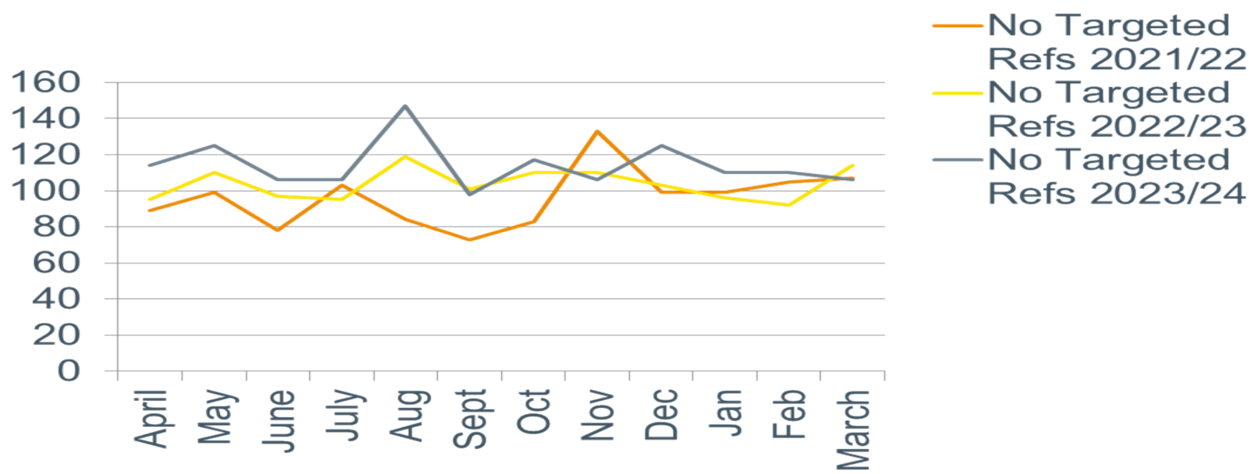
Robust screening for social risk indicators is embedded in all pathways of care, from the initial booking questionnaire up until handover of care to Health Visiting (HV) colleagues. At any point in the pregnancy and postpartum continuum an Enhanced Maternity Care Pathway referral can be completed when a safeguarding concern has been identified or reported, which facilitates information sharing with partner agencies within health. All these referrals are received by the midwifery safeguarding team and are reviewed and a variety of follow up actions completed to ensure that the professionals involved with the child and family have the right information to inform risk assessments and safeguard the unborn child, children, young people and vulnerable adults that present to our organisation and access our services.

During the reporting period, the Maternity Safeguarding team have received 1370 Enhanced Maternity Care Pathway referrals. This equates to 42.3% 38.8% of women booked to deliver at Stockport NHS Trust had identifiable vulnerabilities or unmet needs. The most common indication for completing a maternitytargeted referral was due to perinatal mental health issues.



The Advantis CDS Maternity Safeguarding IT system went live in January 2021, the numbers of Enhanced Maternity Care Pathway referrals received over the past 36 months have been reasonably consistent with an upward trend, which would indicate that the process for identifying vulnerable women and families is well embedded and staff feel confident in using the IT system to alert practitioners to risk and unmet needs.

The chart below compares the last two year's Q1, Q2, Q3 and Q4 data to this reporting year's data.



The number of targeted referrals are averaging 114 per month which places increasing pressure on the maternity safeguarding team to triage them and action them to the appropriate professional in a timely manner. This in turn places pressure on the perinatal mental health midwives, IDVA service and the young person's midwife who need to triage them once they receive them from the safeguarding team.

Maternity Safeguarding Supervision

Safeguarding Supervision within Maternity is delivered differently depending on the area of the service the midwife practices. For the community-based midwives who hold a caseload of families,

they require safeguarding supervision every 3 months. For midwives working in the acute Trust, one safeguarding supervision update session is all that is required which is facilitated through the Public Health Study Day.

There are currently 54 community-based midwives requiring 4 sessions of safeguarding supervision per year. To facilitate these requirements, safeguarding supervision is currently offered either one-to-one with a member of the maternity safeguarding team or as group supervision. Group supervision is delivered by the Community Team leaders as well as the namedMidwife for Safeguarding Children. Group supervision is most suited to those community-based staff who do not case manage significant numbers of safeguarding families, whereas the one-to- one sessions are vital to those midwives who work with more vulnerable families or in areas of more social deprivation.

Year to Date Compliance

Team	Compliance (Rolling 12 Months)	End of March 2023		
		No. Midwives	No. Midwives Compliant	% Compliant
Community	4 or above sessions	63	34	54%
Acute	1 or above sessions	168	117	70%
	Total	231	151	65.37%
Team	**Compliance (Rolling 12 Months)**	**End of March 2024**		
		No. Midwives	No. Midwives Compliant	% Compliant
Community	4 or above sessions	54	27	50%
Acute	1 or above sessions	128	106	83%
	Total	182	133	73.08%

Breakdown of Compliance by Quarter 2022/2

Team	Compliance	No. Midwives	Quarter 1		Quarter 2	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	63	47	75%	37	59%
Acute	1 or above	168	25	15%	27	16%
	Total	231	72	31.17%	64	27.71%

Team	Compliance	No. Midwives	Quarter 3		Quarter 4	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	63	44	70%	27	43%
Acute	1 or above	168	43	26%	39	23%
	Total	231	87	37.66%	66	28.57%

Breakdown of Compliance by Quarter 2023 - 2024

Team	Compliance	No. Midwives	Quarter 1		Quarter 2	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	54	30	56%	33	61%
Acute	1 or above	128	39	30%	21	16%
	Total	182	69	37.19%	54	29.67%

Team	Compliance	No. Midwives	Quarter 3		Quarter 4	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	54	25	46%	25	46%
Acute	1 or above	128	17	13%	27	21%
	Total	182	42	23.08%	52	28.57%

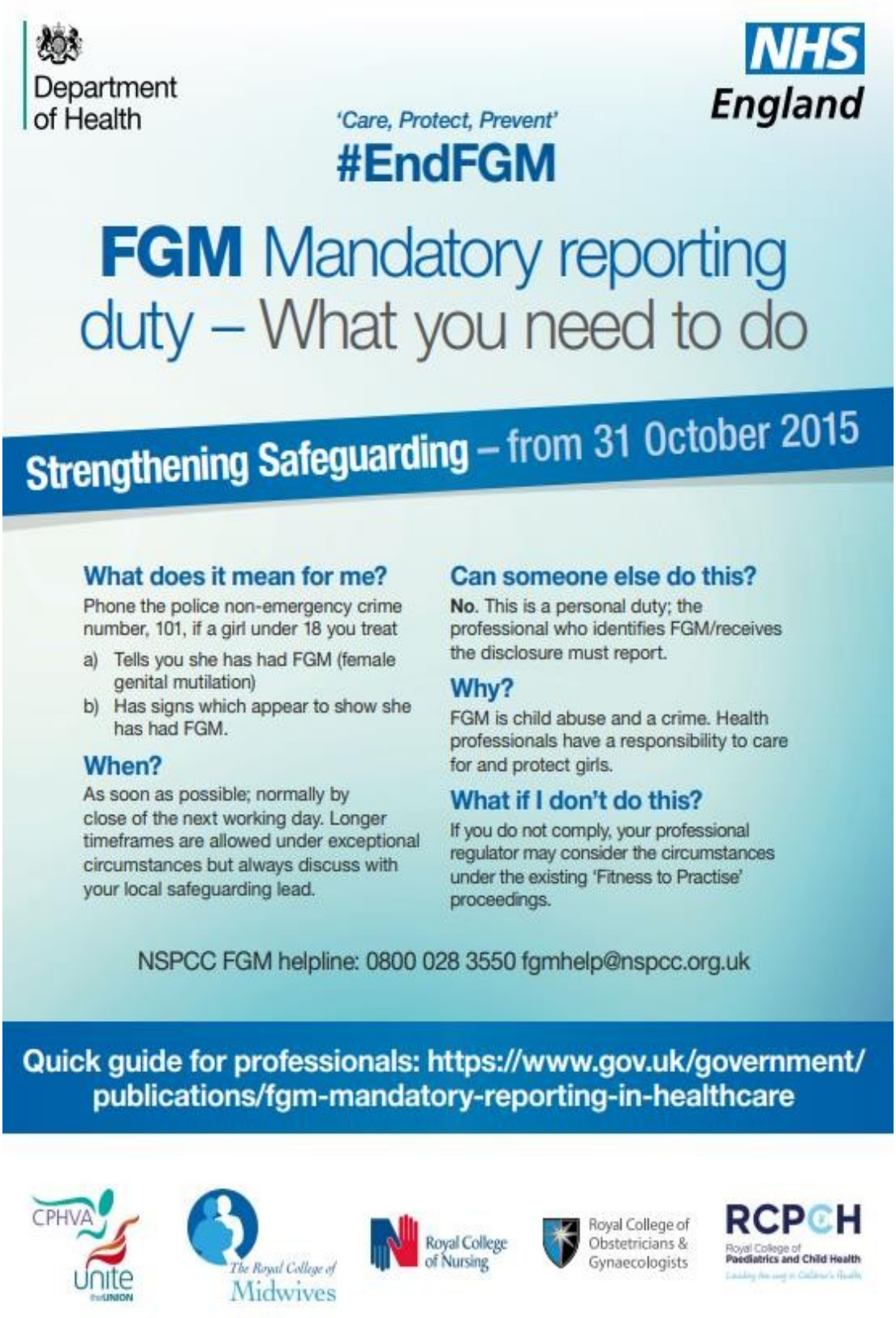
Female Genital Mutilation (FGM)

The safeguarding teams continue to support the Trusts mandatory recording and reporting of FGMdata on a quarterly basis. The FGM enhanced dataset requires organisations to record, collect andreturn detailed information about FGM within the patient population, as treated by the NHS in England. There have been a total of 41 17 reportable cases identified between April 2023 - March 2024, which is a 156% increase from last year's total of 17.

The data collected is used to produce information that helps to:

- Improve how the NHS supports women and girls who have had or who are at risk of FGM
- Plan the local NHS services needed both now and, in the future,
- Help other organisations e.g. local authorities to develop plans to stop FGM happening in local communities.

A new on-line training session on FGM has become a mandatory requirement for all patients facing staff, and as part of the Level 3 safeguarding training offer, the Named Midwife continues to deliver face-to-face FGM training for the Trust.



Adult Safeguarding

A significant part of the Trusts responsibility is contributing to statutory safeguarding enquiries and reviews. As such, the Adult Safeguarding Team has contributed positively to Section 42 Enquiries held under the auspices of the Care Act (2014) throughout the period of this report, furthermore the team support practitioners in providing specialist advice, guidance and support in risk and safety planning, complex care planning and training and educating staff.

The Trust continues to support Local Authorities in their statutory lead role for safeguarding adults and as such actively contribute to safeguarding enquiries (section 42, Care Act 2014) and other reviews. The Adult Safeguarding team continues to attend external strategy meetings, case conferences section 42 outcome meetings to ensure that any lessons learned are disseminated and embedded in Trust practice.

The Trust has a reporting system to enable all staff to escalate any safeguarding concerns to the Adult Safeguarding Team. The cause for concern form can be accessed electronically through the Adult Safeguarding microsite. All concerns are reviewed and where indicated patient records are reviewed to add additional information to support and inform the concern, to escalate immediate concerns and to ensure that the right practitioners are in receipt of the right guidance and support. All actions relating to safeguarding concerns are recorded on a database to support data analysis and reporting via the Trust Integrated Safeguarding Group.

Concerns raised by Trust staff during the reporting period 23/24

The total number of referrals received in this reporting year has increased by **25%** (337) compared to the previous period 2022/23. The increase tells us that there is greater awareness and understanding of how staff report a safeguarding cause for concern. The table below illustrates the trajectory of referrals raised and tells us there is an ongoing spike in the volume of referrals received.

Month	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023/24	119	116	137	158	139	144	123	174	128	163	124	149	1674
2022/23	81	112	114	126	126	111	111	111	111	99	117	118	1337
2021/2022	77	80	66	41	47	52	87	84	77	67	68	81	827
2020/2021	45	79	94	71	55	57	62	73	80	74	16	82	833

Over the last year staff have actively sought support and advice from the safeguarding practitioners and will make contact via phone or email to seek this. Staff have appreciated the advice and support that is given by our safeguarding practitioners and positive feedback has been received regarding the assistance that has been provided. The practitioners have noted there has been an increase in contacts via the cause for concern form, the internal email address or directly to practitioners from staff to the safeguarding team following the adults safeguarding level 3 training. There has also been a significant increase from previous years when lockdown was enforced during the pandemic where we saw less people presenting to hospital and fewer home visits taking place.

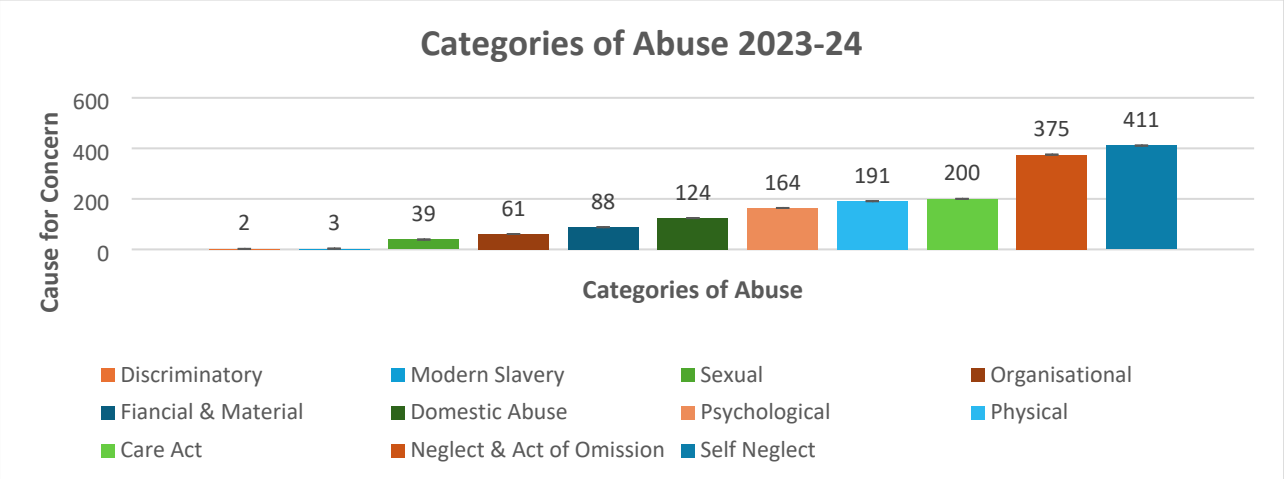
Referrals to Adult Social Care

Month	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023/24	97	79	119	129	99	107	93	132	97	131	113	132	1328
2022/23	61	103	109	67	115	84	94	70	77	33	115	82	1010
2021/2022	68	62	55	41	43	34	56	31	56	56	51	42	595
2020/2021	38	68	73	59	51	44	52	58	71	59	59	74	706

The referrals to the Local Authority have also increased by **31% (318)** compared to the previous period 2022/23. This is a significant increase, based on the total number of referrals received. Out of **1674** of those referrals **20% (346)** were screened and signposted to the most suitable agency for their consideration, or with no further action necessary. This suggests that practitioners will triage each concern to ensure safety planning happens and that referrals to local authority are appropriate.

Categories of Abuse

The main reason for consultation within the safeguarding adult team is relating to categories related to issues of Self-neglect, Neglect and Psychological (See Table below). The team also ensures the completion of domestic abuse DASH forms and referrals to MARAC are completed in a timely manner for high-risk domestic abuse cases.



Procedure For Responding to a Safeguarding Adult at Risk Cause for Concern

We have produced a Standard Operating procedure (SOP) for our Safeguarding processes that ensures we can adequately respond timely and monitor the progress of our enquiries and escalate to local authorities where necessary. The Standard Operating Procedure ensures that Stockport Foundation Trust is adhering to best practice in line with relevant legislation; the Care Act 2014.
The hospital safeguarding team liaises with the Local authority to ensure appropriate process is followed for Section 42 (Care Act 2004) enquiries and the team supports each of the divisions with completion to manage safeguarding concerns.

Safeguarding Adult at Risk Policy

We completed a full-scale review of the Safeguarding Adults at Risk policy and the procedures for Stockport NHS FT staff to follow when responding to a safeguarding concern. The revised version was endorsed in April 2023 and has been relaunched widely within the Trust. Communications are often disseminated widely within the organisation reminding staff they can access the policy via the Trust Intranet and is a standing agenda item in Safeguarding supervision and Safeguarding adults training.

Adult Safeguarding Supervision

Safeguarding supervision is the most influential and effective of safeguarding interventions taken by safeguarding professionals. The Adult Safeguarding Team continues to deliver monthly safeguarding supervision session with all Divisions. Safeguarding supervision is offered to all Band7 and 8a staff either on a one-to-one basis or a group session.
These sessions have increased knowledge and awareness of safeguarding issues, escalations of safeguarding concerns and staff report they feel better supported and competent to deliver their safeguarding role. The provision is also promoted within the Safeguarding level 3 training, and we have seen people request peer supervision following attendance at the training.

Mental Capacity Assessments (Mental Capacity Act 2005)

The Trust continues to provide care for patients under best interest arrangements due to the supervisory body having a backlog of applications requiring a Best Interest Assessment, this reflects the national position.

Staff knowledge of the Mental Capacity Act has improved. While this is a good assessment of the status of the Trust, work is still required to embed the knowledge, skills, and consistency of staff in application of the MCA.

The team provides area specific guidance and training on capacity assessment and completion of DoLS applications. The introduction of How to complete a Mental Capacity Assessment webinar to support staff in assessing capacity was rolled out across the Trust with posters, pocket cards as well as on the intranet to raise awareness to provide clinical staff information on the implementation and statutory responsibilities for MCA.

Deprivation of Liberty Authorisations / Applications April 2023 – March 2024

A standard operational procedure (SOP) was produced to provide the Divisions with guidance on the expectation and standard of DoLS applications and since guidance was introduced, we have seen improvements, the information that is being provided is more extensive and detailed and staff's awareness and understanding around DoLS has increased. Tools and resources have also been produced to support staff with examples of what a good DoLS application looks like and to increase staff development of specific skills around these areas. There are also learning resources to support staff on how to complete a Dols application prior to submitting to the Local Authority which can be found on the Adult Safeguarding microsite.

Monthly audits on the application of DoLS are conducted, and the findings suggest there is a very good level of compliance in the Trust which continues to increase each year, and this is to be recognised. Audits also continue to be monitored with a view to seeing improvements based on feedback the ward staff receive from audit findings and with the inception of the new DoLS standard operational procedure (SOP).

There were **2012** DoLS applications made during the year, compared to **2526** the previous year, a decrease of **20% (514)**. This is a significant reduction although figures from previous years during the pandemic would suggest we have seen an increase in staff awareness on the DoLS process as applications have increased by 40% since the recovery of the pandemic. **18% (370)** of those applications were rejected due to more information being requested, such as capacity to stay within the hospital setting. To overcome this, an escalation process has been produced for such rejected DoLS, to prevent delays and ensure DoLS applications are completed promptly.

DoLS Applications	
Financial Year	**Total**
2023-24	2012
2022-23	2526
2021-22	1689
2020-21	1193

An administrative and clinical review of the DoLS application and/or authorisation form is undertaken prior to submission to the appropriate DoLS supervisory office. This ensures a relevant mental capacity assessment is documented accurately,appropriately, and comprehensively

2022-2023	Q1	Q2	Q3	Q4	Total
Authorised (Urgent)	555	658	709	604	2526
2023-2024					
Authorised (Urgent)	569	492	503	448	2012
Trust Compliant-AMAT	73%	83%	84%	87%	82%
Rejected	212	81	43	34	370
Discharged before processed	26	18	5	12	61
Sent onto The Local Authority					
Stockport	246	303	324	295	1168
Derbyshire	37	44	65	37	183
Tameside	5	5	5	11	26
Cheshire East	15	20	39	24	98
Trafford	1	2	0	2	5
Other	3	3	7	10	23

Audit and Monitoring

The Annual Audit Plan is agreed and approved at the beginning of each financial year. The 2023/24 audit plan was reviewed and shared with our colleagues at the Integrated Care Board (ICB) for assurance of audit activity in the following areas:

- Case File Audits
- Deprivation of Liberty Safeguards (DoLS)
- Safeguarding Adults Assurance
- Patients in hospital with a Learning Disability and/or Autism
- Safeguarding Adults Training

The Safeguarding Adults Assurance audit was developed to gain assurance around staff awareness of the process for reporting a safeguarding concern. The tool was modified to include questions on who the MCA and Prevent Lead within the Trust is and if staff knew how to contact both the Children's and Adult's safeguarding teams. Subsequently, recommendations were made to Divisions within the Trust to have a "Think Family" safeguarding board in clinical areas.

Case file audits demonstrated an increase in the number of high-quality internal safeguarding referrals from practitioners across the Trust where there have been clear, concise, and well-considered immediate actions taken to safeguard individuals. The Adult Safeguarding Team continues to encourage staff to record the actions they have taken on the Cause for Concern form.

Safeguarding Training compliance

Safeguarding training remains a key priority for all employees at Stockport NHS FT, there is a nationally set requirement for levels of safeguarding training as appropriate to individuals' roles and responsibilities.
The Key Performance Indicator (KPI) for safeguarding training is locally agreed with the ICB and is 90%. The nationally agreed KPI for Prevent Level 3 training is 85%.

Adult Safeguarding Training

The Adult Safeguarding Training Intercollegiate guidance is used to inform the Trust training. While the compliance for 2023/24 is shown in the table below, the current activity demonstrates a strong level of compliance in level 1 and level 2 safeguarding training and a strong trajectory of compliance that continues to rise throughout the financial year to ensure practitioners are compliant with completing 8 hours of competency to meet with safeguarding level 3.

Safeguarding Adults Training	2023-24			
	Q1	Q2	Q3	Q4
Level 1 (TARGET 85%)	95.96%	96.53%	95.41%	97.06%
Level 2 (TARGET: 85%)	93.14%	94.74%	94.36%	95.47%
Level 3 (TARGET: 85%)	80.95%	85.70%	86.60%	87.68
Mental Capacity Act (TARGET: 85%)	93.96%	95.18%	95.51%	95.00%
Deprivation of Liberty	94.17%	95.39%	95.97%	95.00%

Safeguards Training (TARGET: 85%)				
Prevent WRAP 3 Training (TARGET: 90%)	95.33%	95.66%	96.20%	95.72
Prevent Basic Awareness (TARGET: 90%)	96.63%	96.05%	95.80%	96.12%

Online training remains the main route to deliver Level 1 and 2 safeguarding adult training. Level 3 face-to-face safeguarding adult training is on offer monthly and delivery has continued with a rolling program where staff can enroll onto. The face-to-face sessions are well evaluated, and the audience will feedback via the E portfolio Learning Pathway. Feedback on themes regarding "what went well" and "what could be better" were asked of learners about the training. Participants gave ratings based on 3 questions regarding relevance, quality, and interactions. The overall rating was 3.4 out of 4. Learners also have the facility to provide optional feedback. All learners who gave top mark feedback stated that the course was interesting, they learned a lot and provided constructive feedback on what they would like to see differently in the future.

Question number	Question text	Responses	Average rating
1	How relevant is the course content to you?	41	3.3/4
2	How well would you rate the overall quality of the course delivery?	41	3.3/4
3	Were you happy with the level of interaction and Q&A opportunities?	41	3.4/4

Oliver McGowan Learning Disability and Autism Tier 1Training

With the introduction of the Health and Social Care Act 2022 a requirement was placed on all CQC registered providers to provide Learning Disability and Autism training to all health and social care staff as appropriate to their role. Following the completion of a training needs analysis all SFT staff were identified as requiring Tier 1 or Tier 2 training and Tier 1 training was rolled out in Q2.

Reporting on training compliance was commenced in Q3 and Trust Tier 1 compliance is currently 91.2% which is above Trust, contractual and regulatory requirements. NHS England are in the process of rolling out the approved trainer training for Tier 2 which is delivered by trainers and experts with lived experience of Learning Disability and Autism which can then be cascaded to individual organisations.

Partnership working to improve outcomes for children and adults.

The safeguarding team contributes daily to support the functioning of the Multi-Agency Daily risk meeting. This function is shared with Greater Manchester Police to ensure health information is shared to inform assessment of high-risk domestic abuse cases. The team have supported health information requests and attend meetings when required.

Multi-Agency Risk Assessment Conferences (MARAC)

The team attends the Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information on individuals who have been identified as at high risk of death or serious harm

though domestic abuse through completion of the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) risk assessment tool. Throughout 2023/24, the team received **34** DASH referrals, of which **30** of those received met the criteria to refer into the MARAC. All individuals who meet the criteria to have their information shared at the MARAC, or any children residing in the household, will have an alert added to their electronic patient record to enable practitioners to identify them as victims of domestic abuse and consider the context of their hospital admission/attendance in relation to any risk. The alert lasts for 12 months and is renewed/extended following any subsequent referrals.

Multi-Agency Adults at Risk

The team attends the Multi Agency Adults at Risk (MAARS) Panel monthly. The panel is intended to identify, risk assess and support adults who would not be eligible for statutory support under the Care Act 2014. The team provides all agencies working in Stockport with information and resources around the Multi-Agency Adults at Risk System (MAARS).

PREVENT

Prevent is part of the Government's Counter Terrorism Strategy called "CONTEST". As part of this strategy, all healthcare staff receive mandatory training, and this must be updated every 3 years (training figures are contained within this report). The Named Professional for Adult Safeguarding is our operational Lead for Prevent and regularly attends Stockport's Channel panel.

The Channel Panel provides support to those who may be vulnerable to being drawn into terrorism.
Channel uses existing collaboration between partners, to support individuals and protect them from being drawn into terrorism. Stockport NHS FT has had **100%** attendance at Channel Panel this year.

All staff have a responsibility to raise concerns where they believe that a patient is at risk of being drawn into terrorist activity or committing a terrorist act. Concerns are reported to the Prevent Lead who refer to Greater Manchester Channel Team. These concerns will be investigated and if felt to be appropriate the individual will be offered the option of being supported by the Channel Panel.

The Trust made **1** referral to Channel panel throughout 2023/24 but was able to assist in sharing information on a further 22 cases at meetings with statutory and non-statutory partners.

Quarterly reports are also shared with NHS England on the Prevent activity per quarter and the data includes information on the volume of referrals received within the Trust and training compliance within the organisation. *(Compliance can be seen in the Training section of this report)*

In addition, due to the noted national increase in domestic abuse notifications there has been a need to review the data in relation to this activity. The final row of the table presented notes on the domestic abuse notifications received by Greater Manchester Police (GMP). Each case is reviewed, and clarity secured regarding the case holding practitioners so the information can be shared effectively, and immediate support can be made available for the family. These figures remain high, and the team are currently reviewing the systems and processes in place to support this function.

Safeguarding Adult Reviews (SAR)
A Safeguarding Adult Review must be conducted where "there is reasonable cause for concern about how the Safeguarding Adults Partnership, members of it or others worked together to safeguard the adult and death, or serious harm arose from actual or suspected abuse" (Care Act 2014). A review may also be commissioned in other circumstances where it is felt one would be useful, including learning from "near misses". During the period covered by this report, SFT provided information to the Stockport Adult Safeguarding Partnership (SASP) for 15 cases that were considered for SAR, compared to 2 in 2022/23 and 1 in 2021/22 which on average is a 90% increase on the previous two years. This means that 3 SARs were commissioned and are actively ongoing. The most common themes seen in SAR referrals to the safeguarding adult partnership this year were mental health (47%), suicide (27%) and self-neglect (20%).

Domestic Homicide Reviews (DHRs)
DHR 12 - This review has now been approved for publication by the Home Office. The report will be published and made publicly available in June 2024.

DHR 13 - The review is now complete, and the report can be published. The review did not have an action plan attached and besides publication there are no further actions to consider.

DHR 17 - Awaiting publication in June/July 2024.

DHR 21 - The report is now in the QA process in the Home Office and the Partnership are currently awaiting feedback.

DHR 22- An author has been appointed and the review has commenced with panel meetings. The IMR from the Trust was submitted by the adult safeguarding team and a pre-inquest date has been set for July 2024. HM Coroner has requested sight of the DHR report as part of that process. Panel members and Author are aware of the protracted timescale for this review.

DHR 23- This review is in the final stages before submission to the Home Office.

Overall, Stockport Safeguarding Adult Partnership Board received 2 DHR referrals in 2023/24, both of which progressed to full reviews (DHR 22 and DHR 23).

LeDeR
The LeDeR annual report 2023/24 will be compiled by NHS Greater Manchester ICB, and data will be collated by them and made available when the report is published.

safeguarding children in Stockport

Safeguarding Adults in Stockport

Provision of staff support

The Safeguarding Practitioners respond to all enquiries or requests for support and advice made by Trust staff. This contact may be requested via email or telephone. Requests vary in subject matter and can be basic requests such as support to open or exit a safeguarding form to more specialised and detailed requests for support and/or consultation.

The Safeguarding Practitioners provide support to staff to assist in the completion of DASH risk assessments, and provide advice on safety planning before referrals to the Independent domestic violence advisor (IDVA) service for additional support.

We provide relevant signposting information to staff and offer specialised advice in cases where staff have less knowledge such as for cases of cuckooing, human trafficking, and modern-day slavery. In addition to managing external and internal safeguarding referrals and providing advice and support to staff, the Safeguarding Practitioners attend the Multi-Agency Adult at Risk (MAARS) meetings, and our Domestic lead practitioner is represented at the Multi Agency Risk Assessment Conference (MARAC) fortnightly.

The Safeguarding Practitioners attend meetings whereby it is deemed that safeguarding oversight and support is required. This includes attending Multi-Disciplinary Team meetings, Complex Case Management, and professionals' meetings.

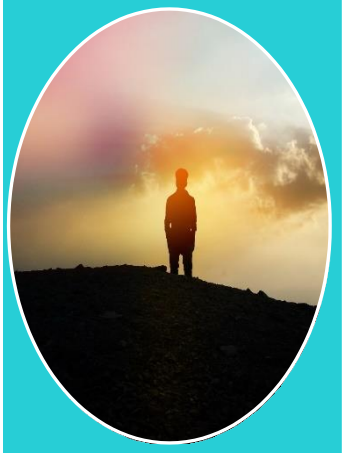
The Safeguarding Practitioners are now involved in delivering Safeguarding Adults Level 3 training and have delivered bespoke bitesize toolbox training wide within the Trust.

Conclusion

This report demonstrates the commitment of the Trust to the safeguarding agenda and the progress made against priorities despite ongoing operational, system and partnership pressures and how we have sustained and enhanced partnership working and strengthened safeguarding collaboration with partner agencies despite capacity challenges. During the reporting period, the safeguarding team has promoted the importance of safeguarding supervision and Think Family being a standard operating process in all aspects of service delivery and has been reactive and visible in ensuring that staff are supported in delivering safe and effective care and interventions, with safeguarding as a 'golden thread' woven throughout the patient journey and our interactions.

We are proud of our achievements and will continue to promote safeguarding as our everyday business with our patients and their families and carers at the heart of everything we do and we would like to extend our thanks to the staff of Stockport NHS Foundation Trust for their support of the safeguarding agenda and their commitment to supporting the families in our locality who use our services, to live in safety and prevent harm experienced through abuse and neglect.

Our Ambitions for 2024/25



Adults

Achieve 95% compliance for Safeguarding Adults Level 3 training.

Regularly conduct audits on safeguarding activities, including MCA compliance, safeguarding training and care for patients with Learning Disabilities and/or autism.

Work collaboratively with all stakeholders to promote positive engagement with people with a Learning Disability and/or autism and their families to develop the provision of reasonable adjustments and accessible information.

Children

Work in partnership with the Public Health Nursing Service to support the Integrated Stockport Family System

Contribute to the Safeguarding Children Team transformation process.

Contribute to the Safeguarding Children supervision review.

Begin to explore the transition of 16–17-year-olds into the adult health service.

Maternity

Continued collaboration with Health Visiting/Early Years services to identify and support vulnerable families at an Early Help level.

Improving the quality of safeguarding documentation across all levels of need and to focus on improving the analysis of health information on the impact on the unborn/newborn child within our documentation.

Work with partner agencies to improve the offer of support to families following the removal of a child at birth.

Looked After Children

Maintain a high standard for the completion of Initial Health Assessments for children who become looked after.

Support the ongoing work to reduce health inequalities for Children in Our Care

Incorporate and report level 3 training for Children in Our Care into all safeguarding training.

To work with business intelligence to consider future reporting and data requirements.

To continue to review the capacity within the Specialist Children in Our Care team in line with increased demand and requirements

Summary of self-assessment submitted by Stockport NHS Foundation Trust

'BRAG' Rating Key			
BLUE	RED	AMBER	GREEN
NOT APPLICABLE Standard does not apply to the Provider.	**NON-COMPLIANT** Non-compliance against standards and/or failure to progress agreed action plan within agreed time scales.	**PARTIAL COMPLIANCE** Partial compliance, action plans in place to ensure full compliance and progress is being made within agreed timescales.	**FULL COMPLIANCE** Fully compliant, however remains subject to continuous quality improvement.

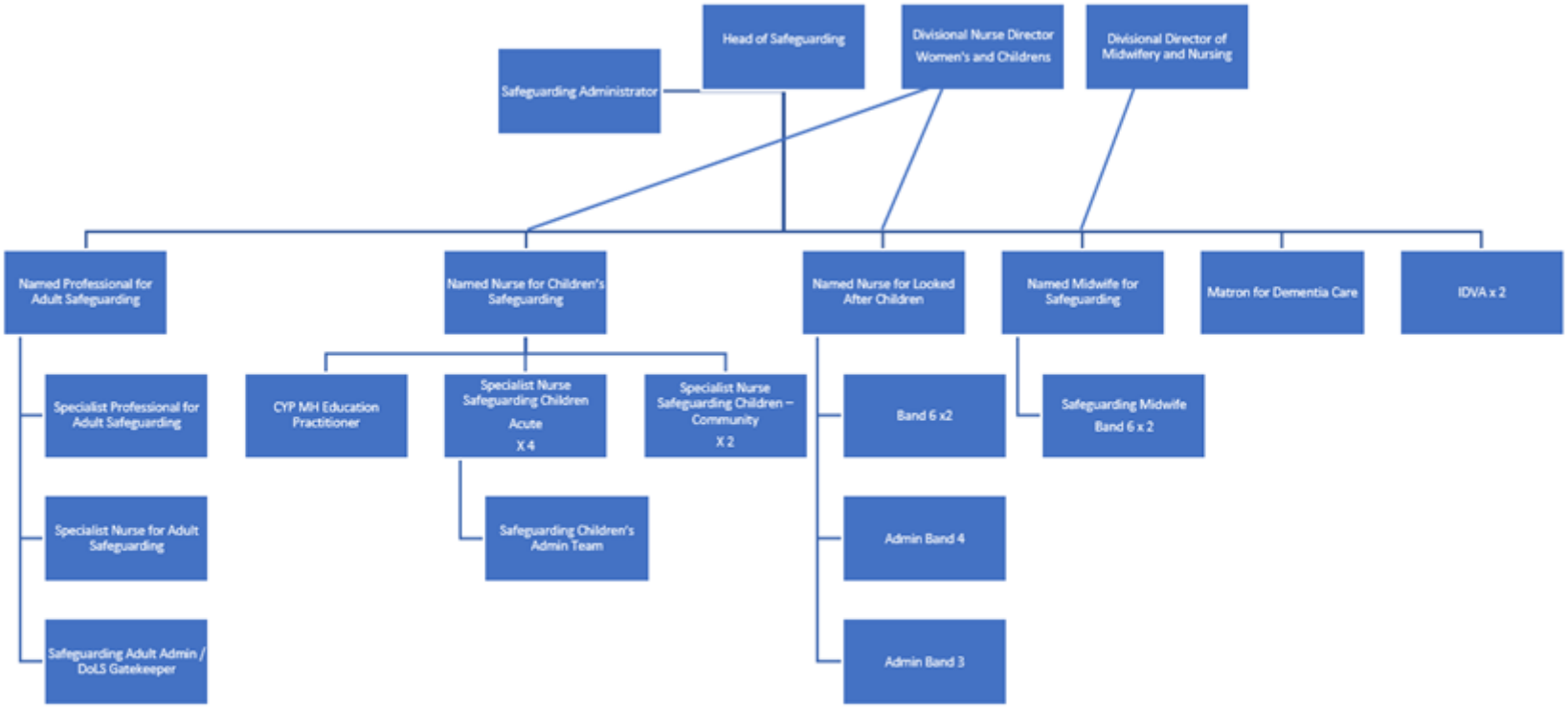
SAFEGUARDING STANDARD 2023-24	FT Rating
Key Line of Enquiry: Organisational Governance and Accountability	
1. There is a provider board lead for Safeguarding Children and Adults at Risk	
2. Provider is linked to Safeguarding Partnerships Boards for adults and children	
3. Provider board regularly reviews safeguarding across the organisation	
4. Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities	
5. Identification of a Named Dr, Named Nurse and Named Midwife for safeguarding children	
6. Identification of a Named Lead for Adults at Risk	
7. Provider has identified the following statutory leads as required by the standard NHS Contract 2023-24; Child Sexual Abuse and Exploitation, MCA/DoLS, Prevent, Forced Marriage.	
Key Line of Enquiry: Safeguarding Processes	
8. Adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and/or adults at risk.	
9. A programme of audit and review is in place that enables the organisation to evidence learning and actions from safeguarding reviews, incidents and inspections.	
10. Systems in place to capture the caring responsibilities of those using the service and if they have any dependants	

11. Information sharing protocols, systems and standards in place within provider and between agencies.	
12. Established processes to share monthly anonymised dataset reports from ED with local community safety partnership.	
13. Provider has process in place to identify and refer service users who are homeless or may be threatened with homelessness.	
14. Provider produces an annual report which includes Learning from Deaths and LeDeR	
Key Line of Enquiry: Safeguarding Policies	
15. Staff have access to policies and procedures	
16. Provider has a safer recruitment policy	
17. Provider has a domestic abuse policy	
18. Robust complaint and whistle blowing policies/procedures in place	
19. Provider has a current Mental Capacity Act policy	
20. Provider has a clinical holding/restraint policy that includes reference to children, MCA and is in line with CQC guidance, MCA/Mental Health Code of Practices and Mental Health Units Act 2018	
21. Provider has a modern slavery and human trafficking statement.	
Key Line of Enquiry: Supervision, Training and Development	
22. Staff working directly with children and adults at risk have access to advice, support and supervision.	
23. There is a training framework which identifies safeguarding training levels for the workforce in line with the intercollegiate documents.	
24. All staff must undertake level 1 safeguarding training as a minimum which includes domestic abuse.	
25. Staff who work with adults and children have completed MCA/DoLS training	
26. Where appropriate staff who may be required to use restrictive physical interventions with children or adults have received specialist training.	
Key Line of Enquiry: Safeguarding Children	
27. There is a process for following up a child/children who 'was not brought' to an appointment.	
28. There is a system for flagging children in relation to safeguarding concerns and Looked After Children	
29. When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.	
30. There is clear guidance as to the discharge of children where there is a child protection concern or who are looked after.	
31. The child's GP and Health Visitor/School Nurse is notified of admissions/discharges for children under 18 years to ED, ambulatory care units, walk in centres and minor injury units and wards.	
32. Provider has a policy and procedure in place to ensure that any child who is an inpatient for a consecutive period of at	

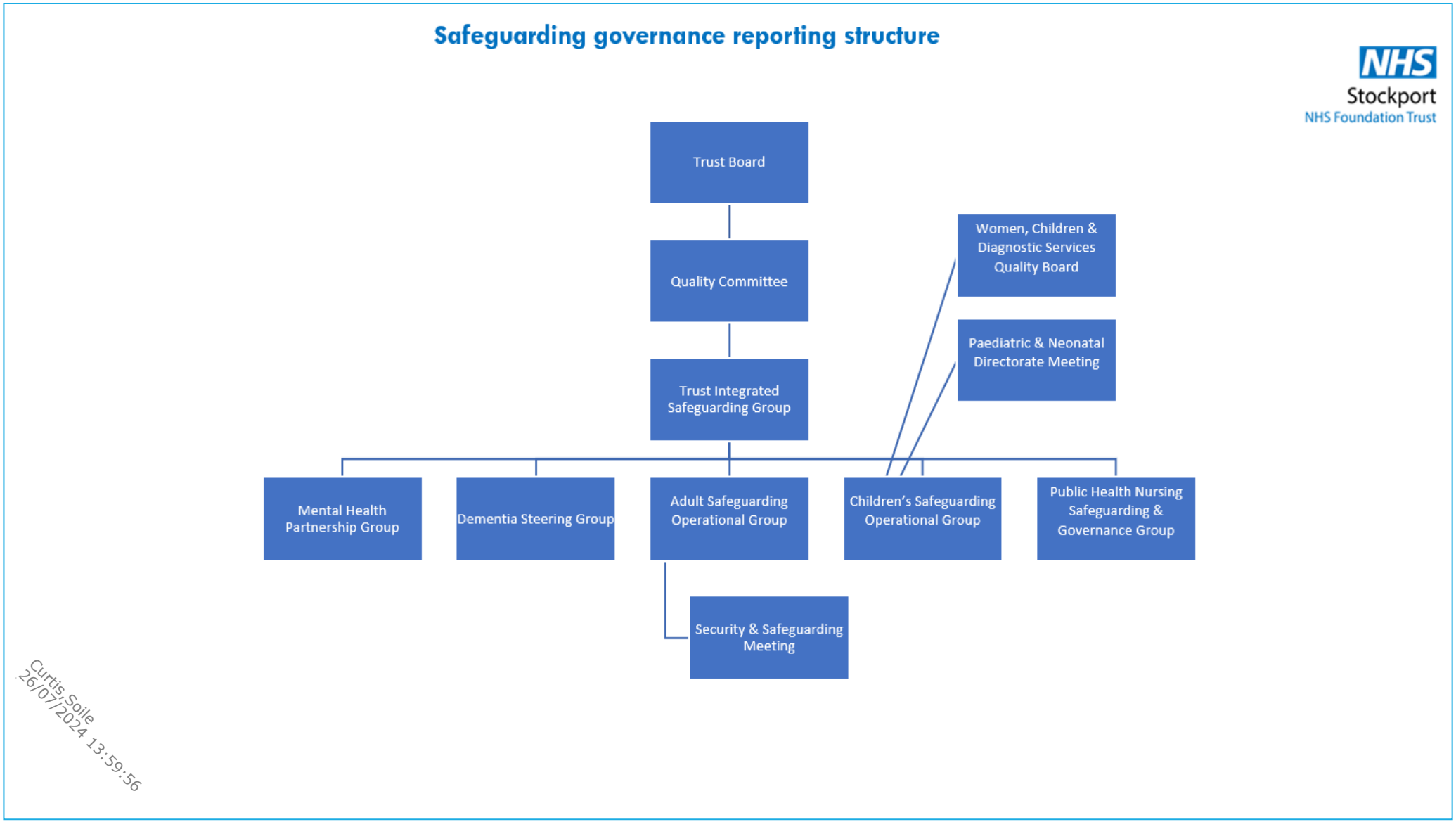
least 3 months are brought to the attention of Children's Social Care in accordance with Section 85 and 86 of The Children Act 1989.	
33. There is good communication between GP's and community nursing services in respect of children for whom there are concerns and Looked After Children.	
34. Provider has a strategic lead for Early Help and clear job roles with Early Help and Lead Professional role.	
Key Line of Enquiry: Safeguarding Adults at Risk 35. There is a system for flagging adults in inpatient care who have learning disabilities, autism/people with neurodiversity or dementia.	
36. There is a discharge policy with accompanying pathways which are in line with the requirements set out within the MCA (2005)	
37. Decision makers under the MCA have a clear referral process to Independent Mental Capacity Advocacy (IMCA) including referrals for Serious Medical Treatment (SMT)	
38. Provider has clear policies and procedures in place to manage non-concordance and high-risk patients who 'do not attend' or 'fail to be brought' also known as 'was not brought' to appointments.	
39. Good communication between GP's and community nursing services, District Nursing Services and allied health professionals in respect of adults for whom there are concerns.	
Key Line of Enquiry: Looked After Children	
40. There is a board lead for Looked After Children	
41. The organisation contributes to multi-agency working and is linked into the Local Corporate Parenting Board	
42. Identification of a Named Dr and Named Nurse for Looked After Children.	
43. Provider Board regularly reviews arrangements for Looked After Children across the organisation	
44. There are systems in place for completing Initial Health Assessments and Review Health Assessments for Looked After Children, to enable the organisation to demonstrate levels of compliance for the completion of these assessments.	
45. All children aged 16-17 should receive a summary of their health records 'Care Leaver Health Summary'.	
46. A programme of Looked After Children related audit and review is in place.	
47. The organisation can demonstrate they engage Looked After Children at each stage of their care planning in order to help them be involved in and taker ownership of their own treatment and care.	
48. The organisation can demonstrate that they have sought Looked After Children's views on what needs to be done to improve services that they use	
Key Line of Enquiry: Mental Capacity Act	
49. The provider can demonstrate the use of Independent Mental Capacity Advocate	

Key Line of Enquiry: Child Death Review	
50. There is a robust notification system in place for all child deaths.	
51. A 'Key Worker' is assigned to every bereaved family following a child death.	
52. A 'Medical Lead' is identified after every child's death to support the family.	
53. All child deaths are reviewed to consider whether they meet the criteria for an NHS Serious Incident.	
54. Child Death Review Meetings (CDRM) are held by the provider. For deaths in a neonatal intensive care unit the CDRM is supported by the use of the National Perinatal Mortality Review Tool (PMRT).	
Key Line of Enquiry: Lampard	
55. All NHS hospital providers should have a policy for agreeing to and managing visits by celebrities, VIP's and other official visitors.	
56. All NHS hospital providers should review their voluntary services arrangements and ensure that they are fit for purpose, volunteers are properly recruited, selected and trained and voluntary services managers have development opportunities and are properly supported.	
57. All NHS provider staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every 3 years.	
58. All NHS provider staff should undertake regular reviews of safeguarding resources, structures and processes, and the behaviour and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as efficiently as possible.	
59. The NHS provider has conducted a risk assessment to determine what 'checking at periodic intervals' means within their organisation in relation to DBS checks.	
60. There is a Trust wide social media policy in place.	
61. Providers should ensure that arrangements and processes for the recruitment, checking and general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	
62. Providers should review their recruitment, check training and general employment processes to ensure they operate in a consistent and robust manner.	
63. NHS providers and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	

Appendix 2
Safeguarding Structure 2024



Appendix 3
Safeguarding governance reporting structure 2024



Meeting date	1st August 2024	**Public**	**X**	**Agenda No.**	17
Meeting	Board of Directors				
Report Title	Research, Development and Innovation (RD&I) Annual Report 2023-24				
Director Leads	Dr Andrew Loughney and Mr Dilraj Sandher, Medical Directors and RD&I Executive Leads	**Authors**	Wiesia Woodyatt, Stockport RD&I Manager Rebecca Roberts, Tameside Research Governance Manager		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are asked to confirm they have received assurance from this report that the RD&I departments across Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust have: - Delivered appropriately throughout 2023-24 with the resource available and in alignment with the joint RD&I strategy. - Identified and managed risks appropriately. - Demonstrated effectiveness, adherence and progress to their respective Terms of Reference for RD&I Committee activity. - Provided assurance that we have delivered research that has had a positive impact on patients, staff and the population.					

This paper relates to the following Corporate Annual Objectives:

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

The paper relates to the following CQC domains:

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users

	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	2.4, 3.1.3.2 and Appendix 3
Financial impacts if agreed/not agreed	Sections 3.1.2 and 4.1
Regulatory and legal compliance	Section 3.1.1.2 and 4.2
Sustainability (including environmental impacts)	N/A

Executive Summary

This report has been reviewed and confirmed by the joint SFT and TGIC RD&I Committee and Clinical Effectiveness Group before passing on to the Quality Committee, Service Quality Assurance Group and finally the Board of Directors for consideration.

The purpose of this report is to inform on both Trust's RD&I performance for 2023-24, focussing on:

- Organisational changes including staffing, engagement and the risks/ implications of an under-resourced workforce.

- Annual financial summary focusing on:
    - Income received to support the research delivery workforce from the NIHR.
    - Re-investment of RD&I generated income to expand the local research workforce and embed a research active culture throughout the organisation.

- Key Performance Indicators (KPIs) from the National Institute for Health and Care Research (NIHR) Greater Manchester Clinical Research Network (GM CRN) and internally for research study set-up, recruitment delivery and research participant experience.

- General assurances for research delivery conduct and risk mitigation including an assessment of the effectiveness of respective RD&I Committees at each Trust.

- General assurances that we have delivered research that has had a positive impact on our patients, staff and the populations we serve.

- Progress update on the delivery of the RD&I joint strategy and recommendations to ensure this continues to be delivered, acknowledging the significant regional financial and local estates challenges we are currently operating within.

1. Purpose

1.1 The purpose of this report is to provide an annual review for 2023-24 of RD&I activity across SFT and TGIC, focusing on KPIs for study set-up, delivery targets, participant recruitment and experience, finances, staffing and engagement. A summary is provided for the gaps currently identified in the RD&I service and the proposal for addressing these over the year ahead to minimise risk. There is an update of the progress made on delivery of the joint RD&I strategy, which was successfully launched in Oct-2022, as well as an assessment of the effectiveness of the separate RD&I Committees at each Trust, before their merger in Jan-2024. This is the first joint, annual RD&I report for the two Trusts, to align with the RD&I 2022-2027 strategy.

1.2 There is a request for these groups and the Board of Directors to confirm if they are assured that the RD&I teams have delivered effectively throughout 2023-24 with the resource available, focused on relevant, high-quality, inclusive research to meet our population's needs, with a robust plan to sustain and continue to improve this in the future across both Trusts.

2. Introduction/ Background

2.1 The Trusts are committed to RD&I as a driver for improving the quality of care we provide to our patients. It is well known that clinical research provides the evidence base to answer key questions that help us tackle health and care issues in our population. However, clinical research and its outcomes can also make a real difference to patient experience, organisational reputation, tackling healthcare inequalities as well as staff satisfaction, development, recruitment and retention. Embedding and maintaining an active research ethos across SFT and TGIC is therefore vital to fostering a better future for our patients and staff. That is why RD&I are cited as key enabling themes in our overarching Trust strategies.

2.2 Research is enabled in both Trusts predominantly through research active healthcare professionals and the delivery staff and service department (i.e. laboratories, pharmacy and radiology) funding support received from the NIHR, coupled with income linked to specific research projects. The NIHR supports the infrastructure for research delivery in the NHS. Support is offered regionally and both SFT and T&Gare currently part of the GM CRN. From 01-Oct-2024, GM CRN will merge with the North West Coast Research Network to create the North West Region Research Delivery Network (NW RRDN), the largest geographical area of the new networks, encompassing a population of 7 million and 33 NHS Trusts, with Manchester University NHS Foundation Trust acting as the regional host.

2.3 In May-2023, the findings from the Lord O'Shaughnessy review were published. This national review was commissioned to offer recommendations on how commercial contract clinical trials can help the life sciences sector unlock UK health, growth and investment opportunities. The review also advised on how to resolve key challenges in conducting commercial clinical trials in the UK, with 27 recommendations outlined. Although the focus of this

review was on commercially sponsored projects, many of the recommendations can be applied to all types of research, with learnings evident from the successful delivery of vaccine and treatment platform trials during the COVID-19 pandemic. The report reinforces the importance of having a robust RD&I infrastructure in our Trusts to ensure its prioritisation. It has proposed the development of new 'SMART' metrics for all ambitions in the UK clinical research vision including tackling set-up timelines/ approvals, improvements in data transparency and utilisation, accountability for performance, protected research time for healthcare professionals and working with primary care/ community partners to optimise our research delivery offerings. Locally, this has resulted in our research portfolios changing again from the previous year, with our core RD&I workforce adapting quickly to changes in study status.

2.4 Supporting projects that endeavour to positively address healthcare inequalities has also become a focus of our 2023-24 research activity. We have seen a number of national drivers emerge, including launch of NIHR ring-fenced funding to support UK-wide projects to tackle inequalities in key areas (e.g. maternity research). T&Ghave embraced this focus by becoming the first site in GM to open the 'Born and Bred in' study (BaBi Tameside), gathering data from pregnant women and their children to improve the health and well-being of people in the locality. SFT are hopefully coming on board with this in the year ahead, collaborating with T&Gfor learnings around the set-up process.

2.5 The Health Research Authority (HRA) also launched a strategic commitment in 2023-24 that 'Health and social care research should be done with and for everyone'. As such, they have worked with the Medicines and Healthcare Products Regulatory Agency (MHRA) to develop a set of questions and supporting guidance for researchers to consider when they design clinical trials/ investigations. This will help ensure clinical research is designed to include people who could benefit from the findings, and that people underserved by research are not overlooked. As SFT and T&Gare generally host sites for national research projects, this theme should become apparent in many more research projects we deliver locally in the year ahead.

2.6 The national and regional landscape changes in 2023-24 have been intense locally, coupled with capacity issues in supporting departments, estates and staffing challenges. The RD&I service has therefore not been able to move as quickly as hoped to progress on strategic delivery. However, this report details these key challenges and difficulties, but also the many successes of 2023-24 and what we hope to build on for the year ahead.

3. Matters under consideration

3.1 Organisation, staff funding and engagement

3.1.1 Organisational changes: Teams, service departments and estate

3.1.1.1 2023-24 was an agile year for the RD&I staffing structure. At SFT, the research delivery leadership roles (Senior and Lead Research Nurse positions) were fully embedded in the team and the expanded research delivery staffing complement was filled, which has enabled the study portfolio to expand into new specialties (e.g. ageing) and run more complex studies (e.g. increases in commercially sponsored projects). T&Ghas seen some expansion in team roles, with some focused research nurse time for anaesthetics and critical care research, a growing area for the Trust, as well as some long-standing staff move on, leading to an influx of new staff into the team. Both teams have also collaborated when opening the same studies across different areas and developing in-house laboratory capacity, to enable sharing of best practice, a model we hope to take even further in 2024-25.

Current team complements are as follows:

Role	**SFT WTEs**	**T&G WTEs**
Administration	4.60	3.85
Governance	3.00	1.40
Research Delivery (Nurse, Practitioners, Fellows)	13.40	6.54
Totals	**21.00**	**11.79**

There have been some significant achievements across both Trusts in the effectiveness of the delivery teams in 2023-24:

- The T&Gsponsored diabetes study FIND-IT, has seen 1,655 service users enrolled in this project. Due to the success of this study, the RD&I team won the 'Putting Participants First' award at the regional Health and Care Research Awards in 2023. The study has also attracted interest from NHS England, who are considering rolling out a screening programme to identify diabetes/pre-diabetes at an early stage.
- SFT's Research Midwife was highly commended in the 'New to Research' category and our Research and Innovation Manager was a runner up for the 'Exceptional Research Delivery Leadership' category in the Regional Health and Care Research Awards 2023:
- Making a Difference Trust Awards 2023: The SFT Research Delivery Team was a runner up for Clinical Team of the Year and our Research Practitioner won the Rising Star category.

3.1.1.2 The key issues impacting service and strategic delivery in 2023-24 arose from high sickness levels in the SFT RD&I core governance team. There has been a prolonged lack of resource to expedite new study set-ups, progress significantly with strategic delivery and move forward work on the development of the new, joint Quality Management System (QMS) across both Trusts. The demands of the existing study portfolio and day-to-day running of the department had to be prioritised. However, discussions have initiated across both organisations on how we can better utilise the 'lean' resource in our governance teams to improve resilience in this area, with consideration being given to a joint business case for shared posts

across the Trusts in the year ahead. Key achievements have happened, despite these challenges, including:

- Highly successful showcase of our research activity across both Trusts in a celebration event in Sep-2023, coordinated by the RD&I governance teams.
- Development of a joint RD&I Committee across both Trusts from Jan-2024.
- Initiation of the development and roll-out of a shared Quality Management System with the following documents launched from between Oct-2023 and Jan-2024: Research Quality Statement of Intent, Research Oversight Policy and Standard Operating Procedures (SOPs) for Research Imaging.

3.1.1.3 The final key issue in 2023-24 has been the capacity challenges from key service departments supporting research and estate issues.

Laboratories: This department had previously cited a 10% overall workload increase year on year at SFT, with no protected time in job plans to support research activity. This has meant continued pressure on laboratory staff to support research activity as an 'add on' to their usual roles (generally through an overtime model), which is not sustainable. However, assurance is in place that previously generated laboratory research income is going to be used to pump-prime a Higher Specialist Scientist Training post from Sep-2024, which will have dedicated research time within the job plan. The RD&I department have also now acquired a refrigerated centrifuge and fridge/ freezer in their area to help with laboratory research capacity. If studies allow, some samples are now being processed on Ward C2 (RD&I Department) by RD&I staff to help alleviate current pressures on the main laboratory equipment and staff. This model is similar to that at TGIC, and their team has been very supportive with sharing SOPs and training for the SFT staff.

Pharmacy: Both Trusts have dedicated Clinical Trials Pharmacist support but have experienced different challenges throughout 2023-24. SFT now has a satellite pharmacy room in their dedicated Trust area, but cannot currently store all Investigational Medicinal Products (IMPs) in there due to lack of temperature control. It is imperative that the deferred 2023-24 business case through capital funding (circa £12K) is re-approved through the Executive Board in April/ May-2024, to enable air conditioning installation. The deferral was due to risks around the RD&I team being re-located in the Trust because of the unexpected Outpatients Department B (OPB) closure. Estates did not want to continue with works in an area that might be re-purposed. There is a significant risk around IMP storage deviations and the Trust's ability to take on more commercially sponsored work if air conditioning installation isn't completed, as the main pharmacy department doesn't have the capacity to house the growing portfolio. T&Galso experienced service continuity issues from reduction in NIHR funding to support pharmacy infrastructure in 2023-24. This has currently been resolved with additional NIHR non-recurrent income allocations being

invested into the service. However, this does remain a risk if future NIHR funding allocations change once the NW/ GM CRN merger takes place.

Estate: The need for appropriate estates facilities has been a recurring theme for both Trusts for RD&I future development and growth. Although T&Ghad acquired some dedicated space on the Trust footprint, the area is in need of renovation and doesn't provide any dedicated clinic facilities. The SFT team has also been at risk of losing their dedicated RD&I area on Ward C2 due to the unexpected closure of OPB in Dec-2023. Currently, the focus has shifted from re-purposing of the RD&I area but there is a significant risk to service continuity and future growth of the service if re-location did take place without adequate service re-provision.

3.1.2 Staff/ Departmental funding

3.1.2.1 At the end of 2022-23, there were 16.59 WTE active staff in the RD&I team, then 21.00 WTE at the end of 2023-24 for SFT, with 10.96 WTE at the end of 2022-23 and 11.79 WTE in 2023-24 for TGIC. For both Trusts, the teams are reliant on continued NIHR annual service support funding to sustain these workforces (as well as dedicated funding for laboratories, pharmacy and radiology), with a number of the SFT posts also reliant on continued growth/ delivery of a commercial portfolio (the non-recurrent income funding currently held will sustain the current team to the end of 2028). Securing future commercial work, Trust investment and a similar or increased level of NIHR funding from the new NIHR RRDNs emerging in Oct-2024 will be the key to continuity of these staffing structures.

3.1.2.2 RD&I staff funding is linked to achievement of participant recruitment targets set by the NIHR GM CRN for enrolment into studies which form part of their portfolio, as well as regular invoicing for specific study work to support Trust funded roles. The figures below demonstrate the NIHR GM CRN's commitment in supporting our Trusts with the infrastructure needed to sustain the study portfolio and are commensurate to funding received in the previous financial year.

Trust	2023-24 NIHR Service Support Income	2023-24 Other Research Income	Totals
SFT	£531,921.86	£208,855.34	**£740,777.20**
TGIC	£452,441.91	£15,254.98	**£467,696.89**

If participant recruitment targets are not achieved, there is a potential financial risk to both Trusts. NIHR funding may not be renewed to the same level or funding may not be available from income generation in future financial years, which could result in redeployment or redundancy of RD&I staff. This hopefully is a low risk but it is still one to be highlighted, particularly with the upcoming NIHR regional changes in Oct-2024 and no clear definition on how funding envelopes will work from 2025-26 at this stage. In 2023-24, both Trusts demonstrated a strong recruitment record with SFT exceeding their NIHR recruitment target of 2,000. Although

T&Gdidn't exceed their NIHR recruitment target of 3,000 participants, recruitment was over 2,500 (The main reason for not achieving this target was due to a reduction in recruitment to the FIND-IT study, as a result of being unable to recruit potential participants in A&E due to the ongoing building works). Given the uncertainty in future NIHR funding models, this track record will hopefully support future funding being secured around the level needed for our current staffing infrastructures. Our RD&I strategy sees a focus on commercial portfolio growth, aligning with national mandates. Both teams are focused on this and other high recruiting studies to help mitigate these risks, but these will only be achievable with robust service department support.

3.1.2.3 Assurance can be provided that all RD&I invoicing is up to date with clear funding distributions at SFT to minimise the financial risk to the Trust around lost income from late or missed invoicing. T&Gstill have some work to do on this and are adopting the SFT established tracking systems, to ensure a consistency in approach across the two Trusts. In Apr-2024, NHS England published 'Managing Research in the NHS' guidance, which Trusts are encouraged to adopt. It encompasses the recommendations of the Lord O'Shaugnessy review (section 2.3). The development of the new joint SOP in 2024-25 for 'Contracts and Financial Management for Research Studies' will be based on this.

3.1.2.4 The joint Trust infrastructure still also requires further evaluation to ensure healthcare professionals have the time/ funding to truly embed research into clinical care and attract staff who wish to improve treatment options for our patients. Discussions continue through the RD&I Committee and with key stakeholders as we deliver on our 5-year strategic plan.

3.1.3 Staff/ Public engagement and impact

3.1.3.1 2023-24 has seen increased and sustained engagement with clinical research delivery from a range of staff, including nurses, clinicians (and trainees) and allied healthcare professionals. This has led to the following positive impacts for our staff and patients.

For SFT, the RD&I portfolio has expanded into 21 specialties with 87 research studies open in 2023-24, recruiting 2,167 participants:

- Introduction of 39 new studies including commercial and non-commercially sponsored work, interventional and observational opportunities.
- Diversification into new research areas aligned with our Stockport population, such as our first ageing study, contributing to a national project looking at frailty and outcomes in clinical environments.
- Significant expansion in cardiology, gastroenterology and rheumatology, choosing high recruiting research projects that could be embedded into standard care pathways.
- Divisional approaches to research delivery, where we saw midwifery teams support the iGBS study, with 583 cord blood

samples taken, contributing to a national project looking at future protection against invasive Group B Streptococcus disease.

- Multi-disciplinary approach taken to deliver a varied stroke research portfolio across acute, rehabilitation and home settings.
- >200 staff with up to date Good Clinical Practice (GCP) training and contributing to study recruitment.
- Excellent uptake of research related training for staff, including Advanced Clinical Practitioners preparing to take on research leadership roles in the future.
- Multiple successes with extended trainee/ departmental support for data driven, timed, 'snapshot' studies to inform the national landscape, such as evaluating current UK practice and clinical effectiveness for acute coronary syndrome rule-out strategies in emergency departments, review of childbirth acquired perineal trauma and patient reported outcomes, post-operative pain and pain relief after day case surgery.

For TGIC, the RD&I portfolio has expanded into 16 specialties with 42 research study opportunities open in 2023-24, recruiting 2,524 participants.

- Introduction of 21 new studies including commercial and non-commercially sponsored work, interventional and observational opportunities.
- Diversification into new research areas aligned with our Tameside population, such as resuming research activity in the stroke department and an increase in reproductive health and childbirth research.
- Significant expansion in the maternity unit, with the opening of the BaBi Tameside study. Tameside is the first site in GM to start recruiting to this study, which gathers data from pregnant women and their children to improve the health and well-being of people in the local area..
- In collaboration with TGIC, the University of Manchester's Spatial Policy and Analysis Lab has successfully secured a three-year PhD studentship from the Economic and Social Research Council. The project entitled 'Spatial differentiation and key determinants of health-related well-being in Tameside and Glossop' commenced in Oct-2023. The PhD research aims to systematically examine the key determinants, and their interrelations, over differential health-related well-being in urban neighbourhoods from a human-environment perspective.
- Continued success for the Trust sponsored study identifying undiagnosed diabetes or pre-diabetes in our patient population.
- >80 staff with up to date GCP training and contributing to study recruitment.
- Excellent uptake of research related training for staff, including the training of over 20 midwives for the BaBi study, several junior doctors completing the training for the RECOVERY and AERIFY trials.

- Multiple successes with extended trainee/ departmental support for data driven, timed, ‘snapshot’ studies to inform the national landscape, such as post-operative pain and pain relief after day case surgery.

The RD&I teams are really proud of the contribution we have made to research delivery in 2023-24, which was celebrated in a highly successful SFT and T&Gresearch showcase event in Autumn 2023, with plans to repeat in 2024. We hope to really highlight the positive impact on staff, patients and our population in this upcoming Oct-2024 showcase event. We have also worked closely with our communications teams to showcase our RD&I achievements in the wider community.

3.1.3.2 The RD&I teams have continued with research publicity from many different angles in 2023-24 to embed the key message to the wider organisation that clinical research is definitely part of everyday business and inclusive for everyone. Some key examples are:

- Development, release and posting of research publication bulletins, research specialty and/ or general research activity newsletters to publicise the different projects available to our patients.
- Presentations at the Advanced Clinical Practitioner, Student Nurse, Junior Doctor and Practitioner forums to showcase research work.
- Regular posting on staff intranet news and RD&I microsite to publicise new studies opening, training/ seminar/ conference/ funding opportunities etc.
- Support at Trust-wide events such as Stockport Pride, Trust recruitment days and celebrating International Clinical Trials Day and other research events to raise the RD&I profile.
- Hosting a successful community research festival at Ashton-Under-Lyne marketplace, where T&Gwon the ‘Best Public Engagement’ award at the regional Health and Care Research Awards 2023.
- Joint press releases on high profile studies and to celebrate successes.
- Partners in a GM NIHR project that has been using data to understand the demographics of our patients. Our contributions have supported the regional team in identifying gaps to help funders, industry and study designers to develop research projects better suited to our communities. In the last year we have been able to capture and securely share year of birth data. The regional ambition is to expand this capability to also capture data fields such as ethnicity and deprivation markers in the years ahead.

The above summary is to provide assurance that the RD&I team has been committed to engaging participants and staff across our healthcare system to deliver the studies that best aligned with the needs of our population, with a focus on inclusivity for all.

3.2 Key Performance Indicators (KPIs) for research

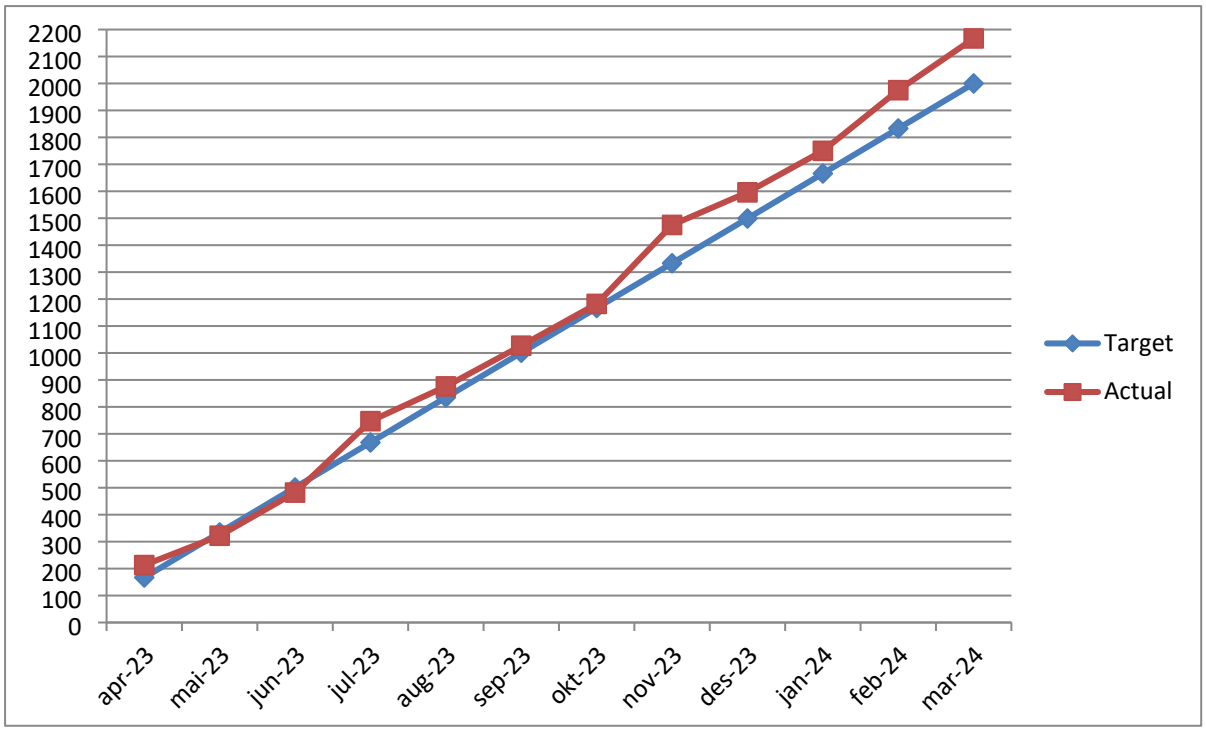
3.2.1 **Department of Health and Social Care (DHSC) KPIs for research**

Previously the DHSC requested that NHS Providers publish their performance around the initiation and delivery of clinical research. The aim was to increase the number of patients who had the opportunity to participate in research and to enhance the nation's attractiveness as a host for research. Historically, SFT and T&Gposted these performance reports on our external facing website pages. Since then, the learnings from the COVID-19 national 'Research Reset' and the Lord O'Shaughnessy Report (section 2.1) had meant that this 'Performance in Initiating and Delivering' publication exercise was archived at the end of 2022-23, with new performance metrics likely to be launched as the new RRDNs come in from Oct-2024. As such, this section will be expanded upon in next year's annual report. There will be a renewed focus on transparency, accuracy, and meeting sponsor expectations.

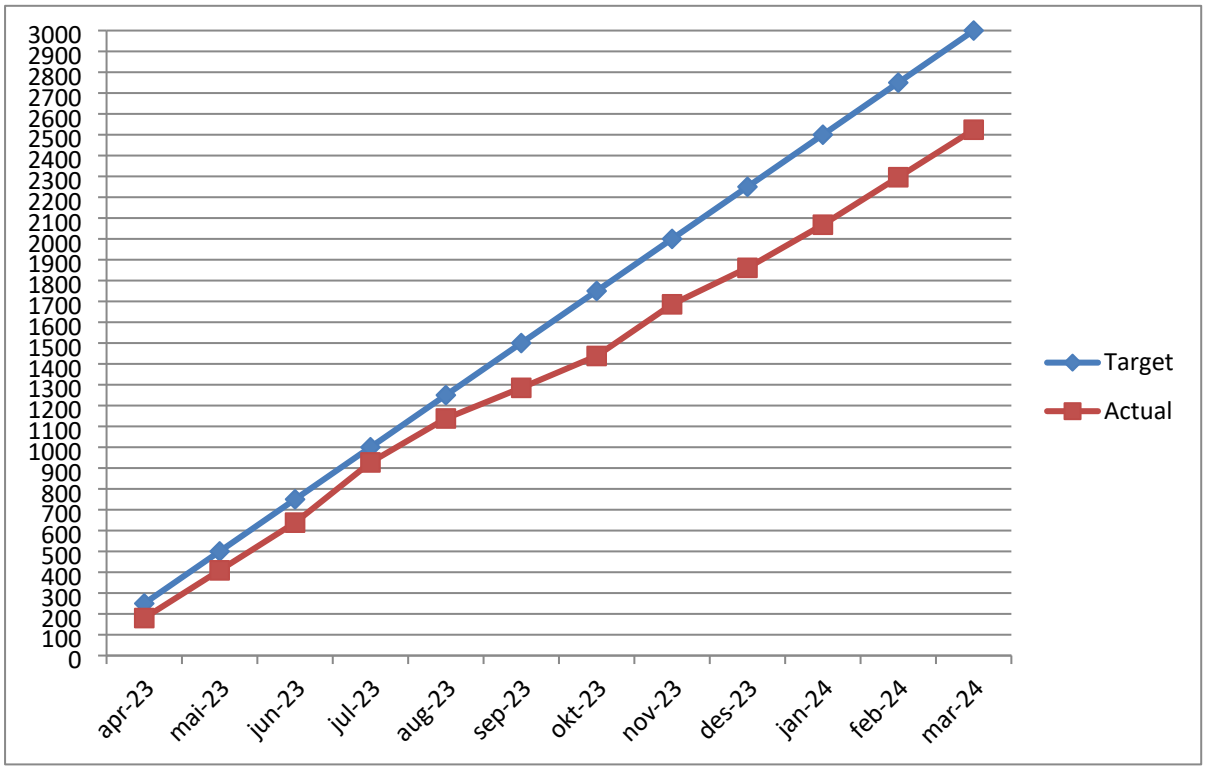
3.2.2 **NIHR GMCRN KPIs for research study recruitment and set-up**

3.2.2.1 Recruitment: The number of patients receiving relevant health services provided or subcontracted by SFT and T&Gin 2023-24 that were recruited during that period to participate in research approved by a Research Ethics Committee (REC) and/ or the HRA was 2,167 (NIHR target of 2,000) and 2,507 (NIHR target of 3,000) respectively. These research studies had undergone strict ethical review and have received a favourable opinion from the REC within the National Research Ethics Service (where required) and HRA, signifying they are of high scientific quality and had been risk assessed. It was fantastic to see both Trusts excelling in their recruitment to research, with commercial work also growing in both Trusts (7 studies open at SFT and 3 studies open at T&Gin 2023-24).

For SFT:



For TGIC:



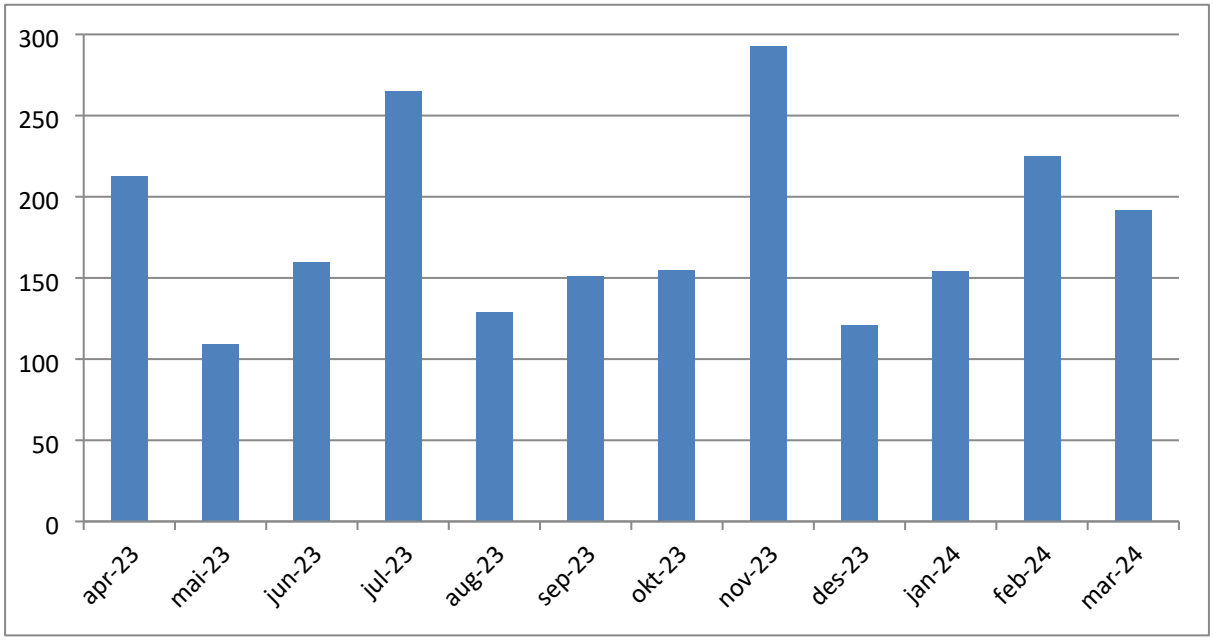
The summary below demonstrates the areas of recruitment growth in 2023-24, compared to 2022-23, really highlighting a return to a more balanced portfolio after the years of the COVID-19 pandemic. Section 3.1.3.1 provides some key highlights around this.

Specialty	SFT Number of Participants Recruited		
	2022-23	2023-24	Difference
Ageing	0	21	+21
Anaesthesia	22	91	+69
Cancer	25	22	-3
Cardiovascular	227	97	-130
Children	72	587	+515
Critical Care	14	19	+5
Diabetes	14	35	+21
Ear, Nose, Throat	0	4	+4
Gastroenterology	62	431	+369
Haematology	30	0	-30
Health Services	0	32	+32
Hepatology	0	5	+5
Infectious Disease	53	2	-51
Injuries, Trauma and Emergencies	7	206	+199
Musculoskeletal	127	226	+99
Ophthalmology	14	23	+9
Primary Care	0	105	+105
Renal Disorders	8	4	-4
Reproductive Health	464	186	-278
Stroke	54	60	+6
Surgery	0	11	+11
Totals	**1,193**	**2,167**	**+974**

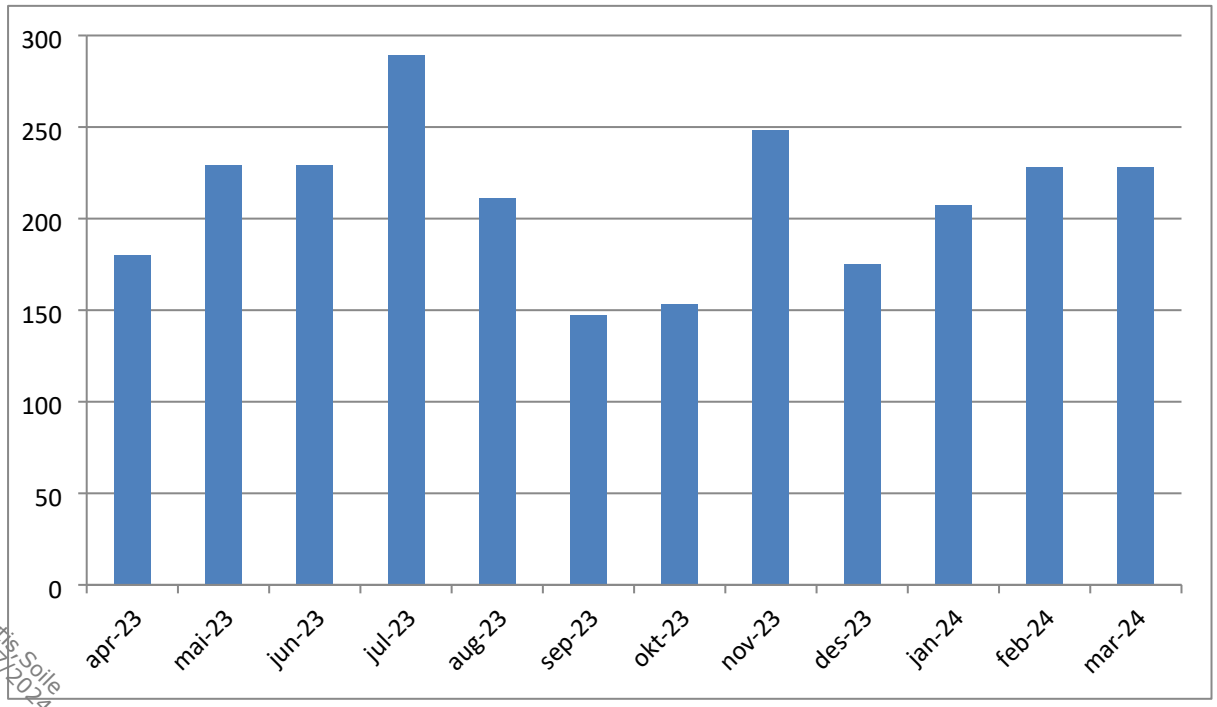
Specialty	T&GNumber of Participants Recruited		
	2022-23	2023-24	Difference
Anaesthesia	39	87	+48
Cancer	7	10	+3
Cardiovascular	47	24	-23
Children	26	28	+2
Critical Care	117	53	-64
Dermatology	0	2	+2
Diabetes	2,362	1,655	-707
Health Services	0	436	+436
Infectious Disease	240	13	-227
Injuries, Trauma and Emergencies	115	19	-96
Mental Health	0	1	+1
Musculoskeletal	5	11	+6
Primary Care	0	110	+110
Reproductive Health	1	26	+25
Stroke	0	19	+19
Surgery	15	30	+15
Totals	**2,974**	**2,524**	**-450**

In GM, SFT was the 7th and T&Gthe 6th highest recruiting Trust. However, with our recruitment numbers combined, this elevates our Trusts to the 4th position overall (behind Manchester University Foundation Trust, the Northern Care Alliance and East Lancashire Hospitals), thus leading the way with patient recruitment compared to all other district general hospital alliances in our region.

Month by month recruitment activity: 2,167 participants for SFT

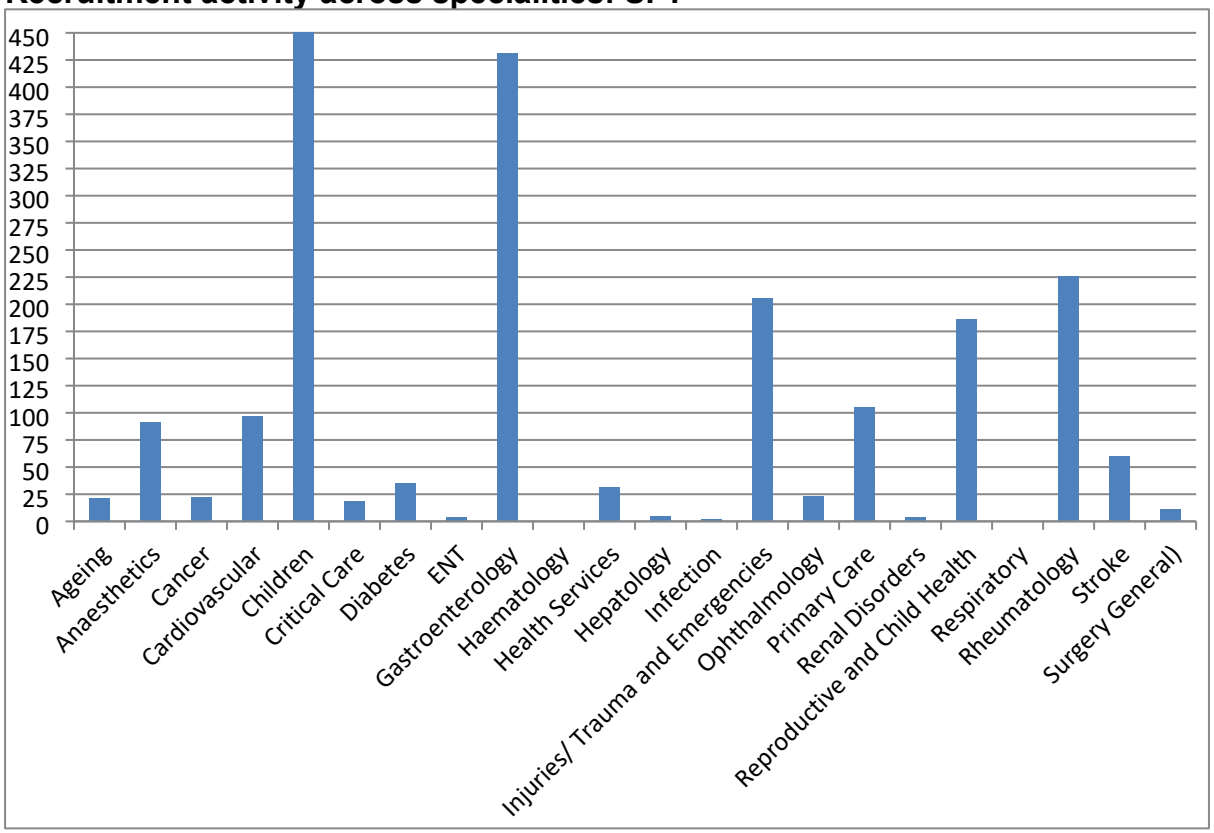


Month by month recruitment activity: 2,524 participants for T&G

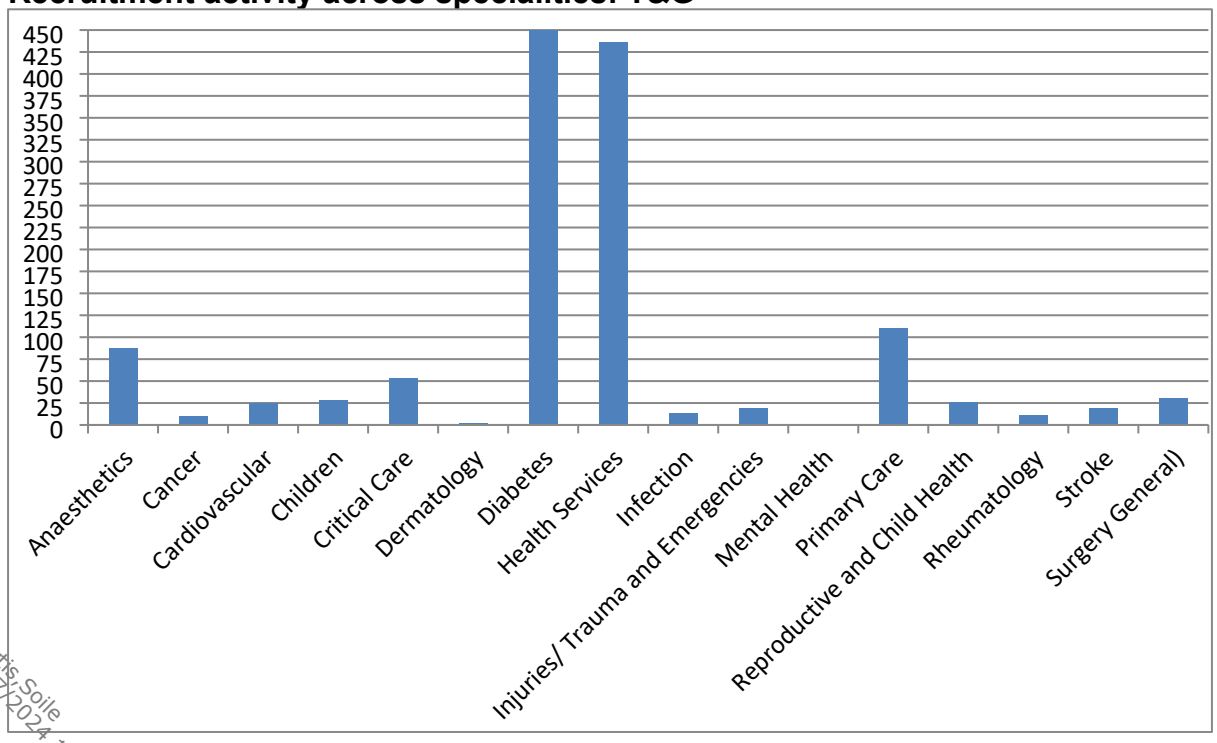


The following charts show the recruitment across different specialisms in each Trust:

Recruitment activity across specialities: SFT

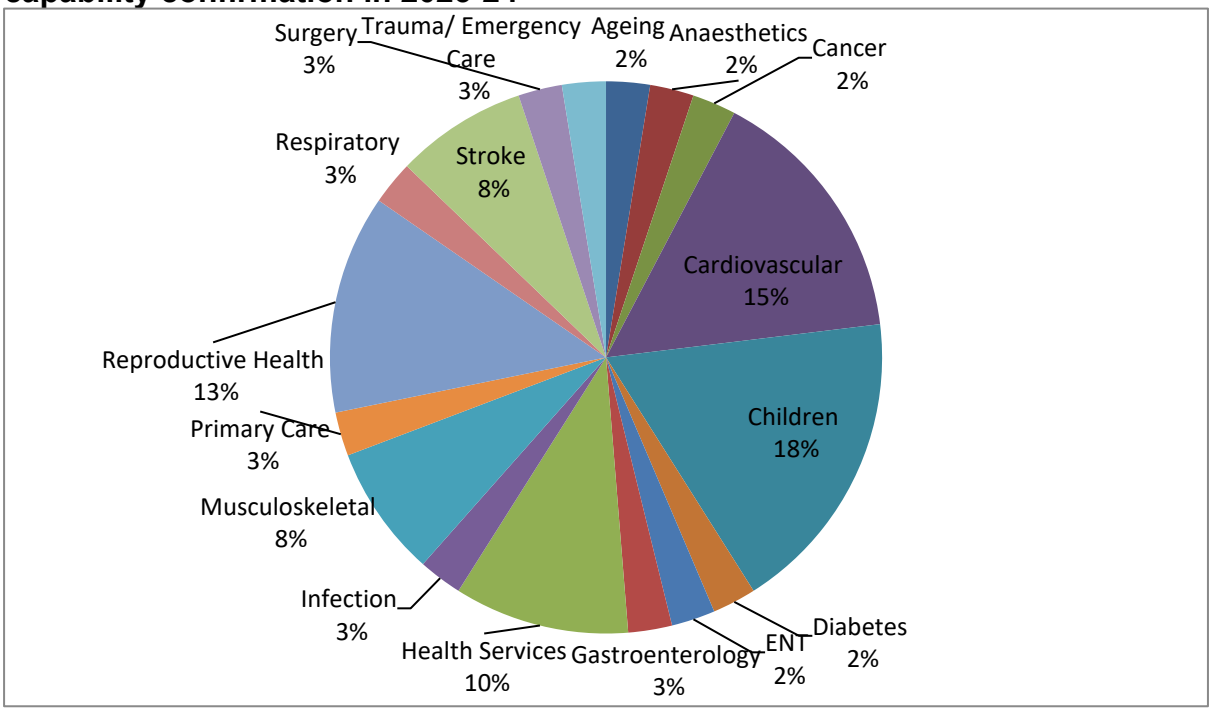


Recruitment activity across specialities: T&G

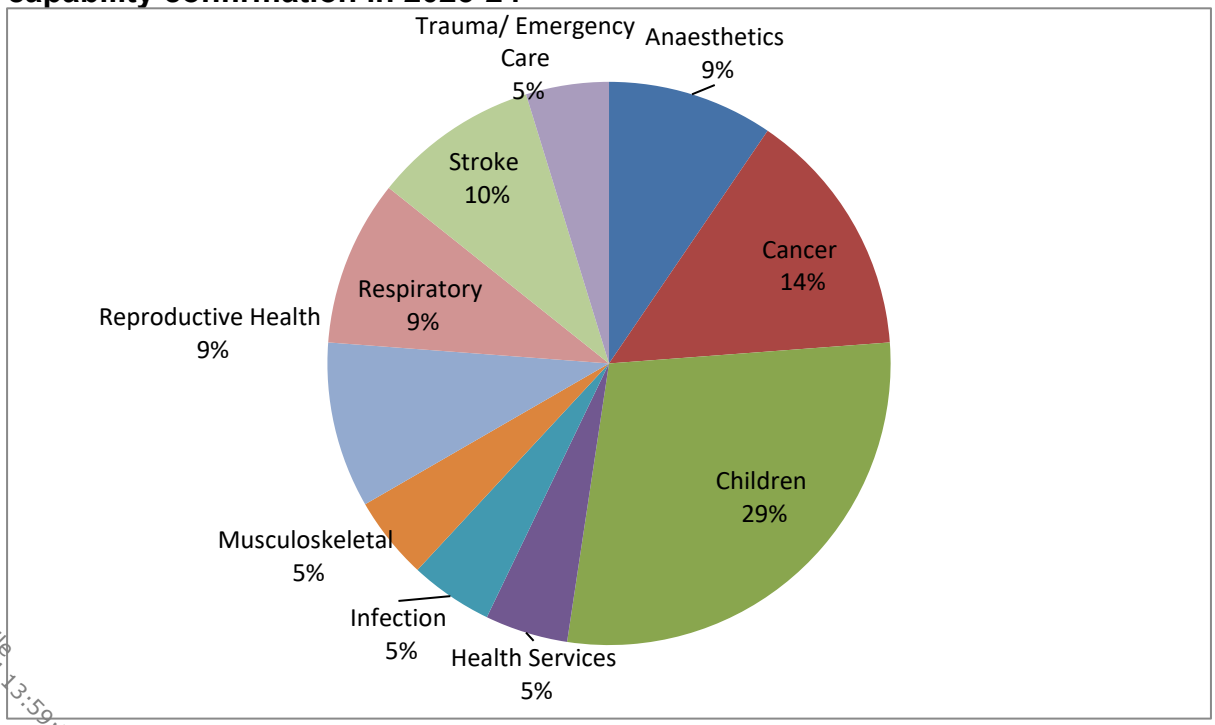


3.2.2.2 Study set-up: In 2023-24, 39 studies were locally assessed and capacity and capability confirmed (compared to 30 in 2022-23) at SFT, with 21 studies at T&Gcompared to 8 in 2022-23. Assurance can be provided that both Trusts have aligned with the DHSC mandate of focused research recovery over a broader range of specialties for our local populations.

SFT: Specialty distribution for new studies issued with local capacity/ capability confirmation in 2023-24



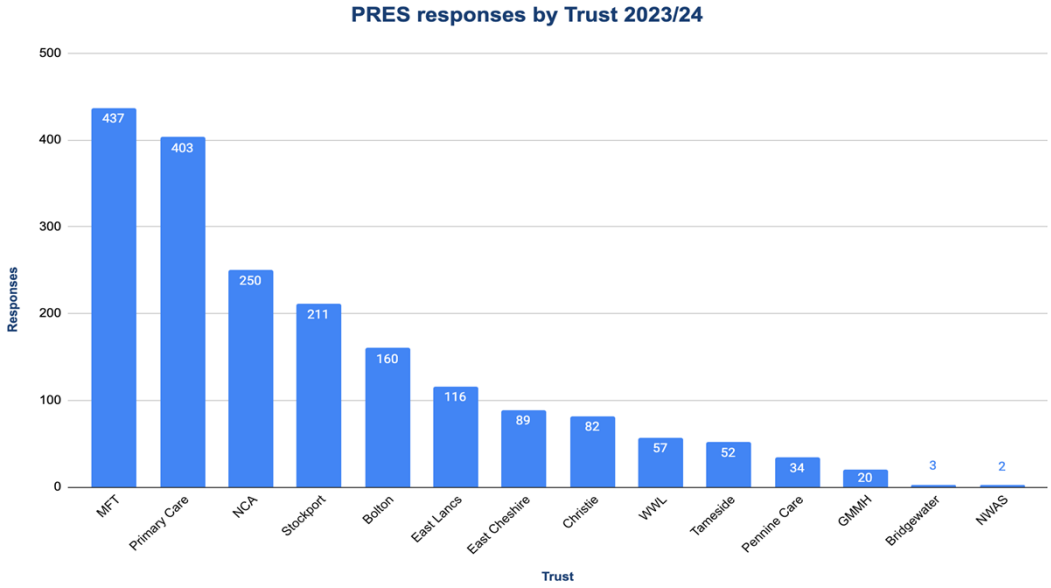
THIC: Specialty distribution for new studies issued with local capacity/ capability confirmation in 2023-24



3.2.3 Participant research experience survey (PRES)

3.2.3.1 A NIHR survey to capture the experience of participants in health research has run annually since 2015-16. It is carried out to help improve the experience of those taking part in research, giving a chance to feedback on what went well and what could be improved. From 2019-20, this survey was made a Higher Level Objective by the DHSC. The elevation of the PRES's profile is in a wider context of increasing appreciation of the importance of access to research being routinely promoted in health care provision.

3.2.3.2 In 2023-24, SFT received one of the highest response rates to the PRES in GM (211 surveys completed, NIHR target was 150) with T&Galso exceeding their target (52 surveys completed, NIHR target was 50). This provides assurance that both RD&I teams are actively seeking feedback on how we are currently performing in this area and what we need to focus on in future to ensure exceptional experiences for our research participants. We should see further increases in 2024-25 given the national changes made for survey accessibility for all our patients.



3.2.3.3 Key questions and responses are summarised below from a GM level, which provide assurance of the overwhelmingly positive experience delivered to our surveyed participants during 2023-24. Our local Trust trends do align with the regional data. Themes identified were the knowledge, professionalism and excellent communication from the SFT and T&Gteams.

3.2.3.4 The critique on how we can improve has also continued to be reviewed and integrated into how we run future studies. Key improvements made from 2023-24 feedback include continued logging of maintenance jobs with the estates teams to ensure areas where patients are seen remain fit for purpose, improved tea/ coffee facilities for visitors, flexibility in appointment times and providing patient information in different formats to suit the needs of individual patients.

A recurring regional theme still stands on how results of research studies are shared. We continue to report this back to study sponsors to ensure this is considered at appropriate study milestones. We also intend to add this to a checklist to remind sponsors about at the point of study closure. We continue to see improvements with this due to national HRA steers, with more studies now issuing regular newsletters and posting study results on 'easy to access' websites.

3.3 RD&I Committee meeting overview and effectiveness

3.3.1 During 2023, the SFT and T&Gorganised and conducted separate RD&I Committee meetings on a quarterly basis, with the first joint Committee taking place on 24-Jan-2024 to align with our strategic direction. Prior to this merger, the RD&I Committee at SFT met on 21-Feb-2023, 15-Jun-2023 and 11-Oct-2023. The T&GRD&I Committee met on 19-Apr-2023, 19-Jul-2023, 18-Oct-2023. Core membership and paper circulation is summarised in Appendix 1 for 2023 for both Trusts.

3.3.2 Upon merging of the RD&I Committees it was found that T&Greport on their annual research audit programme through this annual report. A summary has therefore been included here for 2023-24 activity. SFT don't currently operate an internal audit programme, as the Trust has relied on

regular checks by study-specific, external monitors. However, for 2024-25, there is an ambition for a joint audit programme to be rolled out across SFT and T&Gto help drive quality. This will therefore become a joint report section in 2024-25. The aim is for both Trusts to learn from the audit reports and implement new procedures and training as necessary. For 2023-24, T&Gcompleted 6 mini GCP study audits, all of which were planned.

Audit findings and actions:

Short Study Title	Planned/ For cause	CTIMP/Non CTIMP	Findings
UK-ROX	Planned	Non-CTIMP	Major consent issues- all resolved
FIND-IT	Planned	Non-CTIMP	Minor documentation issues
H2Oil2	Planned	Non-CTIMP	Minor documentation/filing issues
T4P	Planned	Non-CTIMP	Minor eligibility error
ATNEC	Planned	Non-CTIMP	Minor documentation errors
ESPriT2	Planned	Non-CTIMP	Minor documentation issues

3.3.3 The effectiveness report for the T&GRD&I Committee in 2023 can be found in Appendix 2. In 2024-25, this will be a joint report as the Terms of Reference (ToR) have been merged as of Apr-2024. SFT haven't typically prepared such a report previously, as the structure of this annual report does provide the assurances for the key functions listed in their 2023 RD&I Committee ToR around managing risk, safety, quality and performance, tracking strategic delivery, promotion of a research active Trust culture via training/ publicity, as well as partnership building.

3.3.4 To summarise, the effectiveness reports provide assurance that the procedural aspects of the Committees' operations have been effective, and that progress has been made in establishing a research active culture across both Trusts. This will continue to be developed in 2024-25, working with each other and the NIHR RRDN to increase research activity and patient recruitment into studies. The RD&I Committees have complied with their Terms of Reference during 2023-24, and have made progress to improve the research processes and procedures at both sites.

4. Areas of risk

4.1 **Performance/ Business/ Financial:** Reacting to the national changes from the Lord O'Shaughnessy report as well as other NIHR updates from the restructuring of the CRNs to RRDNs (going live in Oct-2024) has been challenging this year due to resourcing. 3.1.1.2 clearly highlights the areas of our service that have suffered due to this. However, working within the structure of our 5-year RD&I strategy has enabled both teams to focus on the key priorities for our staff and the populations we serve.

To help mitigate this and enable the high level of recruitment we have seen across both Trusts in 2023-24, the strength of the established Senior/ Lead Research Nurse structures has shone through. These posts have and will continue to be instrumental in supporting the delivery of our joint RD&I strategy, managing performance, integrating research into the general nursing workforce and ensuring Trust values are continued to be demonstrated in the work of the departments. It is critical that both Trusts maintain a robust level of NIHR participant recruitment, given the changes to come in the new NIHR RRDN, where funding envelopes for 2025-26 and beyond will be under consideration. It is important to note that the Band 7 Senior Research Nurse posts rely on this NIHR funding. R&I income generation can also only support the SFT Band 8a Lead Research Nurse post for another 3 years in the first instance. Future funding from a Trust perspective (i.e. business case) will need to be considered for longer-term sustainability, particularly as the role contributes to the senior nursing professional cover rota, other Trust led needs and will look to collaborate further with T&Gpartners in the future.

The set-up of new studies has continued to be staggered until the RD&I governance teams return to full complement, to ensure we maintain quality and don't overload staff. The future will look at how we share the set-up resource better across both organisations so we aren't duplicating set-up work for studies running at both sites (accounting for the nuances around the two Trusts remaining as separate legal entities).

Finally, the available support from key service departments (laboratories, pharmacy and radiology) and having an appropriate estates footprint is integral to the research portfolio expanding locally. 3.1.1.3 summarises the 2023-24 challenges in these areas. We are reliant on the mitigations and forward planning proposed in this section to ensure future research portfolio growth. Without this, there is a risk that our portfolios won't grow sufficiently to generate the income to sustain and build on the current RD&I team infrastructures. This links to Ambitions 3 and 4 of our key strategic themes of RD&I integration into service development and increasing research funding.

4.2 **Clinical/ Quality/ Reputational (Part 1):** This risk has continued to be rolled over from 2022-23 due to the capacity reasons outlined throughout this report. Although all our RD&I staff are trained in Trust essentials, research legislation and regulations, with protocols provided for each study

conducted, the lack of a fully developed, joint QMS continues to be an organisational risk with reputational consequences if we were to be inspected by external regulatory authorities. It is also an important underpinning factor of our second strategic ambition to embed an inclusive research active culture within our Trust community. At both Trusts, we currently don't sponsor any studies which fall under the MHRA's remit, so the risk of inspection is low (it would only come from a hosted study if triggered due to recurrent safety issues at site or if the study drug was coming close to licensing and our site is randomly selected out of all participating sites). However, the lack of a fully launched QMS and appropriate staffing support means that it would not be prudent for our RD&I service to expand into more complex study sponsorship until this is in place. This is a key strategic step for our Trust as 'home-grown' ideas and development of these locally is really important to our clinical staff. Due to the long-term sickness in the core RD&I governance team in Stockport in 2023-24, this work programme is behind schedule but has started (see 3.1.1.2). The aim is to complete this in 2024-25 so that we have fully standardised processes across SFT and T&Gthat can be cross-monitored, which will support a more cohesive work force across both Trusts, driving improved quality standards.

4.3 **Clinical/ Quality and Reputational (Part 2):** This risk continues year on year for both Trusts. The current structure for health care professional work plans, does not allow for planned, protected research time. Most research work is currently seen as an 'add on', incorporated into other SPA time or in their own time. There is limited funding from the Trusts for protected research time. This then puts pressure on the acceptance of new studies into an area, limiting research portfolio growth. Staff just don't have the time to supervise or act as a Principal Investigator for these studies for ongoing recruitment and follow up. The Trust infrastructures do require further evaluation at executive level to ensure healthcare professionals have the time to truly embed research into clinical care, so that it is an expectation to be research active in a standard care setting. Discussions have continued through the RD&I Committee but need to be acted on at the appropriate level of authority to enact real change locally.

4.4 **Strategic update:** Finally, with the launch of our joint RD&I strategy in Oct-2022, this report holds Appendix 3, which provides a detailed summary of our key achievements to Mar-2024 against our 4 high level ambitions, broken down into 15 objectives:

Ambition	Objective

Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities	1.1	Increase participation and diversity in NIHR studies
	1.2	Increase patient and public involvement in research studies
	1.3	Improve clinical research facilities
	1.4	Deliver NIHR targets
	1.5	Support grant application development
Ambition 2: Embed an inclusive research active culture within our community	2.1	Protected research time
	2.2	Researcher career pathways
	2.3	Increase understanding of RD&I role in clinical care
	2.4	Quicker uptake of new techniques and therapies
	2.5	Data and resources to support research delivery
Ambition 3: Integrate RD&I into service development	3.1	Maximise RD&I potential for translational and applied health services
	3.2	Collaboration to improve health outcomes
Ambition 4: Increase research funding	4.1	Maximise external income opportunities
	4.2	Fiscal transparency
	4.3	increase research infrastructure funding

As referenced throughout this report, we are behind where we would like to be due to resource issues, specifically with QMS development. The review and organisational re-structure of the RD&I core governance roles across SFT and T&Gis also critical (with improved Trust investment) to prevent the same highlighted risks above being re-summarised in the 2024-25 annual report. This will support a more resilient workforce in this area with scope for career development and role diversification, to successfully offer a joint quality/ sponsorship function. This will help safeguard business continuity in the future (through succession planning) and hopefully provide more resilience from staff long-term absences/ vacancies.

5. Recommendations

5.1 It is requested that this report is noted and feedback provided if there are any areas that the reviewing groups are not assured by, or risks they feel

haven’t been appropriately considered and mitigated. Support from Board in the actions to mitigate the more serious risks is also requested, with a focus on the structural re-organisation of the core RD&I offices across both Trusts and protecting research time. It is acknowledged that this re-structure will be a challenge with the Trust’s current financial position. However, whilst the wider Trust circumstances are challenging, there are excellent opportunities for recruitment, retention and quality improvements by investment into RD&I expansion for our patient population.

Appendix 1 – Core Membership/ Paper Circulation for RD&I Committees

SFT: Full research delivery team also copied in.

Name	Specialty	21-Feb-2023	15-Jun-2023	11-Oct-2023
Abbas Ismail	Rheumatology	Apologies received	Absent, no apologies	Apologies received
Adam Pinder	Finance	Absent, no apologies	Attended	Absent, no apologies
Alissa Kent	Research Support Officer (minute taker)	Apologies received	Attended	Apologies received
Andrew Loughney	R&I Committee Chair	Attended (Part)	Apologies received	Apologies received
Appukuttan Suman	Stroke	Apologies received	Apologies received	Apologies received
Carole Sparks	Assistant Chief Nurse	Minutes Only	Minutes Only	Minutes Only
Chris Cooper	Paediatrics	Attended (Part)	Attended (Part)	Attended
David Baxter	Infectious Disease	Absent, no apologies	Absent, no apologies	Absent, no apologies
David Johnson	Orthopaedics	Attended	Attended (Part)	Apologies received
Emma Reid	Radiology	Absent, no apologies	Absent, no apologies	Apologies received
Hywel Garrard	Critical Care	Apologies received	Attended	Attended
James Baker	Principal Pharmacist	Attended	Attended	Apologies received
James Dyer	Cancer/ Urology	Apologies received	Attended (Part)	Attended (Part)
James Ryan	Library	Left Trust	Left Trust	Left Trust
Jane Butterworth	PA to R&I Committee Chair	Minutes Only	Minutes Only	Minutes Only
Janette Hunt	Clinical Audit Operational Manager	Minutes Only	Minutes Only	Minutes Only
Liam Taylor	GMCRN Representative	Apologies received	Attended (Part)	Not Lead Stockport GMCRN Link
Louise Mercer	Rheumatology	Apologies received	Attended (Part)	Attended
Lucy Tomlinson	Reproductive Health	Absent, no apologies	Absent, no apologies	Absent, no apologies
Maddy Pureti	Reproductive Health	Absent, no apologies	Absent, no apologies	Absent, no apologies
Magda Kujawa	Urology	Apologies received	Apologies received	Absent, no apologies
Mamoona Khalid-Raja	ENT	Apologies received	Apologies received	Apologies received
Margaret Cooper	R&D Director TGIC	Minutes Only	Minutes Only	Minutes Only
Mary Barden	Knowledge and Library Services Manager	Not in Post	Minutes Only	Naomi Majek, Assistant Librarian attending

Matthew Jackson	Anaesthetics	Apologies received	Absent, no apologies	Absent, no apologies
Milan Rudic	ENT	Apologies received	Attended	Apologies received
Montaser Haj	Haematology	Absent, no apologies	Absent, no apologies	Absent, no apologies
Neil Powrie	Radiology	Apologies received	Attended	Apologies received
Nicole Beveridge	Infectious Disease	Minutes Only	Minutes Only	Minutes Only
Nicola Hermitage	Clinical Trials Pharmacist	Not in Post	Not in Post	Attended
Paul Buckley	Chief Pharmacist	Attended	Apologies received	Attended
Philip Lewis	Cardiology	Attended	Absent, no apologies	Absent, no apologies
Rebecca Roberts	Research Governance Manager TGIC	Minutes Only	Minutes Only	Minutes Only
Roxana Stanciu	Respiratory	Apologies received	Absent, no apologies	Attended (Part)
Sajal Rai	Surgery	Absent, no apologies	Absent, no apologies	Absent, no apologies
Sara Bennett	Lead Research Nurse	Attended	Attended	Attended
Sharman Harris	Laboratories	Absent, no apologies	Absent, no apologies	Absent, no apologies
Srivasavi Dukka	Haematology	Attended (Part)	Absent, no apologies	Apologies received
Susan Neeson	GMCRN Representative	Not Lead Stockport GMCRN Link	Not Lead Stockport GMCRN Link	Apologies received
Suzy Collins	Acute Medicine	Apologies received	Absent, no apologies	Apologies received
Tracey Stockwell	Procurement	Minutes Only	Minutes Only	Minutes Only
Wiesia Woodyatt	R&I Manager	Attended	Attended	Attended
Wisam Jafar	Gastroenterology	Absent, no apologies	Absent, no apologies	Absent, no apologies

TGIC:

Name	Specialty	19-Apr-2023	19-Jul-2023	18-Oct-2023
Adam Armitage	Paediatrics	Absent, no apologies	Absent, no apologies	Absent, no apologies
Al-Tahoor Butt	Respiratory	Absent, no apologies	Attended	Apologies received
Dilraj Sandher	Medical Director (committee chair)	Attended	Attended	Attended
Edith Curran	Orthodontics Research assistant	Attended	Apologies received	Attended
Edward Jude	Diabetes	Absent, no apologies	Attended	Apologies received
Heather Savill	Lead Research nurse	Attended	Attended	Attended
Justine Toole	Finance	Apologies received	Apologies received	Attended
Mandy Pickersgill	Pathology	Absent, no apologies	Absent, no apologies	Absent, no apologies
Margaret Cooper	Director of R&D	Attended	Attended	Attended
Mary Barden	Knowledge and Library Services	Attended	Apologies received	Attended by other service representative
Michelle Beecroft	Pharmacy	Attended	Attended	Attended
Nicky Mandall	Orthodontics	Attended	Attended	Attended
Rebecca Roberts	R&G Manager	Attended	Attended	Attended
Sandra Harrison	Knowledge and Library Services	Attended by other service representative	Attended	Attended
Shaun Dorey	Radiology	Ad hoc invite	Ad hoc invite	Ad hoc invite
Slawomir Pawlik	Tameside ICB	Apologies received	Apologies received	Absent, no apologies
Stephen Wilson	Patient Representative	Apologies received	Attended	Attended
Tracy Campbell	Deputy Director of Nursing	Attended	Attended	Apologies received

Appendix 2: Compliance with Terms of Reference (ToR)

T&GToR:

- Compliance: The ToR were last reviewed in April 2023 and will be reviewed annually, unless there is the requirement to review earlier.
- Meeting frequency: The Committee held 4 meetings in 2023-24, in accordance to the Terms of Reference (the final joint with SFT). Meetings are held on a quarterly basis.
- Evidence of compliance with each of the key tasks devolved to the RD&I Committee as described in the Terms of Reference are as follows:

1.	**To develop a central point of reference and expertise for the Trust on all matters relating to RD&I.**	The RD&I department provides a central point of contact of reference and expertise for Trust staff and external collaborators. The RD&I Committee meet on a quarterly basis to develop the research processes and procedures within the Trust. The department has implemented a newsletter, information leaflet and has a page on the Trust's internal/ external websites, providing key contact details .
2.	**To foster and develop RD&I awareness and activity within the Trust.**	Several community and Trust research events took place in 2023-24. The RD&I department hosted a research festival in Ashton market place in Jul-2023, to raise awareness of research in the community. A maternity research engagement event took place in Mar-2024, to promote the BaBi Tameside study and other reproductive health and childbirth studies. A joint research showcase event took place in Sep-2023, with SFT hosting. The RD&I department continues to promote research through local communications, via a quarterly newsletter and regular good news stories and research opportunities in the weekly digest. The department also held a research promotion day, for Red 4 Research day and international clinical trials day. The RD&I Department is committed to provide patients with the opportunity to participate in research, if they wish. Research staff aim to ask all eligible patients if they wish to participate in a research study. We also ask service users for feedback via the PRES, to help the department improve research services and experiences.

3.	**To seek further support and undertaking R&D within the Trust (including funding, resources, collaborations, facilities).**	The RD&I department has maintained strong relationships with finance and other supporting departments to provide assistance for research issues such as funding posts within the Trust and improving resources. The RD& department has been working with the finance department and SFT to ensure all invoices are raised and income is distributed according to the costing templates. The department also has strong links with pharmacy, pathology and radiology, to ensure feasibility and support for the studies the Trust conducts. Representatives from each supporting department are invited to the RD&I committee meetings. The department has engaged with several external collaborators, such as the University of Manchester and Ashton Medical Group. The research committee has a member from TG ICB, which will help to facilitate collaborative working.
4.	**To produce, implement and maintain an RD&I strategy for the Trust.**	RD&I has implemented a new five-year research strategy, in collaboration with SFT, in Oct-2022. Details of the strategy are documented earlier in this report.
5.	**To periodically undertake or contribute to events, which promote interest in undertaking and implementing research within the Trust, for example holding Good Clinical Practice training sessions.**	The RD&I department hosted a research festival in Jul-2023, to promote and raise awareness of research in the community. Also, our first joint annual research showcase event with SFT took place in Sep-2023. This was a highly successful and very well attended event, highlighting research achievements and activity and taking place within the Trusts.
6.	**To ensure that appropriate records are kept of all RD&I activity within the Trust and to produce an annual report on RD&I activity. The annual progress report is to be submitted to the Service Quality and Assurance Group who report to the Trust Board. Individual studies are required to submit an annual progress report to the Research Ethics Committee, Trust R&D office and when applicable, MHRA.**	The Committee report annually on the progress they have made and on the Trust's research activity. The annual report is produced by the RD&I department and ratified through the RD&I Committee. The annual report is then submitted to the Service Quality and Assurance Group (SQAG), who report to Trust Board. The RD&I Committee also submit committee minutes to the SQAG on a quarterly basis. Individual studies report to the REC and MHRA annually, where applicable. The department retains appropriate records of all internal and external discussion, debates and decisions. All communication is available in the relevant files and folders stored on the trusts secure IT system and

		wet signed documents are stored within the paper RD&I filing system.
7.	**To ensure links with other relevant departments and functions are maintained (particularly Clinical Governance and Finance) in order to ensure the highest standards of scientific and financial probity and maximised integration into these and other mainstream functions. The minutes from the RD&I committee meetings will be sent to the Service Quality Assurance Group.**	The RD&I Committee has maintained good relations with all departments in order to push research within T&Gforward. A representative from each supporting department is invited to the RD&I committee meetings, where any issues or new procedures can be discussed.
8.	**To ensure that the Trust do not agree to act as Sponsor for CTIMPs.**	The RD&I Committee has ensured that the sponsorship of a CTIMP has not occurred during 2023-24 and will continue to do so. The confirmation letter with the MHRA that the Trust will not sponsor CTIMPs still remains valid.
9.	**To decide on Trust Sponsorship for complex trials which involves the review of the study protocol as a minimum. In extreme/urgent circumstances, such as pandemics where the study in question relates to the outbreak, a chairperson's action may be given. The committee will be informed and presented with the protocol at the next committee meeting/electronically.**	The RD&I Committee has not agreed to undertake the sponsorship responsibilities for any new studies during 2023-24, as no studies have been presented. However, sponsorship oversight is maintained for existing sponsored studies by the research department and regular updates to the RD&I Committee.
10.	**To ensure that potential hosted CTIMPs are reviewed in relation to capacity and risk to determine if T&Gcan support the study and to determine if the study is high, medium or low priority for auditing.**	The RD&I Committee has reviewed several potential hosted CTIMP studies during 2023/24, prior to confirming capacity and capability. The committee members reviewed a minimum of the study protocol.
11.	**To ensure study oversight of hosted**	The Research Governance Manager manages the annual audit

	CTIMPs via TGIC's audit programme and the review of audit activities by T&GRD&I Committee as defined in the Quality Statement of Intent	programme on behalf of the RD&I Committee. Audits are conducted in line with the Audit SOP and prioritisation flowcharts. A summary report of the internal audits conducted is presented to the RD&I Committee as one of the standing agenda items, to ensure there is awareness of findings and to maintain the required oversight of audit activity. A summary of audit activity is documented earlier in this report.
12.	**To provide assistance with R&D issues, SOP compliance or training issues.**	The RD&I Committee assist with any RD&I issues, such as SOP or training compliance via the escalation process described in the committee terms of reference.
13.	**To review and monitor any CAPA action plans, if applicable.**	The MHRA inspection has now received a closure letter. However the preventative actions are an ongoing process to ensure compliance is maintained. This has been incorporated into the committee meetings via several quality control and assurance standard agenda items, such as the training and audit programmes, oversight of hosted CTIMPs and research incidents. There are currently no CAPA plans to be reviewed.
14.	**To co-ordinate the Trust's response to any external requirement for information on RD&I activity.**	The RD&I department is required to share information with the study sponsors and coordinators. We ensure that any patient identifiable information is anonymised onsite, protecting patient confidentiality. Contracts and centre agreements document the actions to be taken in the event of an external requirement for information, such as a freedom of information request in relation to a specific trial. The Committee will continue to monitor information on RD&I activity to co-ordinate the Trusts response to any external requirements.
15.	**To provide the Trust Board with appropriate assurances in respect of any R&D issues which may be identified in the Board Assurance Framework or through other means.**	Minutes are taken at every RD&I Committee meeting and ratified to ensure a correct record of events is kept and accurate information is passed to the SQAG and Trust Board. The Chair of the RD&I committee is also a member of the Trust board, who takes relevant research information to the Board meetings when applicable.
16.	**The ToR for the RD&I Committee are to be reviewed annually.**	The Terms of Reference were last reviewed in Apr-2023. The ToR are next due to be reviewed in Apr-2024, due to the new joint RD&I committee.

Appendix 3 - Quality Metrics For Achievement (To Mar-2024)

Metric	Measure	Achievement / Update (To Mar-2024)
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.1: Increase participation and diversity in NIHR studies**		
Growing number of NIHR studies with Trust participation, with particular emphasis on those presently known to have lower levels of access to RD&I projects due to personal characteristics or socioeconomic status.	Year on year increase in studies opened and offered to our participants across the 2 Trusts: - Benchmark data will be taken from Oct-2022. - Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Focussed expansion in reproductive health (SFT – GBS3), respiratory (both) and cancer (TGICFT – Breast, SFT – Urology, Both – Colorectal) to account for key healthcare inequality areas.	**In progress, not met Year 1:** Both Trusts haven't had the opportunity to increase activity by 10% in year 1 due to staffing challenges. However, similar activity levels have been sustained compared to the previous financial year Progress as below: - 01-Nov-2021 – 31-Oct-2022: 26 studies opened at Stockport across 13 specialities) and 15 studies opened at Tameside across 13 specialities. - 01-Nov-2022 – 31-Oct-2023: 27 studies opened at Stockport across 15 specialities and 15 studies opened at Tameside across 9 specialities. During Year 2 reporting period, both Trusts are seeing an increase in new studies across a wide speciality mix. To date: - 01-Nov-2022 – 31-Mar-2023: 9 studies opened at Stockport across 8 specialities) and 1 study opened at Tameside across 1 speciality. - 01-Nov-2023 – 31-Mar-2024: 21 studies opened at Stockport across 11 specialities) and 7 studies opened at Tameside across 5 specialities. **In progress:** Focussed expansion has started for key areas as Tameside has BABI recruiting well for reproductive health and is supporting the Stockport team to get this up and running as well. Both Trusts are actively scoping out new cancer studies to fit the needs of the local population. We also continue to engage with ACPs/ key ward staff to expand more into our frailty cohort of patients, with studies open and recruiting (i.e. FORCE:SEE for Stockport and WHITE PRESSURE-

Metric	Measure	Achievement / Update (To Mar-2024)
		3 for both Trusts). We have seen success in key areas of our portfolio to align with the populations we see: – e.g. COLOCOHORT at Stockport for colorectal cancer diagnosis/ screening (291 recruited 2023/4), IBD Bioresource for our gastro patients (130 recruited 2023/4), 713 into GBS/ IGBS 'reproductive health into paeds' studies and 212 recruited 2023/24 for our rheumatology patients into IMID. - e.g. FIND-IT at Tameside for diabetes diagnosis in acute admissions (1,655 recruited 2023/24), BaBi 'Born and Bred in' big data collection (>200 enrolled 2023/24), and PQIP at 52 for anaesthetics.
An increased number of investigator-initiated research studies with industrial partners and academic institutions, adopted by the NIHR.	Years 1 and 2 will focus on developing and embedding the quality management system (QMS) and processes needed to be in place before sponsorship of new studies will be viable locally. The aim will be to have 1 research study set-up in this time frame to test the new systems, with either TGICFT or SFT acting as sponsor, and the other Trust as a site.	**In progress:** TGICFT and SFT RD&I leads met in Jan-2023 and a new QMS across both sites was proposed with development over 2023, looking to extend to pharmacy departments as well for research activity. This work plan has been delayed due to staffing issues by but work re-started in Sep-2023, with revised milestones for completion by Oct-2024. New policies/ SOPs started to come through for committee review/ ratification from Oct-2023 (face to face and virtual review) with our new Research Oversight Policy and SOPs for radiology linked research issued in Q1 2024.
Increasing representative sample of participants completing the Participant Research Experience Survey (PRES) with evidence of improvements from feedback.	Year on year or PRES being offered to our participants across the 2 Trusts: - Benchmark data will be taken from Oct-2022. - Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Quarterly reviews will be undertaken through the NIHR data platform for this and feedback acted upon each time. A report will be generated to confirm feedback, achievements and improvements throughout the year.	**In progress and compliant:** Reports from NIHR for SFT for 2022-23 showed achievement of the 100 target, with 233 surveys completed, and in 2023-24 achievement of the 150 target with 210 surveys completed. TGICFT achieved 51 completed surveys for 2022-23, with a target of 50, repeated again in 2023-24. The 2022-23 annual report for RD&I at SFT summarises the feedback and actions taken from that whole year of data. A similar report is currently being produced for 2023-24 and will cover both Trusts.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.2: Increase patient and public involvement in research studies**		
An increased proportion of patients recruited to research	Year 1 will be about setting the baseline of what this looks like across both Trusts.	**In progress:** NIHR GMCRN confirmed in Jan-2023 that our local portfolio management system (LPMS) RPEAK would be adapted to

Metric	Measure	Achievement / Update (To Mar-2024)
studies across all groups within our population, with diversity of participants partaking in studies matching local demographics.	Implementation of either a NIHR e-form through RPEAK (the local portfolio management system for research) for capturing demographic data for each participant recruited from Jan-2023 or utilisation of TGICFT's demographics form for the same purpose, with data collated centrally. Year 2 will then be about using the above data to develop a more targeted plan to increase research awareness across all our population groups.	include year of birth for all enrolled research participants from Apr-2023, which happened. Both Trusts now regularly log this on RPEAK with data sets available for 2023/2024 and onwards. We will review our age diversity mix to see any gaps once we have the full financial year of data in Apr/May-2024. There is a GM-wide DPIA that will continue to add appropriate data sets to our LPMS to help benchmark our demographics splits. These measures will help support our Year 2 work plan to analyse our demographics split and the areas we need to target to ensure equity in research opportunities across our full population. Both Trusts will actively pursue this with the GMCRN team.

Number of Trust events with RD&I participation.	Years 1 and 2 will demonstrate evidence of at least 4 key events annually to showcase RD&I at both Trusts, through avenues such as patient stories at Trust board, International Clinical Trials Day, EDI events, annual research showcase, patient and public workshops etc.	**In progress/ Planned and Completed:** To date, the following have been scheduled or completed at SFT and TGICFT:
		- In Dec-2022, we took a patient story to Trust Board, which was well received and told the story of one our research participants involved in a vaccine booster study, then joining the team as a Research Nurse.
		- SFT/ TGICFT team building afternoon 29-Apr-2023.
		- International Clinical Trials Day activities around 20-May-2023.
		- SFT presence at Stockport Pride in Jul-2023 to raise awareness of research opportunities available locally.
		- TGICFT collaborated with the CRN to host a Research festival in Ashton town centre in Jul-2023, to promote health, wellbeing and research opportunities in the area.
		- SFT/ TGICFT joint research showcase event, hosted at SFT 29-Sep-2023, with an agenda that covered the fantastic work taking place across both organisations.
		- SFT and TGICFT staff and teams short-listed in the regional Health and Care Research Awards 2023:
		  o Putting Participants First - FIND-IT study team (TGICFT) – Winner!
		  o Collaborative Working Achievement – HARMONIE Respiratory Syncytial Virus Study (GM wide collaboration of which TGICFT and SFT were part) – Runner-Up

Metric	Measure	Achievement / Update (To Mar-2024)
		○ Exceptional Research Delivery Leadership – Wiesia Woodyatt, RD&I Manager (SFT) - Runner-Up ○ Best Public Engagement – Tameside Health Research Festival - Winner! ○ Virtual Site Tours (GM wide initiative of which SFT took part) - Runner-Up ○ New to Research – Daisy Pegler, Research Midwife (SFT) – Highly commended. - SFT RD&I team presence at Trust recruitment/ careers day, on 07-Oct-2023 showcasing the careers available in research. - T&Ghosted a maternity research engagement event in Mar-2024 to raise awareness and educate around the BaBi project in Hyde. - SFT/ T&Gpresence at the NIHR GMCRN strategic showcase event at the end of Mar-2024. - The next annual research showcase is also now booked in for 29-Oct-2024, this time to be hosted at TGICFT.
Number of patient and public communications promoting research participation.	External and internal website content will be shared between both Trusts and refreshed for consistency in messaging, for showcasing of the strategy and for updated content to champion the research work delivered locally and regionally. There will be evidence of at least monthly communications shared through Trust channels – microsites, intranet news, weekly email bulletins, newsletter across both Trusts, to showcase the progress of research and this strategy.	**In progress:** Work to actively share website content has been shifted to Q1-2 2024-25 when capacity allows across both SFT and TGICFT teams. We are currently working with library and knowledge services to intertwine their research support offerings (i.e. quarterly publication summaries, searching for SFT/ T&GFT linked research publications, statistics and critical appraisal support). We published our first joint research publication bulletin in Apr-2024. **In progress:** Since strategy launch, there has been a very regular stream of intranet news, RD&I microsite updates and specialty specific newsletters being produced to showcase the RD&I activity at SFT. Quarterly, general and specialty specific RD&I newsletters are also now being produced when capacity allows and shared with research active staff across SFT/ TGICFT (since Jul-2023 for both organisations), with a view to combining these from Jul-2024.

Metric	Measure	Achievement / Update (To Mar-2024)
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.3: Improve clinical research facilities**		
Dedicated clinical research facilities within each Trust.	- For SFT, Years 1-2 will see the clearing of the archived study backlog to free up space for study portfolio expansion on the unit and establishment of a satellite pharmacy on Ward C2 for clinical trials. - For TGICFT, Years 1-2 will see reconfiguration of their expanded research area to create a more fit for purpose environment for clinical research.	**In progress:** - For SFT: o The room to be used for the satellite pharmacy on Ward C2 has now been fitted out with just the air conditioning installation work to take place (hopefully Q1 2024/25) so that remaining fridges/ freezers can be moved into the space to make this area fully operational for clinical trials work. o Approximately 50 studies are currently being worked on to close down fully and move off site for archive. A significant volume of archiving boxes left the department in Autumn/ Winter 2023 and Jan-2024 with more planned for this current quarter to support capacity. o All equipment on C2 has now been logged and the team are in regular communication with estates and other contractors to ensure timely PAT re-testing, servicing and calibration. A new refrigerated centrifuge was delivered in Autumn 2023 to add to the new fridge/ freezer to support improved lab processing capabilities on the ward. Many research samples can now be process in the R&I department to alleviate resourcing pressures in the main labs. o The old sluice area in the department has been de-commissioned and instead has been re-purposed as a secure equipment storage area to support expansion of the commercial portfolio. o For Apr-2024 onwards, we are looking to improve our study documentation storage and monitoring facilities by re-purposing 2 under-utilised areas for a dedicated, secure study documentation store and an improved area for visiting monitor/ audit staff. This has been put on hold for a quarter due to the potential loss of the research department space due to other Trust OP pressures.

Metric	Measure	Achievement / Update (To Mar-2024)
		- For TGICFT, the research dedicated space has now been extended and they are currently re-configuring to ensure the area is fit to support clinical research. A section of the space, provides a dedicated area for lab processing and contains the freezer and centrifuge.
Shared facilities and infrastructure with other external partners (e.g. Higher Education Institutes, working with regional Clinical Research Facilities).	Years 1 and 2 will focus on developing collaborations with the GM Biomedical Research Centre, Health Innovation Manchester and developing the TGICFT based MMU integrated clinical research facility to support objective 1.1.	**Initiated:** Collaboration work started at Feb-2023 RD&I Committee with Lloyd Gregory, Academic Partnerships Director, Health Innovation Manchester (HInM) joining us to provide a background to HInM and possible, future collaborations. Lloyd also presented at the 29-Sep-2023 research showcase day. Work to build a collaboration with the GM Biomedical Research Centre is hoped to pick up once the new BRC Clinical Director has been established in post (start date Apr-2024). TGICFT is now collaborating with Professor Wong at the University of Manchester. A PhD student will work closely with the department on projects regarding health issues and environmental factors. The TGICFT R&D Director is also looking into potential collaborations with Manchester Metropolitan University.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.4: Deliver NIHR targets**		
Improved metrics for study feasibility, set-up and delivering to time and target, with evidence to showcase our organisation and efficiencies.	Year on year increase for improvements across the 2 Trusts: - Benchmark data will be taken from Oct-2022. - Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Each quarter's performance data will be scrutinised and reported back on to see studies which achieved DHSC metrics vs those that didn't to learn from each data set for future improvements.	The DHSC metrics of 70 days for set-up/ recruitment of first patient have now been stood down. There is ongoing work with the NIHR national teams to move to reporting more allied to that which we saw through the pandemic, namely a focus on delivering to time and target. Both Trusts aim to work with sponsors to set studies up in the optimal timeframes for both parties.
An increased portfolio of research studies which has tackled health and care inequalities.	See 1.1-1.2.	See 1.1-1.2.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities		

Metric	Measure	Achievement / Update (To Mar-2024)
Objective 1.5: Support grant application development		
Increased number of grant applications supported by RD&I team and an increased number of funding awards/ national leadership positions presented to local researchers.	Refer to 1.1 for QMS development to support this objective and building sponsorship functions across both Trusts. We will aim for 1-2 awards annually across both organisations, whether that is in a sponsorship or lead site function.	Refer to 1.1.
Ambition 2: Embed an inclusive research active culture within our community **Objective 2.1: Protected research time**		
Increased number of roles with protected research time from supporting funding.	Years 1 and 2 will see discussions being held at Clinical Director level to review key job descriptions/ plans and appraisal process to ensure each key area has some protected research time in for staff – These first two years will be about developing this process. Avenues to fund will be actively explored, costed and utilised (from service support applications, re-investment of research income into research PAs or equivalent – pump priming, active support for GMCRN research PA/ other funding bids etc). A process for active assessment will then be needed to ensure that funding continues to be directed to the right staff (likely Year 3 onwards but assessment matrix to be developed in first 2 years).	**In progress with challenges:** At SFT, started with service departments, before moving to specialty areas. - Pharmacy have protected pharmacist and technician support already in place, using GMCRN service support income and have also re-invested commercial income into developing the satellite pharmacy on Ward C2. - Radiology have protected radiographer and consultant support now in place, again using some of the GMCRN service support income. - Discussions are well developed with labs around embedding similar job role protected time to support as pharmacy/ imaging have done. They are going to utilise RD&I income from COVID work to invest in a HSST role, which will commence in Sep-2024 for 5 years. In the meantime, lab support is provided by a short-medium term 'overtime' model, funded from the income distributed to this department from research work. TGICFT has recently appointed a Critical Care research nurse to oversee our research activity within critical care. A piece of work also needs to be completed in 2024 to introduce a Stockport Clinical RD&I Director role and re-structuring of the RD&I offices to increase capacity across the 2 organisations – How to advertise, implement and fund as part of the wider deliverables of the strategy. This needs to be coupled with work on how to sustain research PA time for staff who have these funded from the

Metric	Measure	Achievement / Update (To Mar-2024)
		GMCRN. Work will be needed in both organisations to maximise income recovery to help support future planning.
Ambition 2: Embed an inclusive research active culture within our community **Objective 2.2: Researcher career pathways**		
An increased proportion of staff being research-active across different groups.	Objective 2.1 will enable this, but Years 1 and 2 will focus on ensuring research awareness/ activity is embedded across all clinical job descriptions and is part of the junior doctor training programme. Research staff will also be requested to actively consider this and engage all AHPs in their specialty areas to support the different research projects coming through.	**In progress:** - The SFT RD&I team now deliver awareness training through the sim rotations for FY2s and other junior documents, first session in Jan-2023 and next planned Oct-2023. - Since the SFT RD&I Manager and Lead Research Nurse presented at the Advanced Clinical Practice conference in Jun-2023, all ACPs are now alerted to new/ existing research projects they can help support with and many have come forward to lead on projects (e.g. GONDOMAR – Gastroenterology, FORCE: SEE – Ageing as well as support for identifying patients for cancer linked studies – e.g. Colorectal TRACC and COLO-COHORT). The RD&I Manager has supported with the development of the research strand of the ACP strategy and delivered Principal Investigator training as part of the rolling ACP education programme in Oct-2023 and Feb and Mar-2024. - The SFT Lead Research Nurse has also raised awareness of research and supporting delivery through the AHP/Nursing and Midwifery forum in Sep-2023. - The SFT team now have a regular slot at the TNA forum for students/ nursing associates/ practitioners and some specialty forums (e.g. maternity, gastro GUT Club) to showcase research at Stockport. - The TGICFT research team has provided training to midwives at the trust for the BaBi study. This has led to the opening of 2 other research studies in maternity and an increase in research interest within the department. - At TGICFT, an AHP has been supported to undertake the role of PI for a stroke study, thus promoting research opportunities in all clinical job roles. - Both Trusts have actively engaged over the last 12 months with

Metric	Measure	Achievement / Update (To Mar-2024)
		anaesthetic/ critical care short-term data snapshot studies, which have increased research engagement with specialty trainees in these areas.
Increased number of staff given academic mentorship, development and training opportunities.	Years 1 and 2 will see re-establishment of NIHR training courses being delivered face to face again across the 2 Trusts, with improved information on Trust microsites/ intranet about the wealth of courses and initiatives available on-line to support a research career. These years will also see the refresh and full development of delivery and sponsorship SOPs plus job descriptions, to ensure consistency of approach across the 2 Trusts. TGICFT/ SFT staff will also regionally lead the NW R&D Managers Forum, by ensuring regular events throughout the year to share best practice and develop the RD&I workforce regionally.	**In progress:** - 20-Oct-2022: PI Essentials on-line course co-facilitated by SFT RD&I Manager and NIHR staff for the local region. - 28-Nov-2022: GCP introduction training day ran at SFT with a focus on training TGICFT/ SFT new staff. - 17-Feb-2023: GCP refresher training day ran at TGICFT by SFT facilitators for TGICFT research staff. - From Feb-2023, SFT has started to regularly share the latest training updates for research with all staff through the RD&I microsite and intranet news pages. - 29-Aug-2023: GCP Introductory Consolidation session ran at SFT, mainly for SFT, TGICFT and Macclesfield staff. - 04-Sep-2023: Becoming a PI on-line course co-facilitated by SFT RD&I Manager and NIHR staff for the local region. - 17-Oct-2023: GCP Introductory Consolidation session planned for region, with booking preference given to South East Sector staff. - 27-Oct-2023: Becoming a PI course to be delivered by RD&I team staff for SFT ACPs. - 03-Nov-2023: GCP refresher session scheduled at SFT, facilitated by SFT staff. - Monthly events have been held throughout Jan-Mar-2024 at SFT (open to all North West colleagues) covering Becoming a Principal Investigator and GCP Introductory Consolidation sessions. **Not started:** Job descriptions across the 2 Trusts will be re-reviewed when RD&I office capacity allows, likely from Q2 2024 to align with the GM regional working group focussing on this. See 1.1 on SOP work. **In progress:** TGICFT RD&I Director has led the development of the 2023/24 and 2024/25 NW Forum content.

Metric	Measure	Achievement / Update (To Mar-2024)
Ambition 2: Embed an inclusive research active culture within our community Objective 2.3: Increase understanding of RD&I role in clinical care		
Improved engagement of our research workforce (measured by the NHS Staff Satisfaction Survey and local recruitment and retention rates).	We will benchmark and review the survey results around staff satisfaction, ensuring these are acted on annually. Years 1 and 2 will see the first, annual joint research showcase day between TGICFT and SFT, open to all staff to celebrate research achievements, in collaboration with our regional partners. See objective 1.2 for details on communications updates.	**In progress**: 2022 staff survey results for SFT RD&I team were received in May-2023 so senior leadership team reviewed and actioned. The 2023 results are just in and an action plan will be shared in the next quarterly update. **Completed:** Joint research showcase day took place on 29-Sep-2023. Next one scheduled for Oct-2024.
Ambition 2: Embed an inclusive research active culture within our community Objective 2.4: Quicker uptake of new techniques and therapies		
Mechanisms developed so research outcomes are shared with senior clinical teams.	We will start the development of strong relationships with Health Innovation Manchester, the GM BRC etc to ensure the results of the research we deliver are made available for evidence-based translation into current practice.	**In progress:** See 1.3 on HInM.
Ambition 2: Embed an inclusive research active culture within our community Objective 2.5: Data and resources to support research delivery		
Improved data systems and digital screening tools in place.	Years 1 and 2 will see our direct input into regional initiatives to improve the data/ digital tools we have to support research delivery, through attendance at NIHR digital champion events. For any EPR updates at the Trusts, we will ensure RD&I is actively represented to ensure new systems that are fit for research purpose, MHRA compliant and will enable research in our area.	**In progress:** See 1.2 for further details on regional plans for demographic data benchmarking. Our Trusts will align. **Initiated:** Meetings have been held with the transformation/ project leads for the new EPR for SFT/ TGICFT. MHRA compliance statements have been shared and RD&I have been listed as a key stakeholder to input into the tender process, likely 2024.
Ambition 3: Integrate RD&I into clinical service development Objective 3.1: Maximise RD&I potential for translational and applied health services		
Increasing research activity among key specialisms.	We will complete a mapping exercise of what are strengths, weaknesses, opportunities and threats are across both Trusts, then align these with regional	**Initiated:** Initial mapping exercise completed at joint Apr-2023 SFT/ TGICFT team day. Next stage of work to commence 2024 to start scoping alignment with NIHR GM BRC etc.

Metric	Measure	Achievement / Update (To Mar-2024)
	strategies (i.e. the BRC) so that we can actively support delivery of research in our strongest areas and pave the way to supporting with future regional bids.	
Ambition 3: Integrate RD&I into clinical service development **Objective 3.2: Collaboration to improve health outcomes**		
Embedded joint working model across the two organisations with leadership infrastructure re-organisation to enable this.	Years 1 and 2 will see the review, update and any re-configurations to ensure we have the right RD&I governance structure across the 2 Trusts to deliver this strategy. This will involve re-defining job descriptions, looking at shared roles across sites (e.g. archivist) and a business case to the joint TGICFT/ SFT board to hopefully fund/ support the changes recommended.	**In progress:** Initial mapping exercise completed at joint Apr-2023 SFT/ TGICFT team day. The RD&I offices have also been working closely together on the new joint policy/ SOP suite and successfully merging the RD&I Committees from Jan-2024. Next steps for 2024 will be designing an improved structure and business case to support a new structure across the 2 organisations to maximise research potential.
Robust university/ academic collaborations in place to support the University Hospital status application.	Foundations will be set for this by the other deliverables listed in this plan.	No further comments.
Ambition 4: Increase Research Funding **Objective 4.1: Maximise external income opportunities**		
Increase NIHR core funding.	Both sites will collaborate with the GMCRN/ other funding routes through the various annual bid processes to ensure stabilised funding (with some growth, possibly at B3-4 level) to support the increased research delivery portfolio expected.	**In progress:** Confirmation received that SFT 2024/25 funding was matched for existing posts from 2023/24 (for first 6 months) and there has been a small allowance of extra funding to support our research nurse team expansion across specialities as well. For first 6 months of 2024/25, TGICFT will continue to receive the same amount of funding for existing posts as per 2023/24. Aug-2023 also saw an uplift from £20,000 to £25,000 annual funding for research capacity building for both Trusts.
Ambition 4: Increase Research Funding **Objective 4.2: Fiscal transparency**		
Annual reporting on research income, expenditure and performance management.	SFT and TGICFT will share their developed income generation and distribution models, to look for a consistent plan across both Trusts in how we generate, distribute and ensure transparency for research income. This will be implemented across Years 1-2.	**Initiated:** SFT have shared their model as part of RD&I Committee minutes in Feb-2023 for TGICFT review. It likely TGICFT will take this model on as they don't currently have a robust income distribution model in place. Further work will be required on this in 2024 given the national changes in how commercial contract

Metric	Measure	Achievement / Update (To Mar-2024)
		clinical research is contracted and budgeted.
Ambition 4: Increase Research Funding **Objective 4.3: Increase research infrastructure funding**		
Sustainability of our research financial position, allowing year-on-year investment.	Years 1 and 2 will scope out SME collaborations to determine if we can secure projects that can be run across both sites, with income generation potential and be of benefit to our local population. Objective 3.2 also highlights the business case plan for hopefully improved Trust funding to realise this strategy in full.	**Not started:** We will look to review this from 2024 as there has been limited capacity to initiate this across the 2 organisations during the winter pressure months and long-term staff sickness/ vacancies.

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Meeting date	1st August 2024	**Public**	**X**	**Agenda No.**	18
Meeting	Board of Directors				
Report Title	Annual Learning from Deaths Report 2023/24				
Director Lead	Medical Director	**Author**	Suzy Collins Learning from Deaths Lead		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to note the processes that the Trust has in place that allow it to learn from deaths and consider whether the actions arising from that process have been appropriate and thereby to take assurance.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of the report is to provide the Board of Directors with information about the Learning from Deaths process in the Trust, to summarise the learning that has been gained over the last year and to provide high level information about the actions that have been taken in response.

With respect to process:

- A high level of LFD activity continues with around 32% of all in-hospital deaths receiving a review.

With respect to clinical practice the following themes have been identified during the year:

- Failure to consider and complete a DNACPR after consultation with patients and their families may be leading to unwarranted attempts at resuscitation at the endo of life.

- A degree of clinically inappropriate over-investigation was also identified, again suggesting a lack of patient-centred focus and a failure to agree realistic expectations for patients admitted to the hospital.

- Delays in the transfer of care from ED to the Trust's medical and surgical specialties and from one ward to another for in-patients, appeared to hinder the quality of care provided in several cases. In the most extreme case, a patient's death was linked to delayed laparotomy, potentially caused by delayed transfer of care.

- Despite reductions in the number of patients with no clinical criteria to reside and reductions in patients with a long length of stay, poor flow through the hospital and transfer-out remains a problem and is associated with a poor quality of care, particularly for people who may not wish to spend their last days of life in hospital.

- In another linked theme it was found that whilst regular senior review of patients across the hospital site was usually achieved, un-necessarily long lengths of stay in hospital sometimes resulted if senior review was not forthcoming, contributing to hospital-acquired morbidity and therefore a poor quality of care.

Actions taken in response to these themes are detailed in the following paper.

1 Purpose

1.1 The purpose of this annual report is to provide assurance to the Board of Directors around the Learning from Deaths function of the Trust

1.2 The report therefore outlines the Trust's Learning from Deaths process, presents the high level themes identified during the last year and describes the Trust's response to those findings. Current benchmarking data are also provided to add context to the report.

2. Background and Links to Previous Papers

2.1 The Trust's Learning from Deaths policy is based on the recommendations of the National Quality Board (2017). The purpose of the process is to ensure that opportunities are taken to learn from the care received by patients dying in the Trust so that actions can be taken to improve the quality and safety of patient care.

2.2 The Trust uses a data collection form based on the Structured Judgement Review (SJR) methodology, which is published in conjunction with the National Mortality Case Record Review programme.

2.3 Cases are selected from a number of sources including: deaths where families, staff or the Medical Examiners have raised concerns, maternal deaths, surgical deaths, paediatric deaths, deaths from the LEDER programme, deaths in critical care, theatres or recovery, deaths in the Emergency Department, cardiac arrest deaths and deaths due to epilepsy, asthma or diabetic ketoacidosis.

2.4 Additional cases can be added if capacity allows and/or following an extraordinary event.

2.5 In keeping with national guidance, all reviewed deaths are graded according to the following scheme, based on the opinion of the reviewer:

Outcome 1: Evidence of serious failings in care, which are likely to have affected the outcome – these are all referred for a second opinion from the Trust LFD Lead and if confirmed are escalated to the Serious Incident Review Group for consideration of formal detailed investigation.

Outcome 2: Evidence of suboptimal management unlikely (on the balance of probabilities) to have affected outcome – referred for departmental M&M review.

Outcome 3: Satisfactory care, no lessons to be learned – no further action.

Outcome 4: Exemplary management – feedback to team.

2.6 All Learning from Deaths reviewers are clinicians (mostly Consultants but with Allied Health Professionals now contributing) and each Division is represented. There is also a Learning from Deaths Trust Lead.

2.7 Quarterly reports are considered by the Trust's Mortality Review Group. Where changes in practice are thought to be worth considering, the relevant bodies are informed via the Patent Safety Group (eg) advice may be given to the Transformation Team or the originating Division.

2.8 The Mortality Review Group also provides data and leads discussion at the Deteriorating Patient Group meeting monthly and provides the Patent Safety Group with a quarterly report for consideration.

2.9 A Learning from Deaths Newsletter is produced and circulated widely across the Trust to promote learning and findings are also considered and disseminated at divisional level. Four quarterly newsletters were published in 2023 - 2024.

3. Matters under consideration

3.1 Regarding SHMI and HSMR:

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who have died following hospitalisation in the Trust and the expected number on the basis of average figures for England, given the characteristics of the patients treated in the Trust. It includes data from patients within 30 days of discharge. The SHMI at SFT is currently better expected and has shown an improving position thoughout the year.

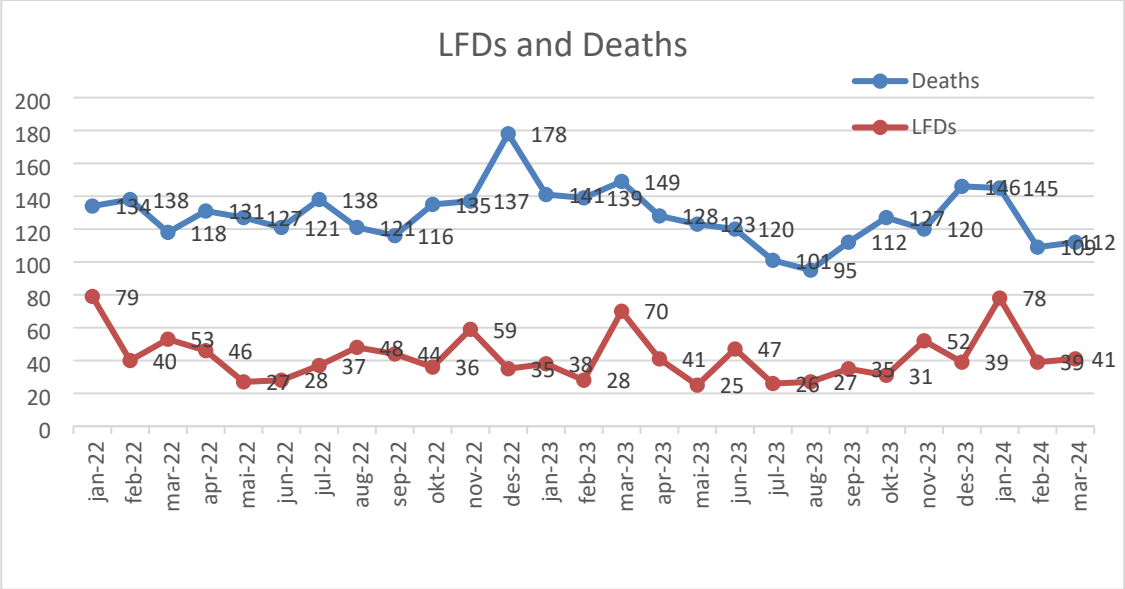
The Hospital Standardised Mortality Ratio (HSMR) is the ratio between the actual number of patients who have died in hospital in the Trust and the expected number using a limited basket of 56 diagnoses, which are known to account for around 80 % of hospital deaths. After a prolonged period in the 'higher than expected' range, the HSMR at SFT is now running at the expected value. This follows a concerted effort from the Trust's coding team to improve coding accuracy for co-morbidities, coupled with the use of an improved coding software function. Whilst pursuing improvements in coding, a series of clinical audits were carried out to provide assurance that the previously elevated HSMR did no reflect poor clinical practice in the Trust.

Date	0423	0523	0623	0723	0823	0923	1023	1123	1223	0124	0224	0324
SHMI												
Observed	1720	1714	1736	1716	1734	1727	1740	1729	1706	1716	1706	
Expected	1726	1726	1741	1750	1786	1802	1813	1822	1817	1831	1841	
Rate	99.3	99.3	99.7	98.1	997.1	95.8	96.0	94.9	93.9	93.7	92.7	
HSMR												
Observed	1193	1196	1204	1171	1164	1158	1147	1130	1115	1111	1076	1042
Expected	1075	1070	1075	1067	1,090	1078	1066	1061	1053	1052	1044	1031
Rate	111.0	111.8	112.0	109.8	106.78	108.0	107.6	106.5	105.9	105.6	103.1	101.1

(Rate of 100 indicates that the Trust is performing at expected levels)

3.2 Regarding Trust processes:

A high level of LFD review activity has been seen in the Trust with 471 report completions from 1487 deaths (31.7 %) in the year 2023 - 2024. The following graphs shows the number of completed reviews month by month since January 2022, with a high degree of consistency apparent.



3.3 Regarding clinical practice:

3.3.1 In the currently reported year most of the outcome judgements were 'outcome 3' as follows across the Trust:

Outcome 1 x 4
Outcome 2 x 33
Outcome 3 x 382
Outcome 4 x 52.

3.3.2 One theme identified during the year was that a failure to consider and complete a DNACPR after consultation with patients and their families may have been leading to unwarranted attempts at resuscitation for some people at the end of their life. This was highlighted in the LFD newsletter and is also being addressed by the Deteriorating Patient Group, who are promoting better patient-centred practice based on realistic expectations and ceilings of care.

3.3.3 A degree of clinically inappropriate over-investigation was also seen, again suggesting a lack of patient-centred focus and a failure to agree realistic expectations for patients admitted to the hospital. This issue formed the theme of a Grand Round and will be revisited at a later date as a topic of learning for new cohorts of trainees and locally employed doctors.

3.3.4 Delays in the transfer of care from ED to the Trust's medical and surgical specialties and from one ward to another for in-patients, appeared to hinder the quality of care provided in several cases. In the most extreme case, a patient's death was linked to delayed laparotomy, potentially caused by delayed transfer of care. The effect was most commonly seen at times when the bed base of the hospital was stretched so a concerted effort to encourage the flow of medically optimised patients out of the hospital was identified as an important response. In addition, improved ED-specialty and

specialty-specialty communication is being encouraged and the earlier shift of clinical responsibility from ED to the medical and surgical specialties is being actively pursued.

3.3.5 Despite reductions in the number of patients with no clinical criteria to reside and reductions in patients with a long length of stay, poor flow through the hospital and transfer-out remains a problem and is associated with a poor quality of care, particularly for people who may not wish to spend their last days of life in hospital. This theme overlaps with other issues already highlighted in this paper. Providing care that matches the wishes of our patients is a priority and as part of this matter, the ability to transfer some patients out of hospital who are nearing the end of life is important. This is a focus for the Trust and the Stockport-Wide End of Life Groups, which have been reconfigured over the last year.

3.3.6 In another linked theme it was found that whilst regular senior review of patients across the hospital site was usually achieved, un-necessarily long lengths of stay in hospital sometimes resulted if senior review was not forthcoming, contributing to hospital-acquired morbidity and therefore a poor quality of care. In response, consultant presence on medical wards in particular has been a focus during the year with Consultant of the Week modelling providing some assistance. It has been recognised, however, that a reimagining and expansion of services for older and/or frail patients in the Trust is now required and proposals for this change are currently being formulated.

4 Areas of Risk

4.1 A focus on stroke-related mortality will be provided to the Trust Patient Safety Group in the Autumn of 2024 in response to the Trust being identified as an outlier for stroke mortality amongst acute NHS Trusts. This may be related to the Trust's status as a regional centre but the relevant data will nevertheless be analysed and assurance sought. Of note, stroke related deaths do occasionally contribute to an increase in the Trust's HSMR but a national audit of practice (SSNAP) has thus far not identified any major gaps in the care the Trust provided.

5 Recommendations

5.1 The Board of Directors is invited to note the content of this report and to take assurance.

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	**X**	**Agenda No.**	19
Meeting	Board of Directors				
Report Title	Risk Strategy and Policy 2024-26				
Director Lead	Nicola Firth Chief Nurse	**Author**	Natalie Davies Deputy Director of Quality Governance		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	Board members are asked to approve the updated Risk Management Strategy and Policy for the Trust.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust Risk Management Strategy and Policy has been reviewed to ensure it remains up to date.

The Strategy and Policy remain largely unchanged. However minor changes including update of Board structure, increased narrative regarding risk appetite and update of the appetite statements has been undertaken.

Board members are asked to receive and approve the updated Risk Management Strategy and Policy.

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Stockport
NHS Foundation Trust

RISK MANAGEMENT STRATEGY AND POLICY

2024-2026

CONTENTS

THE PROCESS - AT A GLANCE

Stockport NHS Foundation Trust recognises that the provision of healthcare and associated activities related to service provision are by their very nature inherently risky. However by understanding the risks we face and managing them appropriately and in a consistent manner we will enhance our ability to improve our services, make better decisions and achieve our principle objectives as an organisation.

Steps within the risk management process are explained as follows:

1. Step 1: Determine Priorities
   As a Trust it is important to set out clear objectives that we aim to achieve.

2. Step 2: Risk Identification
   This involves considering and identifying potential sources of risk to the Trust that may stop us from achieving our objectives Risks may relate to safety, quality, finance, reputation, transformation and innovation etc.

3. Step 3: Risk Assessment and Scoring
   A thorough assessment of risk, including a detailed review of the controls in place to mitigate the risk allows us to score the risk based on the likelihood of the risk happening and the severity/ consequences if it did. This score allows the Trust to prioritise the management of risks and respond appropriately.

4. Step 4: Risk Escalation and Approval
   Dependent upon the risk score the Trust has an approval process for all risk assessments. Risks scoring 15+ are considered significant risks and must be escalated to the Risk Management Committee.

5. Step 5: Managing and Treating Risk
   The way the risk is managed will depend upon the risk appetite of the Trust in relation to that particular risk. Treatment options include: accept the risk, reduce the likelihood of the risk occurring, reduce the consequences of the risk occurring, transfer the risk, avoid the risk.

6. Step 6: Monitoring and Review
   Risk management is a continual process whereby risks should be reassessed in line with the expectations set out within the Risk Management Strategy.

1. EXECUTIVE SUMMARY

Stockport NHS Foundation Trust (here after known as 'the Trust') recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks. This will support the Trust in achieving its principal objectives, and in doing so maintain the safety of its patients, service users, visitors and staff.

Risk management is an integral part of the Trust's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people we serve. As provider of complex services in a challenging and ever changing health landscape, it is accepted that risk is an inherent part of the day to day operational management of the Trust. Robust risk management ensures the Trust is resilient and able to deal with any unanticipated exposure to risk that could threaten our success.

Through the implementation of this Risk Management Strategy and Policy, the Trust aims to ensure that there is a systematic approach for the management of risk that enables the organisation to realise its strategic ambition, as set out in our principal objectives. Stockport NHS Foundation Trust has implemented a Board Assurance Framework which describes the risks against achievement of our principal objectives, alongside a significant risk register which documents additional serious risks to the organisation. Whilst the Trust Board carries overall responsibility for risk management, the key to success is local leadership. It is the responsibility of all staff to identify and report risks that impact on the quality, safety and effectiveness of service provision. The Trust is committed to an integrated risk management system which incorporates all aspects on risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

We recognise that risk management is the responsibility of every employee and requires commitment to collaboration from both clinical and non-clinical staff. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational working and service delivery.

CHIEF EXECUTIVE

2. SCOPE AND PURPOSE

The Risk Management Strategy and Policy describes Stockport NHS Foundation Trust's approach to managing risk both at a strategic and operational level and also serves as a guide to staff on the identification, assessment and management of the risks associated with delivering healthcare at all levels of the organisation.

All risks regardless of their nature or origin will be managed via the process set out in this document. Risk assessments will be maintained via risk registers held on the Risk Management System (Datix).

Risk management is everyone's responsibility. This policy applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised within the Roles and Responsibilities section of this document.

The key objectives of the Risk Management Strategy and Policy are to provide a structure through which the Trust will:

- Embed a positive risk management culture throughout the organisation
- Ensure that there are effective risk management systems and processes in place and that these are continually monitored
- Ensure that staff are aware of the process for the identification, assessment and management of risk at a local, divisional and Trust level along with the committee structures in place to support effective risk management and escalation throughout the organisation
- Ensure staff are aware of their duties in relation to risk management, with clearly defined roles and responsibilities for the management of risk, and clear levels of authority in relation to risk approval and escalation
- Support the population and development of the Board Assurance Framework, significant risk register, divisional and local risk registers
- Identify processes through which the Trust will review, scrutinise and monitor risks at the most appropriate level
- Ensure that staff have the required competencies and capabilities to support a proactive approach to risk management
- Support and promote on-going development as a learning organisation and in doing so maintain a safe environment for patients, employees, contractors and visitors

3. DUTIES AND RESPONSIBILITIES

This section defines the responsibilities for risk management within the Trust. Specific responsibilities reside both with individuals and with committees and groups. These responsibilities are set out below:

3.1. Responsibilities of individual officers and Board Members

The Chief Executive has overall accountability for risk management across the Trust and exercises this responsibility through membership of the Trust Board and through being the Chair of the Risk Management Committee. The Chief Executive delegates general responsibility to those listed below. It is the Chief Executive who signs off the annual governance statement on behalf of the Board.

Executive Directors are accountable to the Chief Executive for the identification, assessment and management of risks arising from areas linked to their executive responsibilities. The Board as a whole is required to provide leadership of the organisation within a framework of prudent and effective control that enables risk to be assessed and managed.

Non-Executive Directors are responsible for providing independent judgement in relation to risk management issues and satisfying themselves that the systems of risk management are robust and reliable. Via the Board level committee structure they provide an additional layer of scrutiny.

The Deputy Director of Quality Governance has responsibility for the development and implementation of the Risk Management Strategy and policy, the effective management of the risk management system (Datix) used to support the effective documentation of risk, and ensuring appropriate monitoring of compliance with the Risk Strategy and Policy. They are also responsible for ensuring risk management training is available for staff across the organisation.

The Trust Secretary has delegated responsibility to work with the Board of Directors to produce the Trust Board Assurance Framework (BAF) and to ensure that the BAF is presented to Board and where delegated the assurance committees of Board.

The Head of Quality Governance has day-to-day responsibility for supporting, training and providing advice to staff in the management of risk. They shall oversee the effective utilisation of risk management processes across the Trust. They shall analyse and distil risk exposures populated on Datix, ensuring a clear and up-to-date picture of risk is available at all times. The Head of Quality Governance will be visible and act as central reference point for risk management issues, providing advice and challenge. They shall oversee day-to-day administrative responsibility of the risk management system (Datix).

The Risk and Safety Team has responsibility for the maintenance of the risk management system (Datix) and ensuring that it supports the management of risk across the organisation. They are responsible for ensuring that all staff can access and report risks in line with the Risk Management Strategy and Policy and will provide support in development and management of risks.

Divisional Directors, including Associate Medical Directors and Deputy Nurse Directors and Head of Midwifery have responsibility for day to day management of risk within their Division, including identification, management and appropriate

escalation of risk within and beyond the Division.

Divisional Quality and Governance Managers have responsibility to support the Divisional Triumvirates in the management and oversight of risk related to the Division including appropriate escalation of risks in line with the Risk Strategy and Policy.

3.2. Responsibilities of managers and staff

All Managers have responsibility for the management of day to day risks of all types, including health and safety. They are charged with ensuring risk assessments are undertaken in their area of responsibilities when a risk is identified, and that action is carried out. They are responsible for escalating any concerns in relation to known risks in their area of work.

All Trust Staff have a duty to ensure that identified risks are reported to their immediate line manage, in order that a risk assessment can be completed where required and any necessary actions considered. Individual members of staff should:

- Work to Trust policies and procedures
- Maintain safe systems of work
- Safeguard confidentiality
- Take care of their own safety and that of their colleagues
- Report risks, incidents and near misses and take remedial action in accordance with Trust policies and procedures
- Attended training as required
- Ensure that the meet professional registration requirements, including those relating to continuing professional development

3.3. Committee structure and responsibilities

The Trust has constituted a number of committees and sub-committees that have responsibility for risk management issues. An organigram of the Board committee structure is shown at Appendix 1.

The Trust Board is accountable for ensuring a system of internal control and stewardship which supports the achievement of the organisation's objectives. The system of internal control ensures that:

- The Trust's principle objectives are agreed
- Principle risks to those objectives are identified and documented within the Board Assurance Framework, including oversight of controls in place to eliminate or reduce risks
- Keep under review the Trust's risk exposure as recorded in the Trust risk register.

The Audit Committee is a committee of the Board of Directors and provides the Board with an independent and objective review of the effectiveness of risk management and

internal controls within the Trust.

The Risk Management Committee is chaired by the Chief Executive and takes overall responsibility for the oversight of significant risks scoring 15 and above across the Trust. It also receives regular risk reports from Divisional and Corporate services. The Risk Management Committee reports to the Audit Committee.

All other Board Level Committees have responsibility for overseeing the management of risks in line with the committee's individual remit, as set out in their terms of reference. Committees should ensure that risk issues are reflected in meeting agendas, work plans and information provided to the committee.

Corporate and Divisional Assurance Groups are responsible for review of divisional and corporate risk registers and the appropriate management and escalation of risk to Directors in line with the Risk Strategy and Policy.

4. GLOSSARY OF TERMS

Term	Definition
Board Assurance Framework	A method for the effective and focused management of the principal risks that rise in meeting the Trust's principle objectives
Consequence	Outcome or impact of an event
Control	The mitigating action intended to reduce the likelihood or consequence of the risk occurring
Initial risk	Exposure arising from a specific risk before any action has been taken to manage it
Likelihood	Used as a general description of probability or frequency
Residual Risk	Risk remaining after implementation of risk treatment
Risk	The combination of the probability of an event and its consequence. Risk is considered in terms of the chances of something happening that will have an impact upon objectives.
Risk Appetite	The amount and type of risk that an organisation is prepared to seek, accept or tolerate
Risk Assessment	The overall process of risk identification, analysis and evaluation
Risk Management	The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects

Risk Score	Magnitude of a risk expressed in terms of the combination of consequences/ severity and their likelihood
Significant Risk Register	All risk assessments scoring 15+ are brought together to form the risk register

5. THE RISK MANAGEMENT PROCESS

The risk management process outlined below describes how risks will be identified, assessed, controlled and monitored.

5.1. Step 1: Determine Priorities

Risk is defined as the effect of uncertainty on the objective. It is therefore essential to be clear about objectives for the Trust and each service and to express these in specific, measurable and achievable ways with timescales for delivery. Priorities will be determined by the Board of Directors and expressed through Divisions, services and personal objectives.

5.2. Step 2: Risk Identification

Risk identification involves examining all sources of potential risk that the Trust may be exposed to from the perspective of all stakeholders throughout the organisation. When identifying potential risk there are two key approaches; the top down and bottom up approach.

Identifying strategic risk (Top down) – Strategic risk management is undertaken through Board and Committee structures and enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trust's principle objectives. In addition to this strategic risks may also be identified via upward escalation of operational risks.

Identifying operational risk (Bottom up) – Operational risk management is supported by staff working in adherence to the organisation's policies and procedures. Operational risks may present themselves via incidents, complaints, patient feedback, inspections or external reviews etc. which may impact on the organisation's ability to meet its objectives.

Types of risk to consider include:

- Risks related to safety and quality
- Risks to resources including:
  - Financial/ value for money
  - People/ staffing
- Risks to Trust reputation
- Risks to regulatory compliance
- Risks to transformation and innovation

The identification of risk is an on-going process and should never be static.

5.3. Step 3: Risk Assessment and Scoring

Once a risk is identified it must be documented within the risk management system (Datix). The risk assessment must include:

- Risk title – This must provide a summary of 'what the risk is' in a clear and concise way
- Risk cause, risk circumstance and risk consequence – Combined these provide an overview of what has caused the risk (for example - high staff sickness), what the circumstances are (for example - unavailability of specialist clinical staff), and the consequence (for example - a potential impact upon delivery of safe care).
- Details of controls in place at the time of assessment, to prevent the risk occurring
- Details of any gaps in control
- Assurance sources in place at the time of assessment
- Actions to be implemented to reduce the risk coming to fruition

Once this detail has been considered and assessed the risk should then be scored. This allows for the risk to be assigned a score which determines at which level the risk will be managed within the organisation. It also assists in prioritising risk and setting investment priorities via revenue and capital budgets and allocations.

Each risk assessment should have three risk scores:

Initial Risk Score: This is the score when the risk is first identified and assessed with existing controls in place. This score will not change for the lifetime of the risk and can be used to measure the impact of the risk controls and mitigations in place.

Residual Risk Score: This is the current risk score at the time the risk was last reviewed. It would be expected that the residual risk score will reduce as actions are completed, and additional controls are implemented. However there may be occasions where residual risk scores increase, for example if external forces on the risk are outside of the Trust's control.

Target Risk Score: This is the score that is intended after the actions to reduce the risk score are fully implemented. This should be aligned to the Trust's risk appetite relating to the type of risk being described.

Risk scores are calculated using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that risk coming to fruition together to give a score of between 1 and 25.

Severity/ Consequence Scoring: This focuses the risk assessor on how severe the consequences of the risk are likely to be. Severity is graded using a 5 point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm or loss. The risk assessor is required to be objective and realistic and to use their experience in setting these levels. The 'Matrix for Risk Managers' at Appendix 2

provides severity scoring guidance.

Likelihood Scoring: This focuses the risk assessor on how likely the risk is of coming to fruition. It is graded using a 5 point scale in which 1 represents an extremely unlikely occurrence and 5 represents a very likely occurrence. It is sensible to focus on the probability that the risk will be actualised given existing controls that are in place. The 'Matrix for Risk Managers' at Appendix 2 provides likelihood scoring guidance.

Utilising both the severity and likelihood score allows the assessor to determine the level of risk.

Severity/ Consequence x Likelihood = Risk score

	Consequence				
Likelihood	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Rare	1	2	3	4	5
Low/Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
High/Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

5.4. Step 4: Risk Escalation and Approval

An integral part of effective risk management is ensuring that risks are escalated through the organisation in line with the relevant governance committee structures. This will ensure visibility of risks throughout the organisation and appropriate management and prioritisation of resources.

Risks are escalated according to their initial risk profile score and/ or residual risk score as summarised below:

Risk Score	Level of Risk	Level of escalation, approval and management	Timescale for review
Score 1-3	Very Low Risk	Very low and low level risks are managed at local service/ ward/ department level in accordance with the identified review date or if any significant change occurs.	Very low and level risk review timescale is determined by local risk arrangements but must take place **at least once every financial year,** unless any significant change occurs.
Score 4-6	Low Risk		
Score 8-12	Moderate Risk	Moderate level risks require management attention and must be presented, and approved at the appropriate Divisional	Risks that are scored between 8 and 12 must be reviewed **at least quarterly** and presented to the

		or corporate group. The Divisional Director, Associate Medical Director and Divisional Nurse Director as a triumvirate team, or appropriate Corporate Director must have oversight of these risks.	appropriate Divisional or corporate group on a quarterly basis to ensure appropriate review and approval. The risk profiles (for risks ≥10) for all Divisions and corporate services are reviewed by the Risk Management Committee at least annually as part of a rolling programme of reviews.
Score 15-25	High Risk	High level risks require immediate escalation to the relevant Divisional Director, Associate Medical Director and Divisional Nurse Director as a triumvirate team. Any corporate risks scoring 15+ require immediate escalation to the relevant Corporate Director. All high level risks require escalation and approval at the appropriate Divisional or Corporate Group and will then be shared at the next Risk Management Committee for final approval and review.	Risks that are scored at 15 or above must be reviewed monthly and reported to appropriate Divisional or corporate groups on **a monthly basis** to ensure appropriate review and approval. All risks scoring 15+ will also be included in the significant risk register presented to Risk Management Committee (RMC). A report from RMC will be presented to the Audit Committee including all risks scoring 15+. Risks scoring 15+ will also be presented to the relevant Board Committee and Board on a quarterly basis.

In order to appropriately track approval of risks within the risk management system the process at Appendix 3 must be followed for all risk assessments completed.

Where the review of risk identifies a change in risk score for example, from the initial risk score to a different residual risk score, the risk must be managed as at the new residual risk score.

5.5. Step 5: Managing and Treating Risk

Alongside the escalation and approval of risk it is imperative that the organisation undertakes a plan to manage any risk it identifies. There are a number of different options for responding to a risk. These options are referred to as risk treatment.

Risk treatment involves identifying the range of options for controlling or treating risk, assessing these options, preparing risk action plans and implementing them. The options available for treatment are:

- **Accept the risk** – if, after controls are put in place, the remaining risk is deemed acceptable to the organisation, the risk can be retained.

- **Reduce the likelihood of the risk occurring** – by preventative maintenance, assessment, relationship management, audit and compliance programs, supervision, policies and procedures, testing, investment training of staff, technical controls and quality assurance programmes etc.

- **Reduce the consequences of the risk occurring** – through contingency planning, disaster recovery and business continuity plans, public relations, emergency procedures and staff training etc.

- **Transfer the risk** – this involves another party bearing or sharing some part of the risk by the use of contracts, insurance, outsourcing joint ventures or partnerships etc.

- **Avoid the risk** – decide not to proceed with the activity likely to generate the risk, where this is practicable

When developing an action plan in order to mitigate/ reduce risk it may be helpful to consider:

- What are the existing controls and are there any gaps?
- What further controls are practical and sustainable?
- Are the controls currently in place designed well – how can they be strengthened?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action plans should be focused on gaps in control and should have clear timescales for completion, a responsible lead for completion and must be appropriate to the level of the current risk. All actions must be documented within the risk management system (Datix).

5.6. Step 6: Monitor and Review the risk

In line with the timescale for review of the risk based upon the risk score, the risk should be monitored and reviewed on an ongoing basis to ensure adequacy of controls and any additional actions required.

6. RISK APPETITE

Risk appetite is defined as the amount and type of risk an organisation is prepared to take in order to meet its strategic objectives. This decision is made after balancing the potential opportunities and threats to a situation. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Every organisation will have a different perception of the level of risk it is willing to seek, accept or tolerate. Risk appetite levels may also vary dependent upon circumstances, for example an organisation may have a low tolerance on risks impacting upon staff and patient safety but may be more willing to tolerate a higher level of risk in relation to service developments which will ultimately bring benefits to the organisation.

6.1. Risk Appetite Statements

Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives'. Risk appetite changes over time as the environment and operating conditions change – it needs to be kept under review and take into account differing views at a strategic, tactical and operational level. Therefore, the Trust Board considers its risk appetite on an annual basis utilising the Good Governance Institute Risk Appetite for NHS Organisations - A Matrix to support better risk sensitivity in decision making. The risk appetite (as determined by the Board of Directors in July 2024) is set out below. Should this change in-year, or during the duration of this strategy, the Risk Management Strategy & Policy will be revised accordingly and communicated via the Trust's internal communications.

The Trust Board has considered its risk appetite utilising the Good Governance Institute 'Risk Appetite for NHS Organisations – A Matrix to support better risk sensitivity in decision taking'. This is shared at Appendix 4.

Expressing risk appetite can support the organisation to take decisions based upon an understanding of the risks involved. The risk appetite statements below support the expectations for risk-taking to managers and improve oversight of risk by the Board.

Risk Element	2024/25	Statement
Finance / Value for Money	Risk Level: Open Risk Appetite: High	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.
Compliance / Regulation	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.
Quality & Outcomes	Risk Level: Cautious Risk Appetite: Moderate	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Reputation	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.
People	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.
Innovation	Risk Level: Seek Risk Appetite: Significant	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.

6.2. Expressing Risk Appetite

The Trust will express risk appetite as set out below:

- **Agreement of an escalation boundary on the risk matrix (likelihood and consequence)**
  All risks that score 15 or above on the risk matrix will be entered onto the Trust significant risk register and will be presented to the Risk Management Committee on a monthly basis. A risk score of 15 or above should therefore be treated as a trigger for a discussion and some challenge as to whether the Trust is willing to accept this level of risk.
- **Risk Appetite Rating**
- All risks will have a risk appetite rating documented within the risk management system (Datix). This will be derived from the risk appetite matrix at Appendix 4 and in light of the risk appetite statements included in the Risk Management Strategy and Policy.

7. Training

The training and development of staff is integral to the Trust's approach to risk management.

- Monthly risk management training will be available to all members of staff involved in risk assessment and management. This will be coordinated by the Deputy Director of Quality Governance in conjunction with Learning and Development.
- All Board members will be invited to be part of a risk based Board development session. This will be coordinated by the Trust Company Secretary and supported by the Deputy Director of Quality Governance.
- Ad-hoc support for risk management will be available upon request through the Divisional Governance and Quality Manager or The Risk and Safety Team.

8. Monitoring Compliance

The following mechanisms will be used to monitor compliance with the requirements of this document:

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
1,2,3,4,5,7, 8,9 ,16,17,18,1 9	Evidence of review of significant risk exposure by the Risk Management Committee at each formal meeting of the committee.	Deputy Director of Quality Governance	Monthly	Risk Management Committee	Deputy Director of Quality Governance/ Chief Nurse	Board of Directors
	Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee	Audit Committee	As requested	Audit Committee	Audit Committee	Board of Directors

9. References/ Associated Documentation

- Good Governance Institute (May 2020) Board guidance on risk appetite

10. IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

Office Use Only

Submission Date:	July 2024
Approved By:	N/A
Full EIA needed:	No

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

1	**Name of the Policy/SOP/Service**	**TRUST RISK MANAGEMENT STRATEGY & POLICY 2022-2025**	
2	**Department/Business Group**	Quality Governance	
3	**Details of the Person responsible for the EIA**	**Name:**	Natalie Davies
		Job Title:	Deputy Director of Quality Governance
		Contact Details:	Natalie.davies@stockport.nhs.uk
4	**What are the main aims and objectives of the Policy/SOP/Service?**	To outline the strategy and process of effective risk management across the Trust	

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

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a differential 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 Impact	See general comments	

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	Trust Workforce: Largest age band: 46-55 (average 44.5 years)		
Carers	Positive Impact Trust Workforce: No Data	See general comments	
Disability	Positive Impact Trust Workforce: 3.32% report disability. 11.94% not declared	See general comments	
Race / Ethnicity	Positive Impact Trust Workforce: BAME make up 16.18%	See general comments	
Gender	Positive Impact Trust Workforce: 79.9% female	See general comments	
Gender Reassignment	Positive Impact Trust Workforce: No Data	See general comments	
Marriage & Civil Partnership	Positive Impact Trust Workforce: 54.9% married & 0.7% Civil Partnership	See general comments	
Pregnancy & Maternity	Positive Impact Trust Workforce: 2.14% on maternity or adoption leave*	See general comments	
Religion & Belief	Positive Impact Trust Workforce: 52.47% Christian	See general comments	
Sexual Orientation	Positive Impact Trust Workforce: 2.12% LGBT 20.09% did not want to declare	See general comments	
General Comments across all equality strands	This Policy is likely to have a positive impact on all protected groups. The policy describes the process to be followed when identifying, assessing and managing risks, confirms the responsibilities of staff and provides user guides to aid them in effective risk management and reporting, taking into consideration protected characteristics and ensuring mitigations/adjustments are put in place. All information will be provided in accessible formats to meet an individual needs/requirements	See general comments	

Action Plan
What actions have been identified to ensure equal access and fairness for all?

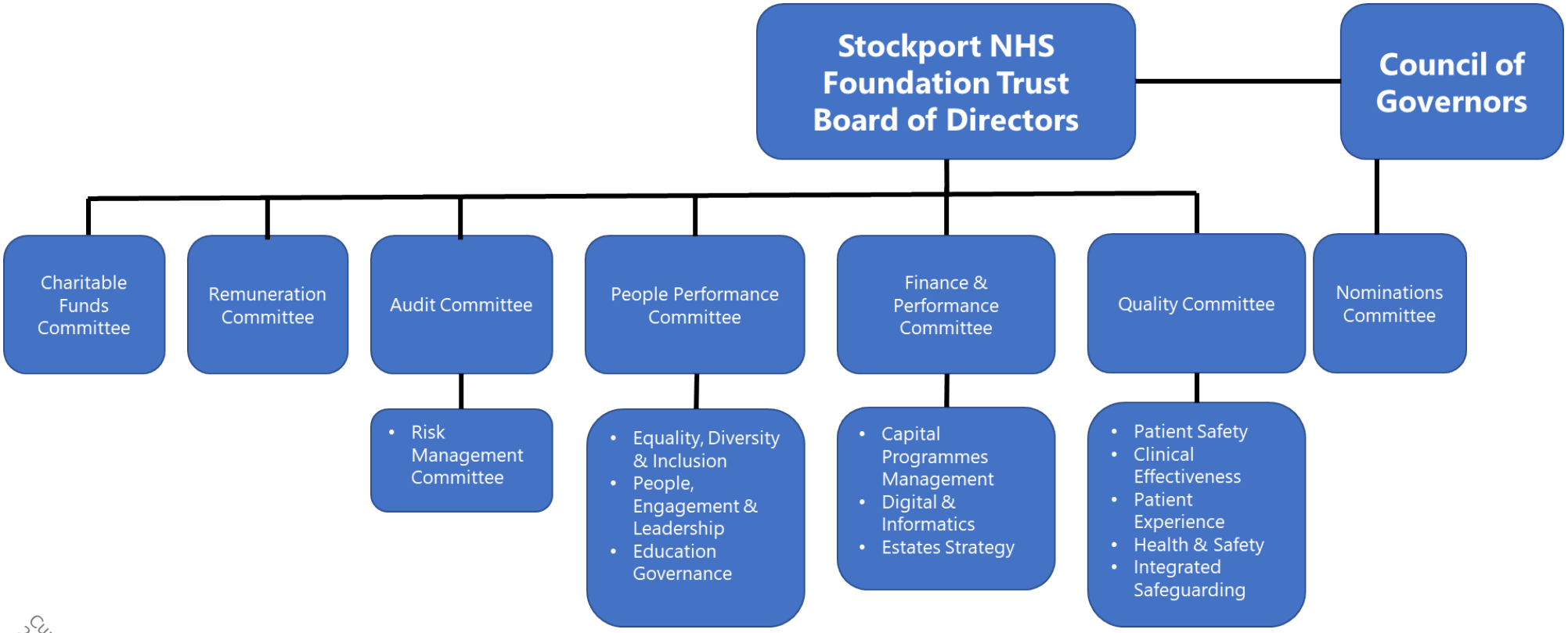
Action	Lead	Timescales	Review &Comments

11. DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy/ Policy
Title	Risk Management Strategy and Policy 2024-2026
Version Number	V4
Consultation	Risk Management Committee
Recommended By:	Risk Management Committee
Approved By:	Trust Board
Approval Date	tbc
Next Review Date	tbc
Document Author	Natalie Davies, Deputy Director of Quality Governance
Document Director	Chief Executive
For use by:	All Staff
Specialty / Ward / Department	All
	Unrestricted

Version	Date of Change	Date of Release	Changed by	Reason for Change
3	**6 July 2022**		**Deputy Director of Quality Governance**	**Rewrite of the previous Risk Management Policy (v2) to become the Risk Management Strategy and Policy including further detail regarding steps of risk management, changes to appendices and inclusion of risk appetite section. EIA also updated and signed off 18 July 2022.**
4	**July 2024**		**Deputy Director of Quality Governance**	**Minor changes to roles and responsibilities. Rewrite of risk appetite section to include new table of appetite statements and additional definition and describe of risk appetite. Update of appendix 1 – Board committee structure**

Appendix 1: Board Committee Structure



Appendix 2: Guidance to severity and likelihood scoring

This grading guidance is taken from the National Patient Safety Agency document 'A Matrix for Risk Managers' (2008).

Severity Score

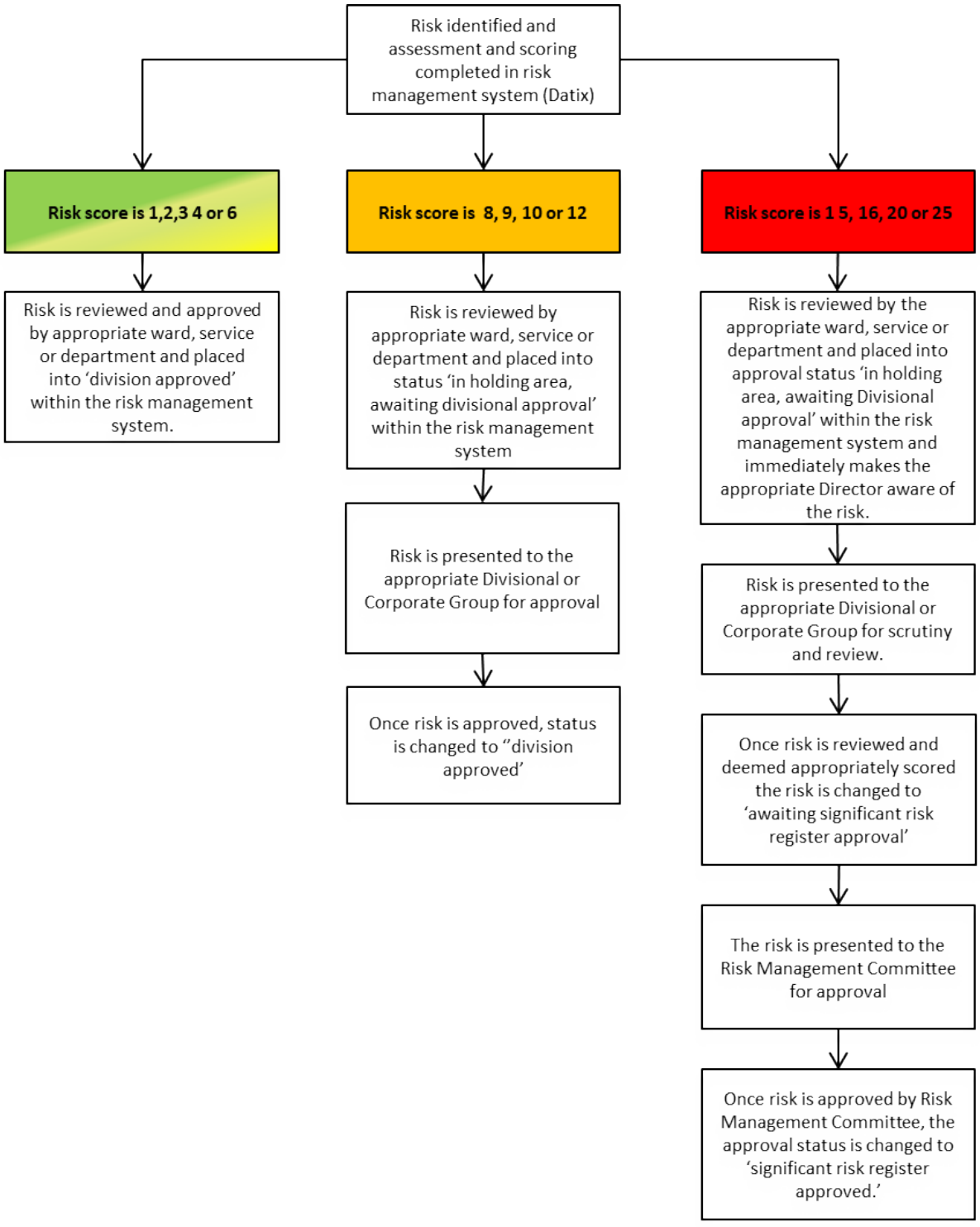
	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsm an inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interrupt i on of >1 hour Minimal or no impact on the	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruptio n of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Score

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Appendix 3: Risk Approval Process



Appendix 4: Risk Appetite Matrix

Risk Level ➡ Key Elements ⬇	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal (ALARP)** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

(Adapted from Good Governance Institute Risk Appetite for NHS Organisations – A Matrix to support better risk sensitivity in decision taking')

NHS
Stockport
NHS Foundation Trust

Meeting date	1 August 2024	**Public**	X	**Agenda No.**	20
Meeting	Board of Directors				
Report Title	Board Assurance Framework 2024/25				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	**The Board of Directors is asked to:** - **Review and approve the Board Assurance Framework 2024/25** - **Review the Trust's current significant risk profile confirming alignment between operational and principal risks.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

All

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	See Risk 4.2
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	All

Sustainability (including environmental impacts)	N/A

Executive Summary

The Trust maintains a Board Assurance Framework as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board. The Corporate Objectives 2024/25 were approved by the Board of Directors in April 2024, with Outcome Measures approved in June 2024, enabling development of the Board Assurance Framework (BAF).

To inform its development, a workshop took place to review the Board's risk appetite entering 2024/25, recognising that risk appetite changes over time as circumstances change.

Principal risks for the opening BAF 2024/25 (Appendix 1) were primarily developed via the relevant board assurance committees based on review of; principal risks 2023/24 year-end position, confirmed risk appetite, key controls and assurances, including any gaps, and required actions.

Principal risks to achievement of the corporate objectives 2024/25 are prioritised in the table below. Those risks considered significant (15+) relate to financial performance and financial sustainability and operational performance. In addition, our highest scoring risks, relate to a fit for purpose estate and quality of care, both of which have both increased in score since the previous quarter. The increased frequency and severity of estates issues over recent months is impacting our operational service delivery, patient and staff experience, alongside financial performance, with an increasing requirement to undertake contingency works and associated increased revenue expenditure. In relation to the quality of care risk, although patient safety has been maintained throughout the recent estates incidents, the frequency by which such incidents are occurring, and the potential likelihood of harm occurring, has been recognised, thus the score increased. Furthermore, and more broadly, the Trust remains alert to the cumulative impact and likelihood of risk to quality of care due to current financial pressures, where mitigating action has been delayed due to financial pressures and external funding approval requirements. With respect to mitigating action, the importance of pursuing a transformation/service improvement approach is recognised (where appropriate) prompting new ways of working that support the delivery of high quality and efficient care.

No.	Principal Risk	Q4 23/24	Q1 24/25	Target Score
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	20	25	8
PR7.4	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus	20	20	8
PR1.1	There is a risk that the Trust does not deliver high quality care to service users.	12	20	8
PR1.2	There is a risk that patient flow across the locality is not effective	16	16	8
PR1.3	There is a risk that the Trust does not have capacity to deliver elective restoration.	16	16	8
PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values	16	16	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	16	16	8
PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan	16	16	8

PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing.	12	12	8
PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities.	NEW	12	8
PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised.	NEW	12	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability.	12	12	8
PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes.	9	9	6
PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport.	9	9	6
PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	9	9	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes.	9	9	6
PR7.1	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy.	9	12	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes.	6	6	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in July 2024), are provided at Appendix 2 to ensure triangulation between operational and principal risks. The significant risks relate to the following areas:

Risk Subtype	**No of Risks**	**Risks Identified**
Capacity and demand of services	3	- Delays in patients being transferred from ambulances to Emergency Department (16) - Capacity not meeting demand in Emergency Department (16) - Failure to achieve turnaround time targets in cell' path' will impact care for cancer patients (16)
Compliance	1	- Risk of harm to paediatric patients if the audiology service does not comply with best practice recommendations (15)
Quality	2	- Risk of adverse outcomes with IBD patients due to delays in commencing treatment due to limited capacity on MDCU (16) - Risk of there being an inability to provide a robust service for the insertion of VADs (15)
People/Staffing	2	- Employee Relations & Industrial Action (16) - Risk of the upper GI service not being able to deliver services due to a lack of nursing support (15)
Financial	3	- Risk of service disruption and loss of asset – The Meadows (15)

		- Risk of insufficient cash reserves (25) - Financial risk to the Division of Women's & Children's of providing required care and support to vulnerable asylum seeking families (15)
Environment	4	- Pathology estate not fit for purpose (15) - Electrical capacity could prevent future electrical schemes and electrical purchases (15) - Constraints in capital and revenue funding resulting in an inability to maintain a safe, fully functioning hospital site (20) - Dangerous & obstructive car parking occurring across the SHH Site (15)
Digital	1	- Risk of total failure of the cooling in the Beech House Data Centre (16)

1. Introduction

1.1 The Trust maintains a Board Assurance Framework as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board.

1.2 The Corporate Objectives 2024/25 and Outcomes Measures were approved by the Board of Directors in April 2024 and June 2024 respectively, enabling development of the Board Assurance Framework (BAF).

2. Risk Appetite

2.1 To inform development of the BAF, a workshop took place in May 2024 to review the Board's risk appetite entering 2024/25, recognising that risk appetite changes over time as the environment and operating conditions change.

2.2 Key areas of discussion at the workshop are summarised as:

- Risk Element: Finance – Board members acknowledged the external environment, with enhanced financial governance and scrutiny, suggesting retention of a 'cautious' approach. However, considering the Trust's financial deficit and necessity to explore all potential delivery options to move to a position of greater financial sustainability, an 'open' approach will be required. It was recognised that adoption of an 'open' approach would be balanced via the risk appetite for Quality & Outcomes and Compliance/Regulation risk elements.

- Risk Element: Reputation – In line with the above, Board members recognised that, in exploring all potential delivery options, it would be necessary to manage the challenges and risks that come with transformational change, therefore aligning with an 'open' risk appetite.

- Risk Element: Compliance/Regulation – Board members acknowledged the range of regulatory bodies, with potential for risk appetite to differ based on specific regulator.

- Risk Element: People – Board members discussed potential shift from an 'open' to 'seek' risk appetite, acknowledging the pilot of digital technologies within the People Directorate, which may be considered disruptive. Current consensus was to continue with an 'open' risk appetite, acknowledging likely shift as greater cross-organisational solutions and innovative use of technology was explored.

- More generally, Board members acknowledged the Risk Appetite Framework provided a framework to consider both optimal and tolerable positions in relation to risk in pursuit of strategic objectives. It was also acknowledged that decisions about specific investments, projects, and strategic initiatives would have interdependencies and considerations across the various elements of risk within the framework.

2.3 The current risk appetite for each risk element for 2024/25, was confirmed as:

Risk Element	2024/25	Statement
Finance / Value for Money	Risk Level: Open Risk Appetite: High	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.

Compliance / Regulation	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.
Quality & Outcomes	Risk Level: Cautious Risk Appetite: Moderate	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Reputation	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.
People	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.
Innovation	Risk Level: Seek Risk Appetite: Significant	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.

3. Principal Risks 2024/25

3.1 Principal risks for the opening BAF 2024/25 (Appendix 1) were developed, in the main, via the relevant board assurance committees based on review of; principal risks 2023/24 year-end position, confirmed risk appetite, key controls and assurances, including any gaps, and required actions.

3.1 Principal Risks closed at the end of 2023/24, as no longer considered principal risks to the achievement of the Corporate Objectives & Outcome Measures 2024/25 are:

- Principal Risk - There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust (ECT).

(Collaboration taking place with ECT is incorporated within a new Principal Risk regarding system working)

3.2 The following Principal Risks from 2023/24 have been reassigned to Board of Directors due to the cross-cutting nature of the risk and oversight of these matters primarily via the Board of Directors:

- Principal Risk 2.2 – There is a risk the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes.
- Principal Risk 3.1 – There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport.
- Principal Risk 5.1 – There is a risk in delivery of high quality service improvement programmes.

3.3 Two new Principal Risks have been identified for 2024/25 for oversight by the Board of Directors:

- Principal Risk 3.2 – There is a risk that collaborative opportunities that exist within Greater Manchester Integrated Care System to address unwarranted service variation and health inequalities are not delivered.
- Principal Risk 3.3 – There is a risk that collaborative opportunities between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not delivered.

3.4 All remaining Principal Risks from 2023/24 have been incorporated within the BAF 2024/25 and have been reviewed and revised as set out in the Board Assurance Framework 2024/25 (Appendix 1).

4. Significant Risks – Corporate Risk Register

4.1 The Significant Risk Register is reviewed at each meeting of the Risk Management Committee, which reports to the Audit Committee, as part of its responsibility to review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, and the effectiveness of the structures, processes and responsibilities for identifying and managing key risks facing the Trust.

4.2 In addition, risks from the Trust's Significant Risk Register are considered via the relevant board assurance committee, ensuring triangulation between operational and principal risks. The Trust's Significant Risk Register (end June 2024) is included at Appendix 2.

5. Board Committee – Key Discussion Areas

5.1 Comprehensive discussion took place via Quality Committee (June and July 2024) regarding the risk score for PR1.1 (Quality of Care) considering:

- the gaps in control in relation to the ageing estate and the increasing frequency of estates incidents impacting on the patient experience, with the potential to cause harm.
- service specific quality related risks on the Significant Risk Register, where mitigating action had been delayed due to financial pressures and external funding approval requirements.

5.2 Quality Committee confirmed that, in the main, an adverse trend/impact on patient safety was not evident through the suite of assurance based reports considered via Quality Committee at this time, and that patient safety had been maintained during the recent estates related incidents. However, the increased frequency and severity of estates issues has adversely impacted patient experience, and there is, over recent months is impacting the likelihood of harm occurring, and in recognition that the Trust is likely to experience more estates issues as the result of our ageing buildings, the potential likelihood of harm increases. Furthermore, and more broadly, the Trust remains alert to the cumulative impact and likelihood of risk to quality of care due to current financial pressures, where mitigating action has been delayed due to financial pressures and external funding approval requirements. Quality Committee reflected that judgement was required with respect to the cumulative impact and likelihood of risk to quality of care because of the gaps in control relating to the estate and financial pressures. With respect to mitigating action, Quality Committee also recognised the importance of exploring a transformation/service improvement approach, where this may be appropriate, prompting new ways of working that support the delivery of high quality and efficient care.

5.3 Aligned to the above discussions, the current finance risks on the BAF 2024/25 are both scored as 16, related to the delivery of the annual financial plan and the development of a multi-year financial

sustainability plan, acknowledging that the Trust has an underlying financial deficit and growth in demand is not recognised.

Stockport NHS Foundation Trust

Board Assurance Framework

2024/25

Corporate Objectives 2024/25

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

1. Key to Board Assurance Framework

CONSEQUENCE MARKERS		LIKELIHOOD MARKERS		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

Risk Matrix					
Impact	Likelihood				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	Risk target achieved
Gap score 1 - 5	Tolerable
Gap score 6 - 9	Close monitoring
Gap score 10	Concern
Gap score > 10	Serious

2. Risk Appetite Framework

Risk Level ➡ Key Elements ⬇	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

3. Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**5.2**	**3.1, 4.2, 5.1**	**7.3**	
4 - Major			**2.1, 3.2, 3.3, 7.1**	**1.2, 1.3, 4.1, 6.1, 6.2**	**7.4**
5 - Catastrophic				**1.1**	**7.2**

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**5.2**
Gap score 1 - 5	Tolerable	**1.1, 2.1, 2.2, 3.1, 3.2, 3.3, 4.2, 5.1, 7.1**
Gap score 6 - 9	Close monitoring	**1.2, 1.3, 4.1, 6.1, 6.2, 7.3**
Gap score 10	Concern	
Gap score > 10	Serious	**1.1, 7.2, 7.4**

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1				**Risk Appetite: Moderate**														
There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards.	Quality Committee	Quality Committee Subgroups established to direct policies and procedures relating to: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established. SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place for ED (2022) and Maternity (2024) Board approved Patient Safety Incident Response Plan, Aug 2023 PSIRF Policy (March 2023) Implementation commenced from April 2024 Established process for managing and learning from: - Incidents including Serious Incidents and patient flow associated harms. - Duty of Candour - Complaints - Legal Claims Mechanisms in place to gather patient experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and locally prioritised audit based on risk assessment. - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths Review process - Medical Examiner Team - Freedom to Speak Up process established. New governance system for end of life care established, including internal group	Impact of employee relations & industrial action issues Impact of continuing operational pressures Poor quality of estate including closure of Outpatients B and additional estate failures. Ineffective system for control of clinic outcome i.e., patient discharge v's clinical follow up required.	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) **Level 2 – Corporate** Quality Committee: - Quality IPR - Key Issues Reports: o Patient Safety (Serious Incidents & Duty of Candour including review of harms from each industrial action) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - CQC Inspection – Maternity Services – High Level Feedback (Report Pending) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all improvement/action plans including: CNST, Saving Babies Lives, Continuity of Carer, Ockenden Report, Maternity Safety Support Programme (MSSP) - LMNS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly) Board of Directors: - IPR - Safe Care Report including nurse establishments/E-roster (Quarterly) and Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** GM Clinical Quality & Effectiveness Group provide high level surveillance for harm. Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey	Indirect or subtle harm from operational pressures or poor quality of estate may be difficult to identify.	Patient Follow Up - Task and Finish Group to oversee determined action: Divisional focus on review of highest risk cohort. Risk stratification of patient list through AI validation. Plan for development of refreshed Quality Strategy	Q3 2024/25 September 2024	5	4	20	12	20				4	2	8

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		reporting to Stockport End of Life Care forum. External Visits & Accreditations Register Learning from Industrial Action Reviews established. StARS – Ward and Community Assurance & accreditation process established. Also established for: Paediatrics, Maternity, Theatres, Community. Safe Staffing - Defined Nurse Establishments - Defined Medical Establishments - Medical Job Planning process in place - Medical Appraisal & Revalidation process in place including quality assessment Maternity Improvement/Sustainability Plan in place and Maternity Strategy. Executive & Non-Executive Maternity Safety Champions in place, visits & meetings schedule. Trust & GM Command & Control Process established - Before, During and After Strike Action. Established Quality Impact Assessment in place for CIP – Sign off by Medical Director, Chief Nurse and Director of People & OD, Director of Operations QIA process part of all Business Cases – All Business Cases reviewed by Exec Team		- Emergency Department Survey MIAA Internal Audits 2022-23: • Risk Management (Substantial) • Clinical Audit (Substantial) • StARS (Substantial) • Quality Spot Checks (Substantial) GMC Medical Trainees Survey												
Principal Risk Number: PR1.2						**Risk Appetite: Moderate**												
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent & emergency care Curtis.Soile 26/07/2024 13:59:56	Finance & Performance Committee	Established models of emergency and urgent care in place in line with national standards. Rapid Ambulance Handover process in place. 'Programme of Flow' established. Reporting via Service Improvement Group Virtual Ward established. Weekly ED Performance Meeting Chaired by Director of Operations Weekly – Locality Patient Flow meeting established. System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient flow management plans). Locality Action Plan in place following recommendations from ECIST.	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside (NCTR). High levels of delayed discharges. Significant increase in unfunded non-elective demand due to levels of patients with NCTR. Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients. Locality Plan relating to intermediate care	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits - Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review				4	4	16	16	16				4	2	8

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Bed Modelling – 18 Month Plan Workforce models in place – Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission - Delayed discharge Patient Flow Associated Harms – Review via Quality Committee. Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.	capacity not agreed with Trust – Reduction in capacity for Pathway 1 and Pathway 2.	Urgent & Emergency Care GIRFT – Chaired by Medical Director Integrated Performance Report – Board (Bimonthly)														
				Level 3 – Independent Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care		Facilitate Tier 1 Deep Dive visit from ECIST & GIRFT *(Implement recommendations from visit)*	Q2 2024/25											
Principal Risk Number: PR1.3								**Risk Appetite: Moderate**										
There is a risk that the Trust does not have capacity to deliver elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards for elective care.	Finance & Performance Committee	Biweekly Trust Performance Meeting. Escalation process in place with Performance Team – 65+ week wait patients and any P2/cancer patients that are not dated. Cancer Quality Improvement Board established chaired by Lead Cancer Clinician GIRFT Programmes in place for all Surgical & Medical Specialties. Booking & Scheduling centralisation Board approved Expanding Elective Care Business Case – In year scheme 2024/25.	Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Delivery of national access standards predicated on availability of GM mutual aid Significant increase in referrals for elective care, including from out of area. Cumulative impact of industrial action (Consultants & Juniors) having significant adverse impact on unbooked and cancelled appointments. Loss of Outpatients B Department	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation Activity Management Group – Data review of elective activity				4	4	16	16	16				4	2	8
				Level 2 – Corporate Divisional Performance Review (Quarterly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 65+ week waits - Overall RTT waiting list size - Cancer 2ww - Cancer 62 day - Diagnostic waits Quality Committee - Patient Safety Report including review of harms (4 x year) Integrated Performance Report (Operational Performance) – Board (Bimonthly)		Monitor impact of Expanding Elective Care Business Case (Quarterly)	From Q2 2024/25										
				Level 3 – Independent SFT Tier 1 Elective Restoration Monitoring NHSE – Activity Returns														

4. Board Assurance Framework 2024/25

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
				GM & National productivity ranking.														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.1				**Risk Appetite: High**														
There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high quality care.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession Planning Approved Organisational Development Plan 2023-2025 Approved Health and Wellbeing Plan 2024. Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Vaccination programmes for both Influenza, Covid and MMR established. Comprehensive staff wellbeing programme established including staff psychology and wellbeing service and staff menopause service. Collaborative Occupational Health Service with T&G – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Big Conversation programme established. Process to improve response rate of 'reason for leaving' in place. Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans 2022 in place. Confirmed approach to flexible working. Industrial Action Planning Group in place Regular deep dive review of temporary staffing and sickness absence led by Deputy Director of People & OD established.	Embedded approach to Wellbeing Conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational & external/internal financial pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports - Health & Wellbeing Plan 2024 – Workstream Reports Equality Diversity & Inclusion Steering Group - EDI Strategy Industrial Action Planning Group **Level 2 – Corporate** Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly) **Level 3 - Independent** CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey MIAA Staff Wellbeing Review, February 2024 – Substantial Assurance.		National Flexible Working Policy approved to be discussed at PDG and JCNC. Roll out of G2 eOPAS IT system for integrated OH service with T&G. Staff Survey 2024 roll out with Comms Plan	August 2024 July 2024 Sept 2024	4	3	12	12	12				4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.2				**Risk Appetite: Moderate**														
There is a risk that the Trust does not actively participate in and progress local collaborative programmes and neighbourhood working leading to suboptimal improvement in primary and secondary health and well-being outcomes.	Board of Directors	Operational & Winter Planning processes established with system arrangements. Capacity & demand modelling for community services Established joint community Health & Well Being programmes e.g. Waiting Well, Active Hospitals, Stop Smoking CURE project. Integrated service models established including: Adults: District Nursing Teams – Work across 7 PCNs with GPs, Social Care, VCSE Children's: Stockport Family – Health, Social Care & Education Adult's: Neighbourhood Leadership Group established with multi partner representation. Children's: Joint oversight groups established with multi partner representation (SEND, Public Health, Safeguarding, Mental Health) Trust represented on the ONE Stockport Health & Care Board (Locality Board) for Stockport via the CEO, Chief Finance Officer and Director of Strategy & Partnerships. Locality Provider Partnership (led by SFT) operational with defined workstreams and focus on population health. ONE Stockport Health and Care Plan & Delivery Plan/Outcomes developed with focus on reducing inequalities and improving population health outcomes. ICS employed Locality Deputy Place Lead in post.	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources. Alignment of Community Services to PCNs – Potential change to PCN geographical footprints	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report Adult's: Neighbourhood Leadership Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board	Community Services Dashboard	Align Trust community services & workforce to PCNs	Ongoing	3	3	9	9	9				3	2	6
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Locality Provider Partnership (Monthly) Locality Board (Monthly)		Board of Directors – Place Collaboration Report	October 2024											
				Level 3 – Independent Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
Principal Risk Number: PR3.1				**Risk Appetite: Significant**														
There is a risk the Trust does not contribute to effective place-based partnership arrangements that support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board, leading to a delay in the delivery of models of care, which support improvements in health inequalities in the local population.	Board of Directors	Locality ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care Board (Locality Board) operational. Membership includes CEO, Chief Finance Officer and Director of Strategy & Partnerships ONE Stockport One Future Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership chaired by SFT CEO Provider Partnership identified four key workstreams based on population health metrics. Operational Planning Guidance and Priorities for 2024/25 in Trust Operational Plan	Controls not yet established in full for the management of the ONE Stockport Health & Care Plan Provider Partnership workstreams are at different stages of development Public Health Registrar (0.4WTE) (to commence in post 1st Aug 24)	**Level 1 – Management** Four workstreams meetings and workshops Locality Executive Meeting (Monthly) **Level 2 – Corporate** Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports (6 monthly) and as required and CEO Report including key strategic developments - ICS - Stockport ONE Health & Care Plan Joint system meetings on ONE Stockport One Future plan Locality Provider Partnership (Monthly) Locality Board (Monthly) ICS Executive Meeting (Monthly) **Level 3 – Independent** Health & Wellbeing Board	Priorities and metrics for each of the four workstreams Robust neighbourhood data to enable Provider Partnership to measure improvement in population health outcomes Completion of NHS providers Health Inequalities Self-Assessment Tool	Develop a plan for each workstream with identified improvement metrics Neighbourhood profiles to be produced by Local Authority / GM BI Board of Directors – Place Collaboration Report & Health Inequalities Self-Assessment Report	Q3 2024/25 Q2 2024/25 October 2024	3	3	9	9	9				3	2	6
Principal Risk Number: PR3.2				**Risk Appetite: Significant**														
There is a risk that the Trust does not contribute to, and as part of the Greater Manchester Integrated Care System (GM ICS) collectively deliver on the collaborative working opportunities that exist within GM leading to limited-service resilience, unwarranted variation of services and inequality in health outcomes for the populations served.	Board of Directors	GM Trust Provider Collaborative GM (TPC) established. Chaired by SFT CEO Relevant SFT Directors part of GM TPC System Boards (Cancer, Elective, Urgent & Emergency Care, Diagnostics, Mental Health and Sustainable Services) GM TPC Director Groups established (Chief Data Officers, Chief Information Officers, Chief Nurses, Chief Operating Officers, Executive Medical Directors, HR Directors, Directors of Finance, Directors of Strategy) East Cheshire Programme Board and weekly operational meetings	No capital or revenue funding identified from commissioners/ICB GM Single Improvement Plan and Sustainability Plans to be developed	**Level 1 – Management** Weekly East Cheshire operational meetings **Level 2 – Corporate** Monthly TPC and Director Group meetings Workplans for each Director Group in place **Level 3 – Independent** Oversight and engagement with the ICB and NHSE		Refreshed ECT Case for Change based on Joint Clinical Strategy GM Acute Provider Collaboration – Board Report GM Single Improvement Plan to be presented to Provider Boards	Q3 2024/25 Q3 2024/25 TBC	4	3	12	New Risk	12				4	2	8
Principal Risk Number: PR3.3				**Risk Appetite: Significant**														
There is a risk that the Trust does not deliver on the collaborative working opportunities that exist with Tameside and Glossop Integrated Care Trust (TGICT) leading to suboptimal pathways of care for the populations served and/or limited-service	Board of Directors	Clinical Service Partnership Group in place between both Trusts. Corporate services collaborative working in place. Joint Executive Director and Senior Manager roles in place.	Failure to gain key support from staff and agreement on the resulting service by service Case for Change. Currently no funding for the programme of work for 2024/25 financial year and use of existing capacity	**Level 1 – Management** Clinical Service Partnerships group **Level 2 – Corporate** Executive Team - Oversight of Key Issues Board of Directors Report **Level 3 – Independent** Awareness and engagement of the ICB and NHSE		Case for change for clinical services SFT & T&G Collaboration – Board Report	Ongoing Q2 2024/25	4	3	12	New Risk	12				4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
resilience across the footprint of both Trusts			No current revenue or capital or recurrent funding identified to support future service changes in 2024/25.															

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
Principal Risk Number: PR4.1				**Risk Appetite: High**														
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	National Long Term Workforce Plan Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment. E-Rostering Workforce Group established. Medical Workforce Group established. Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Weekly Staffing Approval Group (SAG) Workforce Efficiency Group established. Bank & Agency Usage Deep Dive Undertaken. Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available with enhancements of leadership and development offer continuing as identified within OD Plan. Local/ Regional/National Education partnerships Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programmes. Workforce Strategy & Divisional Workforce Plans Refreshed Appraisal Process in place	National workforce shortages particularly for some medical posts exist (e.g. Radiologists, Acute/Stroke Physicians) work continues to attract to these roles/consider alternatives Embedded system for identifying and managing talent not yet available Restrictions on staff capacity to attend and participate in mandatory/statutory training. Bank and agency staff costs above target. Escalation areas remaining open – staffing additional areas required.	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Equality, Diversity & Inclusion Steering Group - Staff Networks **Level 2 – Corporate** People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly) **Level 3 - Independent** NHS National Staff Survey GMC Survey Health Education Visits Model Hospital and comparative benchmarking data Confirm and Challenge by NHSEI NW Regional Team		Refresh of Trust Values	June – Sept 2024	4	4	16	16	16				4	2	8
Principal Risk Number: PR4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning	Career Development Programmes for staff with protected characteristics	Level 1 - Management WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan				3	3	9	9	9				3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.		Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+ and Neurodiversity) Completed review of staff networks and relaunched under agreed improvement arrangements. Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics. Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme Civility Saves Lives Programme - Phase 1 Launched.	Development of Staff Network Chairs and the Staff Networks	Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan EDI metrics for applicants included in People Analytics dashboard															
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually) - WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report	EDI metrics to be built into People Analytics Dashboard.	Inclusion of the wider EDI metrics in People Analytics dashboard to be scoped. Peer Review of Disciplinary Cases with TGH.	July 2024 July 2024											
				Level 3 - Independent NHS National Staff Survey		Communication Plan to be developed for roll out of 2024 Staff Survey	August 2024											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
Principal Risk Number: PR5.1					**Risk Appetite: Significant**													
There is a risk that the Trust does not implement high quality service improvement programmes, as identified through Trust and locality prioritisation, which may lead to suboptimal improvements in quality of care for patients and staff.	Board of Directors	Director of Transformation working across SFT and Tameside & Glossop (utilising experience and knowledge of system-wide transformation programmes across other localities) Trust transformation programmes identified through a formal process of prioritisation linked to corporate objectives (Aims, KPIs, Milestones) Standardised governance & assurance in place for Trust transformation programmes - Service Improvement Group (SIG) chaired by the Chief Executive. External resource in place to support Trust identified improvement programmes. Senior Responsible Officer, Clinical & Operational Lead in place for each Trust transformation programme Transformation Team supporting Stockport Provider Partnership (SPP). SPP identified key priority workstreams (Diabetes, Frailty, Cardiovascular & Alcohol Related Harm) for pathway redesign. Continuous Improvement Strategy developed to build capability across the organisation.	Capacity of operational teams to implement change due to operational pressures.	**Level 1 – Management** Transformation - Programme Boards Provider Partnership Key Priority Areas – Programme Boards **Level 2 – Corporate** Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Stockport Provider Partnership (Monthly) - Priority Workstreams Review Board Report: Transformation Programme (Biannually) **Level 3 - Independent**	Stockport Provider Partnership priority workstreams at various stages of implementation.			3	3	9	9	9				3	2	6
Principal Risk Number: PR5.2					**Risk Appetite: Significant**													
There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements.	Quality Committee	SFT Research Team established. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy) Annual research programme in place. Review of the RD&I team structures across SFT, and T&G and joint governance structures commenced. Input of RD&I to development of Cancer Strategy	SFT does not have control of RD&I governance at T&G. GM Clinical Research Network (CRN) merging to form a North West CRN in 2024/25 with potential destabilising impact.	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report **Level 2 – Corporate** Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2022-23 **Level 3 - Independent** DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)		Review RD&I financial provision by Finance Teams, ensuring financial assurance reporting is standardised across Trusts	Q1 2024/25	3	2	6	6	6				3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: PR6.1				**Risk Appetite: High**														
There is a risk that the Trust does not deliver the 2024/25 financial plan leading to increased regulatory intervention	Finance & Performance Committee	Annual financial plan 2024/25 submitted – Confirmed deficit as part of GM control total Indicative SFT Capital Plan 2024/25 submitted. Annual cash plan 2024/25 in place – Subject to confirmation of cash support. Opening Budgets 2024/25 in place based on submitted financial plan. Established STEP Programme (CIP) and oversight of delivery including STEP deep dive per Division Workforce Efficiency Group – Oversight of temporary staffing spend. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency Divisional Performance Review process - including financial escalation actions based on control totals for divisions. SFT Finance Improvement Group established, chaired by Chief Executive Delivery of budget holder training and enhancements to financial reporting SFI's & Scheme of Delegation in place including authorisation limits – Revised & Board approved GM Provider Oversight Meetings established, chaired by GM ICB CEO. Board of Directors approval of all cash support applications. Stockport System Finance Recovery Group established (Monthly)	Lack of certainty regarding cash provision. Lack of clarity on mechanism for accessing cash support within GM Finalise annual financial plan in line with revised control total for GM, enabling final opening budgets and revised cash flow forecast. Implementation of recurrent CIP Plan Financial impact of further industrial action Financial impact of Outpatients B Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Derbyshire ICB planning expectation on savings, resulting in reduction in income. Finance workforce capacity to support regulatory submissions.	**Level 1 – Management** Division Operation Board - Finance Metrics Divisional CIP Meetings Finance Training Group – Training Materials Cash Action Group (Monthly) - Cash flow monitoring Financial Position Review Group (Monthly)	Visibility of ERF target			4	4	16	16	16				4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Financial Improvement Group (Monthly) Activity Management Group (Monthly) Staffing Approval Group (Weekly) Executive Team (Weekly) Finance & Performance Committee Finance Report (Monthly) CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly) Stockport System Financial Recovery Group (Monthly)		Ongoing actions from each GM Productive Oversight Meeting (POM) Discussion with NHS England on CDEL for Outpatients B and The Meadows	Monthly Q2 2024/25									
				Level 3 - Independent **External** Internal Audit Reports - Key Financial Systems (Substantial) 2023/24 - HFMA Financial Sustainability Review - Confirmation of Self-Assessment. - Provenance of Data (High) **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. Monthly Provider Oversight Meeting (Information Pack) **NHSE**													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3.													
Principal Risk Number: PR6.2								**Risk Appetite: High**										
There is a risk that the Trust does not develop and agree with partners a Trust (3 year recovery plan) and GM Sustainability Plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group Established Trust planning processes - Triangulates activity, workforce and cost. Internal review of drivers of financial deficit review including benchmarking data and levels of efficiency. Refresh of drivers of deficit and loss making services presented to FPRM (Jan 24) Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Prioritisation of investments linked to planning priorities. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency GM business case assessment process in place.	Underlying financial deficit Lack of certainty regarding system funding beyond 2024/25 including reductions due to convergence factor. Requirement for increased % CIP (recurrent/non-recurrent) Elective Recovery Fund (ERF) remains unclear) – Trust not at activity levels compared to 2019/20. Growth in demand not recognised.	**Level 1 - Management**				4	4	16	16	16				4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) Financial Improvement Group (Monthly) Stockport System Financial Recovery Group (Monthly)		Future Funding Flows Group (GM DoFs) – Review of alignment of work undertaken and contract funding. Stockport Locality review of contracts with particular focus on community services.	Ongoing Ongoing										
				Level 3 - Independent Provider Director of Finance GM Meeting **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM Provider Oversight Meeting (Monthly) **NHSE** NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3	GM commissioned drivers of deficit review to be completed	Review of GM drivers of deficit review and development of required actions.	Q3 2024/25										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score: Impact	Current Risk Score: Likelihood	Current Risk Score: Current	Previous Risk Scores: Q4 23/24	Previous Risk Scores: Q1	Previous Risk Scores: Q2	Previous Risk Scores: Q3	Previous Risk Scores: Q4	Target Risk Score: Impact	Target Risk Score: Likelihood	Target Risk Score: Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
Principal Risk Number: PR7.1				**Risk Appetite: Significant**														
There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	Digital Strategy 2021-2026 Capital plan in place for funding of Digital Strategy and receipt of capital funding for core elements of the Digital Strategy from 2023/24 Robust project management infrastructure in place. Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy Major incident plan in place. Change control processes in place. Process in place to respond to Care Cert notifications. Annual penetration tests in place. Anti-virus updates & spam and malware, all user email notifications. Network accounts checked after period of inactivity – Disabled if not used. Digital & Informatics Group established Terms of Reference & Work Plan approved by F&P Committee. Bimonthly reporting.	No capital plans for hardware replacement. Significantly reduced capital availability in 2024-25.	**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				4	3	12	9	12				4	2	8
				Level 2 – Corporate Finance & Performance Committee - Digital & Informatics Group established Bimonthly - Digital Strategy Progress Report - Capital Programmes Management Group – (Monthly): Including digital capital Board of Directors - Biannual Digital Strategy Progress Report		On-going actions from MIAA internal audit of Data Security and Protection Toolkit, and Medical Devices Management review from 2023/24	Q4 2024/25											
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification – Achieved November 2023. DCB 1596 Secure Email Standard Accreditation – Achieved February 2024. MIAA Internal Audit Report June 2024 - Data Security and Protection (DSP) Toolkit Assessment 2023/24 - Achieved "Substantial Assurance" against the veracity of the self-assessment and "Moderate Assurance" against the 10 National Data Guardian Standards. Annual Data Security and Protection Toolkit 2023/24 self-assessment submission 30 June 2024 – Achieved "Standards Met".		Develop and implement action plan for Data Protection & Security Toolkit Assessment 2024/25.	Q4 2024/25											
Principal Risk Number: PR7.2				**Risk Appetite: Moderate**														
There is a risk that the estate is not fit for purpose and does not meet national/regulatory standards, partly due to increasing maintenance requirements, which may lead to: - Inefficient utilisation of the estate to support high quality of care. - Significant disruption to clinical activity. - Poor patient/staff experience.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance 6-facet survey in place. Additional structural surveys completed for Category D and poor condition property assets by Structural Engineers. Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics)	Inability to deliver required levels of estates maintenance due to lack of funding. Inability to deliver required upgrades due to access limitations related to clinical activity pressures Delivery/Transition plan to address highest risk capital stock and decompression of site. New 6 facet update survey currently	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Joint Consultative Group - Compliance with regulatory standards Health & Safety Incidents				5	5	25	20	25				4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report - Estates Strategy Steering Group Key Issues Report		Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel Continue to make case for appropriate levels of targeted investment in the Trust real estate.	March 2025 March 2025											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
- Increased requirement to undertake contingency works with increased revenue expenditure. - Increased health & safety incidents and litigation/claims. - Breach of NHS standards/statutory regulations/ resulting in statutory /regulatory intervention - Loss of Trust reputation.		Site Development Strategy in place. Joint working arrangements with SMBC established to develop community based solutions to support short to medium term development strategy. Project Board and Senior Responsible Officer identified for major capital developments	commissioned and being reviewed.	- Site Development Strategy Progress Report - Estates & Facilities Assurance Report Board of Directors - Site Development Strategy Progress Report **Level 3 - Independent** Estates Return Information Collection (ERIC) Model Hospital Data Set Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance													
Principal Risk Number: PR7.3						**Risk Appetite: Moderate**												
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Mechanisms in place to explore and develop sustainability approach across Stockport locality. Joint appointment of Sustainability Manager between Stockport and Tameside	Inability to deliver required levels of environmental and sustainability improvements due to lack of funding. Decarbonisation Plan	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities				3	4	12	12	12				3	2	6
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)		Decarbonisation Plan Establish Joint Green Group for SFT & T&G Develop new joint Green Plan SFT & T&G	Q4 2024/25 September 2025 Q4 2024/25											
				Level 3 - Independent Estates Return Information Collection (ERIC)														
Principal Risk Number: PR7.4						**Risk Appetite: Moderate**												
There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed. New Hospital Building Programme Expression of Interest submitted – Project Hazel Established governance structure to develop Outline Business Case Project Hazel Business Case ~~in~~ produced and approved by Board of Directors. Site Development Strategy to support and inform immediate site development and maintenance aspirations	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel. DHSC has confirmed that the Trust has been unsuccessful in securing necessary support from the New Hospital Building Programme. New Hospital Building Outline Business Case	**Level 1 - Management**				4	5	20	20	20				4	2	8
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Review of funding approach with partners	Ongoing											
				Level 3 - Independent														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 23/24	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		New Hospital Project Board established, chaired by SFT Chief Executive. including representation from key external partners. Estates Strategy Steering Group (ESSG) established, reporting to Finance & Performance Committee. Joint working arrangements with SMBC established to explore strategic regeneration of the hospital campus.																

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at end June 2024)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
2516	Finance	Risk of significant service disruption / loss of beds / loss of the asset - The Meadows	5	3	15	5	NEW
2650	Surgery	Risk of harm to paediatric patients if the audiology service does not comply with best practice recommendations	3	5	15	3	NEW
2765	Estates & Facilities	Constraints in capital and revenue funding resulting in an inability to maintain a safe, fully functioning hospital site.	4	5	20	4	↔
1711	Corporate – Workforce	Deterioration in employee relations and possible industrial action	4	4	16	4	↔
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	4	4	16	8	↔
2304	Medicine & ED	There is a risk of harm when patients cannot be transferred from ambulances to ED resulting in delays in diagnostics & treatment	4	4	16	8	↔
2713	Medicine & ED	There is a risk of patient harm due to capacity not meeting demand resulting in overcrowding in ED	4	4	16	8	↔
2763	Surgery	Risk of adverse outcomes with IBD patients due to delays in commencing treatment due to limited capacity on MDCU.	4	4	16	4	↔
2452	Clinical Support Services	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔
2609	Women and Children	There is a financial risk to the Division of providing required care and support to vulnerable asylum seeking families	3	5	15	2	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
288	Corporate – Nursing	There is a risk of there being an inability to provide a robust service for the insertion of VADs	3	5	15	6	↔

2196	Estates and Facilities	Dangerous & obstructive car parking occurring across the SHH Site	3	5	15	6	↔
2770	Surgery	Risk of the upper GI service not being able to deliver services due to a lack of nursing support	3	5	15	3	↔
1288	Clinical Support Services	Risk that failure to achieve turnaround time targets in cell' path' will impact care for cancer patients	4	4	16	6	↔
101	Finance	There is a risk that the Trust will run out of cash and therefore have insufficient cash reserves to operate	5	5	25	5	↑

NHS Stockport NHS Foundation Trust

Meeting date	1st August 2024	**Public**	X	**Agenda No.**	21.
Meeting	Board of Directors				
Report Title	Board Committee Assurance – Key Issues Reports				
Director Lead	Committee Chairs	**Author**	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to: – Review the key issues and matters for escalation provided via the Board Committees – Receive the Audit Committee Annual Review and approve the terms of reference and workplan.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee and Audit Committee held during June and July 2024.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Non-Executive Director
Date of Meeting	11 July 2024
Quorate	Yes
The People Performance Committee draws the following key issues and matters to the Board of Directors' attention:	

Item	Key issues and matters to be escalated
People Integrated Performance Report	The Committee received the People Integrated Performance Report, which provided an update on appraisals, time to hire, statutory & mandatory training compliance, agency expenditure and attendance. The Committee confirmed performance in relation to appraisals and time to hire was below target, with all other metrics within target. It was noted, however that performance had improved for appraisals. The Committee received and noted the report, current performance and the actions being taken to continue to drive improvement.
Equality, Diversity & Inclusion Strategy	The Committee received a report providing progress update against each of the Equality, Diversity & Inclusion (EDI) targets set out within the EDI Strategy 2022-25 relating to workforce, culture, assurance & compliance and health inequalities. The Committee confirmed overall positive progress made against the delivery of the EDI Strategy, as supported by the latest EDI performance metrics, albeit acknowledging that that culture change would take some time to embed. The Committee heard that the EDI performance metrics were triangulated with staff survey results, other staff feedback and people management metrics to inform priority areas for action. The Committee received and noted the update on the Trust's EDI Strategy 2022-25 and associated consolidated action plan.
Organisational Development Plan	The Committee received a report providing a six-monthly progress update against the Organisational Development (OD) Plan 2023-25, noting progress made against the following four priority areas aimed at improving organisational culture and performance: • Leadership and working relationships • Talent management • Innovation • OD consultancy It was noted that that EDI remained a golden thread throughout the OD work programme and a number of actions within the plan were helping the Trust to achieve the ambitions set out in the EDI Strategy.

Item	Key issues and matters to be escalated
	The Committee noted good progress with the delivery of the action plan, albeit acknowledging the adverse impact of industrial action, increased operational demands and emerging priorities, which had delayed some planned events and activities and actions relating to talent management, succession planning and career progression. The Committee heard that the OD Service was leading a project on refreshing the Trust's values and behaviours in response staff feedback, with the refreshed values and behaviours due to be launched in the autumn. The Committee recognised that it was important for the culture change to sit across the whole organisation, including the Board, and suggested that it would be helpful for the Board to receive training and development in this area.
Staff Facilities Update	The Committee received a report providing an overview of staff facilities and requirements under the Workplace (Health, Safety and Welfare) Regulations 1992. It was noted that the report had been updated following feedback received from the Committee in March 2024. The Committee recognised challenges caused by the ageing estate and heard that further assessment was required regarding the provision of toilet and hand washing facilities, shower and changing facilities, and out of hours access to rest and eating areas. It was noted that an assigned Capital Project Lead would commence the initial survey in Q2 2024/25, with a progress update to be provided to the People Performance Committee in September 2024. The Committee discussed innovative funding options in the context of significant capital funding constraints.
Guardian of Safe Working	The Committee received a Guardian of Safe Working Report. The Committee confirmed that no immediate safety concerns or patient harm had been identified during the reporting period and noted a focus of the new Guardian of Safe Working on raising the profile of exception reporting and making the process easier.
Staff Survey	The Committee received a report providing an update on actions taken in response to the 2023 NHS National Staff Survey results to improve staff experience. The Committee heard that the staff survey questions had been mapped to the elements and themes within the NHS People Promise and linked to the Trust's Organisational Development and Equality, Diversity & Inclusion Plans. It was noted that planning was already underway for this year's Staff Survey which was expected to launch in September 2024.
Safer Care (Staffing) Report Curtis Soile 26/07/2024 13:59:56	The Committee received a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. It was noted that the report included information on the Pathology staff group, as previously requested by the Committee. The Committee acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being

Item	Key issues and matters to be escalated
	operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Committee heard that robust staffing has been implemented ensuring that the Trust is safely staffed and able to provide high quality patient care throughout the industrial action.
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the three draft principal risks for 2024/25 assigned to the People Performance Committee. It was noted that the current risk appetite for each risk element had been confirmed at a Board risk appetite workshop and had been applied to the draft principal risks. The Committee heard that throughout 2023/24, the People Performance Committee had oversight of three principal risks from the Board Assurance Framework, and that these risks had been reviewed and all three principal risks transferred to 2024/25. The Committee also noted confirmation of the aligned significant risks from the Corporate Risk Register, which were included to ensure alignment with the draft principal risks. It was noted that emerging risks were considered by the Board of Directors, including as part of the annual risk appetite workshop, and through the Risk Management Committee. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2024/25 to Board of Directors in August 2024.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	20 June 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards. The Committee noted the following key highlights: • Emergency Department (ED) performance had seen some improvement over the past months but was currently reported below trajectory for 4 Hour waits. The Committee heard that a deep dive would be held on 10 July 2024 with locality, supported by NHS England and Get it Right First Time (GIRFT) team to support the performance trajectory. • Significantly improved referral to treatment (RTT) position with good reductions in overall wait times and 52-week and 65-week breaches due to the use of the independent sector, waiting list validation and the expansion of elective capacity. • Cancer 28-day continued to perform well above trajectory and national target. 62-day performance was at risk of achieving trajectory, a key driver being non-compliance in the lung pathway affected by regional capacity for PET scans. • Diagnostic position continued to be challenging, driven by significant increases in MR and audiology. Echo has seen considerable reductions in backlog size. The Committee acknowledged challenges around all four core targets. The Committee welcomed the improvement in the 28-day and 14-day cancer standards and, while the 62-day cancer performance was a challenge, the Committee noted the mitigating actions in place to improve performance.
Final Operational Plan Curtis Soile 26/07/2024 13:59:56	The Committee received the final Operational Plan submission for 2024/25, noting that the final plan would be presented to the Public Board meeting in August 2024. The Committee heard that all providers had had to submit refreshed plans to Greater Manchester by 7 June 2024, ahead of the Integrated Care Board's re-submission of finance, workforce and activity & performance templates by 12 June 2024. The Committee heard that the workforce plan had remained the same, and confirmed revision to the revenue and capital submissions, noting a revised planned deficit of

	£43.78, from £46.10m. The Committee heard that there was an opportunity for cash allocations, subject to the system delivering a compliant plan, and acknowledged significant challenges in this area. The Committee noted an updated capital plan and acknowledged challenges in this area, as the committed schemes exceeded the capital envelope. The Committee reaffirmed that it was important for the Trust to continually highlight issues around capital allocation at every available opportunity, particularly where schemes related to key operational or strategic risks. The Committee heard that work was ongoing internally to prepare business cases up to a certain point, to enable capital schemes to be progressed in a timely manner should additional funding become available.
Finance Report – Month 2 Position	The Committee received the Finance Report for Month 2 2024/25. The Committee heard that overall, the Trust position at Month 2 was a deficit of £8.4m which was in line with plan, with a forecast year-end deficit of £43.8m, which was in line with the annual plan for 2024/25. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2024/25 was £24.6m (£12.3m recurrent) and that the plan for Month 2 of £2.5m had been delivered. The Committee heard that the Trust had maintained sufficient cash to operate during May, however this was following revenue support in April. It was noted that the Capital Plan for 2024/25 had been revised to £29.1m, which was now compliant. The Committee noted risks in this area due to the significant gap between funding and expenditure.
Revenue Support Public Dividend Cash Application Quarter 2 2024/25 and Current Risk on Cash	The Committee received a report on revenue support public dividend cash (PDC) application. The Committee heard that provider revenue support was available to all cash distressed providers through a defined process, and that the Trust had previously received revenue support PDC in March and April 2024. It was noted that the Trust had made a further request for revenue support in June 2024, however confirmation of support was still awaited with the application, and consequently the cash risk had increased. The Committee acknowledged the robustness of systems in place with regard to cash management, and noted the significant impact the regulatory demands is having on staff, and the need to minimise the bureaucracy involved in the application of revenue PDC throughout the 2024/25 year. The Committee reviewed the revenue support PDC capital application for Quarter 2 2024/25, including the plans in place to manage cash, and recommended the application for PDC revenue support to the Board for approval.
Contract for Approval: Laundry Services	The Committee recommended the extension of the Laundry Service Contract for 3 years to the Board of Directors for approval.

Electricity Contract & Hedged Position	The Committee received a report on Electricity Contract and Hedged Position and supported the proposal to amend the hedge position for the purchasing of electricity for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Estates Strategy Steering Group The Committee reaffirmed the importance of timely submission of reports and requested that the Estates Strategy Steering Group Terms of Reference and Work Plan 2024/25 be presented to the July Committee for approval.

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KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	18 July 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Finance Report – Month 3 Position	The Committee received the Finance Report for Month 3 2024/25. The Committee heard that overall, the Trust position at Month 3 was a deficit of £13.4m which was £0.1m adverse to plan, relating to costs of unfunded industrial action. It was noted that at this point the forecast for year-end was a deficit of £43.8m, which was in line with the annual plan for 2024/25. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2024/25 was £24.6m (£12.3m recurrent) and that £3.3m had been actioned in Month 3, which was £0.3m favourable against plan. The Committee heard that the Trust had maintained sufficient cash to operate during June, however this was following revenue support in April and a further application for revenue support for July. The Committee noted increased scrutiny and challenges regarding the cash position. It was noted that the Capital Plan for 2024/25 was £29.1m, which was now compliant. The Committee noted risks in this area due to the significant gap between funding and expenditure. The Committee received a verbal update on the Greater Manchester Integrated Care System (GM ICS) financial position and the increased national scrutiny expected, and the need for Stockport to evidence continued grip and control on its operational performance.
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards. It was noted, however that performance compared favourably against GM across all metrics. The Committee noted improvements to the following metrics in month: • Emergency Department (ED) 4-hour standard, with an associated reduction in long waiters in the department. • Patients who are ready for discharge which will support improvements to

	patient flow. • RTT standards with significant improvements in overall wait times and 52- and 65-week breaches. • Cancer waiting times with a continued improvement to the 28-day faster diagnosis performance. • Theatre utilisation remains on an upward trajectory and benchmarks favourably. The Committee noted deteriorating performance against the following metrics in month: • Outpatient Did Not Attend (DNA) rates and consequent impact on clinic utilisation. A further deep dive was planned in this area and would be reported to the F&P Committee in September. • Diagnostic waits in audiology, resulting from capacity issues which had now been resolved. The Committee heard that the Trust had received support from the NHS England "Get it Right First Time" (GIRFT) team in ED, including the refreshing of the ED improvement plan.
Pharmacy Shop Board Report	The Committee received a report providing an update on the 2023/24 financial performance of the Trust's wholly owned subsidiary "Steppig Hill Healthcare Enterprises Ltd". The Committee received and noted the report, including the estimated 2023/24 financial results as reported in the Group Consolidated Accounts, anticipated 2024/25 financial performance and associated risks to performance. The Committee also noted the three year downward trend in financial performance and requested a further update during the year, following the review underway.
Contracts for Approval	The Committee recommended the extension of the EMIS Community Electronic Patient Record contract for 5 years to the Board of Directors for approval.
St Thomas' Development	The Committee received an update report regarding St Thomas' Development. It was noted that the Committee and the Board of Directors would receive a further update in October 2024.
Digital Strategy – Update on Outcome Measures	The Committee received a report providing an update on the delivery of the Trust's Digital Strategy. It was noted that some outcome measures had been included in the report, with further outcome measures to be provided in future iterations of the report.
Board Assurance Framework and Aligned Significant Risks Curtis Soile 26/07/2024 13:59:56	The Committee received a report detailing the draft principal risks for 2024/25 assigned to the Finance & Performance Committee. It was noted that the current risk appetite for each risk element had been confirmed at a Board risk appetite workshop and had been applied to the draft principal risks. The Committee also noted confirmation of the aligned significant risks from the Corporate Risk Register, which were included to ensure alignment with the draft principal risks. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2024/25 to Board of

	Directors in August 2024.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Digital & Informatics Group Key Issues Report The Committee reviewed and approved the Estates Strategy Steering Group Terms of Reference and Work Plan 2024/25.
Any Other Business	The F&P Committee Chair reaffirmed the importance of timely submission of reports to ensure Committee members have sufficient time to read the reports and prepare for meetings.

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Susan Moore
	June, July 2024
Quorate	Yes

The Quality Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Board Assurance Framework June 24 **(opening and closing of meeting, including AOB in July 2024)**	Opening: The Trust Secretary presented the quality related principal risks, to be included within the Opening/Q1 Board Assurance Framework (BAF) 2024/25. The Quality Committee had oversight of 3 Principal Risks (PR) from the BAF. She noted that PR 1.1 (Quality of Care) and PR 5.2 (Research & Development) had been reviewed and transferred to the Opening/Q1 BAF 2024/25. PR 5.2 (Delivery of Transformation/Service Improvement Programmes) had been reassigned to Board of Directors due to alignment with oversight of the risk. The committee specifically discussed risks regarding compliance with best practice guidance for paediatric audiology and stroke services. It was acknowledged that decisions had been taken internally, and not yet implemented due to the requirement for further system level approval. Quality Committee agreed to consider the risk score for PR1.1 (Quality of Care) following consideration of all matters on the agenda, and considering the significant addition of operational estates risks, confirm if escalation was required to the Board of Directors in advance of the meeting in August 2024. Closing: Comprehensive discussion took place regarding potential increase to the risk score for PR1.1 (Quality of Care), currently proposed as 12. Quality Committee recognised there were a number of service/issue specific quality related risks on the Trusts significant risk register, where mitigating action was delayed due to competing financial pressures and external funding approval. In conclusion, Quality Committee determined that, based on the controls in place, and assurances reviewed via Quality Committee since the risk was previously reviewed, the risk score would remain at 12. Quality Committee acknowledged the Chief Nurse, Medical Director and Trust Secretary reviewed the risks prior to presentation at Quality Committee and invited the Deputy Director of Quality Governance to engage in the review, mindful of the alignment between operational and principal risks. The Board Assurance Framework reviewed under AOB in the July 2024 Quality Committee.

	Further consideration to increase to the risk score for PR1.1 (Quality of Care), currently proposed as 12. Financial and operational risks have significantly increased and the Committee considered the impact of this directly on the consequences of: • Safety and quality of care • patient experience • Performance and quality impact. Following an extensive discussion it was agreed that Risk PR1 be included in the Board Assurance Framework to be presented to the Board of Directors in August 2024, in addition to escalation of the increasing tension between financial, operational pressures (specifically estates) and quality of care.
CQC Update Report & External Visits, Inspections & Accreditations Register Report June 2024	The Deputy Director of Quality Governance presented the CQC Update Report, providing confirmation of CQC enquiries received since the last report and update relating to the Emergency Department inspection action plan. The Deputy Director of Quality Governance confirmed update on the Maternity Service inspection action plan would be presented as part of the report going forward. It was noted that there has been a restructure of teams at the CQC and the requirement for monthly and quarterly contact meetings. This is not SFT specific but a national change in the CQC's ways of working. The Deputy Director of Quality Governance presented an overview of the contents of the register of external visits, inspections and accreditations for Q3/4 2023/24, including summary regarding the purpose of the visit and summary feedback received. The committee noted there were no risks associated with external visits that had not previously been identified. The Committee was assured regarding CQC preparation and inspection up to the end May 2024.
Learning from Deaths Quarterly Report July 2024	The Medical Director presented the Learning from Deaths report summarising activity and the learning that has been gained from Q3 2023/24 and provided high level information about the actions that had been taken in response. • A high level of LFD activity continues with around 43% of all in-hospital deaths receiving a review. • A focus on stroke-related mortality will be provided to the Patient Safety Group in the Autumn of 2024 in response to the Trust being identified as an outlier for stroke mortality amongst acute NHS Trusts. This may be related to the Trust's status as a regional centre but the relevant data will be analysed and assurance sought.
Quality Strategy – Objectives 2024/25 and development of next iteration of	The Chief Nurse and Medical Director confirmed that, at its meeting in May 2024, Quality Committee had considered objective measures for 2024/25, acknowledging scope for further clarity regarding outcomes for certain elements.

Quality Strategy June 2024	The target to achieve the use of IPOS (Palliative Outcome Scale) for 25% of patients with recognised deterioration in condition on the District Nurse caseload was considered to be un ambitious in acheiving use for only 25% of patients. The Medical Director commented that further rationale would be sought from End of Life Care leads. This was verbally updated to the Committee in July 2024 with a commitment to increase the ambition from 20% to 90%
Annual Reports June 2024	Annual Research, Development & Innovation (RD&I) Report 2023/24 The Committee recognised research & development was one of the first areas to develop a collaborative strategy with T&G and a potential area of discussion for a future joint board meeting. Quality Committee received the Annual RD&I Report 2023/24, confirming delivery in alignment with the Joint RD&I Strategy. Annual Clinical Audit Report 2023/24 & Forward Programme 2024/25 The Committee noted future reports could highlight the positive impact of clinical audit on patient outcomes and clinical effectiveness, acknowledging the challenge in doing so for a significant number of clinical audits. Quality Committee reviewed and confirmed the Clinical Audit Annual report 2023/24 and the Forward Programme for 2024/25. Annual Infection Prevention Control Report 2023/24 Quality Committee confirmed that it would remain appraised of discussion and action being taken via the Patient Safety Group Key Issues Report and regular reporting of IPC metrics to Quality Committee. The uptake of influenza vaccines in 23/24 was well below target at 28% for frontline staff a decrease from 39% the previous year. The Target for 24/25 is 80% with an offer to staff of 100%. There are increased number of referrals to the Vascular Access Device (VAD) Service, and the identified significant risk relating to provision of a robust service for the insertion of VADs. Early discussions are underway to consider a new way of working or change to the service model. Quality Committee received the Annual Infection Prevention Control Report 2023/24.
StARS Progress Report July 2024 Curtis Soile 26/07/2024 13:59:56	Overview of current assessment ratings, including recent achievement of 'Blue' StARS and repeat Blue StARS status, findings in relation to the Divisions, key themes for improvement Identified as part of the assessment process and actions taken was presented. During April 2024 – June 2024 there have been 20 assessments completed across the Trust including Maternity, Emergency Department, Theatres and Community areas. The Committee noted that Medicines Management and Infection Prevention and Control, continue to be areas of challenge. There is ongoing activity and support and

	challenge where poor practice is observed. The Committee noted that the StARS reviews were announced and planned and a recent MIAA Internal Audit spot check audit, which was unannounced, identified similar areas of concern in the areas visited. (see next item)
Quality Spot Checks MIAA Internal Audit July 2024	The Committee reviewed the report as presented to Audit Committee in July 2024. The report returned an opinion of **Limited Assurance**, with a compromised system of Internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk. Overall Audit Objective: To provide assurance to assess whether the agreed, current key quality aspects of patient care were operating effectively at a local level within the organisation. The wards/areas that were observed during the review are outlined below. The scope of this audit was limited to the controls in operation at the organisation on the day of the audit and included observations within the wards only. For Infection, Prevention and Control, wards visited: Bluebell ward, M4, E3 D7. For Controlled Drugs, wards visited: ED, AMU, D5, A10 The committee reviewed the detailed observations within the report and considered they triangulated mostly with issues as identified in the StARS accreditation finings. The report also referenced observations of repairs not undertaken. The Committee were assured that action plans were progressing. Continued vigilance and communication on fundamentals of care is required with challenge for poor practice and promotion of good practice when observed.
Annual Safeguarding July 2024	This report covers the period from April 2023 to March 2024 and provides assurance that systems are in place to ensure that patients using Trust services are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise. The comprehensive report agenda item 16 at Public Board August 2024.
Quality & Safety Integrated Performance Report June, July 2024 Curtis Soile 26/07/2024 13:59:56	**Quality & Safety Integrated Performance Report (IPR)** Quality Committee reviewed the Integrated Performance Report, which included specific update on quality and safety metrics that were not achieving target, alongside areas of sustained improvement and that were not covered elsewhere on the agendas. The committee noted the positive improvement in mortality measures, (Hospital Standard Mortality rate and Summary Hospital level Mortality Indicators) which are both well within control limits. SFT are no longer an outlier in GM for HSMR. The Chief Nurse re confirmed that, any patient who gets an infection or pressure ulcer whilst on a Virtual ward would be included as hospital acquired. She confirmed

	work was ongoing to ensure this was accurately reported and narrated within the Quality & Safety Performance Report. It was highlighted that, despite an increase in written complaints, timely response times had been achieved. Work continues with AQuA on sepsis antibiotic administration noting NICE guidelines are under review.
Maternity Services: Maternity Services Highlight Report Local Maternity and Neonatal System (LMNS) Safety Assurance Return PMRT Q1 2023/24 Report **July 2024**	The Maternity Services Highlight Report incorporates an update on several of the elements the service is currently working towards, including: • CNST Year 6 • Saving Babies Lives Care Bundle V3 • Midwifery Continuity of Carer pathway (MCOC) • Three year delivery plan for maternity and neonatal services (2023) • Pregnancy Loss review (July 2023) • Perinatal quality surveillance dashboard highlight reports The update also includes an overview of Stockport's performance across GMEC using the Quality surveillance toolkit, ongoing work with the MNVP, Midwifery staffing, overview of incidents, Harm and risk, Equality and Equity plan, Perinatal mental health, StARS and maternity and perinatal safety champions. The business plan to enable compliance to full Neonatal Medical staffing is now with the ICB awaiting approval. The committee acknowledged that rationalising the reporting of content and the many maternity, neonatal narrative and data reports, whilst committing to nationally mandated reporting would be reviewed going forward.
Key Issues Reports June, July 2024	Regular key issues reports received, reviewed, discussed and confirmed/noted. Many of the exceptions from the subcommittees are explored in detail during the main agenda of the Quality Committee. • Patient Safety Group Key Issues Report (verbal in July) • Patient Experience Group Key Issues Report • Clinical Effectiveness Group Key Issues Report • Integrated Safeguarding Group Key Issues Report Of note: A community Pressure Ulcer deep dive is ongoing. Chaplaincy & Spiritual Care undertaking a range of activities to increase visibility to provide support and training to staff and personal chaplaincy to patients ie Blessings, memorials and Friday prayers. PLACE Update It was highlighted that following discussion at the Quality Committee a themed approach had been used to facilitate action plan development and to monitor progress against the large number of actions (292) identified in the PLACE report (June 2024)

	The analysis indicated that several actions had already been addressed, with work already started to address many others. Progress will be monitored via the quarterly reports to PEG.
Escalation to Board	**Following and extensive discussion it was agreed that Risk PR1 be included in the Board Assurance Framework to be presented to the Board of Directors in August 2024, in addition to escalation of the increasing tension between financial, operational pressures (specifically estates) and quality of care.** **PR 5.2 (Delivery of Transformation/Service Improvement Programmes) had been reassigned to Board of Directors due to alignment with oversight of the risk.** **Quality Committee Annual Reports as scheduled in work plan**
Triangulation and Risk to Audit Committee	**Quality Spot Checks MIAA Internal Audit** **The Quality Committee were assured that action plans were progressing. Continued vigilance and communication on fundamentals of care is required with challenge for poor practice and promotion of good practice when observed. This report Triangulates with StARS accreditation.**

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KEY ISSUES REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell
Date of Meeting	**16th July 2024**
Quorate	Yes
The Audit Committee draws the following key issues and matters to the Board of Directors' attention:	

Item	Key issues and matters to be escalated
Audit Committee Annual Review	The Committee received: • Terms of Reference and Work Plan 2024/25 • Audit Committee Annual Review 2023/24 The Committee were assured that its terms of reference had been reviewed against HFMA handbook and updated. The Committee also approved updates to the terms of reference to increase the frequency of reports on Losses and Special Payments and add incidences of SFI breaches to report to Audit Committee. The Committee discussed its self-assessment of the effectiveness of the Committee and reviewed the reasons behind "unable to answer" responses. The Committee agreed that its agenda through its internal audit programme was structured to cover quality, data quality, performance targets and financial control. The Committee were assured that its Board Committee feedback reflected integrated governance and highlighted emerging risks. To strengthen oversight of limited assurance internal audit reports, it was agreed that these reports should be referred to the appropriate Board Committee for discussion with the Executive Director responsible attending the subsequent Audit Committee discuss the report and actions arising. The Committee approved the Annual Review, Terms of Reference and 2024/25 Annual Work Plan and recommended to the Board of Directors for approval.
Risk Management Committee Terms of Reference and 2024/25 workplan	The Committee received the Terms of Reference and 2024/25 Workplan for the Risk Committee and were assured that the responsibilities and accountabilities of the Risk Committee were included appropriately in the updated Terms of Reference and workplan. The Committee discussed in depth how risks were escalated and shared between other Board Committees. It concluded that detailed risks were discussed at the appropriate Committees and that the overarching risk was discussed at Audit Committee with the feedback from the respective non-executive Committee Chairs. Assurance was given that emerging risks in the Trust were also reviewed by the Risk Management Committee.

Feedback from Board Committees.	The Committee received verbal reports on the key risks from the Chairs of the: • Finance and Performance Committees • Quality Committee • People Committee Following on from the Risk Management discussion on triangulation of risks, an example was given where the Quality Committee had reviewed the risk rating score attached to the Trust estate and had concluded that the risk rating should remain at its current level. Similarly, the Finance and Performance Committee risks can be found on the Risk Management Committee agenda.
Internal Audit 2024/25 Plan Progress Report 2024/25 Annual Plan	The Committee received: • Internal Audit Plan Progress Report July 204 • Internal Audit Reports • Follow up Tracker Update The Committee received the final reports for: • Quality Spot Checks – Limited Assurance The Committee asked for assurance on timescales for recommendations as there were fundamental issues raised within the report that required immediate follow up. The Committee were assured that the full report with matters raised will be referred to the Quality Committee for scrutiny. There were specific Estate quality incidents highlighted within this report and assurance was sought as to where Estates Key Performance Indicators were reported. This will be followed up in the outstanding action at Finance and Performance Committee on Corporate Performance. • Data Security Protection Toolkit: - National Data Guardian Standards – Moderate Assurance - Veracity of self-assessment – Substantial Assurance The Follow Up Tracker for Recommendations was presented in its updated format with overdue recommendations separate. There are no concerns with regards to the recommendation tracking process and no critical priority actions outstanding. The draft terms of reference for the CIP Review were presented and approved. The Committee were assured that these addressed earlier concerns on the scope of the audit.
Anti-Fraud Progress Report July 2024 Curtis Soile 26/07/2024 13:59:56	The Committee received the Anti-Fraud Report for July 24 and an update on the status of current investigations. The Committee were given assurance that the Trust had not incurred any financial losses on the national fraud prevention notices issued during June and July 24 to date. The Committee were updated that good progress had been made with the pro-active review of Procurement and that an introductory meeting had been held with the Freedom to Speak Up Guardian.

Losses and Special Payments Register	The Committee received a report received a report from on the annual Losses and Special Payments reported in the financial statements for 2023/2024. The Committee was updated on the significant losses and special payments reported. It sought further information on the loss of the falls equipment included in the report which will be reported to the September meeting. The Committee received assurance that the reporting and incidences of salary overpayments were being closely monitored under the new payroll contract arrangements.
Waiver Report October 2023 to March 2024	The Committee received an update to the Waiver appendix of individual waivers from October 2023 to 2024. To provide further assurance the report had been amended to identify separately where sole suppliers existed and/or off framework suppliers provided better value. The appendix was now split into two sections that identified those that did and did not follow process. The Committee asked for future waiver reports to expand further on the reasons for not following process.
Stock Management Review Update	The Committee received a verbal update on initial follow up actions to the Stock Management Review and note the requirements for a medium to long term plan to address some of the issues raised. A formal report will be presented to the Committee.

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1. INTRODUCTION

1.1 The Audit Committee has considered and confirmed the Annual Review, including the Terms of Reference and Work Plan, and recommends them to the Board of Directors for approval.

2. BACKGROUND

2.1 Section 8.1 of the current Terms of Reference requires that the Terms of Reference of the Audit Committee shall be reviewed by the Board of Directors annually. The Terms of Reference were last reviewed and approved by the Board of Directors on 3 August 2023 and are therefore now due for review. In addition, section 8.2 requires the Committee to review its effectiveness and performance on an annual basis and report the outcome to the Board of Directors.

2.2 The Board of Directors is asked to note that the Committee effectiveness checklist and questionnaire and the Terms of Reference were updated in line with the new HFMA NHS Audit Committee Handbook.

3. COMPLIANCE WITH TERMS OF REFERENCE

3.1 The Audit Committee has a well-established workplan which sets out its annual cycle of work and reporting. This is kept under regular review and updated to consider matters relevant to the responsibilities of Audit Committee.

The Audit Committee also works with the Board's other assurance committees and will receive matters for its consideration and refer matters to other committees for assurance purposes.

Appendix 1 details key matters considered at the Audit Committee during 2023/24. In addition, the Committee also requested the following deep dives / presentations, which were considered at meetings during 2023/24:

- Limited Assurance IM&T Reviews (IT Legacy / Unsupported System Review and Asset Management Review) – Update on Actions

The Committee also has a follow up system to ensure agreed recommendations are implemented in timely manner.

3.2 <u>Internal Audit & Counter Fraud</u>

The Internal Audit Work Plan 2023/24 was approved by Audit Committee at the start of 2023/24 and delivered by Mersey Internal Audit Agency (MIAA), subject to any adjustments agreed by the Committee.

The Committee reviewed in detail the findings of Internal Audit reports. On one occasion, in response to an audit with limited assurance, the Director of Informatics attended the Audit Committee to provide further assurances regarding recommendations/actions to be taken.

Each year, the Audit Committee receives and considers the annual Counter Fraud plan, with regular progress reports and updates and the annual Counter Fraud report provided to Committee.

The Committee has reviewed the performance of the internal audit & counter fraud function in 2023/24 and considers that this is satisfactory in line with the Terms of Reference.

3.3 External Audit

Forvis Mazars are the Trust's external auditors – having taken over this contract from the 2019/20 financial year.

The Committee reviewed the audit for 2023/24 as it progressed including final audit reports and management letters. The audit was complete in June 2024 and all submissions made to NHS England as required.

The current external auditor contract concluded with the conclusion of the financial year 2023/24 audit. The Council of Governors has a statutory duty to appoint (and remove) the NHS foundation trust's external auditor. Audit Committee has responsibility for overseeing, in liaison with the Council of Governors, the process for the appointment of an external auditor and, based on the outcome, making a recommendation to the Council of Governors for award of contract.

In September 2023, the Council of Governors approved the proposed approach for the appointment of an external auditor, including agreement that an External Auditor Appointment Working Group would be established to support this process, with appropriate representation from the Audit Committee and the Council of Governors. Following conclusion of the process, on 26 June 2024, the Council of Governors supported the recommendation from Audit Committee and approved the appointment of Forvis Mazars as the Trust's external auditors for a period of three years (i.e. conducting the 2024/25, 2025/26 and 2026/27 external audit) with an option for this to be extended by a further 2 years subject to mutual agreement.

3.4 Review of Annual Report and Accounts for 2023/24

The Committee considered the draft Annual Report and Accounts, including Annual Governance Statement (AGS) at its meeting in May 2024. The final Annual Report and Accounts were reviewed and recommended for approval to the Board of Directors in June 2024.

4. Committee Effectiveness

An annual assessment has been completed by members of Audit Committee and regular attendees.

The assessment included two parts; a checklist focused on Committee administration and processes; the second on how well the Committee operates over several categories. Both parts of the assessment were updated in line with the new HFMA NHS Audit Committee Handbook.

The checklist focused on Committee administration and processes was completed by the Committee's secretary and distributed to Audit Committee members and regular attendees. The checklist was designed to elicit a simple yes or no answer to each question. There was a single 'no' answer with regard to having clear arrangements in place on how the Audit

Committee works within the Integrated Care System. The assessment confirmed that there were no formal arrangements in place with respect to work with the Integrated Care System, although GM Audit Chairs Forum meets periodically. It also confirmed that the Chair of Audit Committee is a Provider Partner member of the GM Integrated Care System Audit Committee.

The outcome of the second part of the assessment is presented in Appendix 2. The outcome of the self-assessment was largely positive.

Opportunities for improvement based on comments received include:

- Executive Director to attend Audit Committee in response to any limited assurance internal audit report. In addition, the limited assurance internal audit report is to be considered via the relevant Board Committee.
- Focusing feedback from Board Assurance Committees on the management of significant risks emerging or potential risks and adequacy of underlying assurance / control processes. Further guidance will be issued to Chairs of Board Committees via Chair of Audit Committee. In addition, there will be a deep dive of the Board Assurance Framework at mid point of the year.

5. Attendance

Attendance at 2023/24 Audit Committee meetings is provided in Appendix 3. The Committee met on six occasions in 2023/24 (+ two year-end meetings in May and June 2024), and all meetings were quorate.

6. Terms of Reference

A review of the draft Terms of Reference was conducted by the Trust Secretary and Chair of Audit Committee and at the Audit Committee meeting on 16 July 2024. The revised Terms of Reference are included at Appendix 4 of the report for Board approval. The key changes relate to:

- Alignment with HFMA NHS Audit Committee Handbook, Appendix A: Example Terms of Reference

7. Work Plan 2024/25

A review of the draft work plan was conducted by the Trust Secretary and Chair of Audit Committee and at the Audit Committee meeting on 16 July 2024 (Appendix 5).

Board members are asked to note that the ‘year-end’ meeting dates will be determined in line with NHS England (NHSE) financial accounting and reporting year-end requirements 2024/25. Any subsequent change to meetings in 2025 will be communicated to members and attendees as soon as possible.

8. RECOMMENDATIONS

8.1 The Board of Directors is asked to:

- Receive and approve the Audit Committee Annual Review 2023/24, including:
  - Terms of Reference
  - Committee’s Work Plan 2024/25

AUDIT COMMITTEE 2023/24

Topic	23 May 2023	27 Jun 2023	18 Jul 2023	19 Sep 2023	23 Nov 2023	20 Feb 2024	21 May 2024	26 Jun 2024
Audit Committee Work Plan and Attendance	✓			✓	✓	✓	✓	✓
Audit Committee Annual Review (including Terms of Reference, Work Plan and Committee Effectiveness Review)			✓					
Internal Audit Progress Report	✓		✓	✓	✓	✓		
Review of Internal Audit Plan	✓		✓	✓	✓	✓	✓	
Internal Audit Charter	✓						✓	
Anti-Fraud Progress Report	✓		✓	✓	✓	✓	✓	
Anti-Fraud Annual Report	✓						✓	
Anti-Fraud Plan 2024/25						✓		
Internal Audit Annual Report	✓						✓	
Head of Internal Audit Opinion	✓	✓					✓	✓
External Audit Update Report				✓	✓		✓	
External Audit Strategy Memorandum	✓					✓		
Audit Completion Report including Auditor's Report		✓						✓
External Auditor's Annual Report			✓					✓
Review of Annual Governance Declarations/Self-Certifications	✓						✓	
Annual Report	✓	✓					✓	✓
Annual Governance Statement	✓	✓					✓	✓
Key Accounting Issues Report	✓						✓	
Annual Accounts	✓	✓					✓	✓
Review of Going Concern Basis of Preparation	✓						✓	

Topic	23 May 2023	27 Jun 2023	18 Jul 2023	19 Sep 2023	23 Nov 2023	20 Feb 2024	21 May 2024	26 Jun 2024
Management Representation Letter: Financial Accounts		✓						✓
Declaration of Interests Annual Review	✓						✓	
Review of Waivers	✓				✓		✓	
Review of Accounting Policies	✓					✓	✓	
Review of Losses and Special Payments			✓					
Board Assurance Framework Review				✓				
To review arrangements by which staff can raise issues				✓				
Review of Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions						✓		
Conflicts of Interests Policy						✓		
Risk Management Committee Key Issues Report	✓		✓	✓	✓	✓	✓	
Feedback from Board Committees	✓		✓	✓	✓	✓	✓	
Informal Review of Meeting Effectiveness	✓		✓	✓	✓	✓	✓	

Appendix 2: Outcome of Audit Committee Review & Self-Assessment

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/Action
Theme 1 – committee focus						
The committee has set itself a series of objectives for the year.	2 / 3	1 / 3				I have stated agree, as the Audit Committee has a clear work plan to support in delivery of its roles and responsibilities.
The committee has made a conscious decision about the information it would like to receive.	1 / 4	2 / 2				
Committee members contribute regularly to the issues discussed.	1 / 5	2 / 1				
The committee is aware of the key sources of assurance and who provides them.	2 / 5	1 / 1				
The committee receives assurances from third parties who deliver key functions to the organisation – for example, NHS Shared Business Services or private contractors.	1 / 1	2 / 3	2			Annual Assurances could be sought from third parties such as payroll provider.
Equal prominence is given to both quality and financial assurance.	2 / 3	1 / 3				
Theme 2 – committee team working						
The committee has the right balance of experience, knowledge and skills to fulfil the role described in the *NHS Audit Committee Handbook.*	2 / 4	2 / 2				
The committee has structured is agenda to cover quality, data quality, performance targets and financial control.	1 / 1	3 / 4	1			
The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.	1 / 1	3 / 5				Going forward, as standard practice, the Committee should ensure that when receiving a limited assurance internal audit report, the relevant Executive Directors attend.
Management fully briefs the committee on key risks and any gaps in control.	2 / 4	2 / 2				.
Other committees provide timely and clear information in support of the audit committee.	2	4 / 4				Ensure feedback from Board assurance committees is focused on management of significant risks, emerging or potential risks and adequacy of underlying assurance / control processes.
The committee environment enables people to express their views, doubts and opinions.	2 / 5	2 / 1				
Committee members understand the messages being given by external audit, internal audit and counter fraud specialists.	2 / 5	2 / 1				
Internal audit contributes to the debate across the range of the agenda.	2 / 2	2 / 4				
Members hold their assurance providers to account for late or missing assurances.	1 / 1	3 / 5				
Decisions and actions are implemented in line with the timescale set down.	1	3 / 4			1	However, this is not only the case. Must ensure actions deadlines set are viable from

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/Action
						the outset.
Theme 3 – committee impact						
The quality of committee papers received allows committee members to perform their roles effectively.	2 / 3	2 / 3				Recognition during the year of how specific papers may be improved.
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	2 / 4	1 / 2			1	
Debate is allowed to flow and conclusions reached without being cut short or stifled.	2 / 4	1 / 2			1	Chair should not respond to this question.
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored.	2 / 3	1 / 3			1	Chair should not respond to this question.
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well and so on.	1 / 2	3 / 4				
The committee provides a written summary report of its meetings to the Board.	2 / 4	2 / 1			1	
The Board challenges and understands the reporting from this committee.	2 / 2	2 / 1			3	
There is a formal appraisal of the committee's effectiveness each year.	2 / 4	1 / 2			1	
Theme 4 – committee engagement						
The committee challenges management and other assurance providers to gain a clear understanding of their findings.	2 / 2	2 / 4				Please see previous comment regarding limited assurance reports.
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.	2 / 5	1 / 1	1			See my comment re triangulation.
The committee receives clear and timely reports from other Board committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	2 / 2	1 / 4	1			- Chairs of Assurance Committees are members of Audit Committee. - Think this area needs strengthening and relates to the triangulation.
We can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified.	2 / 2	1 / 2			1 / 2	
Theme 4 – committee leadership						
The committee Chair has a positive impact on the performance of the committee.	2 / 5	1 / 1				
Committee meetings are chaired effectively.	2 / 5	1 / 1				
The committee Chair is visible within the organisation and is considered approachable.	1 / 3	2 / 2			1	
The committee Chair allows debate to flow freely and does not assert his/her own views too strongly.	2 / 5	1 / 1				
The committee Chair provides clear and concise information to the	1 / 3	2 / 2			1	

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/Action
Board on committee activities and gaps in control.						
Green = Response from Members / **Blue = Response from Regular Attendees**						

Appendix 3: Audit Committee 2023/24 Attendance Register

Member	Name	23 May 2023	27 Jun 2023	18 Jul 2023	19 Sep 2023	23 Nov 2023	20 Feb 2024	21 May 2024	26 Jun 2024
Core Members									
Chair of Audit Committee, Non-Executive Director	David Hopewell	Y	Y	Y	Y	Y	Y	Y	Y
Chair of F&P Committee/Non-Executive Director	Tony Bell	Y	A	Y	Y	Y	Y	Y	Y
Chair of People Performance Committee/Non-Executive Director	Beatrice Fraenkel	A	A	A	A	Y	Y	A	A
Chair of Quality Committee/Non-Executive Director	Mary Moore	Y	A	A	Y	Y	Y	Y	Y
Non-Executive Director	Marisa Logan-Ward		A (D)	A (D)					
Non-Executive Director	Louise Sell		A (D)	A (D)					
Regular Attendees									
Chief Executive	Karen James	Y	Y	Y	Y	Y	Y	A	Y
Chief Finance Officer	John Graham	Y	Y	Y	Y	Y	Y	Y	Y
Associate Director of Finance, Financial Services	Lisa Byers	Y	Y	Y	Y	Y	Y	Y	Y
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	Y	Y	Y
MIAA	Representative from Internal Audit	Y	N/A	Y	Y	Y	Y	Y	N/A
MIAA	Counter-Fraud Specialist	Y	N/A	Y	Y	Y	Y	Y	N/A
Forvis Mazars	Representative from External Audit	Y	Y	Y	Y	Y	Y	Y	Y
Director of Finance	Kay Wiss	Y	Y	Y	Y			Y	A
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key									
Y	= Present								
A	= Apologies								
A (D)	= Attended as Deputy								

NHS Stockport NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors hereby resolves to establish a Committee, to be known as the Audit Committee (the Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference and by the Board.

1.2 It shall have terms of reference and powers delegated by the Board of Directors and is subject to such conditions, such as reporting to the Board of Directors, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 The Audit Committee will provide report to the Council of Governors identifying any matters in respect of which it considers that action of improvement is needed and recommendation as to the action to be taken.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Audit Committee is to:

2.1 review the establishment and maintenance of an effective system of governance, and internal control, including risk management, across the whole of the organisation's activities (both clinical and non-clinical);

2.2 ensure there is an effective internal audit function established which provides appropriate independent assurance to the Committee;

2.3 review the findings of the External Auditor, as appointed by the Council of Governors, as part of its delegated authority from the Board of Directors and consider the implications and management's responses to their work;

2.4 review and approve for audit the annual report (including Annual Governance Statement), annual accounts and financial statements as part of its delegated responsibility from the Board.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- A non-executive director who should have relevant financial experience and should be appointed Chair of the Committee by the Board. A provision in the Code of Governance states that this should not be the Deputy or Vice Chair or Senior Independent Director.
- In addition to the Chair, at least three non-executive directors, to include the Chair of each of the Trust's Board assurance committees.

3.1.2 All statutory non-executive directors, except for the Chair, are authorised to attend as members of the Audit Committee.

3.1.3 The Chair of the Foundation Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Chair of the Committee.

3.1.4 There is an expectation that the membership will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.5 The following shall attend the Committee meetings on a regular basis:

- Chair of Risk Management Committee
- Chief Finance Officer
- Director of Finance
- Associate Director of Finance (Financial Services)
- Company Secretary
- A representative of the Internal Auditors
- A representative of the External Auditors
- Counter-Fraud Lead

3.1.6 Executive Directors, including the Chief Executive, and/or senior leaders shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

3.1.7 The head of internal audit and representative of external audit have a right of direct access to the Chair of the Committee. This also extends to the local counter fraud specialist.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director with relevant financial experience.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of at least two independent non-executive directors.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 Meetings shall be held at least five times per year, with additional meetings where necessary.

3.5.2 The External Auditor and Internal Auditor shall have the opportunity at least once per year to meet with the Audit Committee without executive directors present.

3.5.3 The Chair may at times convene additional meetings of the Committee to consider business that requires urgent attention.

3.6. Administration

3.6.1 The Trust Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Audit Committee is authorised by the Board of Directors to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain outside legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

5. RESPONSIBILITIES

5.1 Governance, risk management and internal control

5.1.1 To review provision of an effective system of governance, including systems for risk management and clinical audit, and internal control aligned to the overall governance agenda.

5.1.2 To maintain oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

5.1.3 To review processes to ensure appropriate information flows to the Audit Committee from executive management and other Board Committees in relation to the Trust's overall internal control and risk management.

5.1.4 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. In respect of the controls in place to manage risks recorded on the Board Assurance Framework, each Board Committee (through its Chair) shall report regularly to the Audit Committee.

5.1.5 To review the adequacy of arrangements by which staff can raise issues in confidence about

possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

5.1.6 To review the adequacy of the policies and procedures in respect of all local counter-fraud services work.

5.1.7 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence.

5.2 Internal Audit & Counter Fraud

5.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs and priorities of the organisation.

5.2.2 To consider the provision of the Internal Audit service and the costs involved (and make a recommendation to the Board of Directors for award of contract where required).

5.2.3 To oversee on an on-going basis the effective operation of internal audit in respect of:
- Adequate resourcing;
- Co-ordination with external audit;
- Meeting relevant internal audit standards;
- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

5.2.4 To consider the findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

5.2.5 To evaluate performance of the internal audit service against relevant key performance indicators on an annual basis.

5.2.6 Receive the Head of Internal Audit Opinion

5.2.7 To review and approve the Trust's annual counter-fraud workplan, ensuring that it is consistent with the needs of the organisation.

5.2.8 To satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that meets the NHS Counter Fraud Authority's (NHS CFA) standards. In doing so, the Audit Committee will refer any suspicious of fraud, bribery and corruption to the NHS CFA via its Counter-Fraud Specialist.

5.3 External Audit

5.3.1 To oversee the appointment of the external auditor, including the conduct of a market testing exercise at least once every ten years and, based on the outcome, make a recommendation to the Council of Governors for award of contract.

5.3.2 To assess the external auditor's work and fees in line with the contract award, and based on this assessment, make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light

of relevant professional and regulatory standards.

5.3.3 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

5.3.4 To review all external audit reports, including the 'auditor's annual report', together with the management response, and to monitor progress on the implementation of recommendations.

5.3.5 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

5.3.6 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

5.3.7 To ensure mechanisms are in place to engage with the external auditor out with the Audit Committee as maybe required.

5.4 Annual Report & Accounts

5.4.1 To review and approve for audit the Annual Accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

5.4.2 To review and approve for audit the Annual Report and Annual Governance Statement, before they are presented to the Board of Directors, to determine completeness, objectivity, integrity and accuracy.

5.4.3 To review accounting and reporting systems on a cyclical basis for reporting to the Board of Directors, including in respect of budgetary control.

5.5 Scheme of Reservation & Delegation, Standing Financial Instructions and Standards of Business Conduct

5.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, including but not limited to the Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions.

5.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

5.5.3 To monitor the implementation of policy of the Standards of Business Conduct (management of conflicts of interests, including gifts and hospitality) and Codes of Conduct, on behalf of the Board of Directors.

5.6 Other

5.6.1 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

5.6.2 To review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board of Directors.

5.6.3 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.4 To consider the outcomes of significant reviews / other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. This may include, but is not limited to, any reviews conducted by regulators and inspectors within the health and social care sector and professional bodies.

5.6.5 In addition, the Committee will work with other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

5.6.6 Members must consider if there are any equality and diversity implications of decisions they make.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Risk Management Committee

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board of Directors for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board of Directors.

			2024									2025					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
General																	
1.	Review the operation of, and proposed changes to, the **Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions**	Chief Finance Officer								•							
2.	Board Assurance Framework Mid-Year Review	Trust Secretary								•							
3.	To review arrangements by which staff can raise issues	Director of People & OD						•									
4.	Review of **waivers**	Chief Finance Officer		•						•					•	•	
Internal Audit																	
5.	Oversee the conduct of a **market testing exercise for the appointment of an internal auditor** at least once every five years and, based on the outcome, make a recommendation to the Board of Directors for award of contract **** Current Internal Audit contract term is 1 April 2023 – 31 March 2026 (with a two-year extension option)***																
6.	**Approval of the internal audit plan and counter fraud plan** based on risk assessments	Internal Audit											• *Draft*		• *Final*	• *Final*	
7.	**Review of internal audit plan** to ensure it remains consistent with Trust priorities	Internal Audit		•		•		•		•			•		•	•	
8.	**Review of internal audit reports issued since last meeting** and major audit issues arising from audits in progress	Internal Audit		•		•		•		•			•		•	•	
9.	**Review of internal audit follow up report** including follow up of outstanding recommendations and ongoing review of key governance processes	Internal Audit		•		•		•		•			•		•	•	
10.	**Review of Local Counter Fraud specialist activities** through consideration of progress reports	Local Counter Fraud Specialist (LCFS)		•		•		•		•			•		•	•	
11.	**Counter Fraud Annual Report**	LCFS		•											•	•	
12.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	Internal Audit / LCFS		•		•		•		•			•		•	•	

			2024									2025					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
External Audit																	
13.	Oversee, in liaison with the Council of Governors, the conduct of a **market testing exercise for the appointment of an external auditor** at least once every five years and, based on the outcome, make a recommendation to the Council of Governors for award of contract **** External Audit contract term ends in June 2027 with an option to extend by further 2 years.***																
14.	**Assess the external auditor's work and fees** and make recommendation to the Council of Governors re re-appointment or removal of the auditor ****See 13. above***																
15.	**Approval of the external audit plan**, based on risk assessments, and the proposed fee for the next year	External Audit											•				
16.	**External Audit Update Report** including review of outstanding implementation of recommendations with significant / fundamental status as required	External Audit		•		•		•		•			•		•	•	
17.	Policy on the engagement of the External Auditor to supply non-audit services **** Next due for review in Feb 2026***	Trust Secretary / Director of Finance															
18.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	External Audit		•	•	•		•		•			•		•	•	
19.	Private discussions with Internal and External Audit (if required)	Chair		•		•		•		•			•		•	•	
Year End Matters																	
20.	Review of **Accounting Policies**	Chief Finance Officer											• *Draft*		•	•	
21.	Review of **annual accounts progress** and **agreement of final accounts process and timetable**	Chief Finance Officer		•											•	•	
22.	**Annual Report and Accounts** review and recommendation to the Board	Chief Finance Officer / Trust Secretary		• *Draft*	• *Final*										• *Draft*	• *Draft*	• *Final*
23.	**Review of Going Concern basis of preparation**	Chief Finance Officer		•											•	•	
24.	Review **Annual Governance Statement** (AGS) **and related disclosure statements** and make	Chief Executive /		• *Draft*	• *Final*										• *Draft*	• *Draft*	• *Final*

			2024									2025					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
	recommendation to the Board	Trust Secretary															
25.	Receipt of **Annual Internal Audit Annual Report and Head of Internal Audit Opinion**	Internal Audit		•											•	•	
26.	**Audit Completion Report including Auditor's Report**	External Audit			•												•
27.	**Audit Annual Report**	External Audit			•												•
28.	**Management Representation letter: Financial Accounts**	Chief Finance Officer			•												•
29.	Review of **losses and special payments**	Chief Finance Officer				•							•				
30.	Review **Declaration of Interests Annual Report**	Trust Secretary		•											•	•	
31.	Review of **NHS Provider Licence** Compliance	Trust Secretary														•	
32.	Review of **NHS Code of Governance**	Trust Secretary														•	
Board Committees																	
33.	Reports from Board Committee Chairs	Committee Chairs		•		•		•		•			•		•	•	
Subgroups																	
34.	**Risk Management Committee** Key Issues Report *July meeting to confirm Terms of Reference and Work Plan*	Chief Executive		•		•		•		•			•		•	•	
Committee Business																	
35.	**Annual Review of Audit Committee, inc. review of Terms of Reference, Work Plan and Formal Committee Evaluation**	Chair				•											
36.	Informal Review of Committee Effectiveness	Led by Chair		•	•	•		•		•			•		•	•	•

NB. Subject to NHSE financial accounting and reporting requirements for 2024/25, year-end meetings will take place in April/May/June 2025 and the work plan will be followed accordingly.

NHS Stockport NHS Foundation Trust

Board of Directors
2024/25 Annual Workplan

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Standing Items														
Welcome and Apologies	Chair	Oral	✓		✓		✓		✓		✓		✓	
Patient Story	Chief Nurse	Film	✓		✓		✓		✓		✓		✓	
Declarations of Interest	All	Oral	✓		✓		✓		✓		✓		✓	
Minutes of the Previous Meeting	Chair	Paper	✓		✓		✓		✓		✓		✓	
Matters Arising	Chair	Paper	✓		✓		✓		✓		✓		✓	
Action Tracker	Chair	Paper	✓		✓		✓		✓		✓		✓	
Chairs Report	Chair	Paper	✓		✓		✓		✓		✓		✓	
Chief Executive Report	Chief Executive	Paper	✓		✓		✓		✓		✓		✓	
Board Committee Key Issues Reports - People Performance - Finance & Performance - Quality Committee - Audit Committee	Chairs of Committee	Paper	✓		✓		✓		✓		✓		✓	
Trust Planning														
Operational Plan (Draft / Final) • Activity • Workforce • Finance including Capital • Self Certification	Director of Strategy & Partnerships	Paper	✓				✓						✓	✓
Opening Budgets Approval	Chief Finance Officer	Paper	✓ (2025)				✓							
Annual Corporate Objectives & Outcome Measures (Approval and Mid-Year Review)	Director of Strategy & Partnerships	Paper	✓		✓						✓			
Strategy														
SFT Strategy Refresh	Director of Strategy & Partnerships	Paper												✓
GM Provider Collaboration	Director of Strategy & Partnerships	Paper	✓ (2025)						✓					
SFT & T&G Collaboration	Director of Strategy & Partnerships	Paper					✓						✓	

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
People														
NHS Staff Survey	Director of People & OD	Paper	✓											
Workforce Equality, Diversity & Inclusion Strategy Progress Report *(Including WRES, WDES, Equality Monitoring, Gender Pay Gap)*	Director of People & OD	Paper			✓									
Freedom to Speak Up Report	Freedom to Speak Up	Paper	✓		✓				✓				✓	
Well Being Guardian Report	Well Being Guardian	Verbal					✓						✓	
Guardian of Safe Working Annual Report	Guardian of Safe Working / Medical Director	Paper									✓			
Medical Appraisal & Revalidation Report	Medical Director	Paper							✓					
Staff Exclusions	Director of People & OD	Paper	✓		✓		✓		✓		✓		✓	
People & Organisational Development Plan Progress Report	Director of People & OD	Paper					✓						✓	
Safer Care Report	Chief Nurse / Medical Director	Paper	✓		✓		✓		✓		✓		✓	
Annual Nursing & Midwifery Establishments	Chief Nurse	Paper									✓			
Quality														
Annual Quality Strategy Progress Report	Chief Nurse	Paper			✓									
Annual Research, Innovation & Development Strategy Progress Report	Medical Director	Paper					✓							
Annual Safeguarding Report	Chief Nurse	Paper					✓							
Annual Health & Safety Report	Chief Nurse	Paper			✓									
Infection Prevention Control Report	Chief Nurse	Paper							✓					
Annual CNST Declaration/Submission	Chief Nurse	Paper											✓	
Maternity Report	Chief Nurse	Paper							✓				✓	
Annual Learning from Deaths	Medical Director	Paper					✓							
Annual EPRR Report - Core Standards and Statement of Compliance	Chief Finance Officer	Paper									✓			
Transformation / Continuous Improvement Strategy Report (Opening & Mid-Year)	Director of Transformation	Paper			✓						✓			

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Place - Locality Provider Partnership	Director of Strategy & Partnerships	Paper	✓ (2025)						✓					
Finance & Performance														
Integrated Performance Report	All	Paper	✓		✓		✓		✓		✓		✓	
Finance Report including Cost Improvement Programme and Capital	Chief Finance Officer	Paper	✓		✓		✓		✓		✓		✓	
Green Plan Annual Report	Director of Estates & Facilities	Paper			✓									
Site Development Strategy – Progress Report	Director of Estates & Facilities	Paper					(Deferred)	✓					✓	
Digital Strategy Progress Report	Director of Informatics	Paper					✓						✓	
Business Case / Contract Award Approval *(As Required)*	Executive Director Lead	Paper	-		-		-		-		-		-	
Governance														
Board Assurance Framework & Significant Risk Register	Chief Executive	Paper	✓				✓		✓				✓	
Risk Management Strategy & Policy	Chief Nurse	Paper					✓							
Annual Self-Certification (CoS7)	Trust Secretary	Paper			✓									
Code of Governance Annual Assessment	Trust Secretary	Paper	✓											
Going Concern	Chief Finance Officer	Paper			✓									
Standards of Business Conduct: - Fit and Proper Persons - Register of Directors' Interests - Non-Executive Director Independence	Trust Secretary	Paper											✓	
Register of Sealed Documents	Trust Secretary	Paper	✓											
Standing Financial Instructions & Scheme of Reservation & Delegation	Chief Finance Officer	Paper	✓											
Annual Report & Accounts (Additional Meeting)														
Quality Accounts	Chief Nurse	Paper			✓									
Annual Report including Annual Governance Statement	Trust Secretary	Paper			✓									
Annual Accounts	Chief Finance Officer	Paper			✓									
Charitable Funds Annual Report & Accounts *(Corporate Trustee Meeting)*	Chief Finance Officer	Paper									✓			

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Any Other Business	Chair	Oral	✓		✓		✓		✓		✓		✓	
Board Work Plan and Attendance record	Chair	Paper	✓		✓		✓		✓		✓		✓	
Date and Time of Next Meeting	Chair	Oral	✓		✓		✓		✓		✓		✓	

NHS Stockport NHS Foundation Trust

Board of Directors
2024/25 Annual Attendance

Member	Name	4 Apr 24	25 Apr 24	May 24	6 Jun 24	26 Jun 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Interim Chair	Marisa Logan-Ward	Y	Y	Y	Y	Y								
Chief Executive	Karen James	Y	Y	Y	Y	Y								
Chief Finance Officer/Deputy Chief Executive	John Graham	A	Y	Y	Y	Y								
Medical Director	Andrew Loughney	Y	Y	Y	Y	Y								
Chief Nurse	Nic Firth	A	Y	A	A	A								
Director of Operations	Jackie McShane	Y	Y	Y	Y	A								
Director of People & OD	Amanda Bromley	Y	Y	Y	Y	Y								
Director of Strategy & Partnerships*	Paul Buckley	Y	Y	Y	Y	Y								
Director of Communications & Corporate Affairs*	Caroline Parnell	Y												
Senior Independent Director/Non-Executive Director	Louise Sell	Y	Y	Y	Y	Y								
Non-Executive Director	Samira Anane	Y	Y	A	Y	Y								
Non-Executive Director	Tony Bell	Y	Y	Y	A	Y								
Non-Executive Director	Beatrice Fraenkel	Y	Y	A	Y	A								
Non-Executive Director	David Hopewell	Y	Y	Y	Y	Y								
Non-Executive Director	Mary Moore	A	Y	Y	Y	Y								
*Non-Voting														
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**								
Key														
Y	= Present													
A	= Apologies													
A(D)	= Attended as Deputy													