Public Board meeting

Thu 06 June 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

09:30 - 09:30
0 min

2. Declaration of Interests (Verbal)

All

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 4 April 2024 (Paper)

Decision *Marisa Logan-Ward*

04 - Public Board Minutes - 4 April 2024.pdf (13 pages)

09:40 - 09:40
0 min

5. Action Log (Paper)

Information *Marisa Logan-Ward*

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

09:40 - 09:50
10 min

6. Chair's Report (Paper)

Discussion *Marisa Logan-Ward*

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

09:50 - 10:00
10 min

7. Chief Executive's Report (Paper)

Discussion *Karen James*

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

TRUST PLANNING

10:00 - 10:15
15 min

8. Corporate Objectives (Paper)

Decision *Karen James*

- **Review of Outcome Measures 2023/24**
- **Approval of Outcome Measures 2024/25**

08a - Corporate Objectives - Year End Progress 2023-24.pdf (9 pages)
08b - Corporate Objectives 2024-25 Outcome Measures.pdf (6 pages)

FINANCE & PERFORMANCE

10:15 - 10:35
20 min

9. Integrated Performance Report (Paper)

Discussion *Karen James / Executive Directors*

- **Quality**
- **Operational Performance**
- **Workforce**
- **Finance**

09a - Integrated Performance Report - Front Sheet June 2024.pdf (2 pages)
09b - Integrated Performance Report - May 2024.pdf (18 pages)

10:35 - 10:45
10 min

10. Finance Report - Financial Position Month 1 (Paper)

Discussion *John Graham*

10a - Financial Position 2023-24 closing and 2024-25 opening- Front Sheet.pdf (3 pages)
10b - Financial position 2023-24 year end and opening 2024-25 Final.pdf (14 pages)

10:45 - 10:55
10 min

11. Green Plan Annual Report 2023/24 (Paper)

Discussion *Paul Featherstone (Director of Estates & Facilities)*

11 - Green Plan Progress Report 2023-24 - June 2024.pdf (8 pages)

PEOPLE

10:55 - 11:10
15 min

12. Workforce Equality, Diversity & Inclusion Strategy Report (Paper)

Discussion *Amanda Bromley*

12 - EDI Strategy Update (Stockport) 060624.pdf (26 pages)

11:10 - 11:20
10 min

13. Freedom to Speak Up Report (Paper)

Discussion *Amanda Bromley*

13 - Freedom to Speak Up Report.pdf (11 pages)

11:20 - 11:30
10 min

14. Safer Care Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

14a - Safer Care Report - June 2024.pdf (2 pages)
14b - Safer Care Report - June 2024.pdf (26 pages)

11:30 - 11:40
10 min

COMFORT BREAK

QUALITY

11:40 - 11:50
10 min

15. CQC Maternity Services Inspection Report (Paper)

Discussion *Nicola Firth*

- 15a - Maternity Services CQC Inspection Report and Action Plan.pdf (2 pages)
- 15b - CQC Inspection Report - Maternity Services.pdf (25 pages)
- 15c - CQC Action Plan Maternity Inspection September 2023 Final.pdf (10 pages)

11:50 - 11:50
0 min

16. Annual Quality Strategy Report 2023/24 and Objectives 2024/25 (Paper)

Discussion *Nicola Firth / Andrew Loughney*

- 16 - Quality Strategy Report 2023-24 & Objectives 2024-25.pdf (41 pages)

11:50 - 12:00
10 min

17. Annual Health & Safety Report 2023/24 (Paper)

Discussion *Nicola Firth*

- 17 - Annual Health and Safety Report 2023-24.pdf (15 pages)

12:00 - 12:15
15 min

18. Transformation Annual Report 2023/24 (Paper)

Discussion *Hannah Silcock (Assistant Director of Transformation)*

- 18a - Transformation Annual Report 2023-24 - Front Sheet.pdf (3 pages)
- 18b - Transformation Annual Report 2023-24.pdf (31 pages)

GOVERNANCE

12:15 - 12:25
10 min

19. Annual Licence Self Certification (CoS7) (Paper)

Decision *John Graham*

- 19 - Annual Self-Certification - CoS7.pdf (6 pages)

12:25 - 12:30
5 min

20. Going Concern Declaration (Paper)

Decision *John Graham*

- 20 - Going Concern Declaration 2023-24.pdf (4 pages)

STANDING COMMITTEE REPORTS

12:30 - 12:50
20 min

21. Board Committees Key Issues Reports (Paper)

Information

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

21.1. People Performance Committee

Information *Beatrice Fraenkel*

21b - People Performance Committee Key Issues Report - May 2024.pdf (3 pages)

21.2. Finance & Performance Committee

Information *Anthony Bell*

21c - Finance & Performance Committee - Key Issues Report - May 2024.pdf (4 pages)

21.3. Quality Committee

Information *Mary Moore*

21d - Quality Committee Key Issues Report - May 2024.pdf (5 pages)

21.4. Audit Committee

Information *David Hopewell*

21e - Audit Committee Key Issues Report - 21st May 2024.pdf (4 pages)

CLOSING MATTERS

12:50 - 12:50
0 min

22. Any Other Business (Verbal)

12:50 - 12:50
0 min

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

Information

23 - 2024-25 Board of Directors Annual Workplan & Attendance.pdf (5 pages)

DATE, TIME & VENUE OF NEXT MEETING

12:50 - 12:50
0 min

24. Thursday, 1 August 2024, 9.30am, Pinewood House Education Centre

12:50 - 12:50
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 4 April 2024, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Dr Marisa Logan-Ward	Interim Chair
Dr Samira Anane	Non-Executive Director
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & Organisational Development
Mrs Beatrice Fraenkel	Non-Executive Director
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
Mrs Caroline Parnell	Director of Communications & Corporate Affairs*
Dr Louise Sell	Non-Executive Director

In attendance:

Mr Paul Buckley	Director of Strategy & Partnerships*
Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary
Mrs Kay Wiss	Director of Finance
Ms Nadia Walsh	Freedom to Speak Up Guardian *(for item 40/24)*

Observing:

Mrs Sue Alting	Lead Governor
Dr Tushar Mahambrey	Deputy Medical Director
Ms Joanne Martin	Head of Learning & Education

Apologies:

Mrs Nic Firth	Chief Nurse
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mrs Mary Moore	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
31/24	**Apologies for Absence** The Interim Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
32/24	**Declarations of Interest** There were no declarations of interest.	
33/24	**Patient Story** The Board of Directors watched a video from the Volunteers Guiding Team,	

	highlighting the value of Volunteers in guiding members of the public. The Board heard from the Trust's Volunteer Services Manager and two Volunteer Guides who had chosen to volunteer having used the Trust's services previously. The Board of Directors recognised the significant value added by Volunteers and the Interim Chair advised that the Trust held an annual celebration event for Volunteers to acknowledge their contribution. Mr Tony Bell, Non-Executive Director and Mrs Beatrice Fraenkel, Non-Executive Director, queried about the diversity mix of Volunteers and how feedback is captured from Volunteers and other public facing staff regarding themes raised by patients and the public, both anecdotally and more formally, including communicating back how the feedback is used to shape services. The Trust Secretary noted that Volunteers reported to the Patient Experience Group, which reported to the Quality Committee. In addition, the Council of Governors Membership Strategy and Action Plan included the introduction of a 'Meet with Volunteers' session between Governors and Volunteers, which would provide another avenue for capturing feedback. Dr Louise Sell, Non-Executive Director, added that the Chief Nurse was leading a piece of work to improve patient experience reporting. **The Board of Directors received and noted the Patient Story.**	
34/24	**Minutes of Previous Meeting** The minutes of the previous meeting held on 1 February 2024 were agreed as a true and accurate record. The Interim Chair referred to minute number 15/24 in relation to Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assessment, and queried the status of the implementation of key actions to achieve full compliance by March 2024. The Chief Executive provided an update on ongoing work in this area, noting that the outcome would be reported to the relevant Board Committee. The Trust Secretary confirmed that EPRR reported to Health & Safety Group, which reported to the Quality Committee.	
35/24	**Action Log** The action log was reviewed and annotated accordingly.	
36/24	**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 external partnerships, Trust activities and strengthening Board oversight. The Interim Chair highlighted her attendance at the Stockport Health & Wellbeing Board (HWB) and noted that going forward, she was intending to share some of the HWB reports with the Board of Directors for information. **The Board of Directors received and noted the Chair's Report.**	
37/24	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and	

	national strategic and operational developments, including: • Spring budget • Industrial action • Mental health service developments • Operational pressures • Estate issues • Covid memorial exhibition • National Joint Registry • NHS Communicate Award • Learning of the Year • Auditor of the Year In response to a question from the Interim Chair querying how productivity was being defined and measured at Greater Manchester (GM) system and regional level, the Chief Executive advised that a matrix was being used to benchmark against, which included national benchmarking data. She noted that a matrix was being developed for workforce productivity, and in response to a comment from Mrs Beatrice Fraenkel, Non-Executive Director, she acknowledged that the information would need to be triangulated with quality and safety. In response to a question from Mr Tony Bell, Non-Executive Director, querying whether the increased costs associated with industrial action would be funded, the Director of Finance noted uncertainty in this area. **The Board of Directors received and noted the Chief Executive's Report.**	
38/24	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Quality** The Medical Director presented the quality section of the IPR and highlighted challenges and mitigation actions regarding sepsis, infection prevention & control, incidents, pressure ulcers and complaints due to under-achievement in month. The Medical Director advised that the Trust continued to perform well against the timely recognition of sepsis metric and achieving performance above target levels. He noted, however, that antibiotic administration within the necessary timescales continued to be challenging, highlighting key themes in this area. The Medical Director advised that infection rates for C.diff, E.coli and MRSA continued to be significantly higher than associated thresholds and briefed the Board on mitigating actions. The Medical Director reported that hospital acquired level-2 pressure ulcers remained within target threshold, however category 2 community acquired pressure ulcers were a concern, largely due to issues relating to patient decision making. The Medical Director advised that written complaints received had not	

achieved target for two consecutive months, noting that communication had been identified as one of the top two reasons for both formal and informal complaints.

Operational

The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), outpatient efficiency, and theatre efficiency metrics due to under-achievement in month.

The Board heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers for Emergency Department (ED) and Diagnostics performance. It was noted that the metrics had been adversely impacted by the BMA industrial action as well as estate challenges.

The Director of Operations reported that ED had seen a significant increase in attendances year-on-year, adversely impacting 4-hour and 12-hour performance. She briefed the Board on mitigating actions, highlighting a piece of work being undertaken with the locality to understand drivers in this area.

The Director of Operations highlighted challenges with timely access to care home beds, which continued to impact the Trust's ability to discharge or transfer patients with 'no criteria to reside' (NCTR) in a timely manner.

With regard to diagnostics, the Director of Operations advised that imaging and endoscopy had recovered compliance, but ECG remained an area of concern, noting mitigating actions in place.

The Board heard that cancer performance had continued to improve across all standards, with 28-day and 2-week wait performance ahead of target. The Director of Operations advised that RTT continued to show significant improvement, albeit issues with 18-week incomplete pathways remained.

The Chief Executive highlighted the requirement for mutual aid and advised that work was ongoing in GM to establish a single waiting list for elective care and diagnostics, to enable patients to be offered choice across different organisations.

Mr Tony Bell, Non-Executive Director, noted that while the Trust was not forecasting to achieve any of the four core standards, performance compared favourably against GM peers in a number of areas. He also acknowledged year on year improvements and positive performance in areas such as theatre efficiencies and outpatients. The Interim Chair endorsed these comments and welcomed the improvements made in faster diagnostic performance.

In response to a question from Dr Samira Anane, Non-Executive Director, querying if the ED conversion rate had increased from last year, the Director of Operations confirmed that the rates had remained fairly static, noting regular audits in this area. The Chief Executive highlighted an increase in acuity, noting that this would need to be taken into account in future service

planning.

In response to a comment from Mrs Beatrice Fraenkel, Non-Executive Director, noting the need to take account of population growth and mix in strategic planning, the Chief Executive confirmed that population needs were being considered at locality level and the Board would be kept updated on the work of the provider collaborative.

People
The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around sickness absence, agency costs, workforce turnover, appraisal and mandatory training rates due to under-performance in month.

The Director of People & OD reported that sickness absence was above target for February, noting that the position had improved from January. She briefed the Board on mitigating actions, including targeted support and promotion of health & wellbeing initiatives.

The Director of People & OD advised that agency costs had increased in February, noting a focus on reducing high cost agency spend.

The Director of People & OD stated that whilst workforce turnover was still above the target, performance continued on an improved trajectory. It was noted that whilst mandatory training compliance was also showing improvement, performance had been adversely impacted by industrial action.

Mr Tony Bell, Non-Executive Director, referred to the sickness absence trends and queried whether sickness absence was reflective of operational pressures. The Director of People & OD noted that sickness absence levels tended to increase over the winter period, and therefore the increase since October was not unexpected. She advised that real time issues continued to be picked up in between staff surveys, for example through pulse surveys and discussions with staff.

Finance
The Director of Finance presented the finance section of the IPR, noting that more detailed financial information was provided under a separate agenda item.

Mr Tony Bell, Non-Executive Director, requested clearer articulation of challenges in the report's executive summary going forward.

In response to a question from Dr Louise Sell, Non-Executive Director, querying the Trust's decision-making process when going above planned escalation capacity, the Director of Operations confirmed that the Trust had a Full Capacity Protocol in place which was followed when 100% bed occupancy was reached. She advised that that this linked in with Opel actions that included system partners, with a focus on decompressing.

In response to a question from Mr David Hopewell, Non-Executive Director, the Chief Executive and Director of Finance advised that discussions were ongoing on how the Outpatients B demolition would be treated.

	The Board of Directors received and noted the Integrated Performance Report.	
39/24	**Finance Report – Financial Position Month 11** The Director of Finance presented a report providing an update on financial performance for Month 11 2023/24, summarising key extracts from a report presented to the Finance & Performance Committee. The Board heard that the Trust had a deficit of £31.1m at Month 11 2023/24, which was an adverse variance of £2.4m to plan. The Director of Finance reported that, subject to known risks as agreed within the GM ICB, the Trust was forecasting to: - deliver its financial plan for 2023/24 - deliver its capital plan for 2023/24 - deliver its savings plan for 2023/24 with a requirement for increased recurrent delivery - require cash borrowing in March 2024, which was subject to national approval. The Director of Finance stated 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. In response to a question from the Interim Chair querying resolution for the Derbyshire Integrated Care Board (ICB) contract issues, the Chief Executive advised that discussions continued between GM and Derbyshire ICBs in this area. **The Board of Directors received and noted the Finance Report.**	
40/24	**Freedom to Speak Up Report including Annual Self-Assessment and Reflection Tool** The Board of Directors welcomed Ms Nadia Walsh, Freedom to Speak Up Guardian, to the meeting. The Freedom to Speak Up Guardian presented a report providing an overview of her activities since the previous report. She briefed the Board on the content of the report and highlighted the successful awareness campaign held during the Freedom to Speak Up Month, which had resulted in increased reporting and awareness, and the implementation of the Freedom to Speak Up Champions Programme. The Board heard that there had been a significant rise in concerns raised during the reporting period, which was likely to be a consequence of the awareness campaign. The Freedom to Speak Up Guardian briefed the Board on themes and trends observed, noting concerns around communication within the Community Services and the behaviour of some managers which was negatively impacting on staff's willingness to report issues. The Board acknowledged the importance of psychological safety to help foster a safe speaking out culture. Mrs Beatrice Fraenkel, Non-Executive Director, stressed the need for a	

	continued review of FTSU capacity and resource requirements to ensure these remained appropriate. In response to a question from Mr Tony Bell, Non-Executive Director, querying triangulation between FTSU cases and staff survey results, the Director of People & OD noted that there were no surprises regarding concerns raised, and advised that the Organisational Development Plan focused on compassionate care, including introduction of the Civility Saves Lives programme. In response to a question from Dr Louise Sell, Non-Executive Director, seeking assurance regarding action taken to address the issue of fear of detriment for staff raising concerns, the Director of People & OD confirmed that a process was in place for management teams to take action as required, with issue/s to be further escalated to the Executive Team if necessary. In response to a comment from Mrs Beatrice Fraenkel, Non-Executive Director, about staff feeling confident to raise concerns, particularly those from ethnic minority backgrounds, the Director of People & OD advised that FTSU was only one mechanism for staff to raise concerns, with other mechanisms available including big conversations, walk arounds and staff networks. The Director of Communications & Corporate Affairs presented a Freedom to Speak Up (FTSU) Annual Self-Assessment. The Board heard that each year the National Office of the FTSU Guardian recommended that NHS organisations undertake a self-reflection exercise, assessing themselves against a number of statements set out in a reflection and planning tool. The Board received the outcome of the assessment, which had been completed by the FTSU Guardian and Executive and Non-Executive Director leads, acknowledging improvements made over the past year and focus areas for 2024/25. It was noted that the self-assessment toolkit had been considered in detail by the People Performance Committee. The Interim Chair suggested that it would be helpful to include year on year tracking of scores in future reports to enable progress monitoring. **The Board received and noted the Freedom to Speak Up Report and Annual Self-Assessment and Reflection Tool.**	
41/24	**NHS Staff Survey 2023** The Director of People & OD presented the results of the 2023 National Staff Survey. She briefed the Board on the content of the report, noting an overall response rate of 43.49%, which was 1.12% higher than previous year. The Board heard that the staff survey questions had been mapped to the elements and themes within the NHS People Promise, and the Director of People & OD was pleased to report that the Trust had performed best against the Staff Engagement theme in comparison to GM peers. She also advised that the Trust had achieved the third highest score for the 'We are always learning' and 'We are a Team' themes in comparison to the North West benchmarking group.	

	The Board noted the following areas of strength: • Staff feel more positive about the Trust being a great place to work and receive treatment. • They are recognised and rewarded for the valuable contribution they make. • Line managers are more compassionate and supportive, and teams are working better together. • Staff have more opportunities to improve their knowledge and skills so they can reach their full potential. The Board noted the following key areas of focus: • Helping colleagues to put into practice the learning from our Civility Saves Lives Programme and become a more civil and respectful place to learn, develop and work. • Improving appraisal discussions ensuring they are two-way, meaningful and better inform learning and development. • Introducing new approaches to supporting career progression and taking positive action to eliminate discrimination and under representation. • Continue to support colleagues to improve their health and wellbeing and manage work pressures. In response to a question from Dr Louise Sell, Non-Executive Director, querying if a process was in place for individual staff groups to consider their results and review differences between NHS People Promise outcomes, the Director of People & OD acknowledged that high level themes could be explored further. In response to a question from the Interim Chair regarding questions that had not shown any movement in scores since the previous survey, the Director of People & OD advised that any themes would be pulled through the Workforce Race Equality Standard and Workforce Disability Equality Standard reports. The Board of Directors welcomed the improved survey results and thanked colleagues for their hard work in this area, albeit acknowledging that further work was required to improve the response rate. **The Board of Directors received and noted the results of the NHS Staff Survey 2023.**	
42/24	**Safe Care (Staffing) Report** The 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 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.	

	In response to a question from Mr Tony Bell, Non-Executive Director, querying the issue of obtaining accurate information on vacancies, the Director of People & OD and Director of Finance advised that this related to issues with the correlation of information between Trac and ESR and briefed the Board on mitigating actions. In response to a question from Mr Tony Bell, Non-Executive Director, querying difficulties in identifying sustainable funding for the Staff Psychology and Wellbeing Service (SPAWS), the Director of People & OD acknowledged the merit of the service, whilst highlighting challenges in measuring its impact and the need for service prioritisation in the context of significant financial challenges. Mrs Beatrice Fraenkel, Non-Executive Director, stressed the importance of appropriate investment to ensure quality and safe staffing. In response to a question from the Interim Chair about histology backlog issues, the Medical Director confirmed that further detail would be included in the next iteration of the report. **The Board received and noted the Safe Care (Staffing) Report.**	
43/24	**Corporate Objectives 2024/25** The Chief Executive presented a report detailing the proposed Corporate Objectives for 2024/25. She briefed the Board on the content of the report, which proposed that the 2023/24 Corporate Objectives be rolled over to 2024/25, as the priorities remained valid in light of national, system and locality requirements. The Board heard that detailed outcome measures would be presented to the Board of Directors in June 2024. The Interim Chair highlighted the importance for the metrics to be SMART, with focused measurement of what was trying to be achieved. **The Board of Directors reviewed and approved the Corporate Objectives 2024/25.**	
44/24	**Board Assurance Framework 2023/24 – Quarter 4** The Chief Executive presented the Board Assurance Framework (BAF) 2023/24 as at the end of Quarter 4, noting that all BAF risks were regularly reviewed by relevant Board Committees. She briefed the Board on the report and the principal risks and associated mitigations. Furthermore, a gap analysis between current and target risk score was provided. The Board heard that risks relating to the current estate and securing funding for the strategic regeneration of the hospital campus were the highest scoring risks. It was noted that other significant risks continued to be delivery of the annual financial position and future financial sustainability; delivery of operational access standards and restoration of services; and workforce challenges. Non-Executive Directors reflected on the consideration of BAF risks at Board Committees, confirming support to the proposed risk scores. Mr Tony Bell, Non-Executive Director, referred to a discussion held at the Finance & Performance Committee, where it had been suggested that the 2024/25 strategic risks should be reviewed to ascertain whether they should all be	

	assigned to Committees or if some should sit with the Board. In response to questions from Mrs Beatrice Fraenkel, Non-Executive Director, about the GM Integrated Care Board (ICB) risk register and how risk was managed at ICB level, the Chief Executive advised that the ICB was developing their risk register, noting that the process was an evolving one. Mrs Fraenkel expressed view that it was important for the ICB to understand the consequence of its actions on individual trusts. **The Board of Directors reviewed and approved the Board Assurance Framework 2023/24 as at Quarter 4, including action proposed to mitigate risks.**	
45/24	**Standing Financial Instructions and Scheme of Reservation and Delegation** The Director of Finance presented updated Standing Financial Instructions (SFIs) and Scheme of Reservation & Delegation (SORD), noting that these had been reviewed by the Audit Committee and were recommended to the Board of Directors for approval. She briefed the Board on the content of the report, highlighting key changes proposed to the SFIs and SORD. In response to a question from the Interim Chair querying the changes to the SORD in relation to the Reservation of Powers for the Council of Governors, the Trust Secretary confirmed that the inclusion reflected existing statutory duties of governors and was in line with best practice and supported compliance with the code of governance for provider trusts. **The Board of Directors reviewed and approved the Standing Financial Instructions and Scheme of Reservation & Delegation.**	
46/24	**Annual Review of NHS Provider Trust Code of Governance** The Trust Secretary confirmed an annual review of the Trust's compliance with the FT Code of Governance had been undertaken, with a compliance checklist appended to the report. She stated that the Trust complied with the Code's provision, expect for: - **Explain: Provision C.4.7** – Boards strongly encouraged to carry out an externally facilitated developmental review using the well-led framework at least every three years. - **Explain: Provision E.2.2** – Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure. The Trust Secretary advised that the Trust's Annual Report 2023/24 would confirm compliance with the provisions of the Code and an explanation of the reasons for departure from provisions C.4.7 and E.2.2 on the basis that: - An independent board governance review was completed by Deloitte LLP during 2014/15. Subsequently a series of external reviews including CQC Well Led Inspection (October 2018 and February 2020) and NHS England/Improvement Governance Review (November 2019) undertaken. An independently facilitated Well Led mapping review was conducted by AQuA in 2021, providing an overview of the Trust's evidence against the Key Lines of Enquiry (KLOEs) within the Well Led framework, and developmental actions for the purpose of	

	continuous improvement. In March 2023, completion of self-assessment and agreed KLOE ratings considered by Board, March 2023. Full external facilitated review not undertaken; internal audit plan utilised to undertake a Well led Position Statement (Substantial Assurance). *(Provision C.4.7)* - In February 2022, the Council of Governors agreed that all new Non-Executive Director positions would be remunerated in line with 'NHS England Chair and non-executive director remuneration structure'. This decision has subsequently been implemented. Furthermore, the Council of Governors agreed that existing Non-Executive Directors, who are reappointed for a further term of office, would remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective, thereby differing to the 'NHS England Chair and non-executive director remuneration structure'. The Chair's remuneration is in line with the NHS England remuneration structure. *(Provision E.2.2)* **The Board of Directors reviewed and confirmed the outcome of the annual review of compliance with the Code of Governance, including disclosures to be included within the Annual Report 2023/24.**	
47/24	**Annual Trust Seal Report** The Trust Secretary presented a report on the use of the Common Seal during 2023/24. **The Board of Directors received and noted the report and confirmed the use of the Common Seal during 2023/24.**	
48/24	**Board Committees Annual Review: Including Terms of Reference and Work Plans for Approval** The Trust Secretary presented the outcome of the annual reviews of Board Committees (Finance & Performance Committee, People Performance Committee and Quality Committee) including confirmation of the effective operation of the Committees during the year, opportunities for improvement and review of the Terms of Reference and Work Plans, which were presented for approval. The Trust Secretary confirmed that the annual review of the Remuneration Committee and Audit Committee would be presented to the Board in June 2024 and August 2024 respectively, following year-end meetings of these Committees. Mr Tony Bell, Non-Executive Director, welcomed the evaluation process and in particular the identification of opportunities for improvement. **The Board of Directors reviewed and approved the outcome of the Board Committee Annual Reviews 2023/24 including approval of the Terms of Reference and Work Plans for the following:** - **Finance & Performance Committee** - **People Performance Committee** - **Quality Committee**	

49/24	**Board Committees – Key Issues Reports** **People Performance Committee** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the key issues report from the People Performance Committee meeting held on 14 March 2024. She briefed the Board on the content of the report and detailed key people related issues considered. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues reports from Finance & Performance Committee meeting held on 15 February 2024 and 21 March 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 Acting Chair of Quality Committee (Dr Louise Sell, Non-Executive Director) presented the key issues report from the Quality Committee meetings held on 27 February 2024 and 26 March 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.** • **Reviewed and supported the Local Maternity and Neonatal Systems (LMNS) Submission as recommended by the Quality Committee** **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 20 February 2024. He briefed the Board on the content of the report and detailed key issues considered. **The Board of Directors reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.**	
50/24	**Any Other Business** The Chief Executive advised that this would be the last Board meeting attended by the Director of Communications & Corporate Affairs. The Board thanked the Director of Communications & Corporate Affairs for her contribution to the Board of Directors and expressed their best wishes for the future.	
51/24	**Date and Time of Next Meeting** Thursday, 6 June 2024, 9.30am, Pinewood House Education Centre.	

52/24	**Resolution** *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
01/22	1 Dec 2022	199/22	Freedom to Speak Up Toolkit	The Board of Directors agreed that a workshop / group maybe established to further consider and progress the toolkit prior to bringing it back to the People Performance Committee and Board if required. **Update February 2023** – Date to be confirmed. **Update March 2023** – Freedom to Speak Up Report, including update regarding Action Plan to progress recommendations from toolkit to be presented at PPC in May 2023, and determine if requirement for further workshop. **Update June 2023** – Discussed via PPC and agreed to defer establishing a working group at this time. Further action to be determined as required. **Update October 2023** – Further review of toolkit and action plan agreed to be presented to PPC in March 2024 – Confirmed on PPC Work Plan. The Board agreed to keep the action open as the toolkit would require Board sign off once it had been through PPC. **Update April 2024** – Toolkit on agenda. Action closed.	Director of People & OD / Director of Communications & Corporate Affairs	Closed

On agenda
Not due
Overdue
Closed

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

Meeting date	6th June 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 the Trust has continued to experience significant operational pressures both within the hospital and across community services. Our ageing estate, particularly on the hospital site, is a continuing challenge and regularly impacts on our services. This has become the focus of significant media attention over the last few weeks.

The GM system overall remains in a difficult position, both in terms of finances and operational performance. We continue to work with GM system leaders and partners to address the design and implementation of sustainable solutions.

Despite the challenges, the Trust is showing improvement across several of our operational performance metrics and continues to deliver against the NHS People Promise.

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

3. External Partnerships

I met with the CEO of Pennine Care NHS FT and discussed some of the exciting developments taking place, such as the opening of the new Female Psychiatry Intensive Care Unit at Stepping Hill and capacity and demand challenges across the locality. The mental health partnership across our respective organisations is working well. Non-Executive Directors from both Trusts are meeting in June as part of strengthening relationships.

I met with Caroline Simpson, CEO Stockport MBC, where we reflected on the improvements of partnership working at place and specific areas of challenge across health & care in 2024/25. We were optimistic about the approach to health prevention.

Following a successful board development session in April, further momentum is building around Stockport's partnership approach to tackling health inequalities. The Trust's Lead Nurse for Health Prevention and I met with the executives at Life Leisure CIC and explored areas for further collaboration on patient pathways and staff health and wellbeing.

4. Trust Activities

As part of the financial turnaround programme of NHS Greater Manchester ICB, supported by PwC, I have attended the Finance and Recovery Meetings with executive colleagues. The requirements of the programme remain a significant challenge, but focus remains on delivering high quality and safe care to our patients.

I visited our Gastroenterology Service and had a tour around our new JAG-accredited endoscopy department. It was great to hear how the service has evolved over the last 10 years from just two consultants to now ten consultants.

Colleagues from Research and Innovation gave a tour around the department on Ward C2. It was a real insight to see the scale of our research operation and discuss the opportunities for expanding our capability for clinical studies and partnerships. Research-active hospitals are associated with reduced mortality and improved overall care[1].

I spent an afternoon at Kingsgate House meeting teams who provide specialised community services: Continence, Heart Failure, Single Point of Access (SPOA), District Nursing, Diabetes, Dietetics, Pulmonary Rehab, Oxygen, Musculo-Skeletal/Physio and Orthotics.

I was invited by the Operational Support Team to observe the one of the monthly Long Length of Stay (LLOS) meetings chaired by the Deputy Medical Director. It was an insight into some of the complexities of discharges and demonstration of effective multidisciplinary team and multi-agency working to ensure our patients are safely discharged to the most appropriate place.

Another excellent annual Health & Wellbeing Event was held on 10th May in Pinewood. Very well attended and a good opportunity to talk to staff, partners and exhibitors about the Trust's health and wellbeing offer.

5. Strengthening Board Oversight

In line with NHS England good practice, I have carried out performance appraisals for the Chief Executive and all Non-Executive Directors. The process and outcome of those appraisals will be reported through the Remuneration Committee and Council of Governors, respectively.

The Senior Independent Director conducted my performance appraisal in line with Provider Chair Competency Framework and the outcome will be reported through the Nominations Committee and Council of Governors.

We held a Board Development Session focussed exclusively on the chair appointment and benefits of provider collaboration. This session wad externally facilitated which supported fresh perspective and questions to the discussion. We are currently planning sessions for July and September.

Following the Stockport NHS Foundation Trust Council of Governors meeting in May, the Council of Governors from both Tameside & Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust have supported the future appointment of a Joint Chair.

[1] Jonker L, et al. (2019) *Patients admitted to more research active hospitals have more confidence in staff and are better informed about their condition and medication: Results from a cross sectional study.* Journal of Evaluation in Clinical Practice.

The Joint Chair will be the chair of both Trusts' Board of Directors and Council of Governors, appointed through a single recruitment process.

Plans will now commence to develop and take forward a robust recruitment process, led by a Joint Nominations Committee of the Council of Governors. This process will support the Trusts in recruiting the best person to lead our organisations, driving even greater collaboration and delivering better outcomes for our patients, colleagues and the sustainability of both organisations.

6. Other activities

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

- Chair of Consultant Interview panels: Paediatrics, ENT Thyroid, Histopathology
- Regular discussions with Non-Executive Directors, Executive Directors, Chief Executive, and the Deputy Chief Executive, Chair of Tameside & Glossop NHS FT.
- Attended Maternity and Neonatal Safety Investigations Programme Team (MNSI) provider update meeting.
- Meetings with:
    - NW Regional Director and GM ICS Chief Executive
    - GM Trust Chairs
    - GM System Leaders
    - Lead Governor
    - Freedom to Speak Up Guardian
- Attended Staff Disability and Wellbeing Network
- Board sub-committee member: Charitable Funds.
- Chair - Council of Governors meeting (formal and informal meetings).

Meeting date	6th June 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:

- 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

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 Care Quality Commission (CQC)

Well Led
At the beginning of April, the CQC published guidance for trusts on assessing the well-led key question under its new approach. The guidance was developed jointly by CQC and NHS England.

The new approach is structured around eight quality statements for well-led, as set out under the new single assessment framework, with a strong focus on leadership, culture and governance. We will be exploring this further as part of our Board development programme.

Review of Care Quality Commission (CQC)
As part of the Cabinet Office's Public Bodies Review programme, the Cabinet Office and Department of Health and Social Care (DHSC) have confirmed a review of CQC's effectiveness is to be undertaken. The review programme aims to periodically review the governance, accountability, efficacy, and efficiency of existing arm's-length bodies, including in response to significant changes in approach.

Dr Penny Dash, Chair of North West London Integrated Care Board, has been appointed as Chair of the review, which was launched in May 2024 and is set to conclude findings in Autumn 2024. The review will investigate CQC's effectiveness and examine the suitability of CQC's new single assessment framework methodology for inspections and ratings of CQC.

2.2 NHS England Oversight & Assessment Framework

The NHS Oversight and Assessment Framework was last updated in 2022 and has been used to inform support requirements for improvement and regulatory action for both Integrated Care Boards (ICBs) and Provider Trusts.

NHS England has worked with a range of stakeholders to update the Framework and is currently in a period of short consultation based on a draft version. The updated version of the Framework intends to provide greater clarity regarding the roles and responsibilities of the different NHS organisations, achieve balance between the focus on immediate and medium-term priorities and outcome measures, clearly set out how organisations will be overseen, including a clear expectation of how NHS England will determine the support segmentation of Provider Trusts and assess ICBs.

It is anticipated the final Framework before will be launched in July 2024. In support of this, NHS England will also publish an Insightful Board series which will set out a

larger range of metrics that well governed Boards should be considering through their governance arrangements.

3. Greater Manchester System

The GM system is under national scrutiny, due to its significantly challenged financial and operational position. Following submission of the Trust's operational plan 2024/25 to GM in April 2024, GM is continuing to engage with NHS England and Trusts, particularly in relation to the financial and capital plans.

4. Trust

4.1 Operational Pressures

The Trust continues to operate under significant operational pressure, impacting our ability to achieve national access standards across both elective and non-elective care.

We ran a multi-agency discharge event (MADE) 20th May – 24th May. The event brought together our local health system to help support improved patient flow across the system, recognise and unblock delays, and where possible improve and simplify complex discharge processes. It included colleagues from across the Trust in both the hospital and community, the Integrated Care Board (ICB), our locality, social care, mental health services and the voluntary sector.

Our priority is to ensure that our patients are cared for in the right place, by the right service, at the right time. Good patient flow is essential to making this happen, and patient flow is everybody's business. During the MADE event, we encouraged teams and individuals to share their ideas about how we can improve patient flow and capacity.

We were also pleased to be praised by the NHS Cancer Programme, who recognised the work done to reduce the 62 day pathway backlog, and improve Faster Diagnosis Standard Performance, with the Trust moving out of Tier 1 support for cancer.

4.2 Estates Issues

Our ageing estate, particularly on the hospital site, continues to impact on our services. Recent incidents have included the closure of our Outpatient B department, and leaks in our radiology and ICU departments which temporarily cancelled or delayed procedures whilst the problems were resolved. Additionally, some operations have been delayed slightly due to the impact of building works for our new emergency and urgent care campus.

The age of our estate was one of the reasons for our application to the Government's New Hospitals Fund, which was unfortunately unsuccessful. While we still have ambitions to build a new hospital for the people of Stockport, 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. That will mean we are likely to experience more business continuity issues as the result of our ageing buildings.

4.3 Successes & Celebrations

Top in safety for bowel cancer surgery
New national audit results show that Stockport NHS Foundation Trust is among the safest places in the country for bowel cancer surgery.

The new results from National Bowel Cancer Audit (NBOCA) State of the Nation report reveal a 93% survival rate for patients undergoing bowel cancer, compared to the national average of 84%. That's the best rate in the North of England, and the second best throughout England and Wales.

Around 200 patients undergo bowel cancer surgery at Stepping Hill Hospital every year, with cases similar to other hospitals in terms of risk and complexity. The hospital has a specialist bowel cancer team which includes surgeons, oncologists, radiologists, radiographers, cancer nurses and stoma therapists, as well as state-of–the-art critical care facilities. This ensures each patient has the highest quality advice, support, and care throughout their time with the hospital.

Neonatal team receive top accreditation for integrated family care
The neonatal team based at Stepping Hill Hospital recently received the top level of national accreditation for a model of care which ensures close partnerships between midwives and families.

They received the top Green accreditation in Family Integrated Care (known as 'FICare') following an independent assessment from the North West Neonatal Operational Delivery Network (NWNODN).

FICare is a model of neonatal care first introduced in 2021 and promotes a culture of partnership between families and neonatal staff, enabling and empowering parents to become confident, knowledgeable, and independent primary caregivers.

Making a difference awards
The public are being offered their opportunity to say a big thank you to members of the Stockport NHS who have made a real difference to them.

Recognition of Stockport NHS staff or volunteers who have shown hard work, dedication or amazing care can be nominated in our Making A Difference Every day awards which are now open to the public through completion of an the online form.. An awards ceremony will be held later in the year to announce and celebrate the winners.

Dying Matters Week – New volunteers supporting enhanced end-of-life care

Our Trust introduced new specialist volunteers, 'SWAN companions' as part of

the new SWAN Model of Care being launched at throughout the Trust. The launch coincided with Dying Matters Awareness Week, 6 – 12th May 2024.

The SWAN Model is part of a national programme for NHS and other care staff, to support and guide a consistently high standard of care for patients and their families and carers during the last days and hours of life, and after death.

Implementing the SWAN Model has included developing and distributing new ward resources and patient information leaflets, and sourcing sensitive memory-making packs and comfort packs which are offered to families and carers.

NHS
Stockport
NHS Foundation Trust

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	8
Meeting	Board of Directors				
Report Title	Annual Corporate Objectives – Progress against Outcome Measures 2023/24				
Director Lead	Karen James, Chief Executive	**Author**	Paul Buckley, Director of Strategy & Partnerships Andy Bailey, Deputy Director of Strategy & Partnerships		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note progress in delivery of the Trust Objectives for 2023/24.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

✓	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
✓	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
✓	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
✓	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
✓	PR6.1	There is a risk that the Trust does not deliver the annual financial 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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	Objectives 1-4
Financial impacts if agreed/not agreed	Objective 6
Regulatory and legal compliance	Objective 1
Sustainability (including environmental impacts)	Objective 7

Executive Summary

This paper reports on progress against the Trust Objectives and Key Outcome Measures for 2023/24.

The Board will note that papers discussed at Board and its Committees are aligned with the corporate objectives. The key outcome measures relating to the Corporate Objectives for 2023/24 will be familiar to Trust Board members as these are discussed at the relevant Trust Board Committees.

The Trust Board is asked to note the year end position against the corporate objectives

Our Objectives for 2023/24

NHS Stockport NHS Foundation Trust

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.

Our Vision

To work with partners to improve health and wellbeing outcomes for the communities we serve

Our Values & Our Mission

Chris Soile 31/05/2024 13:23:44

We Care
About each other; our patients and their families; the communities we serve; and the environment.

We Respect
Each other; our patients and their families; and our partners.

We Listen
To each other; our patients and their families; and our partners.

Our Mission
Making a difference every day.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
1 - Deliver personalised, safe and caring services.	Deliver national waiting time / performance requirements, including: • 76% seen within 4hrs in ED by March 2024	🔴	The trust did not meet the four-hour emergency care standard, with a year to date performance of 61.1%. Performance compared favourably against GM Peers (53.5%).
	• 97% G&A bed occupancy by Mar 24 and Critical Care bed occupancy at 92%	🟡	G&A bed occupancy for the year 2023/24 was 91.8%. Critical Care bed occupancy for the year 2023/24 was 75.2%
	• Eliminate waits of over 65 weeks for elective care by Mar 24	🟢	In November 2023, the target was eased nationally to focus on reducing 65 week waits and eliminating the longer 78 and 104 week waits. The final position for March 2024 was a reduction to 663 patients waiting over 65 weeks for elective care.
	• Reduce NCtR to 73 by Mar 24	🔴	In March 2024 there were 81 patients with No Criteria to Reside against a target of 73. The Trust is working with Place teams including the Local Authority as part of the Safe and Timely Discharge work to focus on reducing the levels of NCtR. The Trust has seen also a reduction following escalation to the GM ICB, for those patients residing within Derbyshire.
	• 100% ambulance handovers within 60 mins.	🟡	Average performance over the year of ambulance handovers take place within 60 minutes was 93%
	• < 82 cancer patients waiting over 62 days by Mar 24	🟢	The Trust reported 49 patients waiting over 62 days at the end of March, significantly below the target level of 82.
	• 75% performance against cancer faster diagnosis standard by Mar 24	🟢	The Trust is reporting compliance against the 28-day FDS in March at 83.5%
	• 90% of diagnostic tests in under 6 weeks by Mar 24	🟡	Performance of 85.8% was achieved against the standard as of March 24.
	• 80% Virtual Ward beds occupancy by Mar 24	🔴	Virtual ward average bed occupancy for March was 68%.
	• 85% Theatre Utilisation	🟢	Uncapped touch time utilisation is 86%.
	• Move 5% of outpatient attendances to PIFU by Mar 24	🟡	Performance for the last two months has continued to show improvement and is now at 4.5% for March. Stockport continues to be ranked 1st in GM for PIFU.
	• 70% of Urgent community responses <2 hours	🟢	The Trust continues to deliver above the standard with the current rate at 97.3%.
	To secure a local Ophthalmology service for Tameside through a partnership with Stockport NHS FT	🔴	The Ophthalmology strategy changed due to the closure of OPB. A joint service with Tameside is not currently in scope as the Stockport service focuses on restoring activity following the closure of OPB.
	The new incident reporting system (PSIRF) is embedded across the organisation.	🟢	The Trust has completed the transition to the Patient Safety Incident Response Framework in line with NHS contractual requirements. The Patient Safety Incident Response Plan was approved in August 2023 and approval of the PSIRF Policy in March 2024. New PSIRF methodology was implemented successfully involving numerous stakeholders from across the organisation.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
	To improve the quality and safety of our services through delivery of the Quality and Safety Strategy Objectives for 2023/24.	●	Performance against the Quality Strategy metrics are monitored via an agreed governance and assurance framework. Good progress has been made in all areas as seen in via regular reports to Quality Committee.
	To meet maternity safety standards and CNST maternity requirements.	●	The Trust has declared compliance against all 10 safety standards which has been verified via NHSR external process.
	To enhance and embed the end-of-life care model.	●	The Trust has implemented the SWAN model to support and guide the care of patients and their loved ones during end-of-life care, and afterwards.
	To continue the roll out of the STARS Accreditation Programme, improving the number of areas achieving 'green' status.	●	Trust target achieved: • 70% Combined Green and Blue • 12% Red areas. 78 assessments have been undertaken across total of 43 clinical areas including.
	All SIs are reporting within 48 hours and a software system for all SIs is embedded across the organisations.	●	An Incident review Group meets every Tuesday, to review incidents reported in the previous week and shared lessons learnt via the weekly Risky Business newsletter. Incidents are monitored by the Datix system.
	To complete a well led assessment against key lines of enquiry.	●	Well Led Self-Assessment reviewed by Board in March 2023, to support well led review. In light of financial and operational pressures, determined to utilise internal audit to undertake 'Well Led Position Statement' to be completed by Q4. Outcome reported to Audit Committee in February 2024 – Substantial Assurance. A Well led Self-Assessment will be completed in 2024/25, including cross-reference to the new well led guidance for CQC.
2 - Support the health and wellbeing needs of our community and colleagues Curtis Soile 31/05/2024 13:23:44	To reduce sickness and absence levels through the roll out of the Trust's new Health and Wellbeing Policy.	●	Sickness and absence rate YTD 5.8% - just below the target of 6%
	The Locality Provider Collaborative has established programmes to improve primary/secondary health and wellbeing outcomes through evidence-based interventions.	●	One Stockport Locality collaborative continues to meet and workstreams have been agreed with the provider partnership (diabetes/cardiovascular disease/alcohol related harm/frailty) with SROs and programme specific work plans in place.
	The Trust Strategy is refreshed during 2023/24 financial year (Q4).	●	The Trust Strategy remains valid until 2025. Following changes within key posts (executive director and departure of the Trust chair) this work was paused. A refreshed strategy will be developed over the latter part of 2024/25 following the appointment of a new board chair.
	The Trust Planning round is undertaken and completed in Q3-Q4 2023/24.	●	The Trust has submitted its operational plans, approved by board.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
3 -Develop effective partnerships to address health and wellbeing inequalities.	In collaboration with partners and stakeholders, a Locality Plan is developed which is aligned with the GM ICP Strategy.	●	The latest version of the ONE Stockport Locality Plan has been refreshed, updated and submitted to board, awaiting feedback from NHSE.
	To begin to integrate corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.	●	Resources in corporate teams have been integrated in several areas: • Joint Occupational Health services (provided by SFT) • Joint payroll (provided by T&G) • Other workforce and OD roles work across both Trusts. • Strategy & Partnerships team now work across both trusts. • Transformation team has been aligned across both Stockport and Tameside. Other corporate functions continue to review collaboration opportunities with plans reviewing broader integration where appropriate.
	To continue to explore areas for collaboration across clinical services across Tameside & Glossop and Stockport Trusts.	●	The positive impact of joint working across the two organisations to date includes: • Sharing of skills, knowledge and experience between the two Trusts. • Sharing of good practice between teams working in similar functions for each Trust, to address unwarranted variation. • Opportunities for joint systems e.g. finance ledger. • Joint procurement which will lead to greater productivity and efficiencies. • Bringing together corporate functions to address sustainability challenges whilst securing greater efficiencies through economies of scales. Priorities for exploring clinical collaboration opportunities in 2024/25 have been agreed jointly with the respective executive teams.
	To progress the agreed plan to support a centralised model for Stockport's Intermediate Care Bed Base.	●	Work is ongoing with the local authority to develop a healthy living campus at the former St Thomas' Hospital site. The Board received and endorsed the outline business case in Q4.
4 - Develop a diverse, talented and motivated workforce to meet future service and user needs	To increase integrated workforce models through the development of Trust outcomes.	●	The workforce &OD team continue to facilitate senior leadership events and division/directorate leadership sessions to explore and plan how we further integrate workforce models and design more efficient and impactful ways of working. OD consultancy support has been provided to divisions to help improve performance and culture.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
	To complete a Medical Workforce Plan for those difficult to recruit specialties.	●	The Medical WFP action is complete and is included in overall strategic WFP document approved via PPC. Currently reviewing the divisional WFPs which feed into the Trust overarching plan and are linked into the operational plan discussions.
	To implement the Trust's Equality, Diversity and Inclusion Strategy objectives for 2023/24.	●	The Board has received regular updates on the continued progress that has been made with the implementation of the Trust's EDI objectives that include career progression opportunities for BME staff, improvement with staff networks and improvement of metrics & handling of reasonable adjustments regarding for staff with disabilities.
	To improve retention and reduce bank and agency usage in accordance with the Trust improvement trajectories.	●	Staff retention rate YTD is 98.9%, with our annualised adjusted turnover rate at 11.64% at month 12. In March 2024, 3.8% of the total pay bill related to agency usage, above the target of 3.7%. Bank usage accounted for 83% of our overall temporary pay bill, against the GM target of 75%. The YTD position is 4.8% of the total pay bill related to agency usage which whilst above the target is an improved position in comparison the to the YTD position in March 2023, of 6.7%.
	To respond to staff survey feedback to demonstrate improvements.	●	The 2023 NHS staff survey results have been published and the Trust has achieved an improved position. A communications plan has been implemented that celebrates our results and highlights the areas which require further improvement. Divisions/directorates have devised action plans aimed at improving their survey results which will be monitored by the People Board. We achieved the highest staff engagement score & the top scores in 6 of the 9 survey themes compared to our Greater Manchester benchmarking group. At an organisational level we continue to deliver key strategies/plans aimed at improving colleague experience (inc. People Plan, EDI Strategy, Organisational Development Plan, Health & Wellbeing Plan).
5 - Drive service improvement through high quality research, innovation and transformation.	Develop locality-wide research programmes through facilitation of system wide trials.	●	The Stockport research delivery team has continued to expand the research portfolio for our local population throughout 2023/24, with opportunities available to our patients in 21 specialities, with 87 different research study opportunities open, recruiting >2,150 participants. A full update will go to the joint Exec Board, likely in Jun/ Jul-2024.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
	To implement the Trust Research and Development Strategy objectives for 2023/24.	●	Delivery of the joint Stockport/ Tameside RD&I strategy continues, with full details of achievements and progress to date captured in the RD&I annual report, due at Exec Board Jun/ Jul-2024.
	To deliver, in partnership, the Community Diagnostic Centre, to the agreed specification and within Q4 2023/24.	●	South-East Manchester CDC is to go live in Denton Crown point on 1st August 2024 with the following modalities CT, MR, Dexa and ECHO, these services will be provided in partnership with In Health.
	To complete an update of the Trust's website.	●	Progress on the new website remains ongoing. Completion is expected by the end of Q2 2024/25.
6 - Use our resources efficiently and effectively.	To deliver the Trust's Financial, Revenue and Capital Plan.	●	The Trust ended financial year 2023/24 £2.2 million adverse to plan. This is £0.7m adverse to plan for GM ICB system reporting purposes, which was the agreed out-turn position.
	To deliver the Trust's financial efficiency programme (TEP/CIP).	●	The Trust delivered the full £26.2m savings target in 2023/24. Recurrently £8.9m was delivered, which is a £1.4m shortfall for 2024/25.
	To complete the final accounts for the year end which receive a compliant audit report.	●	Final accounts have been completed and submitted. On track to deliver a compliant audit report.
	Achieve greater productivity and efficiency levels in endoscopy, outpatients, theatre, day cases, LoS, to achieve upper quartile performance levels (model hospital).	●	The Trust has seen improvements in operational efficiency metrics, including • Endoscopy average 96% utilisation between June 23 – March 2024. • Reduction in DNA rate in March 2024 to 1.4%. • Diagnostic backlog reduced to 0 patients waiting over 6 weeks.
7 - Develop our Estate and Digital infrastructure to meet service and user needs.	To deliver the Emergency Department (ED) expansion scheme.	●	Phase 1 (RAT) and Phase 2 (SDEC/Paeds) have been completed and handed over. Works to remaining phases remain ongoing. Meetings held with regional team regarding project completion dates - now anticipated as Q4 FY 24/25
	An EPR Business Case and recruitment process is completed across both Tameside and Stockport Foundation Trusts	●	Following Trust Board approval, and additional work requested on financial elements of the case, the joint Outline Business Case (OBC) was submitted for external approval in May 2023. The case was supported by GM (recognising an affordability gap) and was passed to Regional Team (on 24/05/23) for review, prior to submission to the national EPR Investment Board. Discussions aimed at reaching a satisfactory affordability position remain ongoing; the case will then be submitted to the national team for final approval.
	The rollout of the new digital Laboratory Information System is completed.	●	LIMS implementation programme currently working towards a go-live date Q3 2024/2025.
	Complete the Meadows PFI hand back process.	●	Formal notice has been provided to Project Co that the Trust intends to exercise the option of purchasing the facility.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Year-End Progress
			Work continues with stakeholders to deliver a transition plan to ensure the contractual and purchase arrangements can be executed by Sep 2024.
	To develop and implement a Way Finding Strategy.	🔴	The Estates Strategy Steering Group has endorsed the establishment of a task and finish group which will develop a strategy and specification for implementation in 2024/25.
	To deliver the Trust's Green Plan objectives for 2023/24.	🟡	During 2023, good progress has been made towards meeting the net zero targets, including introducing the first electric community ambulance, supporting a reduction in carbon emissions. A new Sustainability Manager has begun to work across Stockport and Tameside to deliver a joint Green Plan for the Trusts and establish a joint Sustainability Group. We continue working closely with Greater Manchester colleagues to support delivery and share best practices.
	To continue to engage key stakeholders in the development of the new hospital OBC and to complete a transition plan for the hospital site to address the poor capital stock which will include Outpatients B and Pathology.	🟡	The Trust submitted a bid in partnership with the Local Authority to the national Future New Hospitals programme. We were informed in May 2023 that our scheme was not successful. Discussion has since taken place within the Integrated Care System about the need for a new hospital in Stockport, but no funding source is identified to support this. Discussions with locality partners have continued regarding shared long-term aspirations to create a town centre health hub. Following the closure of Outpatients B in November 2023 a full options appraisal was undertaken to review immediate and longer-term options for the re-provision of OP services.

NHS Stockport NHS Foundation Trust

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	8
Meeting	Board of Directors				
Report Title	Annual Corporate Objectives – Draft Outcome Measures for 2024/25				
Director Lead	Paul Buckley, Director of Strategy & Partnerships.	**Author**	Andy Bailey, Deputy Director of Strategy & Partnerships		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to endorse the draft outcome measures aligned to the Corporate Objectives for 2024/25.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

✓	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
✓	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
✓	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
✓	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
✓	PR6.1	There is a risk that the Trust does not deliver the annual financial 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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	Objectives 1-4
Financial impacts if agreed/not agreed	Objective 6
Regulatory and legal compliance	Objective 1
Sustainability (including environmental impacts)	Objective 7

Executive Summary

The purpose of this report is to present the draft outcomes measures aligned to the agreed Corporate Objectives for 2024/25.

The Trust Board is asked to endorse the draft outcome measures.

1. Purpose

1.1 The purpose of this report is to present the draft outcome measures aligned to the agreed Corporate Objectives for 2024/25.

2. Background

2.1 Following approval by the Trust Board to maintain the same overarching Corporate Objectives for 2024-25, a set of draft outcome measures have been developed aligned to Executive Directors' portfolios. These allow the Executive Team and Board to monitor key programmes of work, enabling the Trust to meet its statutory obligations and deliver its Strategic Plans.

2.2 As a reminder, the Board is provided with a mid-year and end-of-year update on progress against delivery of our objectives.

3. Outcome Measures for 2024/25

3.1 Draft outcome measures are included as appendices to this paper.

3.2 The outcome measures have been updated to reflect:

- New/updated outcomes in line with the national planning guidance for 2024/25
- Continuation of measures from 2023/24 where relevant
- Updates received from executive directors.

4. Recommendation

4.1 The Board is recommended to endorse the draft outcome measures aligned to the agreed Corporate Objectives for 2024/25.

Our Objectives for 2024/25

Stockport NHS Foundation Trust

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.

Our Vision

To work with partners to improve health and wellbeing outcomes for the communities we serve

Our Values

Chris Soile 31/05/2024 13:23:44

We Care

About each other; our patients and their families; the communities we serve; and the environment.

We Respect

Each other; our patients and their families; and our partners.

We Listen

To each other; our patients and their families; and our partners.

Our Mission

Making a difference every day.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*
1 - Deliver personalised, safe and caring services.	Deliver national waiting time / performance requirements, including: • 78% seen within 4hrs in ED by March 25
	• 92% bed occupancy for G&A, Paeds and Adult Critical Care across 2024/25
	• Maintain zero waits of over 65 weeks for elective care by Sep 24
	• Reduce waits of over 52 weeks for elective care by end of Mar 25
	• 77% performance against cancer faster diagnosis standard by Mar 25
	• 70% performance against cancer 62 day waits standard by Mar 25
	• 95% performance diagnostic tests in under 6 weeks by Mar 25
	• Improve access to virtual wards by ensuring utilisation is consistently above 80%, with a focus on frailty, acute respiratory infection, heart failure and CYP.
	• 85% Theatre Utilisation
	• Proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
	To ensure the new Patient Safety Incident Response Framework (PSIRF) is embedded across the organisation.
	To improve the quality and safety of our services through delivery of the Quality and Safety Strategy Objectives for 2024/25.
	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition.
	To continue the roll out of the STARS Accreditation Programme, improving the number of areas achieving ‘green’ and ‘blue’ status.
2 - Support the health and wellbeing needs of our community and colleagues	To support the Health & Wellbeing of our colleagues through a range of Health & Wellbeing initiatives, reducing sickness and absence levels.
	To take an active role in the delivery of Locality Provider Collaborative programmes to improve primary/secondary health and wellbeing outcomes through evidence-based interventions.
	The Trust Strategy is refreshed during Q4 following the appointment of a new chair
	The Trust Planning round is undertaken and completed in Q3-Q4 2024/25.
3 -Develop effective partnerships to address health and wellbeing inequalities.	To progress further integration of corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.
	To develop joint working opportunities for collaboration between Tameside & Glossop and Stockport within the priority clinical services identified; Gastroenterology & Radiology.
	Develop and implement a process to monitor the benefits of collaboration between Tameside & Glossop and Stockport
	To increase participation in and awareness of the wider partnership agenda across locality and GM collaborative programmes
	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
	Support the locality vision for development of an intermediate care facility ensuring it supports the needs of the Trust and Community Patient Population.
4 - Develop a diverse, talented and motivated	To continue with the OD, Talent and Leadership Plan, strengthening leadership and management approaches, fostering and improving working relationships within teams and across the organisation.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*
workforce to meet future service and user needs	To develop workforce plans that builds on the future workforce requirements, new roles, apprenticeships and is in line with the NHS Long Term Workforce Plan.
	Continue implementation of the Equality, Diversity & Inclusion Strategy focussing on progression/talent management and improving colleague experience.
	Continue to build the Place-Based collaborative working partnership with the Local Authorities within Tameside & Stockport, working with colleges in both localities to co-create and deliver employment opportunities for our residents of Stockport and Tameside.
	To reduce bank and agency usage, particularly premium expenditure in line with NHSE targets.
	Increase staff retention and attendance through implementation of all elements of the People Promise retention interventions
	To respond proactively to staff survey feedback to demonstrate improvements.
5 - Drive service improvement through high quality research, innovation and transformation.	Develop locality-wide research programmes through facilitation of system wide trials.
	To implement the Trust Research and Development Strategy objectives for 2024/25.
	To implement the Trust Transformation & Service Improvement strategy objectives for 2024/25.
	To deliver, in partnership, the Community Diagnostic Centre, to the agreed specification by Q3 2024/25.
	To complete an update of the Trust's website.
6 - Use our resources efficiently and effectively.	To deliver the Trust's Financial, Revenue and Capital Plan.
	To deliver the Trust's financial efficiency programme (STEP/CIP).
	To complete the final accounts for the year end which receive a compliant audit report.
	To improve operational and clinical productivity, making full use of the opportunities highlighted through GIRFT, The Model Health System and other benchmarking and best practice guidance.
7 - Develop our Estate and Digital infrastructure to meet service and user needs.	To complete the Emergency Department (ED) expansion scheme.
	To complete the Meadows PFI handback process.
	To complete the EPR Business Case and recruitment process across both Tameside and Stockport
	The rollout of the new digital Laboratory Information Management System is completed.
	To agree a plan for the replacement or refurbishment of the Beech House datacentre to mitigate significant issues with cooling equipment.
	To develop and implement a Way Finding Strategy.
	To deliver the Trust's Green Plan objectives for 2024/25
	To continue to engage key stakeholders in the development of the new hospital OBC and to complete a transition plan for the hospital site to address the poor capital stock.
	To develop a business continuity plan for Pathology services to address the fragility of the estate.
	To progress the revised TIF scheme to build a new Outpatient facility subject to NHSE approval.

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	9
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
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
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
	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	
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

April 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 one of the lowest rates across GM.
- The Trust continued to perform well against the timely recognition metric. Antibiotic administration performance continues to be challenging. Areas of concern are out-of-hours services within the surgical division.
- Reported infection rates for C.diff continue to be increasing, with E.coli and MRSA showing strong improvement in trends. New internal targets for reducing infection rates have been set for 2024/25.
- We continue to perform well against all Stroke and Falls metrics.
- Category-2 pressure ulcers across hospital and community settings are showing improving trends. There have been an unusually high number of category 3 & 4 pressure ulcers reported in the community this month.
- Written complaint rates are showing an increasing trend over the last 6 months. Timely response to complaints has been decreasing, although does achieve the 95% target for April.
- Patient safety incident rates are on an increasing trend. New measures related to Patient Safety are included in the report this month.
- Smoking during pregnancy performance has not changed significantly, but new targets introduced for 2024/25 mean April is showing as an under performance.
- Registrable still-birth rate is above 0 for April, but annual rates are still well below the National and GM average.

Operations Highlight

Exception reports included this month relate to performance against Emergency Department, No Criteria to Reside, Diagnostics, RTT, 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. Improvement plans are being developed to support recovery and achievement of the 5% target by March 2025.
- With new national targets for 2024/25, the Trust is performing well against all cancer metrics for April. 28-day FDS has achieved now for the 3rd consecutive month.
- 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, PIFU and Clinic Utilisation continue to perform well when benchmarked against GM colleagues. For DNA rates, Stockport is ranked 2nd across GM, and for PIFU Stockport continues to be ranked 1st.
- Continued improvements in theatre performance trends have been affected by the planned theatre shut-down to support the UEC work. Teams continue twice-weekly performance meetings to focus on key themes to drive further improvement.

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

Workforce Highlight

Exception reports included this month relate to performance against Appraisal rates only.

- Performance against the substantive staff-in-post metric continues to be well above target with strong improvement seen in the latest 6-month trend.
- Although slightly increased from March, the monthly sickness absence rate for April continues to show overall improvement and is reported below target for the 2nd consecutive month. Norovirus outbreaks in the ward-areas did have a negative impact on short-term sickness in April.
- Agency costs continue to show strong improvement compared to total PAY costs and are reported below the target threshold for the 2nd consecutive month.
- Workforce turnover shows a strong improvement in performance trend across the last several months.
- Appraisal rates across all staff groups shows an improving trend, although all divisions are still reported below the 95% target threshold. We continue to engage divisions with reminders, direct contact and regular training support.
- Mandatory training rates have seen strong improvement over the last several months and are above the 95% target for April.

Finance Highlight

- The Trust has submitted a plan with an expected deficit of £46.4m for the financial year 2024-25. The deficit assumes delivery of an efficiency target of £24.6m of which 50% is recurrent.
- At month 1 2024-25 the Trust position is in line with plan – a deficit of £5.0m.
- Underspends on pay costs are triangulated to the reduction in temporary staffing used in April 2024, where there has been a reduction in the use of bank staff and agency staff.
- At early stage in the financial year, timing adjustments have been made to recognise costs not yet notified.
- The Cost Improvement (STEP) programme is profiled on a stepped basis with an increased requirement in the second half of the year. There has been a positive start to the year with the plan being achieved in month; however, only 10% of this is recurrent compared to a 50% target.
- Revenue support of £5.4m was drawn down in April 2024 to support the Trust cash position.
- The Trust has submitted a non-compliant capital plan of £42.5m. This is currently being reviewed by GM, with a likelihood that the Trust will be asked to significantly reduce the plan.

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: SHMI	Feb-23 to Jan-24	≤ 100		↑	92	●	●
Sepsis: Antibiotic administration	May-23 to Apr-24	≥ 90%		↗	75.5%	▲	▲
Sepsis: Timely recognition	May-23 to Apr-24	≥ 90%		↑	97.4%	●	●
C.diff infection rate	May-23 to Apr-24	≤ 32.75		↘	38.48	▲	▲
Covid-19 infection rate	May-23 to Apr-24			↑	0.95		
E. coli infection rate	May-23 to Apr-24	≤ 31.41		↑	31.77	▲	●
MRSA infection rate	May-23 to Apr-24	≤ 0		↑	0.45	▲	●
Stroke: Overall SSNAP Level	Dec-23	≥ C		→	A	●	●
Falls causing moderate+ harm	Apr-24	≤ 22	1	→	1	●	●
Falls due to lapses in care	Apr-24	≤ 425	20	↗	20	●	●
Falls rate	Apr-24	≤ 3.51	2.43	↗	2.43	●	●
Pressure Ulcers: Community, Cat 2	Apr-24	≤ 114	8	↗	8	●	●
Pressure Ulcers: Community, Cat 3&4	Apr-24	≤ 38	7	↘	7	▲	▲
Pressure Ulcers: Hospital, Cat 2	Apr-24	≤ 79	4	↗	4	●	●
Pressure Ulcers: Hospital, Cat 3&4	Apr-24	≤ 8	1	→	1	▲	▲
Complaints: Timely response	Apr-24	≥ 95%	95.8%	↘	95.8%	●	●
Complaints: Written Complaints Rate	Apr-24	≤ 7.9	9.67	↘	9.67	▲	▲
Never Event Incidence	Apr-24	≤ 0	0	→	0	●	●
Patient Safety Alerts	Apr-24	≤ 0	3	↘	3	▲	▲
Patient Safety Incident Investigatio..	Apr-24		2	→	2		
Patient Safety Incident Rate	Nov-23 to Apr-24			↓	86.68		
Early Neonatal Deaths	Apr-24	≤ 0	0	→	0	●	▲
Maternity Diverts	Apr-24	≤ 0	0	→	0	●	●
Registrable Stillbirth Rate	Apr-24	≤ 0	4.05	→	4.05	▲	▲
Registrable Stillbirths	Apr-24	≤ 0	1	→	1	▲	▲
Smoking In Pregnancy	Apr-24	≤ 4%	4.9%	↗	4.9%	▲	▲

Legend

1-month Forecast

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

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

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

	Reporting Period	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	Apr-24	≥ 78%	63.2%	↗	63.2%	▲	▲
Patients in department over 12 hrs	Apr-24	≤ 2%	10.7%	↘	10.7%	▲	▲
No criteria to reside (NCTR)	Apr-24	≤ 61	71	→	71	▲	▲
Discharge ready	Apr-24		84.1%	↗	84.1%		
Delayed discharges	Apr-24		3.6%	→	3.6%		
Diagnostics: 6 Week Standard	Apr-24	≤ 5%	21.1%	↘	21.1%	▲	▲
62-day standard	Apr-24	≥ 70%	77.3%	↗	77.3%	●	▲
28-day standard (FDS)	Apr-24	≥ 77%	79.6%	↑	79.6%	●	●
14-day standard (2WW)	Apr-24	≥ 93%	98.1%	→	98.1%	●	●
Incomplete pathways 18-week %	Apr-24	≥ 92%		↗	50.8%	▲	▲
52-week breaches	Apr-24	≤ 3783		↑	2633	●	●
65-week breaches	Apr-24	≤ 0		↑	572	▲	▲
Activity vs. Plan: Elective	Apr-24	≥ 100%	100.6%	→	100.6%	●	●
Activity vs. Plan: Outpatient	Apr-24	≥ 100%	102.1%	↗	102.1%	●	●
Activity vs. Plan: ED Attendances	Apr-24	≤ 100%	94.6%	↗	94.6%	●	●
Outpatient DNA rate	Apr-24	≤ 6.3%	7.4%	↗	7.4%	▲	▲
Outpatient clinic utilisation	Apr-24	≥ 90%	90.1%	→	90.1%	●	●
Patient initiated follow up (PIFU)	Apr-24	≥ 5%	4.2%	→	4.2%	▲	▲
Capped Touch Time Utilisation	Apr-24	≥ 85%	78%	↑	78%	▲	▲
Average cases per 4-hour session	Apr-24	≥ 2.8	2.81	→	2.81	●	●
Workforce Scorecard							
Substantive Staff-in-Post	Apr-24	≥ 90%	94.2%	↑	94.2%	●	●
Sickness Absence: Monthly Rate	Apr-24	≤ 6%	5.5%	↗	5.5%	●	●
Workforce Turnover	Apr-24	≤ 12.5%	12.4%	↑	12.4%	●	●
Staff Retention Rate	Apr-24		99.2%	→	99.2%		
Appraisal Rate: Overall	Apr-24	≥ 95%	91.2%	↗	91.2%	▲	▲
Mandatory Training	Apr-24	≥ 95%	95.3%	↑	95.3%	●	●
Agency Costs %	Apr-24	≤ 3.7%	3.1%	↑	3.1%	●	●
Finance Scorecard							
Capital Expenditure	Apr-24	≤ 10%		→	-54.5%	●	●
Cash Balance	Apr-24			↘	19.2		
CIP Cumulative Achievement	Apr-24	≥ 0%		→	0%	●	●
Financial Controls: I&E Position	Apr-24	≤ 0%		↑	-0.1%	●	●

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

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%	97.4%	↑	● ● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	75.5%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

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

Timely Recognition

- 96% timely recognition in April.
- 12 month rolling figure 97%, ahead of trust target of 95%.
- 105 records included in audit- 101 compliant.
- 3 fails occurred within Integrated Care and 1 within Surgery
- 3 fails occurred Out of Hours.
- 2222 not utilised in 1 incident.

Antibiotic Administration

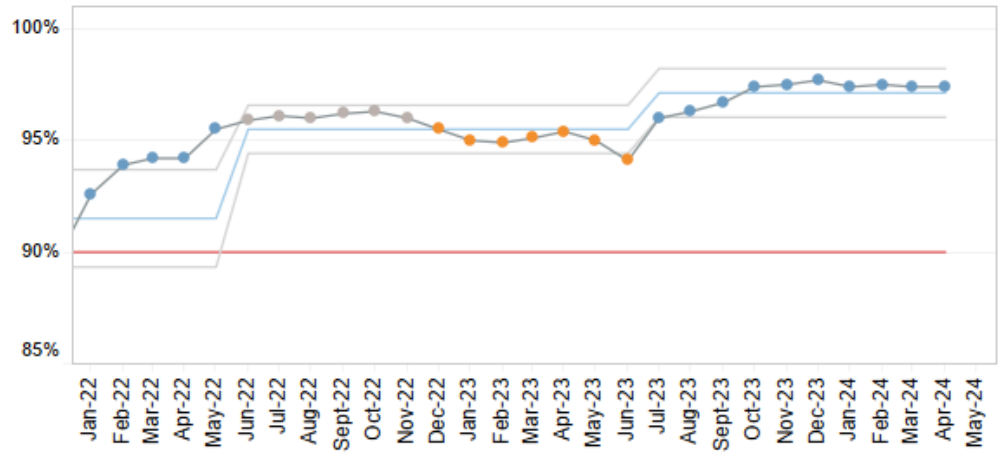
- April compliance 79 %
- 12 months rolling figure now 75% below trust target of 95%.
- 27/34 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- 6/7 fails occurred Out of Hours.
- 6 fails were red flag triggers and 1 was amber flag trigger.
- All fails within Surgical Division.
- Delays: 5 min, 32 min, 63 min, 127 min, 150 min, 9hrs 11min, 13 hr 11 min, (average = 227 min)
- Themes: Delay in administration evident in 4 fails. Delayed prescribing occurred in 6 fails; in 3 incidents this was compounded by prescribing as scheduled dose.
- Time due to administration: 0 min, 9 min, 33 min, 64 min, 90 min, 160 min, 484 min. (average= 126 min)
- Sepsis6 completed by clinician in 2 incidents.
- Sepsis6 completed by clinician for 28 % triggers

Key Events/ Ongoing Issues

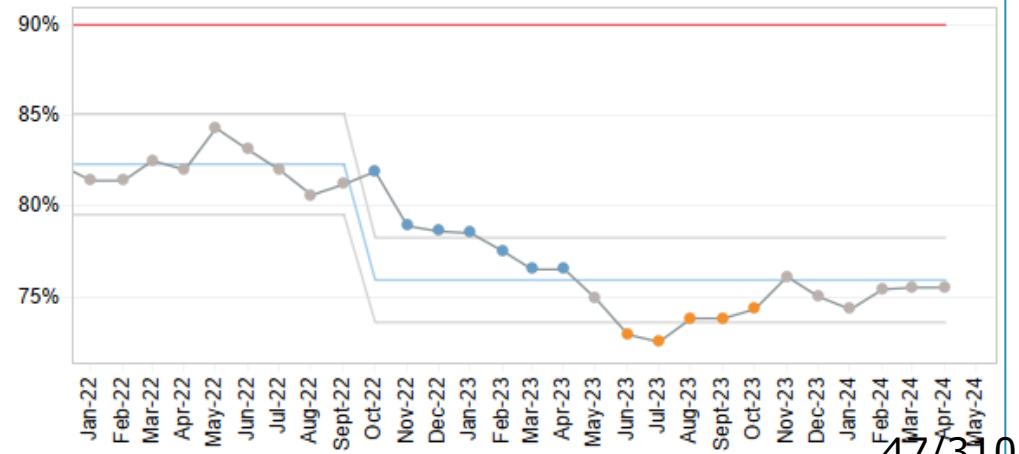
- 18 staff attended toolbox sessions April.
- Sepsis Star Certificate awarded C6
- Medical education teaching FY1 5/04/24.
- Sepsis link nurse Webex 8/5/24. Spring newsletter already circulated.
- Funding request for screening tool development sent 18/4/24.
- Blood culture task and finish meeting 8/5/24

Update provided by	Emily Abdy
Executive Lead	Nic Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Quality **Infection Prevention & Control**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 32.75	38.48	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 31.41	31.77	↑	▲ ▲ ▲ ▲ ▲ ▲	●
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	0.45	↑	▲ ▲ ▲ ▲ ▲ ▲	●

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 7 HOHA and 3 COHA cases in April. The Trust is over the projected threshold of 6 for the end of April.
- From April 24 the UKHSA issued mandatory changes to the case apportionment criteria, any patients on virtual wards or integrated care facilities will now potentially be included as hospital cases. Patients who are admitted directly from ED, their decision to admit date will be classed as their admission date. This has resulted in 2 additional HOHA cases for the Trust this month.
- 6 cases have been presented to the HCAI Panel and 4 cases await panel review in May. The most common themes so far are audit score improvements, Antibiotics being appropriate and issues with timely sample taking.
- The latest National figures (February 2024) rates Stockport fourth out of the seven GM Trusts which is the same as the previous month.

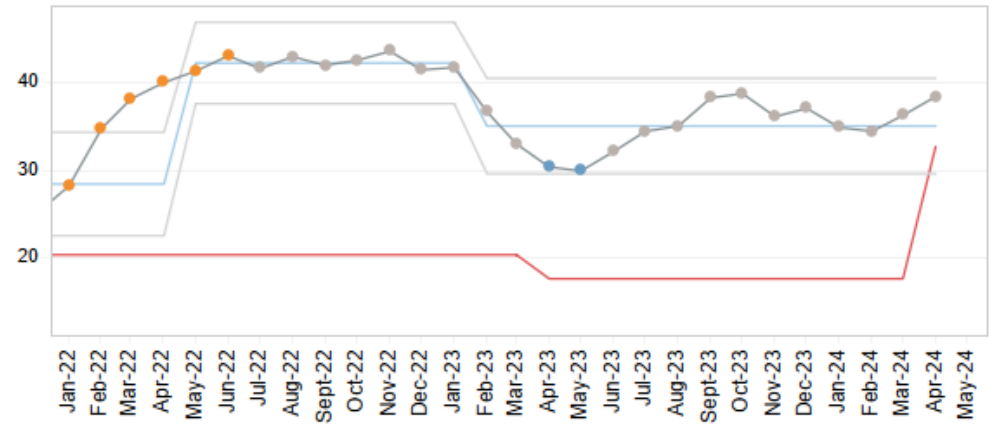
E.Coli

- There were 2 HOHA and 1 COHA case in April. The Trust is under the projected threshold of 5.8 for the end of April.
- The latest National figures (February 2024) rates Stockport fourth out of the seven GM Trusts which is the same as the previous month.

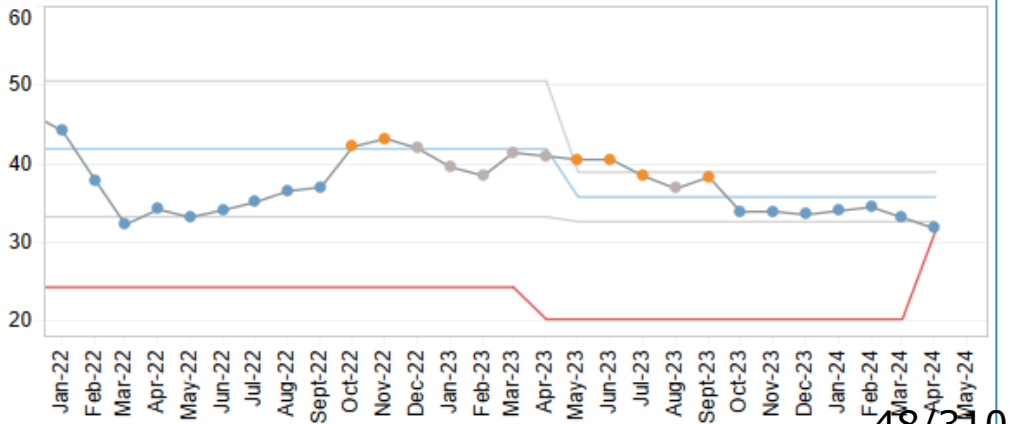
MRSA

- The Trust had 0 cases of MRSA in April against a zero-tolerance threshold.
- The latest National figures (February 2024) rates Stockport fourth out of the seven GM Trusts which is an increase from the previous month.

Performance for C.diff infection rate



Performance for E. coli infection rate



Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

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	4			
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	1			
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	8			
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	7			

Hospital

- All pressure ulcer incidents are investigated for any areas of lapses in care where learning and improvement can be identified.
- In April we have had 4 category 2 pressure ulcers reported. None were as a result of a medical device.
- Of the 4 incidents reported, one was as a result of a lapse in care (LIC) and one showed no lapses in care (NLIC), however 2 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 for 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 will be in the coming weeks.
- The new training programme for the year has been published
- A successful pressure ulcer collaborative took place in April. A multi-disciplinary event aimed at learning from the past year and promoting our quality improvement strategy for the next year.

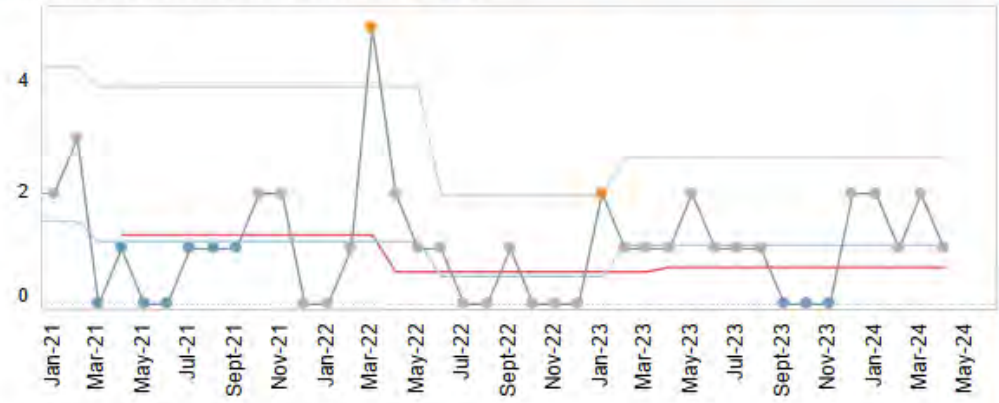
- In April there has been one category 3 pressure ulcer. In this incident no lapses in care were found.

Community

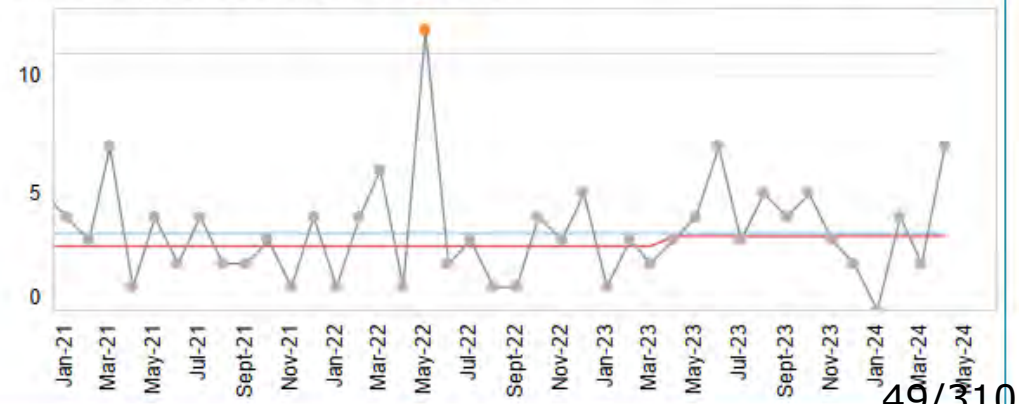
- In April we have had 8 category 2 pressure ulcers reported.
- Of the 6 incidents 2 have had the investigation completed and both found no lapses in care.
- Improvement against our investigation time frame is required within community setting.

- In April there have been 7 Category 3 and 4 ulcers in the community. This is unusually high number within month of cat 3 or 4 pressure ulcers.
- Due to the high number reported in April this caused a delay in the investigations being completed, of the 7, 3 have been reviewed at PSIRG and found no lapses in care, with 4 waiting to be heard.

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

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

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%	95.8%	↘	●	●	●	●	▲	●	●
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	9.67	↘	●	●	▲	▲	▲	▲	▲

Complaints Rate

53 formal complaints were received in April 2024 - Clinical Support Services = 1, Integrated Care = 6, Medicine and the Emergency Department = 16, Surgery = 17, Women & Children = 6, Corporate = 7, Estates & Facilities = 0

We continue to see a high number of formal complaints being received at the Trust. Complaints about communication continues to be the main point of concern throughout complaints closely followed by concerns about treatment. Top five themes for formal complaints in April 2024 was as follows:

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

There were 287 new informal concerns received in April 2024. We continue to see a rise in the number of new cases being received with concerns about appointments being the main concern for our patients. For April 2024 over 44% of the issues raised in month were pertaining to appointment concerns. The top five themes for informal concerns in April 2024 was as follows:

1. Appointments, 2. Communication, 3. Patient care
4. Admin procedures & record management, 5. Clinical treatment

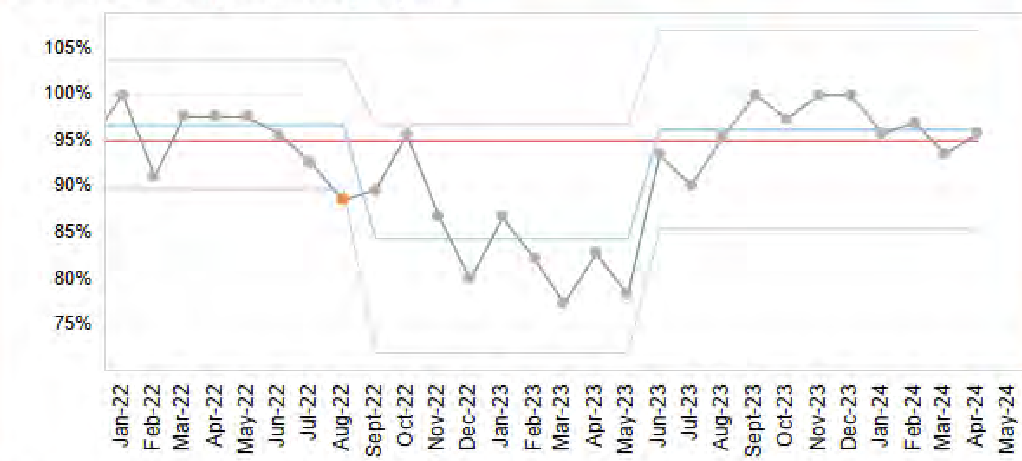
Timely Response

48 responses were sent in April 2024, 46 of these were sent within the agreed timeframe, resulting in a 95.8% response rate.

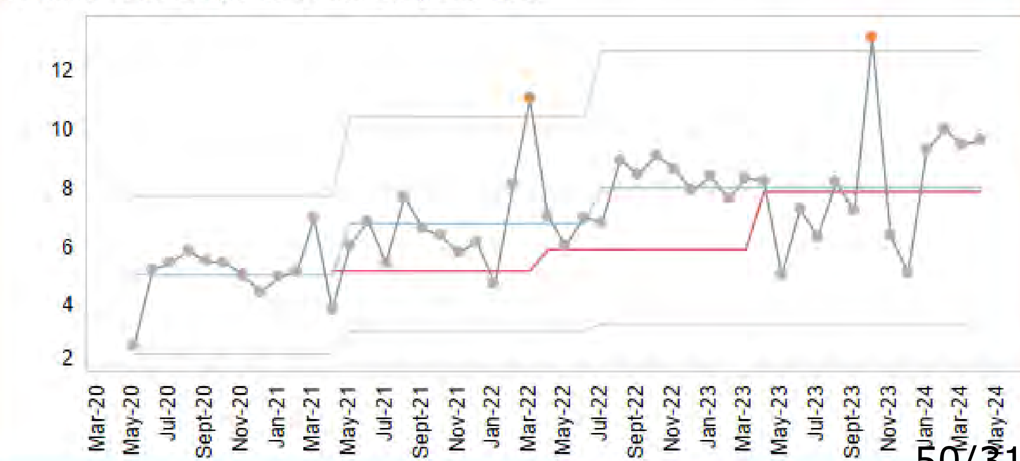
The above response rate is an incredible achievement considering the ongoing pressures at the Trust, increase in the number of complaints and on the availability of clinical staff ability to undertake administrative work. The complaints case officers continue to liaise with the divisional complaints facilitators on the status of the complaint investigation. When a delay is anticipated contact is maintain with the complainant in order to keep them updated.

Signed off by	Natalie Davies
Executive Lead	Nic Firth

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



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	0	→	● ● ● ▲ ● ●	●
Patient Safety Alerts	The number of national patient safety alerts not completed to deadline.	<= 0	3	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
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.		86.68		▲ ▲ ▲ ▲ ▲	

Patient Safety Incidents

There are no issues related to patient incidents to report.

The Incident Review Group meets on a weekly basis to review incidents with a focus on those where harm has been attributed, as well as other topics of interest.

Pressure ulcer incidents are reviewed at the Pre Harm Free Care Panel on a weekly basis.
Patient falls incidents are reviewed at the Falls Review Panel on a weekly basis.
Security & Safeguarding Meeting takes place to review Security related incidents.

There were no National Patient Safety Alerts with completion deadlines in April 2024.

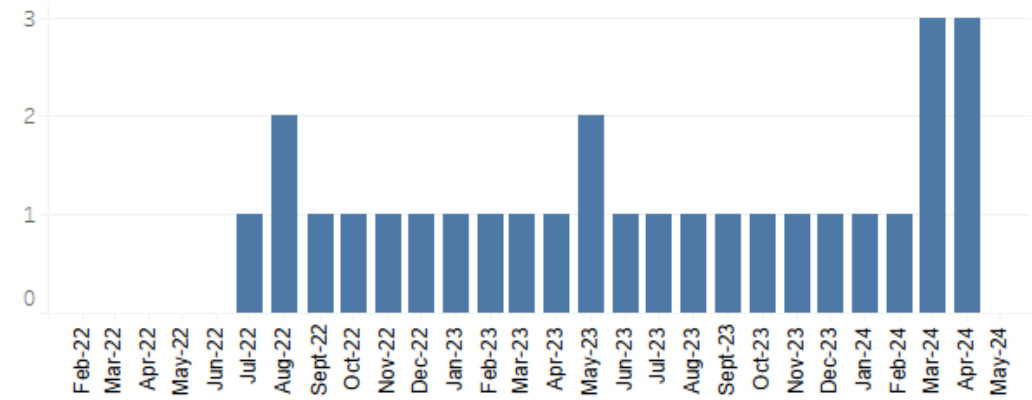
There are three National Patient Safety Alerts with completion deadlines from previous months where the Trust remains non-compliant.

- NatPSA/2024/001/DHSC - Shortage of GLP-1 receptor agonists (GLP-1 RA) update.
- NatPSA/2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.
- SHOT/2022/001 - Preventing transfusion delays in bleeding and critically anaemic patients.

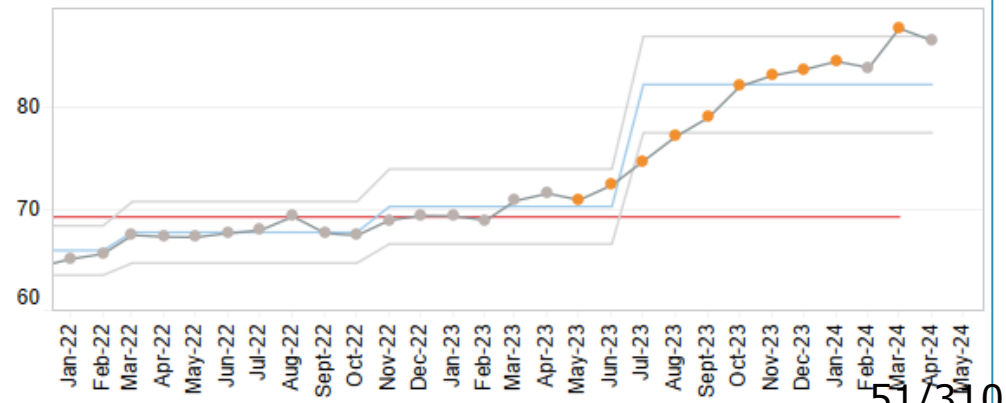
Patient Safety Incident Investigations (PSII)

- There were two Patient Safety Incident Investigations declared in April 2024:
  - One declared as Local Priority 2: Pressure Ulcers
  - One declared as Local Priority 1: Nutrition and Hydration

Showing number of Patient Safety Alerts



Performance for Patient Safety Incident Rate



Signed off by	Natalie Davies
Executive Lead	Nic Firth

Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	0	→	● ● ▲ ● ● ●	▲
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	1	→	● ● ▲ ● ▲ ▲	▲
Registrable Stillbirth Rate	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. Calculated..	<= 0	4.05	→	● ● ▲ ● ▲ ▲	▲
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%	4.9%	↗	● ● ● ● ● ▲	▲
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 count excludes women whose smoking status was not known at the time of delivery. 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.

Registrable Stillbirth
There has been 1 registerable stillbirth in April 2024.
26+6 week fetal death in utero.
This case will be reviewed by the MDT as part of the perinatal Mortality Review Toolkit (PMRT)

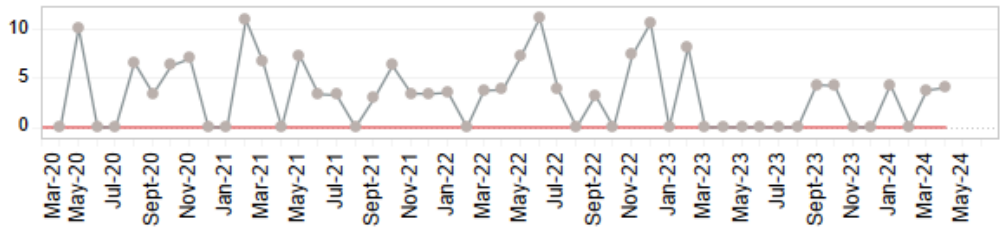
The registerable still birth rate, number of babies born with no signs of life at 24 weeks or more per 1000 total births for April is 4.05 % This refers to 1 stillbirth in April (26+6 week Fetal Death in Utero FDIU)

It is useful to reflect over the previous years to see improvement/deterioration. For example the trust stillbirth rate for 2023 currently is 2.26 per 1000 births, this is well below GM and National average and has reduced from our 2022 rate of 4.52

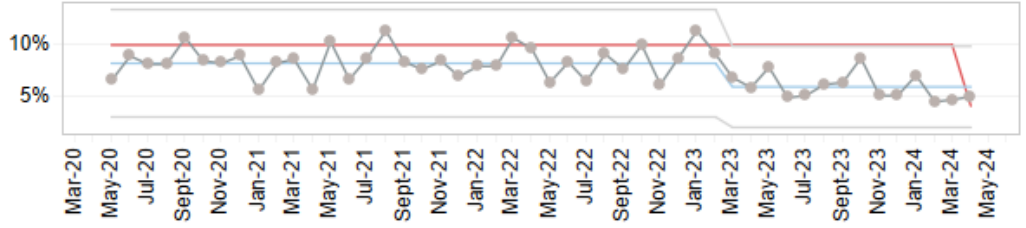
Smoking in Pregnancy
The percentage of women smoking at the time of delivery (SATOD) in April was 4.9% against a national target of <6% and GMEC target of <4% by 2026

- 243 women delivered at SHH in April
- 243 Women had a smoking status recorded
- 0 women had an unknown status
- 231 Women had a status of no or never smoked
- 12 had a status of yes

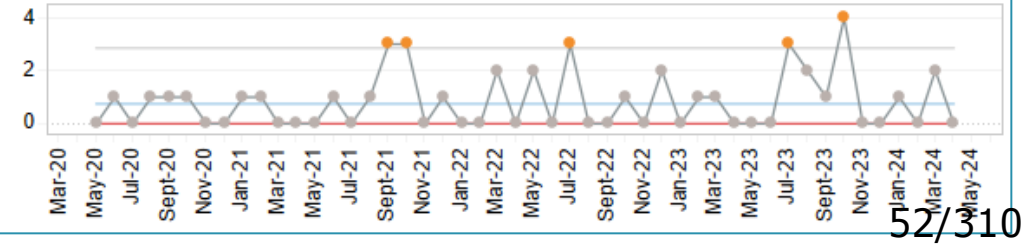
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Signed off by	Sharon Hyde
Executive Lead	Nic Firth

Operations **Emergency Department**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 78%	63.2%			
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%	10.7%			

April Summary

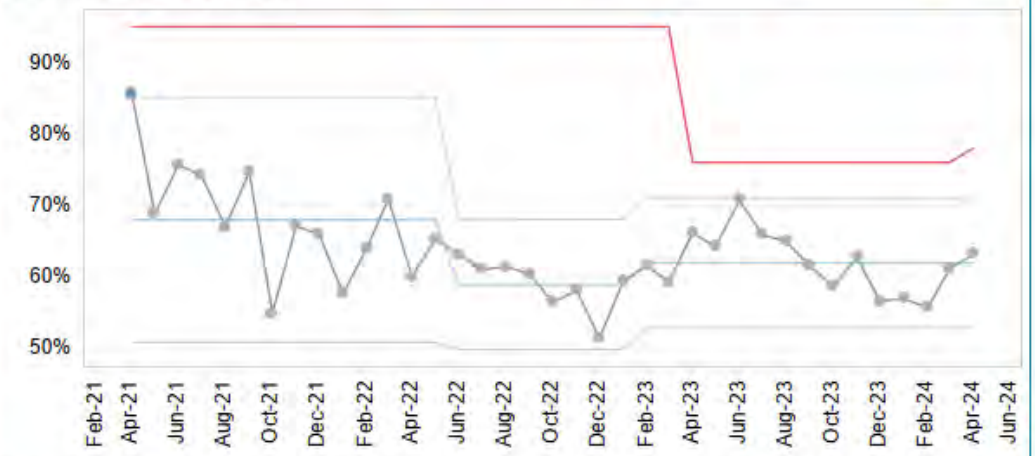
- April 2024 performance against the UEC 4hr standard saw an increase from 61.1% in March 2024 to 63.2%
- None of the caveats in the operational planning to delivery of the 75% standard were delivered, thus performance is compromised
- Daily attendances have increased slightly to 293 in April 24 vs 283 in April 23
- Admissions to hospital remain static at an average of 82 per day, a 28% conversion rate
- 12 hour waits remained high in April at 308 which is a decrease from 856 in March. 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

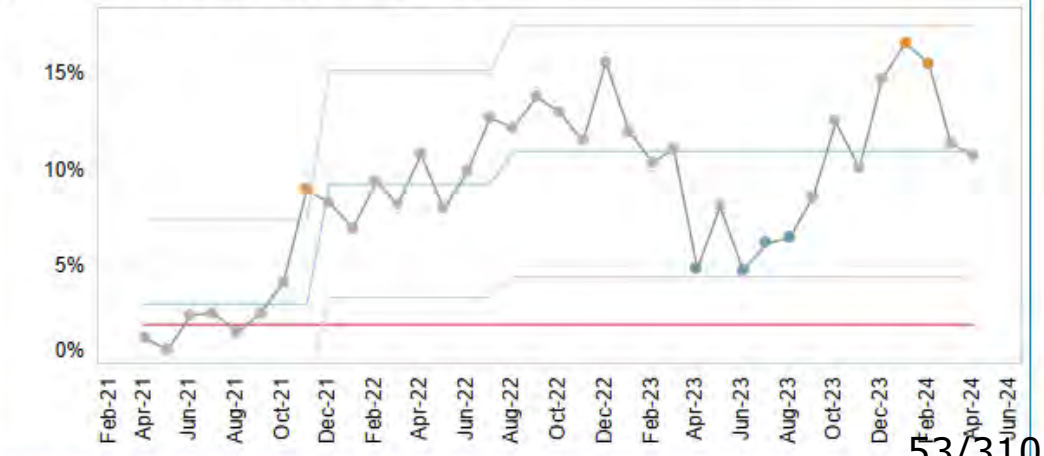
- Weekly Trust ED performance meetings to enable flow from each service to improve ED performance
- Emergency Department Improvement Project supported by transformation to support schemes including front door processes, Urgent Treatment Centre and diagnostic pathways to improve 4hr A&E performance
- Continued focus on admission avoid - virtual ward, primary care, SDEC
- ED/NWAS collaborative meetings to support ambulance handover improvement times
- Partnership collaboration continues with Pennine Care, with weekly and monthly meetings ongoing to discuss and resolve service challenges
- Continued focus on red rigour for breach avoidance and breach validation processes

Curtis.Soile
31/05/2024 13:23:44

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Signed off by	Catherine Cotton
Executive Lead	Jackie McShane

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	71			

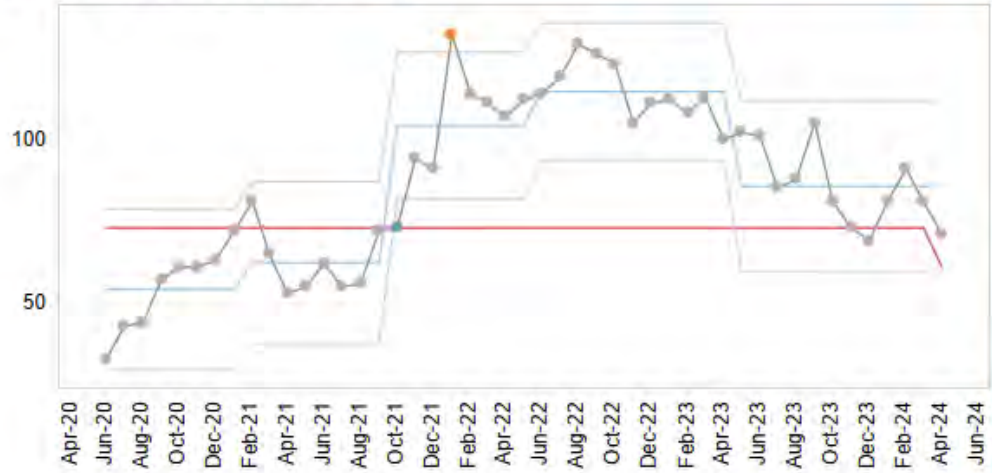
April Summary

- The number of patients with no criteria to reside (NCtR) reduced in month.
- Improved NCtR position re Derbyshire and member of staff from Derbyshire present daily within the Integrated Transfer Team .
- Out of Area work with localities continuing; patients with a length of stay over 7 days since being NCtR being escalated to ICB.
- 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 5 patients to be discharged a day by this route however this is not currently being achieved.
- Trusted Assessor link nurse role commenced for 3-month period to reduce need for care homes to attend the trust to assess patients for themselves is proving positive.

Key Actions

- Work continues to embed and improve operational systems and processes across the wards through the Programme of Flow initiative and within the Discharge to Assess services especially across Pathway 1 and 2.
- NCtR dashboard now live which gives visibility of all patients with a NCtR within the Acute Trust.
- Electronic Transfer of Care referral form live on Advantis – continues to be reviewed but early signs show reduced duplication .
- Weekly meetings with out of area partners to support improved flow out of the Acute setting and escalation processes are in place.
- 'Meet and Greet' process to include a question to highlight Derbyshire residents to support early escalation.
- Stockport escalation pathways for NCtR continue to be reviewed; to agree escalation process with system partners in line with GM expectations
- Spot purchase process in place however review of available community beds to meet patient need being undertaken.
- 6-week review taking place of the Transfer of Care Hub model and associated Health and Social Care workforce.

Performance for No criteria to reside (NCTR)



Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

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%	21.1%			

ECG
April un-validated position was 871 breaches, which is was an increase of 61 from the previous month. However this is below the trajectory position of 918 by 47.

May predicted position is 852 breaches which is a decrease in breaches of 19 compared to April however will leave us above trajectory set at 806 by 46 breaches.

Imaging - MR
Increase in patients waiting over 6 weeks due to loss of additional capacity at Wythenshawe site. Additional capacity has been agreed for 800 scans during May and June which should recover the position by the end of June. A further bridge will be required until the CDC goes live in August.

Audiology
Pre Covid, no surveillance patients waited past their planned due date, since Covid there has been a backlog that the department have managed internally. These patients are now required to be reported on DMO1.

Following recent paediatric audiology peer review, mitigations were required to be put in place which retain children on the waiting list as a failsafe. This has led to increase in waiting list numbers.

Key Actions

- Echo – out to agency to start weekend lists from the 18th May this will give us an additional 220 slots across May and June and will mean we end May below trajectory; awaiting signoff of contracts.
- MR – confirm additional MR capacity for July and August

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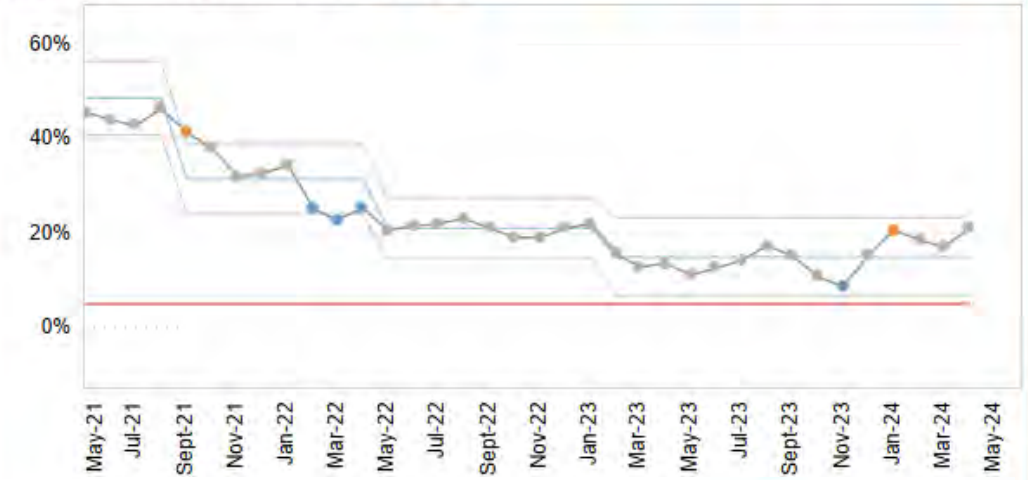
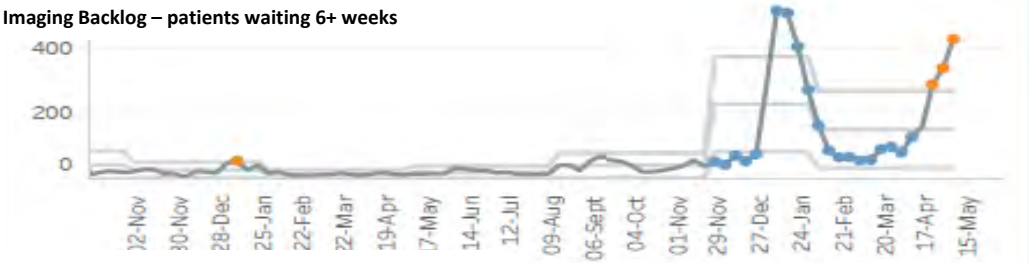
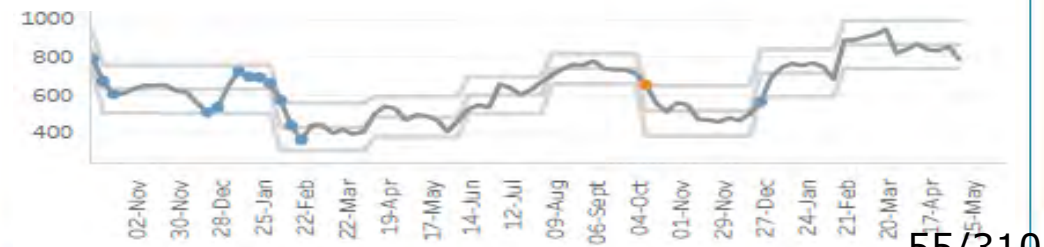
Performance for Diagnostics: 6 Week Standard



Imaging Backlog – patients waiting 6+ weeks



Echo backlog – patients waiting 6+ weeks



Signed off by	Mike Allison / Karen Hatchell / Catherine Cotton
Executive Lead	Jackie McShane

Operations **Referral to Treatment (RTT)**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	50.8%			
52-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	<= 3783	2633			
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	572			

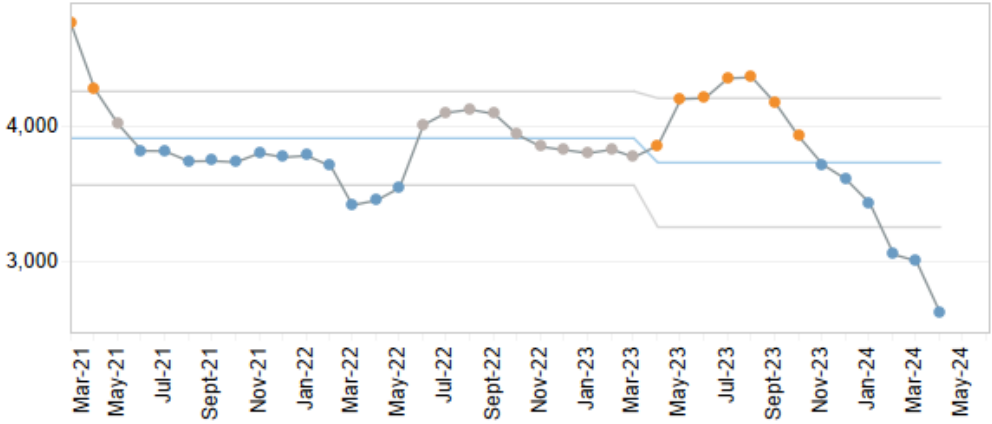
April Summary

- The Trust has no patients waiting over 104 weeks & saw an improved position in month for patients waiting over 78 & 65 weeks to commence treatment.
- The Trust reported 5 patients waiting over 78 weeks at the end of April-24 due to patient choice, complexity, or short-term fitness issues. All patients will be dated for treatment in May and the Trust continues with the aim of reducing to zero for 78ww by the end of May-24.
- For 65ww patients, the Trust had set a trajectory of 687 patients for the end of April-24, however the trust was ahead of trajectory with only 572 patient over 65ww.
- For 52ww patients, the trust at the end of April-24 had 2633 which is ahead of the trajectory of 2761 and the lowest number of 52ww patients since December 2020.
- The Trust continued to work with the ICB & other GM trusts on the mutual aid strategy to support the reduction of long wait patients. The trust has also continued to work with two Independent sector providers under a direct sub-contract for 24/25 to support ENT & Ophthalmology.
- Digital waiting list validation continues to help cleanse the waiting lists and support the position.

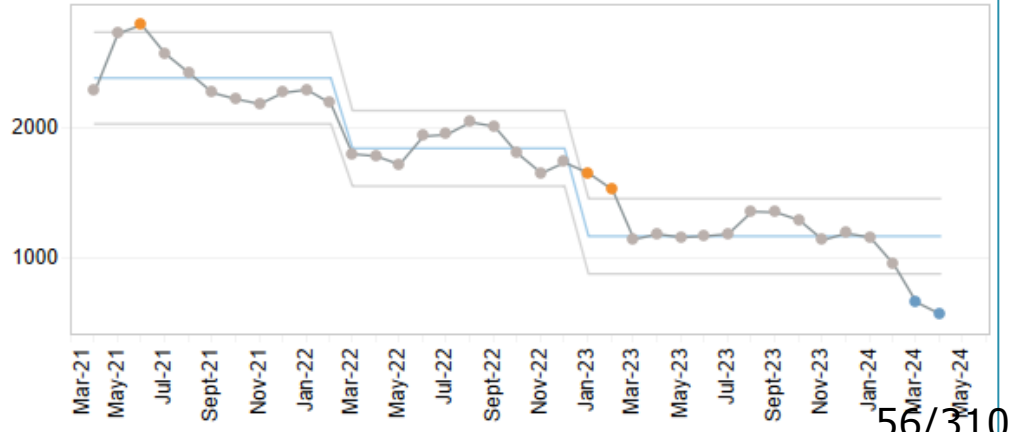
Key Actions

- Focus on providing additional capacity, prioritise long waiters and validate WLs against the access policy.
- Work continues to try and meet the challenge of reducing to zero patients waiting over 78ww by the end of each month, and work towards eliminating all 65ww's by the end of September-24.
- Daily RTT performance PTLs have been put in place to drive performance & aid in expediting pathways.
- Following additional funding within the 2024-25 contract, plans have been agreed and are now being mobilised to expand elective capacity across several pressured specialties in order to reduce to zero 65 week waits by the end of September-24.
- The Trust is working collaboratively with the ICB & other Greater Manchester Trusts to continue to facilitate mutual aid opportunities where possible.
- To support the end of September target for 65 week waits, the Trust has set an internal target to have no patients waiting more than 52 weeks for their first appointment by the end of June-24

Performance for 52-week breaches



Performance for 65-week breaches



Update provided by	Dan Riley
Executive Lead	Jackie McShane

Integrated Performance Report
Exception

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%	7.4%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
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%	4.2%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

DNA

DNA rate has risen slightly to 7.4% but remains below the 2023 benchmark. Stockport continues to be the second best in GM. Significant further improvement is needed to achieve the 6.3% target.

Clinic Utilisation

Overall utilisation is at 90% and at target. Once exclusion have been removed overall utilisation improves to 97%.

The centralised booking team performance was maintained at 95% overall. Non central booking team clinics improved to 100%.

PIFU

April 24 has fallen slightly to 4.2% (1178) against a target of 4.4% (1207) ever, Stockport continues to be ranked 1st in GM for PIFU.

Key Actions

- DNA's – Additional work with offsite clinics to ensure patients has been completed in April.
- Clinic utilisation – A review of booking arrangements has been completed. Outcomes to be reviewed with findings and recommendations to be completed
- PIFU - Specialties continue engaging with the GIRFT Further Faster initiative and is helping teams look at opportunities to increase the use of PIFU in their specialities and this work

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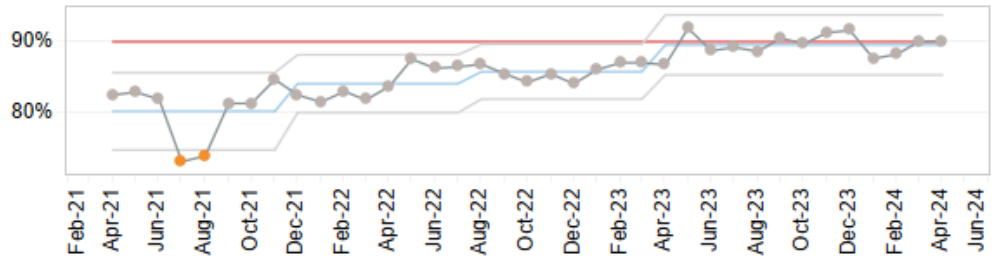
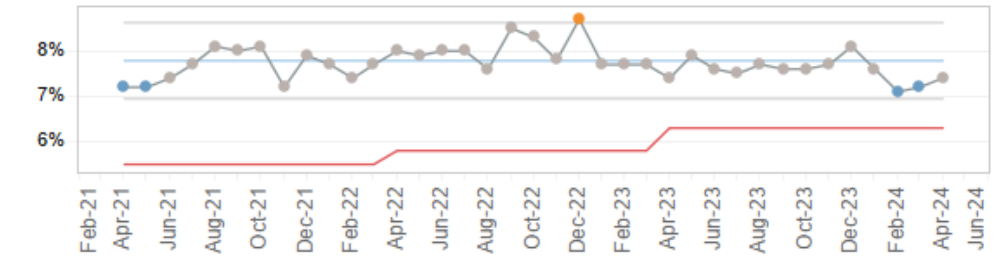
Signed off by	Mike Allison
Executive Lead	Jackie McShane

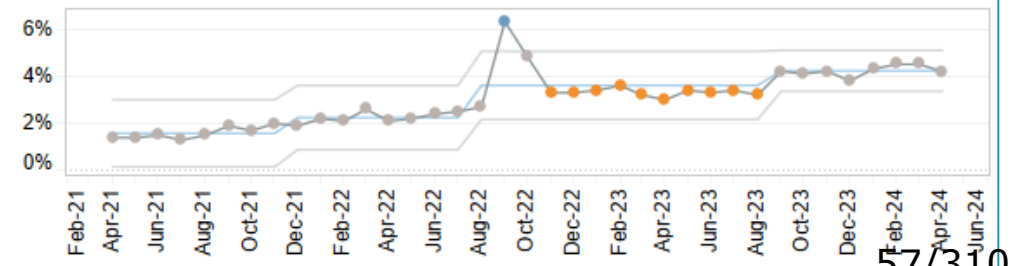
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



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%	78%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲
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	2.81	→	▲ ▲ ● ▲ ▲ ●	●

April Summary

- Model Health (refresh 07/04/24) performance data for CTTU: For the first time in a few months, the Trust at 75.5%, has dropped to below Peer (76.6%) and National (77.3%) – attributed to inefficiencies caused by estate related issues in March. However, Trust performance is reporting as 2nd best in GM.
- Trust tableau data for April shows week to week movement between 75.5% and 78.9%. Based on the monthly average, CTTU has dropped from circa 79% in February and March, to 77.7% in April – negatively skewed by less favourable performance for specialties such as Ophthalmology (46 sessions achieving an average of 59.8%) and Pain (6 sessions achieving an average of 54.8%). Main Theatres is consistently achieving >80%, however, both SEC and Maple have been averaging approx. 63% for the last 3 months.

Key Issues

- Planned shutdown of Main Theatres 8-11 for a five-week period from Monday 15th April 2024 to Friday 17th May 2024 (inclusive) to enable essential EUCC construction activities. Mitigating actions have been put in place, but the opportunity for flexibility in the event of a failure of estate has been compromised, for example, Th14/15 uninterruptable power.
- An infection prevention issue has impacted on delivery of theatre sessions in Maple Suite.
- Discrepancy in minutes booked for procedures and actual minutes the procedures are taking, leads to early finishes which impacts the CTTU %.
- Maple & SEC continue to negatively skew the Trust average CTTU

Key Actions

- Twice weekly Theatre Performance Review Meetings re-focus including:
- Lost touch-time thematic analysis & opportunities. Using Ophthalmology as an example, in April 37% of sessions started late and 43.5% of sessions finished early.
- Extra scrutiny of significantly under-performing areas e.g. Maple & SEC

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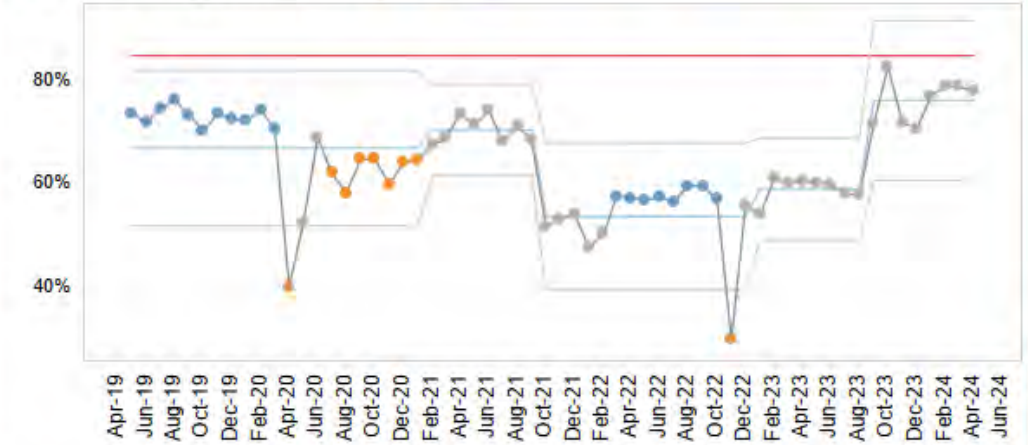
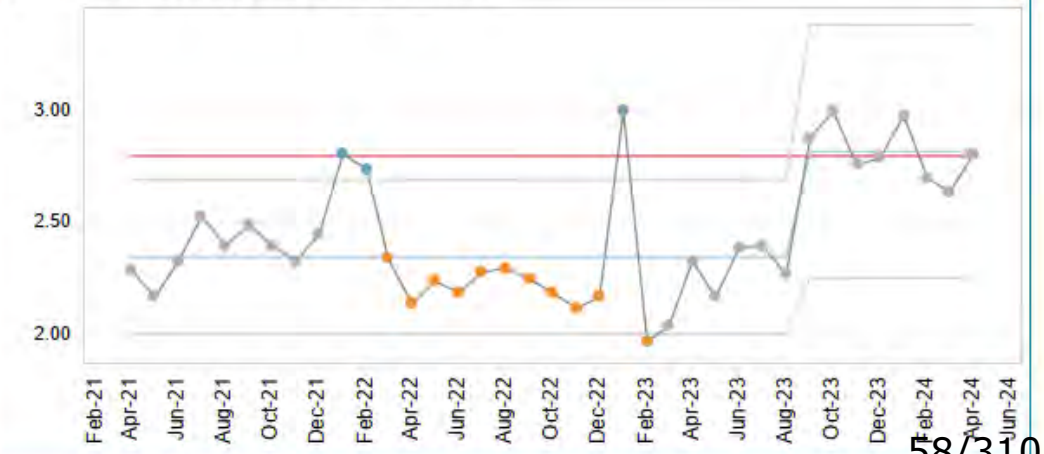
Performance for Capped Touch Time Utilisation



Performance for Average cases per 4-hour session



Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Workforce **Appraisal Rate**

	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%	91.9%			

April Summary

- We have seen an increase in Performance Appraisal compliance and we currently stand at 90.88% for the month of May.
- All divisions are below the target of 95% with Corporate Services and Medicine & Urgent Care (including Emergency Department) reporting under 90%.

Actions

- A deep dive was undertaken to see if there was any correlation between poor performing areas and uptake of appraisal training, however, there was no evident trend.
- We continue to engage divisions with reminders, direct contact, regular training and support.
- From 1st June our refreshed appraisal documentation, along with our 'lets talk' one to one meeting documents will be launched. This launch will be supported by a communications campaign and support sessions for managers.

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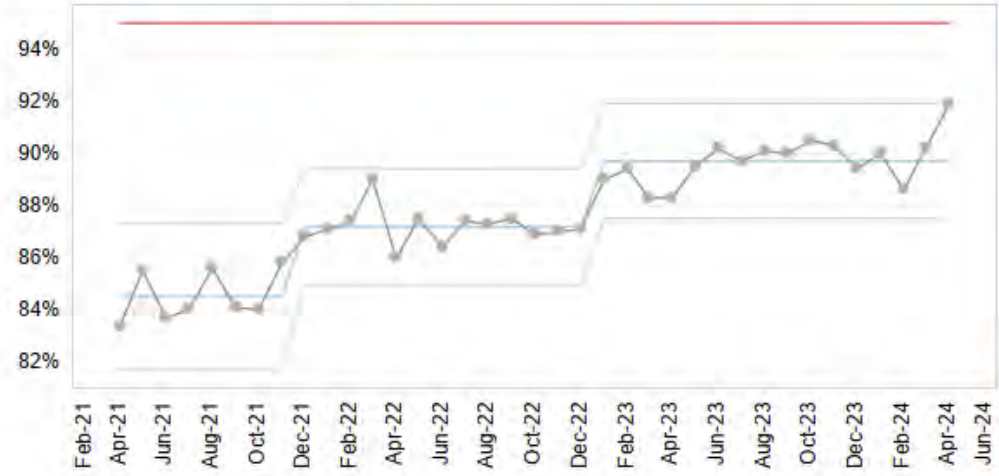
Performance for Appraisal Rate: Overall



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

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%	-54.5%	→	● ● ● ● ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		19.2	↘		
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	0%	→	● ● ● ● ● ●	●
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	-0.1%	↑	▲ ▲ ▲ ▲ ▲ ●	●

Key Risks

- Cash remains one of the biggest risks for 2024-25. As the Trust has already received revenue support there are more stringent controls on non-pay expenditure and recruitment in line with correspondence from NHSE. Further clarification on approval processes is awaited from GM ICB.
- Following the agreement of the additional consultant pay award related to 2023-24, clarity is still being sort as to whether there will be any revenue support to cover this.
- 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.
- 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 all schemes considered continue to be assessed through the Quality and Equality Assessment process.

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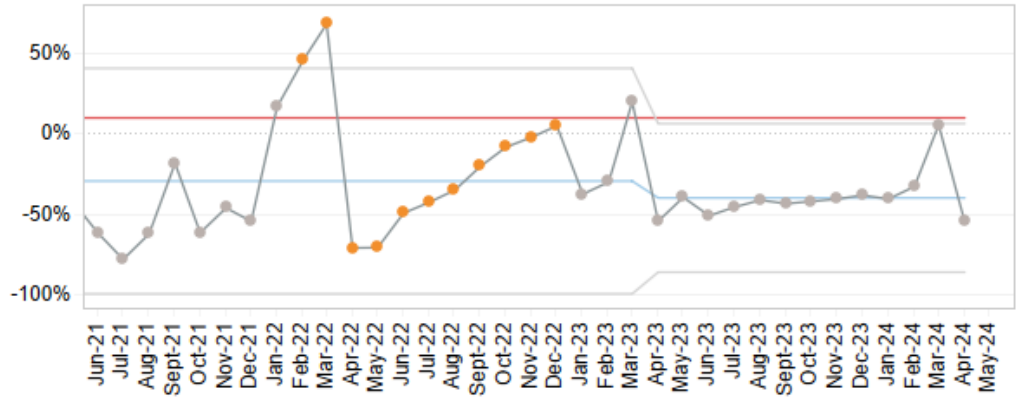
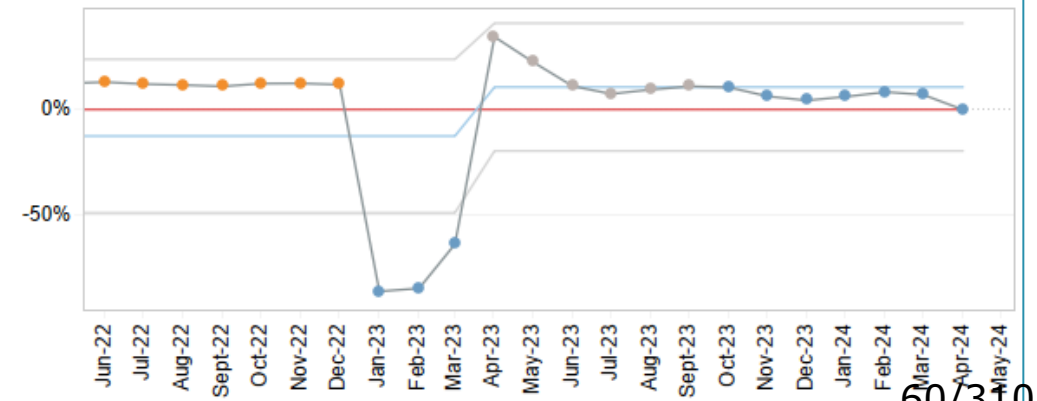
Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Update provided by	Tracy Coburn
Executive Lead	John Graham

NHS Stockport NHS Foundation Trust

Meeting date	6th June 2024	**Public**	**X**	**Agenda No.**	10
Meeting	Board of Directors				
Report Title	Financial Position 2023/24 year end and 2024/25 M01				
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 year end 2023/24, pending external audit approval • receive the Financial Position report for 2024/25 M01 • 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 delivered the planned deficit of £32.2m in 2023/24, pending external audit approval. A detailed finance paper was presented to the Finance & Performance Committee on the 18th April 2024.

The Trust has a planned system deficit of £46.1m in 2024/25, pending final approval by GM ICB. A detailed finance paper was presented to the Finance & Performance Committee on the 16th May 2024.

This paper is the summarised key extracts from the above reports. The paper seeks to give assurance that, subject to known risks as agreed within the GM ICB, that the Trust will:

- 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

In order to deliver the financial plan for 2023/24 the financial governance in place has been strengthened with a series of grip and control actions, at a high-level these include review of all vacancies, focussed action on reduction in agency costs and reconciliation of budgeted posts. This will continue in 2024/25.

NHS
Stockport
NHS Foundation Trust

Board of Directors

6th June 2024

Financial Performance 2023/24 out-turn and 2024/25 M01

John Graham
Chief Finance Officer

Contents

Stockport NHS Foundation Trust

1. Overall Financial Position 2023-24

NHS Stockport NHS Foundation Trust

Income & expenditure Position	In-Month			Year to date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Total Income	**48.3**	**52.3**	**4.0**	**434.0**	**438.9**	**4.9**	**434.0**	**438.9**	**4.9**
Substantive Staff	(35.2)	(35.2)	0.0	(288.0)	(287.3)	0.7	(288.0)	(287.3)	0.7
Bank Staff	(2.2)	(3.2)	(1.0)	(28.3)	(36.0)	(7.7)	(28.3)	(36.0)	(7.7)
Agency Staff	(1.7)	(1.0)	0.7	(20.4)	(15.7)	4.7	(20.4)	(15.7)	4.7
Pay Costs	(39.1)	(39.4)	(0.4)	(336.8)	(339.1)	(2.3)	(336.8)	(339.1)	(2.3)
Drugs	(1.9)	(1.8)	0.1	(23.1)	(23.4)	(0.3)	(23.1)	(23.4)	(0.3)
Clinical Supplies & Services	(2.4)	(3.7)	(1.3)	(25.8)	(29.6)	(3.8)	(25.8)	(29.6)	(3.8)
Other Non Pay Costs	(5.3)	(4.1)	1.1	(54.2)	(52.9)	1.2	(54.2)	(52.9)	1.2
Below the Line	(2.3)	(5.7)	(3.4)	(25.9)	(27.9)	(2.0)	(25.9)	(27.9)	(2.0)
Total Expenditure	**(50.9)**	**(54.7)**	**(3.8)**	**(465.7)**	**(472.9)**	**(7.1)**	**(465.7)**	**(472.9)**	**(7.1)**
TRUST SURPLUS / (DEFICIT)	**(2.6)**	**(2.4)**	**0.2**	**(31.8)**	**(34.0)**	**(2.2)**	**(31.8)**	**(34.0)**	**(2.2)**
Pharmacy Shop	-	0.0	0.1	-	0.1	0.1	-	0.1	0.1
Add back Fixed Asset Impairment	-	1.6	1.6	-	1.6	1.6	-	1.6	1.6
Add back Reversal of Fixed Asset Impairment	-	(0.2)	(0.2)	-	(0.2)	(0.2)	-	(0.2)	(0.2)
Remove capital donations/grants/peppercorn lease I&E impact	0.0	0.0	(0.0)	0.3	0.3	(0.0)	0.3	0.3	(0.0)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(2.6)**	**(0.8)**	**1.7**	**(31.5)**	**(32.2)**	**(0.7)**	**(31.5)**	**(32.2)**	**(0.7)**

1. Overall Financial Position 2023-24

NHS Stockport NHS Foundation Trust

The March 2024 (M12) financial position is a deficit of £32.2m which is £0.7m adverse to plan and in line with the year-end forecast agreed as part of the GM ICS position.

The Out Patient B impairment following the loss of the building was also transacted at a cost of £1.9m and has been contained within the overall agreed control total. This was managed by income received for industrial action and ERF, and further review of accruals and balance sheet.

Therefore the key variance to plan remains the non-receipt of the cost of capital funding from GM ICS.

The CIP plan was also delivered for the year, albeit not all recurrently.

The first submission of the draft accounts was on the 24th April 2024 and are in the process of external audit review.

1. Overall Financial Position 2023-24 - Capital

NHS Stockport NHS Foundation Trust

Description	Month 12			Year To Date M12			2023-24		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Estates	6.1	11.9	5.8	39.0	32.7	(6.3)	39.0	32.7	(6.3)
Equipment	0.3	1.5	1.2	1.8	2.4	0.6	1.8	2.4	0.6
IFRS16	-	2.6	2.6	12.4	4.4	(8.0)	12.4	4.4	(8.0)
IT	2.8	4.2	1.4	9.5	7.1	(2.4)	9.5	7.1	(2.4)
Total	**9.2**	**20.2**	**11.0**	**62.7**	**46.6**	**(16.1)**	**62.7**	**46.6**	**(16.1)**

- The original 2023/24 Capital plan started at £62.7m.
- Following various adjustments throughout the year the final plan figure was £46.6m, including £4.4m for IFRS16.
- Capital spend totalled £42.177m against a plan of £42.178m excluding IFRS16, therefore the GM ICS capital total was achieved.

2. Overall Financial Position 2024-25 M01

NHS Stockport NHS Foundation Trust

Income & expenditure Position	In-Month			Year to date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Total Income	**35.4**	**35.6**	**0.2**	**35.4**	**35.6**	**0.2**	**426.9**	**426.9**	**-**
Substantive Staff	(24.6)	(24.6)	0.0	(24.6)	(24.6)	0.0	(282.1)	(282.1)	-
Bank Staff	(2.8)	(2.5)	0.3	(2.8)	(2.5)	0.3	(34.7)	(34.7)	-
Agency Staff	(1.1)	(0.9)	0.2	(1.1)	(0.9)	0.2	(12.7)	(12.7)	-
Pay Costs	(28.5)	(27.9)	0.5	(28.5)	(27.9)	0.5	(329.5)	(329.5)	-
Drugs	(1.9)	(2.0)	(0.0)	(1.9)	(2.0)	(0.0)	(23.5)	(23.5)	-
Clinical Supplies & Services	(2.8)	(2.8)	(0.0)	(2.8)	(2.8)	(0.0)	(31.9)	(31.9)	-
Other Non Pay Costs	(5.0)	(5.7)	(0.7)	(5.0)	(5.7)	(0.7)	(58.8)	(58.8)	-
Below the Line	(2.3)	(2.3)	0.0	(2.3)	(2.3)	0.0	(29.6)	(29.6)	-
Total Expenditure	**(40.4)**	**(40.6)**	**(0.2)**	**(40.4)**	**(40.6)**	**(0.2)**	**(473.3)**	**(473.3)**	**-**
TRUST SURPLUS / (DEFICIT)	**(5.0)**	**(5.0)**	**0.0**	**(5.0)**	**(5.0)**	**0.0**	**(46.4)**	**(46.4)**	**-**
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	0.0	0.0	0.0	0.2	0.2	-
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(5.0)**	**(5.0)**	**0.0**	**(5.0)**	**(5.0)**	**0.0**	**(46.1)**	**(46.1)**	**-**

2. Overall Financial Position 2024-25 M01

NHS Stockport NHS Foundation Trust

The current financial plan was submitted in line with the GM plan with a deficit of £46.4m with a cost improvement programme of £24.6m.

The plan at month 1 is a deficit of £5.0m and the actual position is line with the plan.

In month there is an underspend on pay costs of £0.5m which is triangulated to the reduction in temporary staffing used in April 2024, where there has been a reduction of 104.5 wte bank staff and 25 wte agency staff.

At early stage in the financial year, timing adjustments have been made to recognise costs not yet notified.

The Cost Improvement (STEP) programme is profiled on a stepped basis with an increased requirement in the second half of the year. There has been a positive start to the year with the plan of £1.0m being achieved in month; however only 10% of this is recurrent compared to a 50% target.

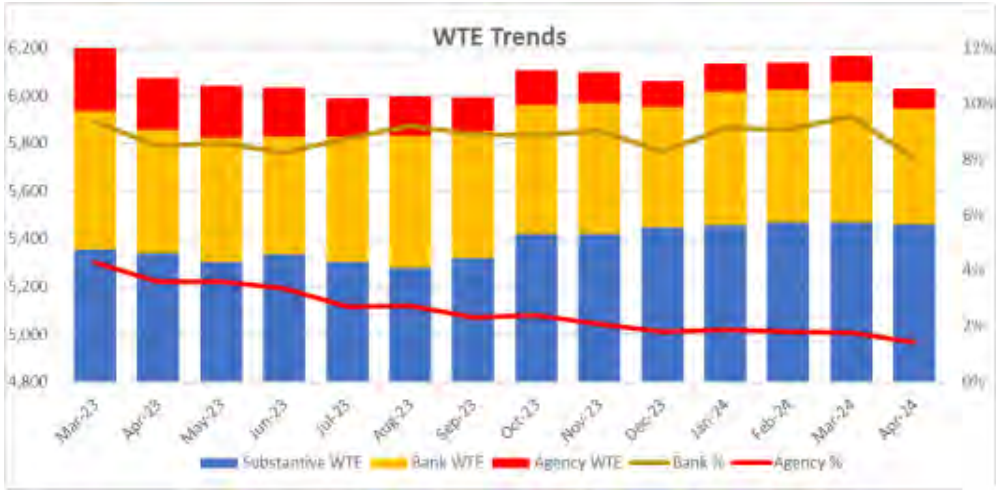
Revenue support of £5.4m was drawn down in April 2024.

2. Overall Financial Position 2024-25 M01

NHS Stockport NHS Foundation Trust

Pay Type	April 2024 (M01) Plan £000s	Actual £000s	Variance £000s
Substantive Staff	(24,611)	(24,597)	14
Bank Staff	(2,799)	(2,476)	323
Agency Staff	(1,057)	(876)	181
Pay Costs	(28,467)	(27,949)	517

Bank and Agency WTE Reduction



There has been a small drop in substantive staffing in M01 2024-25 when compared to March 2024, however bank has reduced by 104.5wte and agency by 25wte which is a positive start to the new financial year.

As part of the Trust's grip & control processes the Staffing Approval Group continues with its weekly vacancy review and oversight of long-term agency approvals. Final approval of all vacancies is via the Executive Team. The Trust also has a Workforce Efficiency Group with oversight of all temporary staffing costs.

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	*Bank %*	*Agency %*
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%*

3. Stockport Trust Efficiency Programme (STEP)

NHS Stockport NHS Foundation Trust

Year to date **delivered** schemes totals **£1.0m**

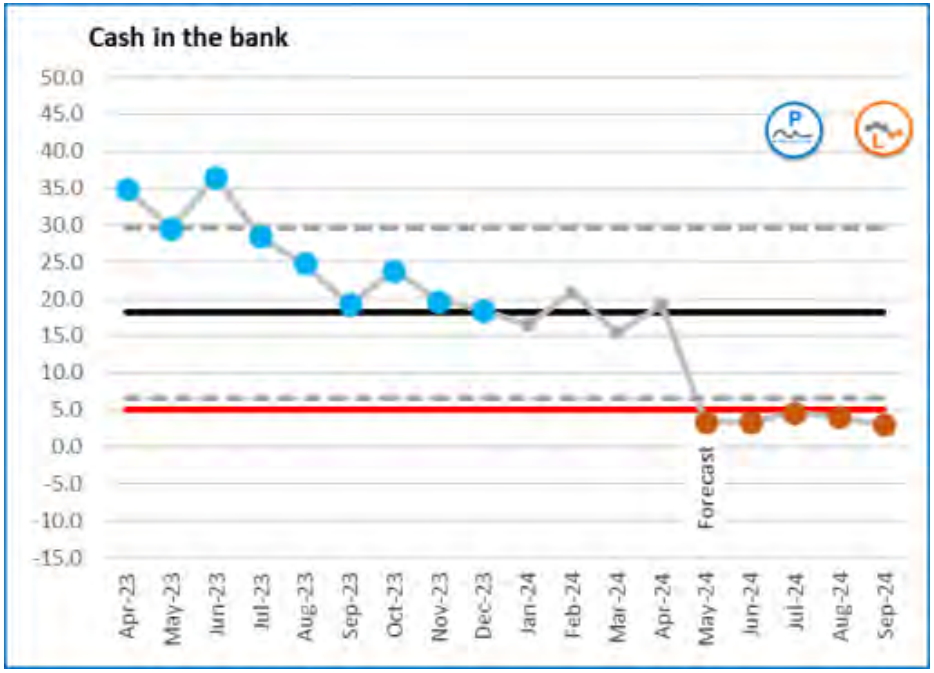
Total savings achieved **£2.3m** (9.4%) of the **2024/25** in year target of **£24.6m**

Profile of savings target weighted to end of year will increase challenge from M07

Key Points

- Delivered month 1 savings target of £1.0m, and £2.3m (9%) of annual target
- £1.4m of recurrent savings have been delivered at month 1
- The Trust STEP target for 2024-25 is £24.6m. This is split evenly between recurrent and non-recurrent savings.
- The STEP target for 2024-25 has been weighted toward the last 6 months of the year, this will mean that from month 7 delivering the in month target will become more challenging. Part of the reason for the phasing links to confidence in delivery where failure to deliver would affect cash flow. To deliver the level of CIP will require transformation of service delivery; these discussions are on going and will also include the consideration of unpalatable schemes e.g. reduction of services

4. Cash



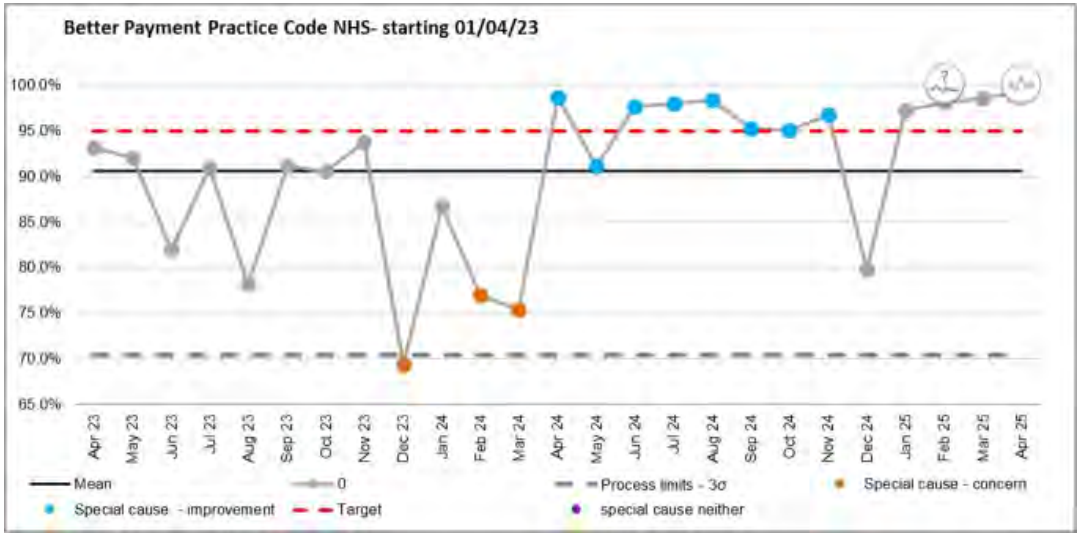
Cash balance at the end of April 2024 was £19.2m an increase of £3.7m from the end of March.

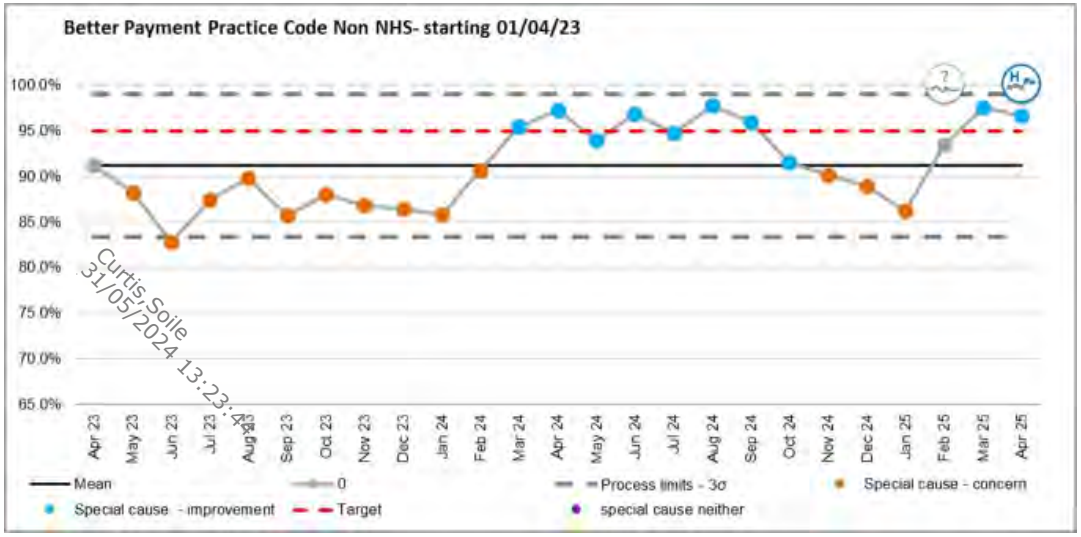
Revenue Support of £5.4m was received in April. Revenue Support will not be required in May; however, support is anticipated over the remainder of the financial year up to the forecast trust deficit of £46.3m.

Capital Creditors at the end of April were £9.3m. Further capital cash is likely to be required pending confirmation of the Capital Plan for 24/25.

The well-established Cashflow Monitoring Group will continue to closely monitor the cash position; this is another aspect of the grip & control measures in place at the Trust.

4. BPPC





The Better Payment Practice Codes (BPPC) monitors the number of invoices and value of invoices; and the combined performance for NHS and non-NHS. BPPC sets the target for 95% of all valid invoices to be paid within the agreed timeframe.

Performance against the standard is shown in the charts, and continued to be above the target in April.

5. Capital

Description	Month 1			Year To Date M1			2024-25		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Estates	3.0	1.1	(1.9)	3.0	1.1	(1.9)	37.3	37.3	-
Equipment	-	-	-	-	-	-	-	-	-
IFRS16	1.0	-	(1.0)	1.0	-	(1.0)	3.5	3.5	-
IT	-	0.3	0.3	-	0.3	0.3	1.8	1.8	-
Total	**4.0**	**1.4**	**(2.6)**	**4.0**	**1.4**	**(2.6)**	**42.5**	**42.5**	**-**

The Trust has submitted a capital plan of £42.5m including £3.5m for IFRS16. This plan is currently being reviewed by GM system.

Capital spend in April 2024 relates to schemes that were in progress and contractually committed into 2024/25 including:

- Emergency Care Campus
- Modular Ward (TIF)
- MRI Development
- Boiler House Roof Replacement (RAAC)

6. Risks to Delivery of Plan

NHS Stockport NHS Foundation Trust

Contract Income & Elective Recovery Fund

The 2024/25 ERF baseline has now been issued, and targets are broadly in line with 2023/24 with an adjusted to be added for independent sector activity commissioned by the ICB on our behalf in 2023/24.

The NHS Derbyshire ICB contract is yet to be agreed, but the current offer is £0.9m less than included in the GM lead commissioner contract schedule. NHS Cheshire & Mersey ICB have also not yet issued a contract, but this is less of a risk as they are likely to follow GM's lead.

Cash

Cash remains one of the biggest risks for 2024-25. As the Trust has already received revenue support there are more stringent controls on non-pay expenditure and recruitment in line with correspondence from NHSE. Further guidance on how the GM system will apply the approval of vacancies and expenditure is awaited.

Cash is also required to fund the capital programme and guidance on the process for this would be welcomed.

6. Risks to Delivery of Plan

Stockport NHS Foundation Trust

Estate risks

The limited availability of capital given the condition of the estate at Stockport presents a higher revenue risk from both and expenditure perspective and a loss of income.
The Trust is currently reviewing posts which were previously capitalised which will now move back into revenue and this will increase the reported permanent WTE.

Industrial action

Additional costs and loss of activity due to industrial action has not been included in the planning process. As the junior and SAS doctors have voted for a mandate to take industrial action this would impact on activity, expenditure and cash. There is also concern about the potential for GP industrial action and the potential for yet further growth in Emergency demand.

Pay awards

Following the agreement of the additional consultant pay award related to 2023-24, clarity is still being sort as to whether there will be any revenue support to cover this. 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.

NHS Stockport NHS Foundation Trust

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	11
Meeting	Board of Directors				
Report Title	Green Plan Annual Report 2023/24				
Director Lead	Paul Featherstone Director of Estates & Facilities	**Author**	Laura Swann Sustainability Manager		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	**The Board of Directors are asked to review and confirm the Green Plan Annual Report 2023/24 including current challenges and future opportunities.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
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
	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
X	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)	All

Executive Summary

The report provides the Board of Directors with an update on progress made against the Green Plan in 2023/24. The report was reviewed via the Finance & Performance Committee at its meeting in May 2024.

The report outlines the key achievements in 2023/24 in relation to delivering the Green Plan, alongside current challenges, and opportunities. Going forward the Green Plan Group for Stockport NHS Foundation Trust will be combined with the Sustainability Group at Tameside & Glossop Integrated Care NHS Foundation Trust, to create one collaborative group. The establishment of a joint group would then support the delivery of a new joint Green Plan across both Trust from January 2025.

1 Introduction

The Stockport NHS Foundation Trust Green Plan sets out our aims and commitment to improve the environment for our communities and become a sustainable healthcare provider. Through the plan we commit to reaching net zero by 2040 for the emissions we directly control, by reducing our carbon emissions, reducing waste to landfill and improving local air quality.

The Geen Plan was approved in February 2022 and supported by the launch of the Trusts Green Group. The group is made up of stakeholders from a variety of departments, all committed to delivering the objectives of the Green Plan.

This report provides an update on progress during 2023/24 against the Green Plan objectives.

2 Review of Objectives

2.1 Developing a low carbon organisation and workforce

Training – The Group has begun to explore carbon literacy training for the Green Group members, with further plans to expand it to all members of staff. The Trusts Energy and Sustainability Manager has explored opportunities to develop a carbon literacy module of training for widespread delivery. The Carbon Literacy course will teach the basics of climate change science combined with targeted actions and will detail what an individual can do to help. This will support our goal of becoming a carbon literate NHS Trust and will be further progressed in 2024.

Dr Bike Event - In partnership with Cycle Solutions, Our Cycle to work provider a ‘Dr Bike Event’ was organised to encourage staff to bring in their bikes for minor repairs and general cycling advice. The event proved popular with the Trusts cyclists and those considering 2 wheels instead of 4. Feedback was positive and staff members were appreciative of the free service provided by the Trust.

Sustainability Day - A Sustainability Day was organised with attendees from Stockport Council, Water Plus, and Cycle Solutions. Staff were given sustainability and energy efficiency advice. Water-plus kindly distributed free water savings kits and staff had an opportunity to explore new electric bikes and ask questions around the cycle to work scheme. There are plans to organise similar events in 2024.

Job Descriptions and Sustainability - Workforce colleagues have assisted with the development of proposed wording to be added to future job description for all Trust employees. Once introduced, this will be a welcomed addition to our pre-employment literature which will help highlight our commitment to all elements of sustainability.

2.2 Reducing Our carbon footprint

Estates Decarbonisation Plan- The Trust have been exploring options to commission an Estates Decarbonisation Plan. A bid was submitted to the Low Carbon Skills fund Phase 5 in May 2024 to seek funding to carry out this work. There is very limited funding available across the country, but we will find out at the end of July if we have been successful. This work is vital to enable the creation of robust plans and investment into our green journey. We are also working jointly with Stockport Council to explore the potential for the establishment of a Heat network in Stockport, to provide a sustainable heat source in the future.

Catering – The canteen has a fresh fruit and vegetable bar, although primarily in place to offer healthy options we are also trying to encourage enhanced alternatives to processed, packaged products and more vegetarian/vegan options. In addition, the standard patient menu has a plant-based option which is less carbon intensive.

2.3 Developing lower carbon models of care

Anaesthetic Gasses - The NHS Standard contract requires all Trusts to have reduced their desflurane usage to less than 10%. The Trust has now ceased using desflurane in surgery, meeting this target. We are working with our anaesthetists to reduce the use of nitrous oxide and volatile anaesthetic gases even further.

2.4 Reducing local air pollution through sustainable transport

Electric Vehicles -The plan to gradually replace all the existing fleet vehicles with electric vehicles is underway. The Trust currently owns 4 electric vehicles, and a new electric tail lift vehicle is due to be delivered at the end of the summer. This is in line with our commitment to have a zero-emission fleet and reduce our air pollution levels in the communities we serve.

Bike Stands - £10,000 of funding was awarded by Transport for Greater Manchester which we used to install and improve current bike stands. The funding was used to install a new bike shelter near Oak house, and bike stands near Pinewood house. The existing stands were reused in other areas to avoid waste.

2.5 Reducing waste and moving to zero landfill

Reusable Alternatives in Theatres - The Theatres Department, supported by Procurement have replaced the plastic gallipots and kidney dishes with reusable alternatives.

Food Waste - Patient food waste is monitored, and feedback provided to wards in order to improve processes and reduce food waste. Any food waste that is produced is sent off-site and converted to biomass, as an alternative going to landfill.

This year the Trust carried out a trial using coloured plates to serve patient meals instead of the standard white plates. This was based on the theory that coloured crockery makes the food more appealing to patients and food waste is reduced as a result. The Trust found that the use of coloured crockery enhanced our patient experience around mealtimes, with particular interest relating to patients with Dementia and the contrast provided by the plate colour and what effect if any it had with this cohort of patients in terms of increased

consumption. A reduction in overall average waste of 9.2% was seen across both wards involved in the trial on the coloured plate vs standard plate. The implementation of coloured plates will now be proposed.

Waste management - Effective waste management is one of our core principles and we are committed to reducing our carbon footprint and improving understanding of the importance of effective waste management in the NHS. To work alongside our current waste management team the Trust has appointed a Dangerous Goods Safety Advisor (DGSA) to advise on all aspects of waste.

In 2023 a Waste Steering Group was established to ensure effective waste management throughout the Trust. A new Waste Policy has been introduced and new Standard Operating Procedures have been adopted.

Work has progressed this year to improve bin stickers and signage relating to waste management and the Trust have been working closely with our waste companies to provide effective training at ward level to staff.

New confidential waste bins have been introduced throughout the Trust to ensure compliance with Information Governance.

Walking Aid Reuse Scheme – The Trust introduced a walking aid reuse scheme in October 2022, which is centred on the usage of mobility aids both at Stepping Hill and within the Community of Stockport. The scheme has proven to be a huge success, with a total of 1,367 walking aids returned to the Trust in 2023/24 and 1,094 cleaned, refurbished and reissued. This has resulted in a reduction in our carbon emissions of 24.04 tCO_2e.

2.6 Reducing water use and including sustainable drainage solutions for new build

Reducing Water Use - The Trust has identified a large number of water leaks which can often go unnoticed for substantial periods of time. To assist with prompt detection of water leaks, installation of sub-meters and water data loggers has been completed. Further water loggers will be installed in phases to avoid prolonged water supply interruption to the site.

2.7 Lower carbon procurement and catering, including action to reduce single use plastics

Sustainable Procurement - Sustainability and the social value of all tenders is scored at a minimum of 10% of the overall available tender score as per Government guidelines or more where appropriate to the particular tender, which includes specific accountability to environmental and sustainability responsibilities and must include criteria around carbon reduction.

Single Use Plastics - The catering department has phased out single use plastics, for example, takeaway meal boxes and takeaway cutlery.

2.8 Sustainable building design and climate change adaptation

Sustainable Buildings - A number of Capital projects undertaken in 2023/24 that impact on energy consumption:

- Replacement of pipework for water and steam and heating
- Main corridor steam leak repairs
- Multiple Roof Replacements and repairs
- Healthier Together – Theatre
- Boiler house roof replacement
- Invested in electrical infrastructure long term plans (including, but not limited to replacement switchboard, distribution boards, generators and transformer)
- Upgraded MRI scanner
- Upgraded x-ray/fluoroscopy equipment
- Replacement emergency lighting
- Upgrades to BMS controllers
- OPD B demolition – disposed of poor condition estate that we struggled to heat

All new projects, where applicable, use the HTM and BREEAM guideline to achieve the highest sustainability standards possible.

Climate Change Adaptation and Resilience – We are working closely with colleagues across Greater Manchester to consider how we can adapt to the impacts of climate change to ensure we can effectively manage the increasing summer temperatures, storms and high rainfall. This work will be developed in 2024 to consider the potential impacts and how we can mitigate against the risks.

3. 2023/24 Performance Update

The impact of the work to deliver the Green Plan can be measured by the Trust's emissions.

A full update on Scope 1,2 and 3 emissions for 2023/24 is not yet available, as we are awaiting data. However the biggest emissions of CO_2 in the Trust come from Natural Gas and electricity consumption (72% - approximately 48% natural gas and 24% electricity).

Energy Consumption data - The consumption of energy in 2023/24, compared to previous years is shown in the table below. We have seen a slight increase in the consumption of gas and a large increase in electricity consumption this year. The increases in electricity consumption can be attributed to an increase in construction works on site and changes to onsite activity e.g. electric vehicle charging. During 2024, consideration will be given to enhanced metering to enable better monitoring and control of usage.

Years	Gas (kwh)	Electricity (kwh)
2016/17	31040831	12907495
2017/18	30185153	12848845
2018/19	31229742	12676387
2019/20	32358588	12311526

2020/21	32667002	12559835
2021/22	32766055	13076062
2022/23	31072441	12878372
2023/24	31123016*	14078700*

*Figures include some estimated data so could be subject to slight change

The gas and electricity consumption for 2023/24 has been converted (using the UK Government GHG Conversion Factors) into tonnes of CO_2e and compared with the 2020/21 data used in the Green Plan.

Scope	Measure	2020/21	2023/24
1	Natural Gas	5596	5693
2	Electricity	2939	2915

This shows a slight increase in emissions from natural gas and a very slight reduction from electricity. It may be expected that the increases in electricity usage would see an increase in the CO_2 emissions. However, there has been a change in the conversion factor, due to the percentage of renewable generation across the grid, which has impacted on the calculation.

4. Current Challenges and Future Opportunities

We have identified a risk that we may not achieve the target set in our Green Plan to reduce our carbon emissions to Net zero by 2040. This risk has been added to the Risk Register and specific operational risks will be reflected on the Trusts Risk Register as required.

During 2023, whilst progress has been made towards meeting the net zero targets, there have been significant challenges. The primary challenge was the departure of the Energy and Sustainability Manager in July 2023. With support from the Executive, the post was successfully re-banded, and a new Sustainability Manager was appointed and has been in post since late February 2024. The post holder has begun to work across Stockport and Tameside to deliver the respective Green Plans.

With a joint Sustainability Manager across both Trusts, it is now proposed that a joint Green Plan Delivery Group is established to coordinate the delivery across both Trusts. This will provide an opportunity to learn from best practice across both organisations and also provides the opportunity to look to establish a joint Green Plan from January 2025, when the current plans are due to be reviewed. A joint Green Plan would be supported by the establishment of an annual Action Plan for each trust setting out the key deliverables for each financial year. Progress against the key deliverables would then be actioned through the Green Plan Delivery Group and reported back to the Finance and Performance Committee and Board at each Trust every 6 months.

Funding to deliver sustainability projects remains a challenge and we need to be looking ahead at external funding opportunities and be bid ready with projects that can be delivered quickly

when funding opportunities present themselves. Two external funding applications have been made in April / May 2024 and we should find out if they have been successful in late Spring / Early Summer.

- Nature Recovery Ranger – A National Lottery bid has been submitted by the Centre for Sustainable Healthcare for a Nature Recovery Ranger to work across Stockport Foundation Trust and Tameside and Glossop Foundation Trust. Nature Recovery Rangers work with NHS partners at healthcare sites across England to improve the quality of green spaces, and help to integrate nature into patient care, staff wellbeing and community engagement. Their aim is to maximise the role that green spaces play in the prevention of health issues, supporting recovery and the creation of a healthier environment.
- Low Carbon Skills Fund Phase 5 – A bid has been submitted for £95k of funding to produce a Heat Decarbonisation plan for Stepping Hill Hospital.

There is a significant amount of work to do to co-ordinate delivery across both Trusts and it is therefore essential that we recruit a Sustainability Officer to support the Sustainability Manager. This would ensure that there is capacity to deliver progress and to be proactive to look for further funding opportunities to support progress. The job description for this role is currently being reviewed ahead of recruitment.

The successful delivery of the Green Plan requires support from all staff, at all levels across the organisation. In 2024 we need to focus on how we can facilitate cultural change and ensure the delivery of the Green Plan is built into all decision-making processes.

The Green Group membership is comprised of a cross section of SNHSFT personnel, including senior leads from a variety of departments from a range of specialities.

Meeting date	6 June 2024	**Public**		**Agenda No.**	12
Meeting	Trust Board				
Report Title	EDI Strategy Update				
Director Lead	Amanda Bromley, Director of People and OD	**Author**	Stuart McKenna, Assistant Director of HR (Inclusion and Colleague Experience)		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	The Board is asked to note the progress of the Trust's EDI Strategy 2022-25 and associated consolidated action plan.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe	X	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
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	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
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality 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	Throughout
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

In March 2022 we launched our Equality, Diversity and Inclusion (EDI) Strategy, which sets out the Trust's EDI ambitions and key objectives for the next 3 years.

This report builds on the previous reports presented to the People Performance Committee, including the Trust's 2023 Workforce Race Equality Standard Report (WRES), 2023 Workforce Disability Equality Standard Report (WDES), 2023 Gender Pay Gap report and the 2022 NHS national staff survey results report.

The EDI Strategy focuses on 4 priority areas:

- Priority 1: Workforce
- Priority 2: Culture
- Priority 3: Assurance and compliance
- Priority 4: Health inequalities

The following summarises the progress made against each of the EDI targets set out within the EDI Strategy:

Workforce:

- Within our non-clinical workforce, we have seen increases in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 12.5% and 8% respectively. We have seen a small increase in the proportion of BAME staff at Band 8A+, from 3% to 5.2% (target 8%).
- Within the clinical workforce we have seen an increase in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 20.4% and 19.7% respectively. We have seen a fall in the proportion of BAME staff at bands 8A+, from 6.3% to 5.7%, since the last report.

- There has been an increase in the proportion of disabled staff across the Trust to 5.2%, although there has been no change in the proportion of disabled people on the Trust Board.
- The Trust mean gender pay gap has fallen significantly, from 22.79% to 16.96%, and is just above the target of 15.5%.
- There have been small improvements in the proportion of disabled staff (non-clinical) in bands 1-4 and 5-7. However, since the last update, where the target for bands 8A+ had been reached, the proportion has now fallen back below the target. Within the clinical workforce (excluding medical staff), there has been an improvement on the baseline figures, with the target now reached at Band 8A+.
- There has been no change in terms of disability representation at the Board level.

<u>Culture:</u>

- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff is 185. This means that there BAME staff are more likely to enter the formal disciplinary process, compared to white staff. This is a worsening position compared to the previous report.
- There has been a significant increase in the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff. This represents a worsening position compared to the previous report. It should, however be noted, that the overall numbers are small, which may skew the result.
- The relative likelihood that white candidates will be appointed from a shortlist comparted to BAME candidates has fallen significantly. This represents a significant improvement on the previous 12 months, and the current relative ratio meets the target set out in the strategy.
- There has been a significant decrease in the proportion of BAME respondents in the staff survey reporting bullying or harassment from managers, team leaders or another colleague. This is now 21.6%, a decrease from 31% in the previous year. Whilst this is an improvement, the figure remains above both the target and baseline figure.
- There has been a reduction in the proportion of disabled staff reporting discrimination from managers or team leaders from 19.9% to 14.78%. This is against the strategy target of less than 10%.

A range of EDI related actions have been completed since the launch of the Trust's refreshed EDI Strategy 2023-26. This includes: the appointment of Board sponsors for staff networks, the development and roll out of workplace adjustment and equality impact assessment (EIA) training, and the celebration of a variety of religious and secular events throughout the year, including a successful Iftar event for staff during Ramadan. In addition, the Inclusion and Colleague Experience Team has recruited to a long-term gap within the team, who as from April 2024 is supporting the delivery of the EDI Strategy.

On 8 June 2023, NHS England published the NHS EDI improvement plan[1]. The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience.

The Trust has also committed to work on the non-mandatory North West Anti-racism framework which was launched in 2022 by the NW BAME Assembly. The framework outlines the actions to change racial inequality within the workforce, service provision and organisational culture.

A reprioritisation exercise has taken place, recognising where there are potential overlaps and duplication in the requirements of each individual plan. A copy of the consolidated action plan is provided in **appendix one** of the report.

It is evident from our latest EDI performance metrics that the impact of delivering our EDI Strategy is making a positive difference and is something to be proud of. As with any culture change, progress is slow however we are starting to see some green shoots. We are confident from triangulating our EDI performance metrics with our staff survey results, other staff feedback and our people management metrics that the EDI Strategy is focusing on the right priority areas for action.

[1] NHS England » NHS equality, diversity and inclusion (EDI) improvement plan

1. Introduction

1.1 The Trust's EDI journey to create an inclusive workplace for everyone is informed and directed by a number of mandated and non-mandated national and strategic plans and frameworks. The Trust's EDI Strategy 2023-26 focuses on four priority areas: 1) Workforce, 2) Culture, 3) Assurance and compliance, and 4) Health inequalities

1.2 Additionally, we are required to produce annual Workforce Race Equality Standard (WDES) and Workforce Disability Equality Standard (WDES) reports, and Gender Pay Gap reports. The People Performance Committee has previously received these reports and their associated action plans which evidenced the progress being made on our EDI agenda.

1.3 On 8 June 2023, NHS England published the NHS EDI Improvement Plan[2]. The aim of this plan is to improve EDI, and to enhance the sense of belonging for NHS staff to improve their experience. This plan sets out targeted actions to address the prejudice and discrimination (direct and indirect) that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The plan itself sets out six high impact actions, as well as a number of specific actions related to protected characteristics within the Equality Act 2010.

1.4 The Trust has also committed to work on the non-mandatory North West Anti-Racist Framework which was launched in 2022 by the NW BAME Assembly. The framework outlines the actions to change racial inequality within the workforce, service provision and organisational culture. Since the first iteration of the framework in 2022, it has undergone further development, with a bronze, silver and gold rating system. Consequently we need to assess where we are against the ratings with support from the Staff Race and Equality Network. The NW Anti-Racist Framework is important to pursue and many of the actions on this framework link with those in the NHS EDI Improvement Plan.

1.5 A single consolidated EDI action plan has been developed and will include local recommendations to ensure the success and sustainability of the work and to address local-specific issues. As part of consolidating the plan, a reprioritisation exercise has been undertaken as a result of the NHS Improvement Plan and the self-assessment of the NW Anti-Racist Framework. A copy of the consolidated plan is provided in **appendix one**.

1.6 This report provides an update on progress made against the specific targets set out in the Trust's EDI Strategy 2022-25.

[2] NHS England » NHS equality, diversity and inclusion (EDI) improvement plan

2. Progress against our EDI Performance Targets

2.1 Workforce

2.1.1 The following table provides a summary of the progress made against the targets set within the 'Workforce' element of the EDI Strategy.

Objective	Baseline	Target	May 2023	Oct 2023	May 2024	Progress
	Increase in the BAME diversity (non-clinical)					
Bands 1-4	10.5%	12.5%	12.5%	13.1%	13.9%	Target exceeded
Bands 5-7	6.9%	8%	9.3%	11.1%	10.5%	Target exceeded
Bands 8A+	3%	8%	3.8%	4.8%	4.5%	Improvement on baseline
	Increase BAME diversity (clinical – non M&D)					
Bands 1-4	18.4%	20.4%	24.7%	29.2%	29.8%	Target exceeded
Bands 5-7	17.7%	19.7%	20.5%	26.7%	27.3%	Target exceeded
Bands 8A+	5.1%	8%	6.4%	6.3%	5.7%	Improvement on baseline
	Increase disabled/LTC diversity					
Whole Trust	3.2%	8.2%	3.4%	4.7%	5.2%	Improvement on baseline
	Increase disabled/LTC diversity (non-clinical)					
Bands 1-4	4.4%	8.8%	5.2%	6.3%	6.7%	Improvement on baseline
Bands 5-7	3.7%	7.4%	3.5%	4.0%	5.0%	Improvement on baseline
Bands 8A+	2.6%	5.2%	1.4%	5.8%	4.5%	Target met Oct 23, but subsequently fallen
	Increase disabled/LTC diversity (clinical – non M&D)					
Bands 1-4	3.4%	6.8%	3.7%	4.5%	5.5%	Improvement on baseline
Bands 5-7	2.9%	5.8%	3%	4.9%	5.3%	Improvement on baseline
Bands 8A+	2%	4%	1.4%	3.6%	4.0%	Target achieved
	Increase in disabled representation on the Board					
Min 1 person	0%	6.1%	0%	0%	0%	No improvement
	Address gender pay gap (GPG) [3]					
Reduce mean GPG in line with public sector economy	23.77%	GPG as per 2026, or 15.5% whichever is smaller	22.79%	22.79%	16.96%	Significant reduction on baseline figure
Reduce mean bonus GPG	51.45%	<10%	53.08%	53.08%	31.31%	Significant reduction on baseline figure

- Within our non-clinical workforce, we have seen increases in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 12.5% and 8% respectively. We have seen a small increase in the proportion of BAME staff at Band 8A+, from 3% to 5.2% (target 8%).
- Within the clinical workforce we have seen an increase in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 20.4% and 19.7% respectively. We have seen a fall in the proportion of BAME staff at bands 8A+, from 6.3% to 5.7%, since the last report.

[3] Figures based on the 2023 Gender Pay Gap report. Figures are calculated annually. The next report is due in spring 2025.

- There has been an increase in the proportion of disabled staff across the Trust to 5.2%, although there has been no change in the proportion of disabled people on the Trust Board.
- The Trust mean gender pay gap has fallen significantly, from 22.79% to 16.96%, and is just above the target of 15.5%.
- There have been small improvements in the proportion of disabled staff (non-clinical) in bands 1-4 and 5-7. However, since the last update, where the target for bands 8A+ had been reached, the proportion has now fallen back below the target. Within the clinical workforce (excluding medical staff), there has been an improvement on the baseline figures, with the target now reached at Band 8A+.
- There has been no change in terms of disability representation at the Board level. In the event that a vacancy at this level arises we will undertake a pro-active positive action approach to recruitment.

2.2 Culture

2.2.1 The following table provides a summary of the progress made against the targets set within the 'Culture' element of the EDI Strategy.

Objective	Baseline	Target	Oct 2023	May 2024	Progress
Reduced relative likelihood disparity regarding entry into disciplinary processes (BAME) to parity					
	1.14	1	1.14	1.85	Worsening position compared to baseline
Reduced relative likelihood disparity regarding entry into capability processes (disabled / LTC) to parity					
	1.22	1	4	9	Worsening position compared to baseline
Reduced relative likelihood disparity regarding shortlisting and being appointed from shortlisting (BAME)					
	2.43	<1.5	2.49	1.24	Target Achieved
Reduced disparity regarding bullying & harassment from managers / team leaders in staff survey (BAME)					
	18.1%	<12%	31%	21.6%	Improvement on previous year, but still above baseline
Reduced disparity regarding discrimination from managers/team leaders in staff survey for (disabled / LTC)					
	24%	<10%	19.9%	14.78%	Improved position on baseline
Proportion of BAME staff across each of the AfC clusters (All AfC staff)[4]					
	Jan 2022	**May 2023**	**Oct 2023**	**May 2024**	**Progress**
Bands 1-4	15.6%	21.1%	21.0%	21.7%	Since the start of the strategy, there has been a 6.1% growth in the proportion of BAME staff in this group
Bands 5-7	19.3%	25.2%	25.2%	25.7%	Since the start of the strategy, there has been a 6.4% growth in the proportion of BAME staff in

[4] Metric reviewed in 2023 to establish the proportions of BAME staff in each AfC range, as a proxy for career progression.

					this group
Bands 8A+	5.3%	5.6%	5.8%	5.3%	Since the start of the strategy, there has been no growth in the proportion of BAME staff in this group
Proportion of BAME staff across the medical workforce					
	Jan 2022	**May 2023**	**Oct 2023**	**May 2024**	**National data sets[5]**
Foundation Trainees	27.3%	42.1%	43.4%	41.6%	46.2%
Specialist and Associate Specialists	70.9%	76.8%	77.3%	60.3%	57.5%
Consultants	45.5%	44.7%	44.2%	45.6%	39.0%

2.2.2 The following provides a summary of the progress made against the targets set within the culture element of the EDI Strategy:

- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff is 185. This means that there BAME staff are more likely to enter the formal disciplinary process, compared to white staff. This is a worsening position compared to the previous report.
- There has been a significant increase in the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff. This represents a worsening position compared to the previous report. It should, however be noted, that the overall numbers are small, which may skew the result.
- The relative likelihood that white candidates will be appointed from a shortlist comparted to BAME candidates has fallen significantly. This represents a significant improvement on the previous 12 months, and the current relative ratio meets the target set out in the strategy.
- There has been a significant decrease in the proportion of BAME respondents in the staff survey reporting bullying or harassment from managers, team leaders or another colleague. This is now 21.6%, a decrease from 31% in the previous year. Whilst this is an improvement, the figure remains above both the target and baseline figure.
- There has been a reduction in the proportion of disabled staff reporting discrimination from managers or team leaders from 19.9% to 14.78%. This is against the strategy target of less than 10%.
- At each of the AfC Bands 1-4 and 5-7 clusters, there has been growth in the proportion of BAME staff across each cluster. There has been no growth in the proportion of BAME staff at Band8A and above.
- Data also shows that the distribution of BAME staff within the medical workforce is either consistent or better with national benchmarking data, with the exception of foundation trainee doctors, where the proportion of BAME trainees is slightly below the sector averages.

2.2.3 The NHS staff survey provides the annual measure for some of our EDI targets. This report provides the latest figures from the national NHS staff survey, that were made available in January 2024. Alongside the annual survey we continue to use our employee voice channels such as Staff Networks and the Big Conversations

[5] MWRES 2022: NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts

Programme to gather qualitative evidence on how BAME and disabled staff are feeling about working for the Trust.

2.2.4 In addition to the above we have undertaken listening sessions with each of the staff networks, which have been used to theme each meeting for the rest of the year.

2.3 Assurance and Compliance

2.3.1 All statutory reporting, including WRES, WDES, Gender Pay Gap and the Annual EDI Monitoring Report were completed for 2023/24 and approved by the People Performance Committee. We are required to publish the reports on the Trust's website before October 2024.

3. Progress against the EDI Strategy Action Plan

3.1 On 8 June 2023, NHS England published the NHS EDI improvement plan[6]. The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. This plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The plan itself sets out six high impact actions, as well as a number of specific actions related to protected characteristics within the Equality Act 2010.

3.2 The Trust has also committed to work on the non-mandatory North West Anti-Racist Framework which was launched in 2022 by the NW BAME Assembly. The framework outlines the actions to change racial inequality within the workforce, service provision and organisational culture. Since the first iteration of the framework in 2022, it has undergone further development, with a bronze, silver and gold rating system. The NW Anti-Racist Framework is important to pursue and many of the actions on this framework link with those in the NHSE EDI Improvement Plan.

3.3 A reprioritisation exercise has taken place, recognising where there are potential overlaps and duplication in the requirements of each individual plan. A copy of the consolidated action plan is provided in **appendix one** of the report.

3.4 Below is a high level summary of the action that has been taken since October 2023 to help progress our EDI journey *(this is not an exhaustive list – the action plan provides more details):*

- Completed a review of our staff networks, which included:
    - Establishing a Staff Neurodiversity Network.
    - Holding listening sessions with each staff network and used these to inform the themes of network meetings for the remainder of the year.
    - Appointed Board level sponsors to 3 of our staff networks and seeking to recruit sponsors to the remaining 2 (Carers Network and LGBTQ+ Network).

- Developed and delivered training on the provision of workplace adjustments, and undertaking meaningful equality impact assessments. These sessions have been run in collaboration with Tameside and Glossop NHS FT from January 2024 onwards.

- Held our annual Iftar, bringing together staff to break their fast during the month of Ramadan.

[6] NHS England » NHS equality, diversity and inclusion (EDI) improvement plan

- Throughout Disability History month we promoted a variety of resources, including our guides to support disabled staff, the DAWN network, and our disability history month timeline.

- Throughout LGBTQ+ History month, we promoted the LGBTQ+ staff networks, a variety of podcasts and other resources, celebrating this year's theme **'**Medicine – #UnderTheScope'.

- Throughout World Autism week, the newly established Neurodiversity Staff Network promoted a range of resources for supporting staff and service users with autism.

- Celebrated a number of other national EDI events and campaigns including National Day of Staff networks, and plans are well underway for the celebration of NHS Equality, Diversity and Human Rights week, International Day against homophobia, Biphobia and Transphobia, as well as our annual presence at Stockport Pride.

- Accessible role profiles have now been created for HCAs, Domestics, Porters and Catering Assistants. Adverts and inclusivity statements on job adverts have been reviewed and recruitment materials and links are made available through events such as Stockport Pride.
- Introduced a quarterly EDI newsletter to raise awareness of the EDI activities taking place and to try and ensure a greater awareness of the EDI agenda amongst staff.

3.5 It should be noted that it has been extremely challenging to deliver the EDI Strategy 2022-25, alongside the Organisational Development Plan 2023-25 and other key priorities within the context of staff absences and operational pressures. Despite colleagues going above and beyond some EDI actions are significantly behind plan and the actions relating to talent management and career progression had to be paused. To remedy this we are currently agreeing revised timescales with lead officers who will then provide a greater focus on this area of work over the coming months to get back on track.

4. Conclusion and Next Steps

4.1 It is evident from our latest EDI performance metrics that the impact of delivering our EDI Strategy is making a positive difference and is something to be proud of. As with any culture change, progress is slow however we are starting to see some green shoots. We are confident from triangulating our EDI performance metrics with our staff survey results, other staff feedback and our people management metrics that the EDI Strategy is focusing on the right priority areas for action.

4.2 Whilst progress is being made, it is clear from our action plan and some of the results that there is more to do.

4.3 Our aim is to go beyond being complaint with EDI, becoming strategic and integrating EDI into everything we do. The ultimate goal is to be a leader in EDI practice, and to inspire others to emulate our success.

5. Recommendations

5.1 The Trust Board is asked to:

- Note the progress of the Trust's EDI Strategy 2023-26 and associated consolidated action plan.

Appendix 1: Our Consolidated EDI Action Plan

Blue	Action is complete	Amber	Action mainly on track with some minor issues
Green	Action is on track	Red	Action not on track with major issues

Original Plan(s)	Action	Lead(s)	Original Deadline	Revised Deadline	Progress	RAG Rating	Theme
S1	Build relationships with local organisations supporting people into employment to ensure our vacancies reach a diverse audience, with a particular focus on disability/long term condition (LTC).	Recruitment team	Jun-23	Jun-23	Ongoing attendance at recruitment fairs and help to arrange in-house recruitment events; Initial meetings being arranged with Job Centre organisations and VCSO that support seeking employment; Key partner in Stockport EDI Strategy for anchor organisations (Council, Health, ICS) and VCSO. Recruitment Manager linking in with EDI Manager to support ongoing strategies.	Blue	**Recruitment**
S2	Routinely share our vacancies to ensure our advertising efforts for new vacancies reach people with protected characteristics such as Job Plus, GM EDI Network, RNIB, Black History Recruitment, Pink News and Voice.	Recruitment team	Jun-23	Jun-23	Adverts and inclusivity statements have been reviewed. Recruitment materials and links available through events such as Stockport Pride.	Blue	**Recruitment**
S3	Undertake mandatory implicit and association bias awareness training as part of the recruitment training for all managers with responsibility for current and future recruitment and selection.	Recruitment team/Inclusion and Colleague Experience	Oct-23	Jun-24	A cross site training programme is being developed across Stockport and Tameside to offer a suite of protected characteristic insight training options for managers and the wider organisation. Unconscious bias training course is available for deployment.	Amber	**Training and Development**

S4	Review and draw up role descriptions which are more accessible and user friendly and therefore targeted to a wider audience.	Recruitment team	Jun-23	Jun-23	Role profiles have now been created for HCAs, Domestics, Porters and Catering Assistants.	Green	**Recruitment**
S5	Work with 'Pure Innovations', those on apprenticeships and Guaranteed Interview schemes to ensure people with protected characteristics can transition to employment following initial work experience and training programmes.	Recruitment Team	Jun-23	Jun-23	Working with Pure Innovations, providing info for upcoming vacancies as well as coaching on the application process. We have held initial meetings about how to formalise the recruitment process. We are reviewing other supported internship models across GM and process mapping to enable robust and dedicated supported internship employment pathway and a quantifiable conversion rate from supported intern to employee. Role profiles have now been created for HCAs, Domestics, Porters and Catering Assistants.	Green	**Recruitment**
S6	Work with our recruiting managers to identify existing talent and proactively develop staff for internal promotion and progression opportunities for with protected characteristics when appropriate new vacancies arise towards equality of opportunity and support development and succession planning.	Recruitment team/ Talent, Leadership & OD Consultancy Team	Dec-23	Sept-24	Work is underway to develop our approach which will be presented to EMT in July 2024.	Amber	**Talent Management**
S7	Develop staff conducting interviews and selection for all Band 7 and above vacancies by providing appropriate toolkits for recruiting managers. E.g. offering maternity / paternity and returner's scheme support packages; more flexible work patterns: part-time; job share or compressed hours.	Recruitment team/ Talent, Leadership & OD Consultancy Team	Dec-23	Sept-24	Inclusive recruitment training is currently being organised.	Amber	**Resources and guidance**
S8	Offer coaching to female consultants for Clinical Excellence Award.	Talent, Leadership & OD Consultancy Team	Nov-23	Jul-24			**Talent Management**

S9	Reasonable adjustment training.	Inclusion and Colleague Experience Team	Dec-22	Dec-22	As part of Disability History Month 2022, new disability guidance documents were launched for staff and managers. Disability Awareness Training rolled out from Jan 2024 onwards.	Blue	**Training and Development**
S10	Establish a Reverse Mentoring Scheme.	Talent, Leadership & OD Consultancy Team	Mar-24	Mar-24	A Reverse Mentoring Scheme has been launched. To date 2 employees have put themselves forward to be a mentor (1 disabled employee & 1 BAME employee). We currently have 2 NEDs that have agreed to be a mentee and we are seeking more Board Members and staff to take part in the scheme.	Blue	**Talent Management**
S11	Undertake focus group sessions with female specialist grade doctors to understand the potential barriers to promotion, as a means of reducing the gender pay gap.	Talent, Leadership & OD Consultancy Team	Sep-23	Sep-24			**Engagement**
S12	Profiling recently promoted/appointed female consultants who can describe their professional journey.	Inclusion and Colleague Experience Team/Talent, Leadership & OD Consultancy Team	Sep-23	Sep-24			**Talent Management**
S13	Positive action on development programmes to female, ethnically diverse, and disabled staff.	Talent, Leadership & OD Consultancy Team	Mar-24	Dec-24			**Talent Management**
S14	Actively create development opportunities, leadership courses, secondments, shadowing and work experience for ethnically diverse and disabled staff.	Talent, Leadership & OD Consultancy Team	Mar-24	Dec-24			**Talent Management**

S15	Review staff networks, identify improvements, refresh process, brief managers, and relaunch.	Inclusion and Colleague Experience Team	Jun-23	Jun-23	Review of staff networks undertaken. Network dates to be rolled out using thematic approach, promoted through staff EDI newsletter, and reminder comms throughout the year through social media, and all established comms channels	Blue	**Engagement**
S16	Review existing programmes and incorporate Anti-Racist Framework. Develop process and implement.	Inclusion and Colleague Experience Team	Oct-23	Oct-23	The Anti-Racist Framework was presented to the EDI Steering Group for assurance. Relevant actions incorporated into this plan.	Green	**Governance and reporting**
S18	Create an inclusion calendar of events and awareness days/months.	Inclusion and Colleague Experience Team/Comms Team	Dec-22	Dec-22	Calendar in place and promoted.	Blue	**Resources and guidance**
S19	Establish a process for completing the WRES, WDES and GPG ensuring governance assurance meet reporting deadlines.	Inclusion and Colleague Experience Team	Apr-23	Apr-23	The Trust's 2023 WRES, WDES and GPG reports were produced on time and presented to the EDI Steering Group & People Performance Committee.	Blue	**Governance and reporting**
S20	Define system and process for all EDI grievances and or concerns raised to ensure reported appropriately either informally or formally e.g., equality champion network are logged; for the purposes of identifying trends throughout the organisation.	Employee Relations Team	Dec-23	Sept-24	Work is underway to establish a system/process that captures all EDI formal & informal grievances and concerns.	Amber	**Workforce**
S21	WRES – Workforce Race Equality Standard.	Inclusion and Colleague Experience Team	31 May 2024 - data and action plan submitted ; 31 October 2024 - external report published	31 May 2024 - data and action plan submitted; 31 October 2024 - external report published	NHS WRES and WDES Team brought the reporting period deadline forward to 31 May 2023. The Trust's 2023 WRES report was presented to the EDI Steering Group in April 2023 and People Performance Committee in May 2023.	Green	**Governance and reporting**

S22	WDES – Workforce Disability Equality Standard.	Inclusion and Colleague Experience Team	31 May 2024 - data and action plan submitted ; 31 October 2024 - external report published	31 May 2024 - data and action plan submitted; 31 October 2024 - external report published	NHS WRES and WDES Team brought the reporting period deadline forward to 31 May 2023. The Trust's 2023 WRES report was presented to the EDI Steering Group in April 2023 and People Performance Committee in May 2023.	Green	**Governance and reporting**
S23	GPG – Gender Pay Gap	Inclusion and Colleague Experience Team	Mar-23	Mar-23	The Trust's 2023 Gender Pay Gap Report has been presented to the EDI Steering Group and People Performance Committee.	Blue	**Governance and reporting**
S24	Annual PSED Report – Public Sector Equality Duty Report	Inclusion and Colleague Experience Team	Mar-23	Mar-23	The Trust's annual PSED Report has been presented to the EDI Steering Group and People Performance Committee.	Blue	**Governance and reporting**
S25	Establish position on maturity matrix for Equality Delivery System (EDS)	EDS task and finish group	Feb-24	Jun-24	An EDS22 task group is in place which is working on the Trust's EDS22 submission which is required by end of Jun-24.	Amber	**Health Inequalities**
AFS5, AFG2, NPRace2	Develop and EDI dashboard, including relevant WRES/WDES metrics for managers to use in their areas, and for the Board to review progress.	SM & IH	New / Combined action	May-24	Fundamental level EDI data currently available in People Analytics. Following publication of WRES and WDES data. Currently examining opportunities to put this data into People Analytics.	Red	**Data**
NPDis1	Demonstrate year-on-year improvement in disability declaration rates so that ESR data is accurate about people with a disability, as measured by the WDES.	SM, JP & IH	New / Combined action	Dec-25	Current data shows increasing trend in disability declarations. The appointment of our Disability Advisor will promote this work. Target of 7% by the end of the current EDI strategy.	Amber	**Data**

NPRel1	ESR and qualitative data should be tracked to highlight the experience of people with different faiths or no faith through all stages of the employment journey. For example, NHS organisations can track turnover data by religion to identify and address trends.	SM	New/Combined action	Apr-24	Currently faith data is routinely analysed in the annual EDI report. Metrics include workforce composition, recruitment, leavers and turnover. Any disparity will result in additional actions being undertaken. Data will be triangulated with 2023 staff survey data on faith.	Blue	**Data**
NPLGBT2	Review organisational data for LGBT+ staff across multiple sources such as ESR, TRAC, NHS Staff Survey and local qualitative and quantitative data from LGBT+ staff networks and communities. This will inform the key areas of concern that need to be addressed.	SM	New / Combined action	May-24	Currently LGB data is routinely analysed in the annual EDI report. Metrics include workforce composition, recruitment, leavers and turnover. Any disparity will result in additional actions being undertaken. Data will be triangulated with 2023 staff survey data on sexual orientation. Additionally evidence will be drawn from the staff survey listening events, and published in a full report to coincide with International day against homophobia biphobia & transphobia (IDAHOBiT).	Blue	**Data**
AFG5	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans. WRES and anti-racism action plans to be co-produced with staff networks.	SM	New / Combined action	Oct-24	Plan an annual event for Black History Month, bringing together WRES, anti-racist work, and coincide with publication of the annual WREs and WDES action plans.	Amber	**Engagement**
NPDis5	NHS organisations should take steps to address the disproportionate levels of bullying and harassment experienced by disabled staff. Progress can be measured by the annual NHS staff survey results.	KR	New / Combined action	May-24	This action is behind plan due to competing priorities. The findings of the Trust's 2023 staff survey results will be utilised to identify the action that will be taken.	Red	**Engagement**

AFG4	The organisation can evidence diverse representation within their disciplinary and grievance processes. Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.	FTSUG	New / Combined action	Sept-24		Amber	**FTSU**
AFB2	An anti-racism statement to be produced and published detailing organisational commitment to racial equity.	SM	New / Combined action	Jun-24	Utilise cross departmental WRES action group to consider anti-racism statement.	Red	**Governance and Reporting**
AFB3	Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.	SM	New / Combined action	Feb- 24 *(and reviewed annually through the WRES and Annual EDI monitoring report)*	Trust EDI Strategy contains explicit stretch targets in relation to race-based disparity.	Blue	**Governance and Reporting**
AFG3	Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.	NB/LR	New / Combined action	Jun-24	Establish group following the publication of 2024 WRES data.	Amber	**Governance and Reporting**
AFB4	The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report. (Within the last 12 months).	EDS Task & Finish Group	New / Combined action	Mar-25	Following publication other first set of EDS 2022 submission in 2024, EDS group to consider focus on a particular race related health inequality in 2025.	Amber	**Health Inequalities**
AFS2	All leaders at Band 8A and above must have an appraisal/ personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	TH & KB	New / Combined action	Apr-25			**Leadership**

AFS3	Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. 75% of Executive and Non-Executive Directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.	TH & SM	New / Combined action	Dec-24			**Leadership**
AFS4	A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee/ board meetings.	Board secretary	New / Combined action	Dec-24			**Leadership**
NPH1	Chief Executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	Board secretary	New / Combined action	Mar-25 Mar-24	EDI strategy update presented to Board twice annually.	Amber	**Leadership**
NPDis2	Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff, such as the Calibre Leadership programme or Disability Rights UK development programmes. Progress can be measured by tracking the number of disabled staff in leadership roles.	DAWN and Coll Exp & Inclusion Team	New / Combined action	Dec-24		Amber	**Leadership**

NPRace1	Boards should be able to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades. Appraisals of senior executives will include a focus on EDI, as recommended by the Messenger Review.	Board secretary	New / Combined action	Dec-24		Amber	**Leadership**
NPRace3	To tackle race discrimination effectively Boards must give due consideration to national policies and recommendations from other arms-length bodies such as the Equality and Human Rights Commission inquiry and General Medical Council. In addition, Boards must proactively raise awareness of their commitment with patients and public.	Board members	New / Combined action	On-going		Amber	**Leadership**
NPRace4	Boards should ensure concerns raised about race discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians.	Board members/ FTSUG	New / Combined action	On-going		Green	**Leadership**
NPRel3	Boards should ensure concerns raised about religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including by encouraging diversity in Freedom to Speak Up guardians.	Board members/FTSUG	New / Combined action	On-going		Green	**Leadership**
NPLGBT4	Executive teams within the organisations should actively talk about the benefits of allyship as well as champion, and sponsor LGBT+ staff networks. They should also build the concept of allyship into existing and new development programmes.	Board sponsors	New / Combined action	On-going		Green	**Leadership**

NPAge3	NHS organisations should work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities, and by considering alternative entry routes to the NHS, such as apprenticeships and volunteering.	IH & JM	New / Combined action	On-going	An Inclusive Recruitment Improvement Action Plan has been implemented which covers this specific action. Additionally, the Trust runs a 'Pathways into Employment' Group with representatives for local community organisations. The group's terms of reference & membership is currently being reviewed.	Amber	**Recruitment**
NPDis3	Implement recommendations from the inclusive recruitment and promotion practices programme, and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles in the NHS. This can be tracked via the WDES, using Trac data.	Recruitment Team	New / Combined action	Sept-23	The Trust has an Inclusive Recruitment Improvement Action Plan, and the most recent WDES metrics demonstrate that there is no difference in the likelihood of disabled people being appointed from a shortlist compared to non-disabled people.	Amber	**Recruitment**
NPDis6	NHS organisations should ensure that their reasonable adjustments policy is effectively and efficiently implemented and achieves year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work.	SM	New / Combined action	Mar-23 and annually thereafter through staff survey responses	Reasonable adjustment guidance implemented. Improvements the staff survey results relating to the proportion of disabled staff who had received the adjustments required to do their work.	Amber	**Resources and guidance**
AFB1	This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	EDI Sponsor	New / Combined action	TBA			**Talent management**

AFS1	Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.	TH & KB	New / Combined action	TBA	Not yet started due to competing priorities.		**Talent management**
AFG1	Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.	TH & KB	New / Combined action	TBA	Not yet started due to competing priorities.		**Talent management**

NPH2	Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025). Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.	TH & KB	New / Combined action	Jun-24 Oct-24	Not yet started due to competing priorities. A Working Group is in place that involves Trust reps and colleagues from local agencies/organisations working together to improve pathways into employment from underrepresented groups.	Amber	**Talent management**
NPH3	Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce. Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns.	Employee relations, SM, TH	New / Combined action	Mar-24 2025-2026 Mar-24	Gender pay gap and actions published annually. Ethnicity pay gap calculated and published for 2024. National flexible working policy and manager guidance adopted and due for implementation.	Amber	**Talent management**

NPAge1	Line managers should have meaningful conversations with their teams, to align personal aspirations with job roles and requirements. This should include the option of phasing retirement and exploring alternative work patterns.	TH & KB	New / Combined action	Sep-24	The Trust is introducing on 1st June 2024 the new 'Let's Talk' Toolkit which provides managers and staff with templates & guidance to help them to have more meaningful conversations including 121/check-ins, annual appraisals and 6-month appraisal reviews. The toolkit is supported by briefing sessions and 1-day course skills course for managers.	Blue	**Talent management**
NPDis4	Commissioners and providers of talent management and career development programmes must ensure that these are fully accessible and inclusive. Progress can be measured by tracking the number of disabled people in leadership roles.	TH & SM	New / Combined action	On-going		Green	**Talent management**
NPLGBT3	Organisations to ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training.	SM	New / Combined action	Jan-24	LGBTQ+ training forms part of the Trust's mandatory EDI training. Compliance is monitored on a monthly basis.	Blue	**Training and Development**
NPLGBT5	Organisations to ensure that LGBT+ staff are closely involved in the development and delivery of its LGBT+ training and educational interventions and its health & wellbeing programmes so that these are fully inclusive.	SM	New / Combined action	Jan-24	LGBT+ employees are routinely engaged in the development and quality assurance of LGBTQ+ training programmes.	Amber	**Training and Development**
AFB5	Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.	Employee relations	New / Combined action	Jan-24	Explicit processes exist to address racial harassment, through the Trust's Respect Policy and Reduction in Violence and Aggression Strategy.	Blue	**Workforce**

NPH4	Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as the national NHS health and wellbeing framework (by October 2023). Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025).	SM	New / Combined action	Aug-24	Wellbeing conversations promoted through a variety of channels: posters with QR codes, social media posts, Trust wide comms. Utilise the 2023 staff survey responses to establish potential hotspots within the Health and Wellbeing question set, to specifically target further work.	Amber	**Workforce**

NPH5	Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options. Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback. Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety. Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that p-personal development plans focus on fulfilling potential and opportunities for career progression.	JM	New / Combined action	Mar-24	A comprehensive onboarding programme is in place for internationally recruited staff that includes pre-communication on a number of issues such as accommodation, sourcing a NI number, GP practice and local information.	Amber	**Workforce**
NPH6a, S10a	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.	SM	New / Combined action	Apr-24	Data analysis of bullying and harassment by protected characteristic to be completed in Mar-24 and presented to the EDI Steering Group in Apr-24.	Amber	**Workforce**

NPH6b	Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.	Employee relations team	New / Combined action	Mar-24	Currently reviewing internal conduct process in its entirety, which will incorporate learning from internal review, peer review and insights from legal services.	Amber	**Workforce**
NPH6c	Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.	Employee relations team	New / Combined action	Jun-24	The national people policy framework sexual safety policy is anticipated in June 2024. In the meantime, the Trust is working through the NHSE sexual safety charter action plan.	Amber	**Workforce**
NPH6d	Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff.	FTSUG	New / Combined action	On-going		Amber	**Workforce**
NPH6f	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence. Have mechanisms to ensure staff who raise concerns are protected by their organisation.	SPAWS	New / Combined action	Mar-24	All individuals who raise concerns formally are signposted to SPAWS.	Blue	**Workforce**
NPAge2	Organisations should encourage flexible working as part of local attraction, recruitment, retention and return plans. The plan should embed the NHS Pension Scheme and highlight its value across the career journey, with special focus on flexible retirement for staff in late stage careers.	Recruitment Team	New / Combined action	On-going		Amber	**Workforce**

NPRel2	NHS organisations should review their policies and processes to ensure they are supportive of religious expression in the workplace. This includes access to facilities for prayer, understanding of cultural differences, including religious clothing, and flexibility around religious observances such as the Sabbath and Ramadan.	SM	New / Combined action	On-going		Amber	**Workforce**
NPSex1	NHS organisations to focus on closing the gender pay gap and improving the experiences of the lowest paid people, extending the Mend the Gap Review recommendations for medical workforce to the wider workforce.	SM, NB & LR	New / Combined action	Dec-24	Following publication of GPG report in March 2023, specific actions, including extending the mend the gap review to be implemented.	Amber	**Workforce**
NPSex2 (cross ref NPH3)	NHS organisations should ensure that their flexible working policy is easily accessible and suitable for all their staff; supporting their work–life balance, management of caring responsibilities, health and wellbeing, and enabling continued professional development.	Employee relations	New / Combined action	Sep-24		Amber	**Workforce**
NPSex3 (cross ref NPH3)	NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues. This will ensure they fully support colleagues experiencing menopause, maximising their wellbeing and allowing them to work for as long as they wish to contribute.	Employee relations, LP	New / Combined action	Sep-24		Amber	**Workforce**

Meeting date	**6th June 2024**	**Public**		**Agenda No.**	13
Meeting	The Board of Directors				
Report Title	Freedom to Speak Up - Update				
Director Lead	Amanda Bromley, Director of People and OD	**Author**	Nadia Walsh – Freedom to Speak Up Guardian		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

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

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

NGO Guidance and Webinars: Adherence to NGO guidance and participation in relevant webinars enhanced knowledge and skills, improving FTSU processes. Regular communication with guardians ensured a cohesive approach to FTSU activities.

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

Staff Survey Results Staff survey results for Stockport showed an encouraging increase in percentages on speaking-up questions, indicating a positive shift in staff perception towards speaking up within the organisation.

Case Contacts: An increasing trend in Freedom to Speak Up contacts was observed in Quarter 4 recording 52 contacts, reflecting an increased awareness and willingness among staff to raise concerns. Response times deviated from the target of 24 hours, ranging from three to five days due to increased caseloads and external factors.

Updates on Open Cases: forty cases have been closed with four cases initiating contact but deciding against formalising concerns, with reasons undisclosed; thirteen cases were signposted to a more appropriate department after an initial conversation relating to concerns and desired outcomes.

Themes and Trends: Themes and trends emerged, including perceived detriment and barriers to speaking up, highlighting the need for clear guidelines and fostering a culture of accountability and transparency.

Cultural Awareness and Understanding: There are emerging concerns regarding perceived racial discrimination within pockets of the trust, particularly among nursing and HCA staff both inside the trust and within the community. An observation saw that staff may not always fully understand cultural differences, leading to situations being perceived as aggressive, rude, or lacking in manners. While this behaviour is not excusable, educating staff about cultural diversity can enhance their understanding of themselves and others.

Addressing Inappropriate Behaviour: An observation worth noting is the presence of behaviours within our organisation that appear to go unaddressed, often accompanied by phrases such as "you know what they are like" or "that's just how they are." This pattern suggests a tendency to excuse behaviours that may not align with our organizational values of respect and professionalism.

Clarity of Reporting Systems and Understanding Differences: Observations made during the reporting period is the lack of clarity among staff regarding the various reporting systems available for raising concerns. To address this challenge, a targeted initiative was undertaken to enhance staff understanding and empowerment in utilizing the appropriate reporting channels. This involved the creation of a "Spot the Difference" poster, aimed at highlighting the unique features and purposes of each reporting avenue. *See appendix 1.*

Routes to Speaking Up: In response to the high volume of case contacts observed, efforts have been made to enhance accessibility and clarity regarding the various avenues available for staff to speak up. Recognising the importance of providing clear guidance, a document titled "Speaking Up Routes" has been developed to depict the different channels through which staff can raise concerns. *See Appendix 2*

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

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

1. Introduction

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

2. Overview of FTSU Role Activities

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

I have conducted five visits to various departments, wards, and teams as part of our ongoing efforts to foster open communication and identify potential concerns. These visits allowed for direct engagement with frontline staff, providing them with an opportunity to express their thoughts and feedback in a supportive environment. It is worth noting that I am currently working with the PEF team on how best to raise awareness of FTSU with students and also share information with regards to areas of concern in terms of FTSU.

Moreover, I attended a regional meeting where I had the opportunity to discuss and share best practices with peers from other organisations. This collaborative platform enabled us to exchange valuable insights and receive updates on industry trends, further enhancing our approach to fostering a culture of speaking up.

Freedom to Speak up Champions: I have chaired three FTSU Champion meetings. Currently, we have two dedicated champions within the organization, strategically distributed across nursing, midwifery, and administration. However, we are actively addressing to increase the size through a new trust-wide campaign launched in April, aimed at recruiting more champions from diverse backgrounds across the organisation.

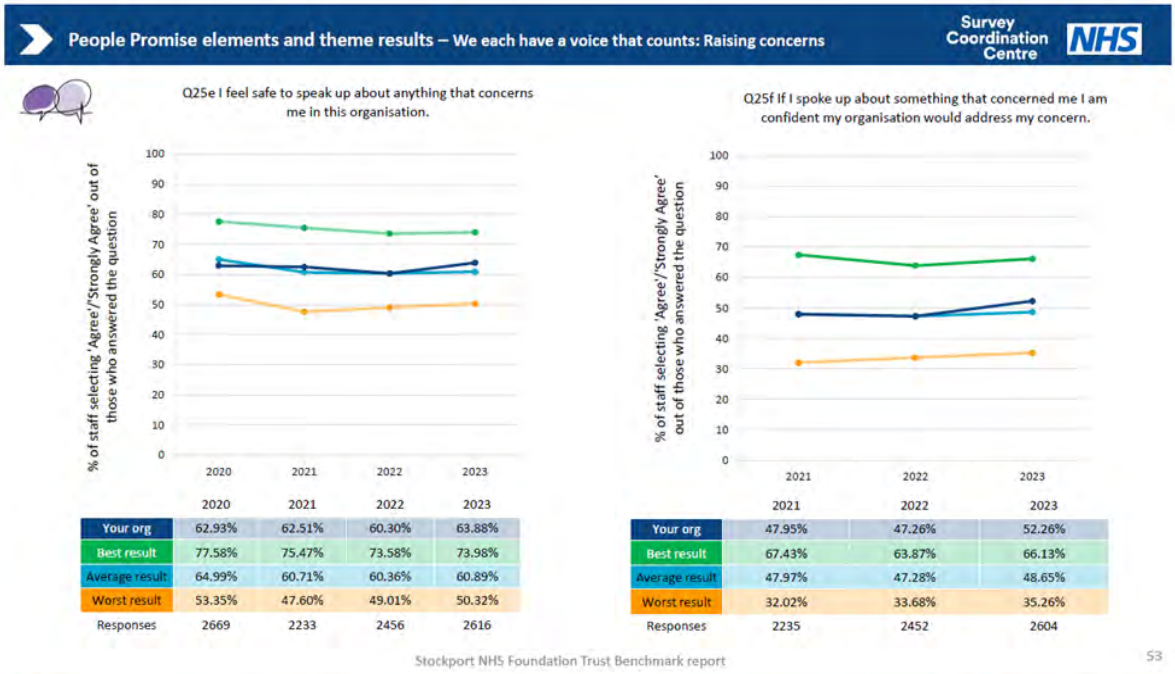
The role of a Freedom to Speak Up Champion is vital within our organisation. While they may not directly handle cases, their primary responsibility lies in serving as a point of contact and support for staff members who wish to raise concerns or provide feedback. They play a crucial role in signposting individuals to appropriate channels and ensuring that every voice is heard and respected. It's worth noting that the champions received a total of six case contacts during this quarter.

NGO Guidance and Webinars: I have kept abreast of the latest updates via the latest NGO guidance, and I have participated in relevant webinars to enhance knowledge and skills. I have applied the insights gained from external resources to improve FTSU processes. An example of this would be a refresher webinar on Collecting Freedom to Speak up Data that is in line with new guidance.

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

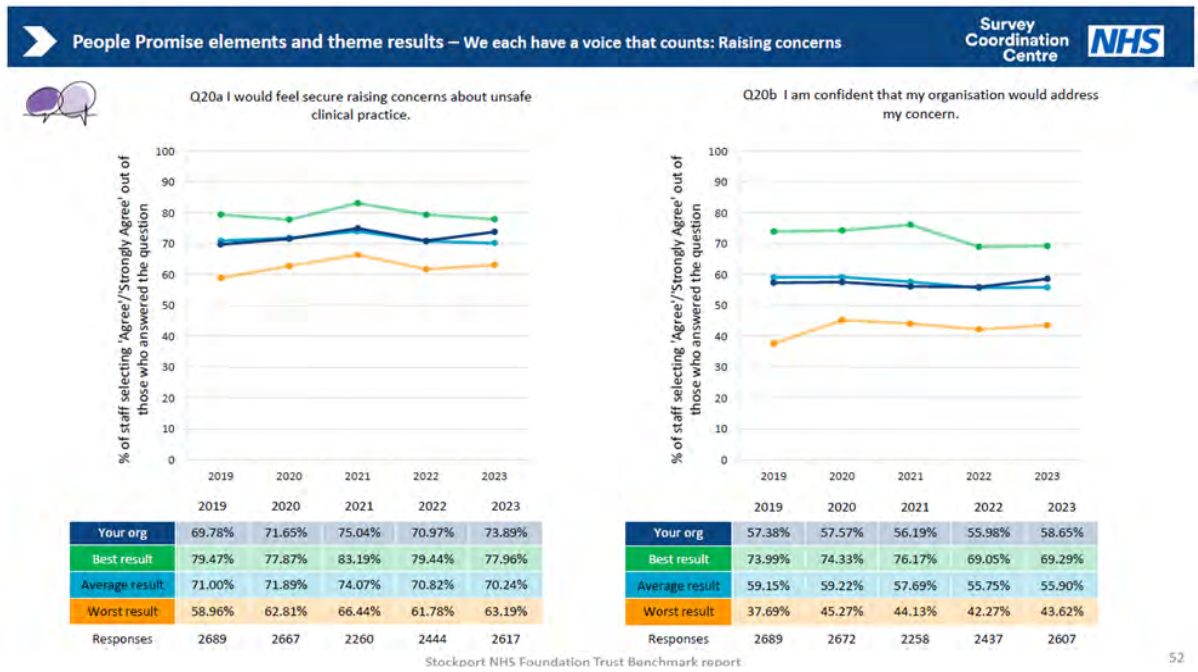
3. Staff Survey Results

The staff survey results for Stockport show an increase in percentages on each of the four speaking-up questions compared to last year. This positive trend indicates that staff are feeling increasingly able to speak up within the organization. This improvement reflects the collective efforts of everyone in the trust to foster a culture where voicing concerns is encouraged and valued. It's a testament to the commitment of all staff members to create an environment where open communication thrives and where and where every voice is heard and respected.



	2020	2021	2022	2023
Your org	62.93%	62.51%	60.30%	63.88%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2669	2233	2456	2616

	2021	2022	2023
Your org	47.95%	47.26%	52.26%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	2235	2452	2604



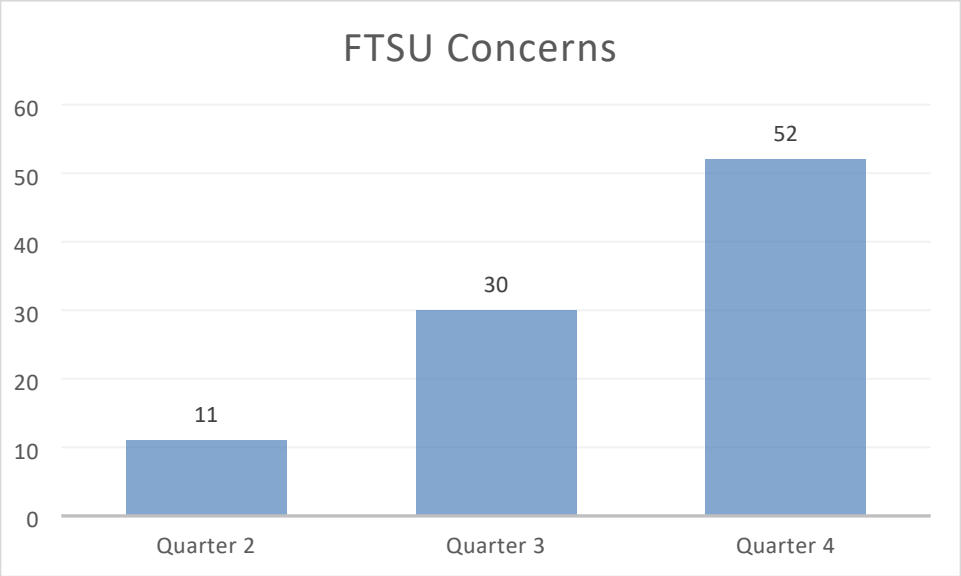
	2019	2020	2021	2022	2023
Your org	69.78%	71.65%	75.04%	70.97%	73.89%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2689	2667	2260	2444	2617

	2019	2020	2021	2022	2023
Your org	57.38%	57.57%	56.19%	55.98%	58.65%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2689	2672	2258	2437	2607

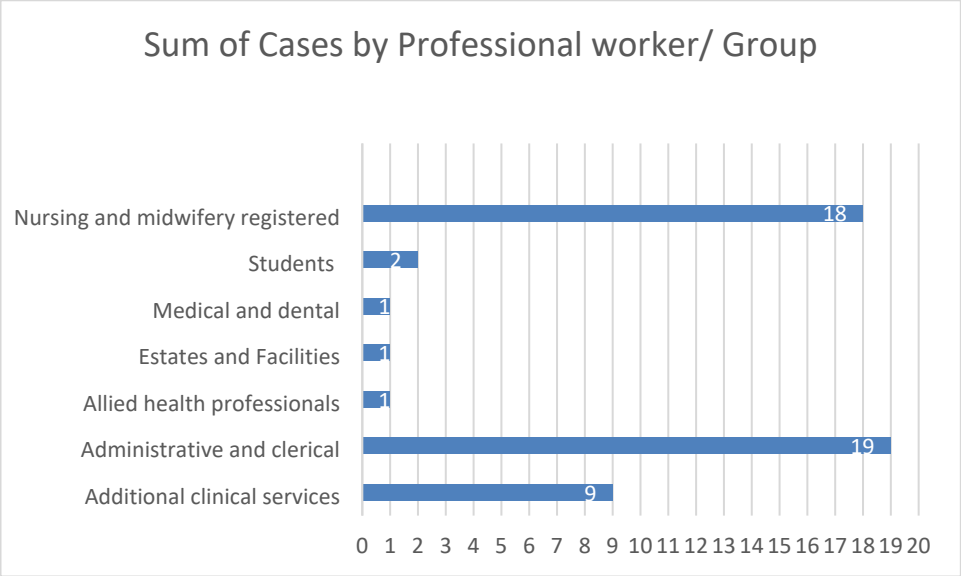
4. Case contacts

The table below details the number of Freedom to Speak Up contacts received, indicating a notable increase over successive quarters. Quarter 2 recorded 11 contacts, which escalated to 30 contacts in Quarter 3 and further rose to 52 contacts in Quarter 4. This upward trend

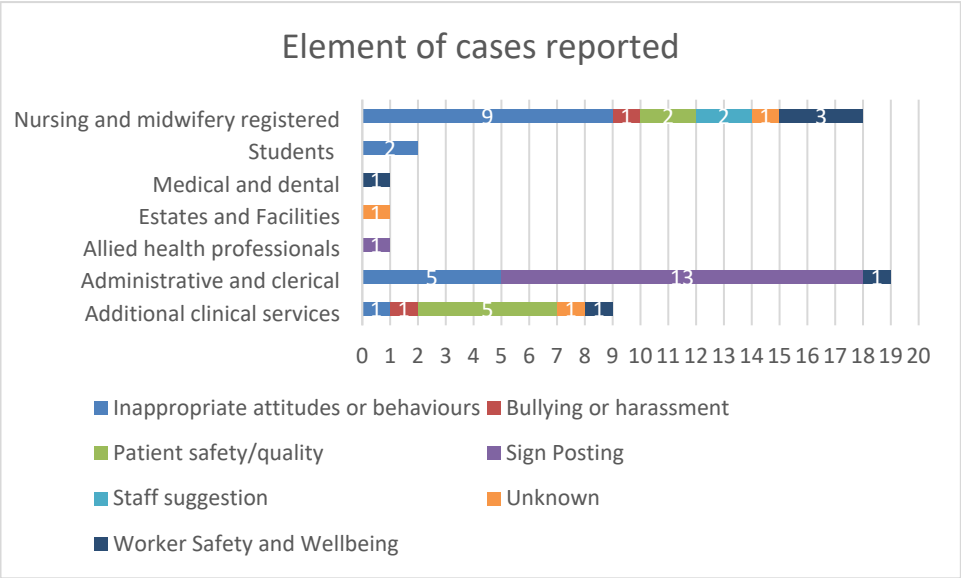
underscores a substantial rise in engagement with the Freedom to Speak Up initiative, reflecting increased awareness and willingness among staff to raise concerns.



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



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



While the aim is to respond to concerns raised within 24 hours, this quarter saw a deviation from this, with response times ranging from three to five days.

5. Updates on Open Cases:

From Quarter three, two cases remain unresolved, one is awaiting a grievance decision and the other having opted to raise a grievance after a dissatisfying outcome meeting. Currently, out of the fifty-two concerns officially raised, twelve remain open. Ten are undergoing an investigation pending feedback, while one awaits feedback following an investigation that yielded unsatisfactory outcomes, leading to the staff member's departure due to alleged bullying. Another case necessitates additional support for next steps.

One case, ongoing since June, is in the process of appealing a grievance decision, with the outcome pending. Six concerns initially routed to a Champion were redirected for assistance or guidance from the FTSU Guardian after initial discussions.

6. Closure of Concerns

Forty cases have been closed with four cases initiating contact but deciding against formalizing concerns, with reasons undisclosed and thirteen being signposted to a more appropriate department after an initial conversation relating to concerns and desired outcomes.

7. Patient Safety Concern Raised

A total of seven patient safety concerns were raised this quarter by nursing staff and support workers both within the trust and in the community. Five concerns were raised by a specific team within the community and two were raised within a specific department within the trust. Community issues were appropriately addressed and resolved by senior leadership. The latter has a meeting date set to address concerns from both a patient safety and staff wellbeing point of view as part of grievance. The concerns raised from this specific team were incident reported.

8. Themes or Trends

Themes or trends are starting to emerge across the FTSU data pool, with concerns originating from various sources both within and outside of the trust. I have explained in further detail below.

9. Cultural Awareness and Understanding

There are emerging concerns regarding perceived racial discrimination within pockets of the trust, particularly among nursing and HCA staff both inside the trust and within the community. An observation saw that staff may not always fully understand cultural differences, leading to situations being perceived as aggressive, rude, or lacking in manners. While this behaviour is not excusable, educating staff about cultural diversity can enhance their understanding of themselves and others. It can also encourage mindfulness of their own behaviours, fostering a more inclusive and respectful work environment

10. Perceived Detriment as a Barrier to Speaking Up

An obstacle to open communication within our organisation is the fear among staff of potential harm or negative consequences for voicing their concerns. In certain areas of our trust, this fear of speaking up has become deeply entrenched, leading individuals to feel trapped in a continuous state of avoidance. Rather than confront issues directly or engage in constructive dialogue, staff members resort to extreme measures, such as leaving their positions, or becoming absent from work to evade potential conflicts or repercussions. It is worth noting that three staff members who used the FTSU route to raise a concern have exited the trust, and six are actively pursuing alternative employment opportunities.

It is worth noting that for a small proportion of staff, the perceived risk of facing harm for speaking up arises from hearsay and anecdotes circulating within teams. However, upon closer examination, it becomes evident that some of these accounts lack first-hand evidence. These narratives, although lacking substance, can instil fear and inhibit staff from raising concerns. It is crucial to dispel these misconceptions by providing reassurance.

11. Friends and Family connections as a barrier to speaking up

In some cases, staff have refrained from speaking up due to concerns about potential repercussions from colleagues who are family members or friends. This fear can inhibit open communication and impede the sharing of valuable feedback. Additionally, there is a perception among staff that certain individuals receive special treatment based on personal connections, leading to feelings of inequity and distrust within the organisation. This perception may also deter leaders from effectively managing concerns, particularly when individuals in senior positions have personal relationships with those involved. Consequently, employees on lower bands may feel disadvantaged if a friend or family member occupies a senior position relative to their line manager. To address these challenges, it's crucial to establish clear guidelines regarding impartiality and conflict of interest. Fostering a culture of accountability and transparency can help prioritize organisational values over personal relationships, promoting a safer and more inclusive workplace."

12. Routes to Speaking Up

In response to the high volume of case contacts observed, efforts have been made to enhance accessibility and clarity regarding the various avenues available for staff to speak up. Recognizing the importance of providing clear guidance, a document titled "Speaking Up Routes" has been developed to depict the different channels through which staff can raise concerns.

This document serves as a central resource, outlining the multiple routes available for staff to voice their concerns effectively. It is a working progress, with the aim of incorporating hyperlinks to the Freedom to Speak Up (FTSU) policy and other relevant reporting mechanisms. By consolidating this information into one centralised document, staff can make informed choices regarding how they choose to speak up. To enhance staff understanding and empowerment in utilizing the appropriate formal reporting channels a "Spot the Difference" poster was also created.

See Appendix 1 and 2.

13. Clarification of Informally Raised Concerns

It is noted that there may be uncertainty amongst some managers regarding the handling of concerns that are informally raised but not formally submitted. There appears to be a distinct difference in the way managers manage these informal concerns, leading to potential inconsistencies in addressing them. In light of this, it may be beneficial to establish clear expectations and guidelines for handling informally raised concerns. By setting out explicit procedures and expectations, managers can ensure a consistent and fair approach to addressing these concerns, thereby promoting transparency and accountability throughout the organisation.

14. Capacity

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

15. Resources

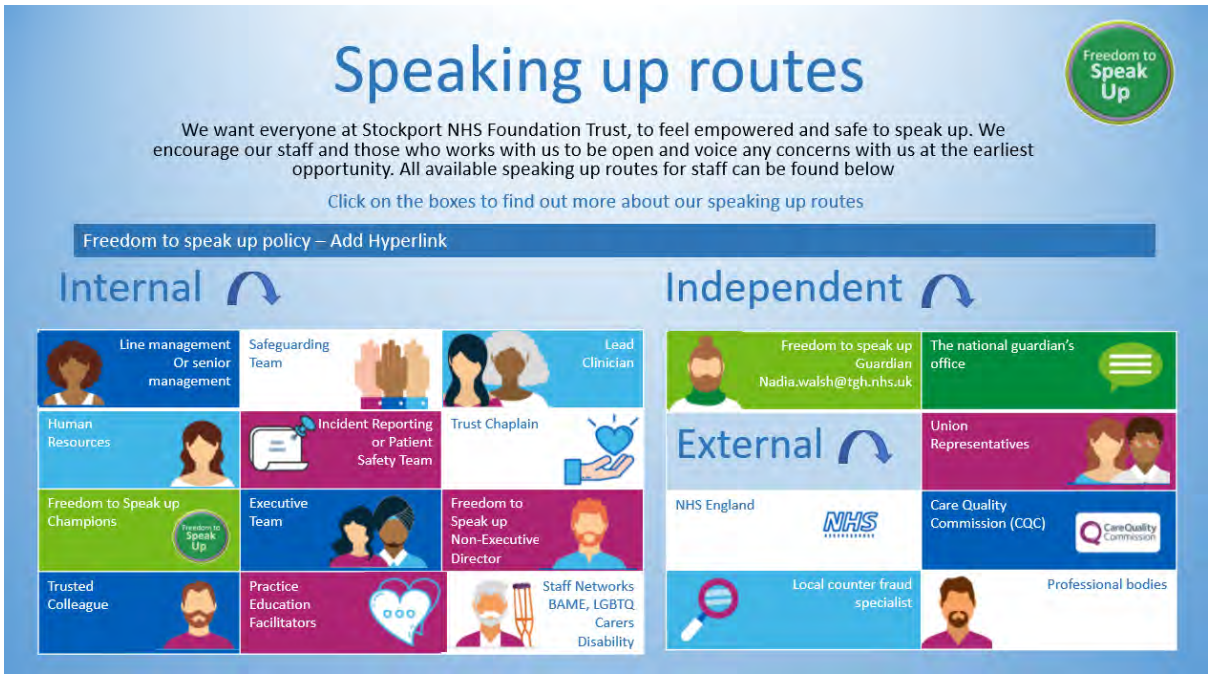
The Guardian currently works part-time – two days a week at both Stockport and Tameside & Glossop Integrated Care NHS Foundation Trust. The time commitment for the role is considered on an annual basis as part of the yearly review of the Trust's FSU arrangements.

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

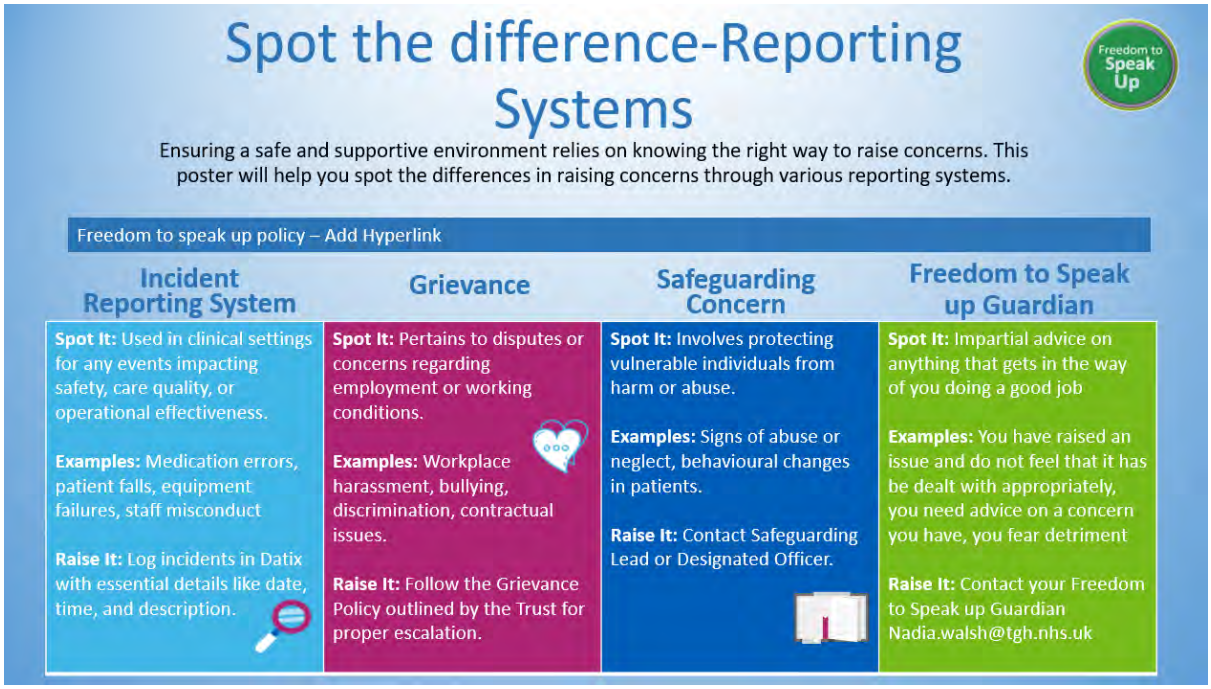
16. Recommendations

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

Appendix 1



Appendix 2



Meeting date	6th June 2024	**Public**	X	**Agenda No.**	14
Meeting	Board of Directors				
Report Title	Safer Care Report				
Director Lead	Nic Firth, Chief Nurse Dr Andrew Loughney, Medical Director	**Author**	Rebecca Cunliffe, Matron for Workforce		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust'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
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality 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	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	

Executive Summary

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

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

Safe Staffing Report – May 2024

Contents

Stockport NHS Foundation Trust

1. Introduction

NHS Stockport NHS Foundation Trust

The safe staffing report provides the Board 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 Board 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 :

- A rostering dashboard is currently under development & will be tested in late June by key stakeholders
- Supernumerary tiles are currently being reviewed to ensure these are used appropriately
- Pharmacy teams have been added to Healthroster and the monthly KPIs
- Healthroster has been upgraded. The Rostering Team are working through the changes & notifying relevant colleagues of the changes
- The Rostering Team are working closely with NHSP to identify the issues for retrospective bookings & will provide training where appropriate
- Annual leave in Clinical Support Services (CSS) & Integrated Care are below the expected 8.9% & therefore in red
- The CSS roster approval is below 29% & therefore in red
- The Women & Childrens roster unavailability is above the 35% acceptable limit & therefore in red

Roster period : 22nd April – 19 May 2024								Roster period : 25 March – 21 April 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	11.9%	52.5	17.3%	19.1%	288.3	386.6	-98.3	726.5	n/a
IC	8.4%	63.76	15.5%	24.4%	1,657.5	807.6	849.9	1,403.28	62.50%
Medicine	10.6%	61.65	20.9%	31%	1,297.9	1,228.2	69.6	5,408.3	60.34%
S&CC	10.6%	69.33	21.7%	35.2%	1,857.9	1,001.6	856.3	5,257.9	54.88%
W&C	14.1%	42.78	36.4%	19.1%	756.1	656.8	99.3	405.5	60.71%
CSS	8%	21.75	10.20%	0.10%	1,130.01	881.09	248.9	785	n/a
Total	10.6%	47.69	20.33%	21.48%	6,988	4,962	2,026	13,986.48	59.61%

Data provided by the Rostering Team

3. Vacancies

NHS Stockport NHS Foundation Trust

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	58.64	1.65	10
Corporate Services	95.16	-3.81	40
Emergency Department	106.52	-17.32	9
Integrated Care	360.53	-28.84	26
Medicine & Urgent Care	340.87	-42.24	30
Surgery & GI	438.96	-32.74	19
Women, Children & Diagnostics	402.61	-10.11	20
Grand Total	1803.29	-133.41	154

The data above covers the positions of registered nurses (RNs) and registered midwives (RMs), nursing associates (NAs) and staff awaiting PINs in April 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 Divisions, Head of Learning & Education, Divisional Nursing Directors (DNDs) and Workforce. A SOP has been circulated outlining how the Trust will ensure that nursing students are supported throughout the interview and appointment, recruitment process and induction to the Trust. This process is going to be led by the Pastoral Care Lead. We currently have a member of staff on redeployment on a 4 week trial.

4. NHS Professionals & Agency Usage

NHS Stockport NHS Foundation Trust

All day and night shifts now only have visibility to agencies at 24 hours, other than Theatres. Agency usage in April was 9.2% we expect May to be below 9%

Significant work is underway in Theatres, as 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 **£258,997**. Theatres have several staff currently undertaking training and new starters awaiting start dates following a successful recruitment event. In the Month of April retention is 100%.

The table below shows the percentage of shifts picked up by NHSP bands 2, 3, 4, 5, 6 and 7 days, nights & Saturdays, Sundays & Bank Holidays .

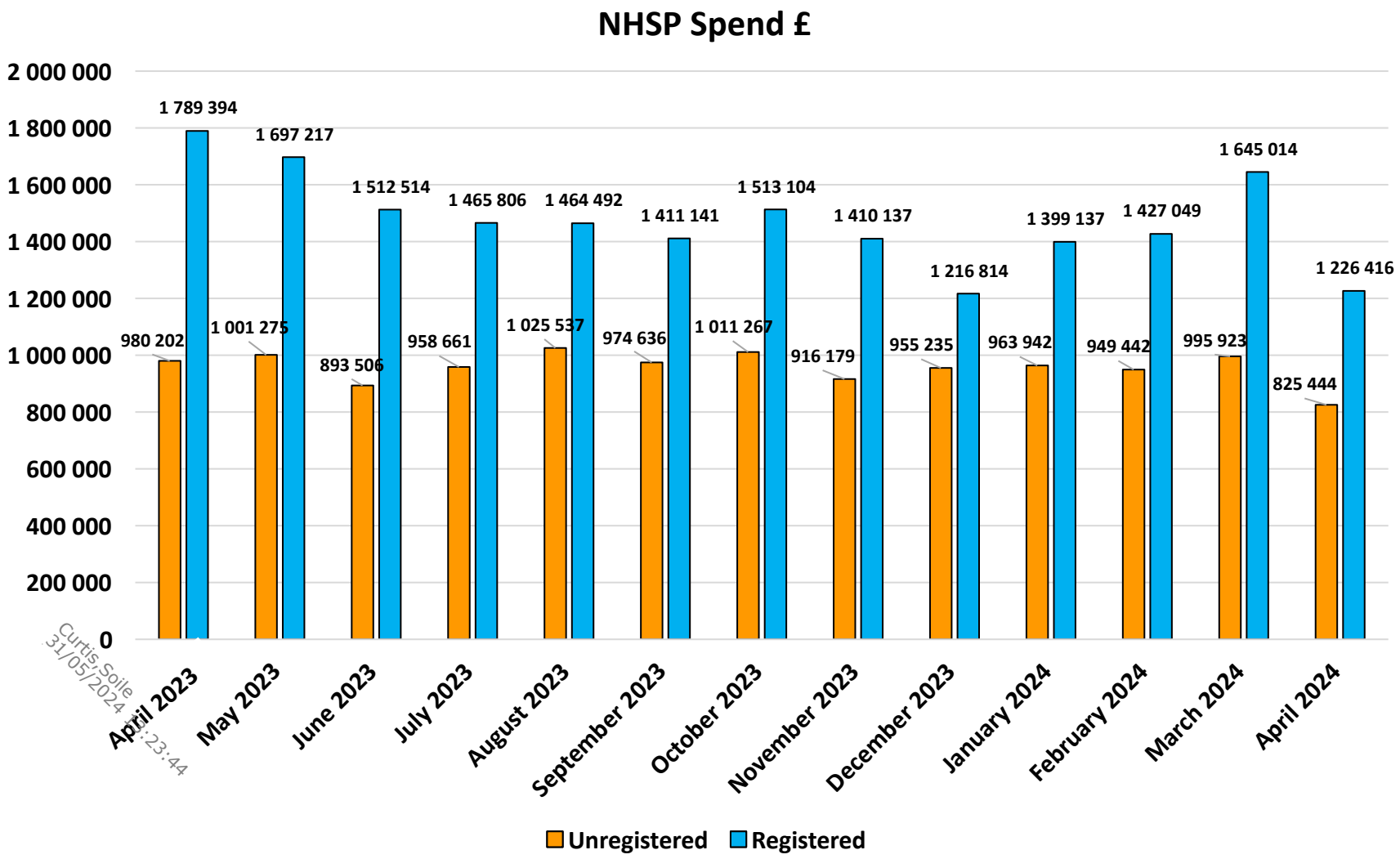
	March 2024			April 2024		
Nursing	**Day**	**Night & Saturday**	**Sunday & BH**	**Day**	**Night & Saturday**	**Sunday & BH**
Band 2	**62.6%**	**98%**	**97%**	**70.30%**	**97.90%**	**97.90%**
Band 3	**100%**	**100%**	**100%**	**79.70%**	**96%**	**98.60%**
Band 4 & 5	**40.8%**	**100%**	**100%**	**51.30%**	**77.20%**	**87.20%**
Band 6 & 7	**53.8%**	**41.5%**	**65.4%**	**88.40%**	**98.40%**	**89.50%**

	March 2024			April 2024		
Maternity Triage, Maternity 2, Maternity 3, Jasmine, Delivery	**Day**	**Night & Saturday**	**Sunday & BH**	**Day**	**Night & Saturday**	**Sunday & BH**
Band 2	**62.6%**	**98%**	**97%**	**41.10%**	**89.70%**	**100%**
Band 3	**100%**	**100%**	**100%**	**75.50%**	**100%**	**100%**
Band 4 & 5	**40.8%**	**100%**	**100%**	**100%**	-	-
Band 6 & 7	**53.8%**	**41.5%**	**65.4%**	**38.40%**	**35.20%**	**64%**

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.

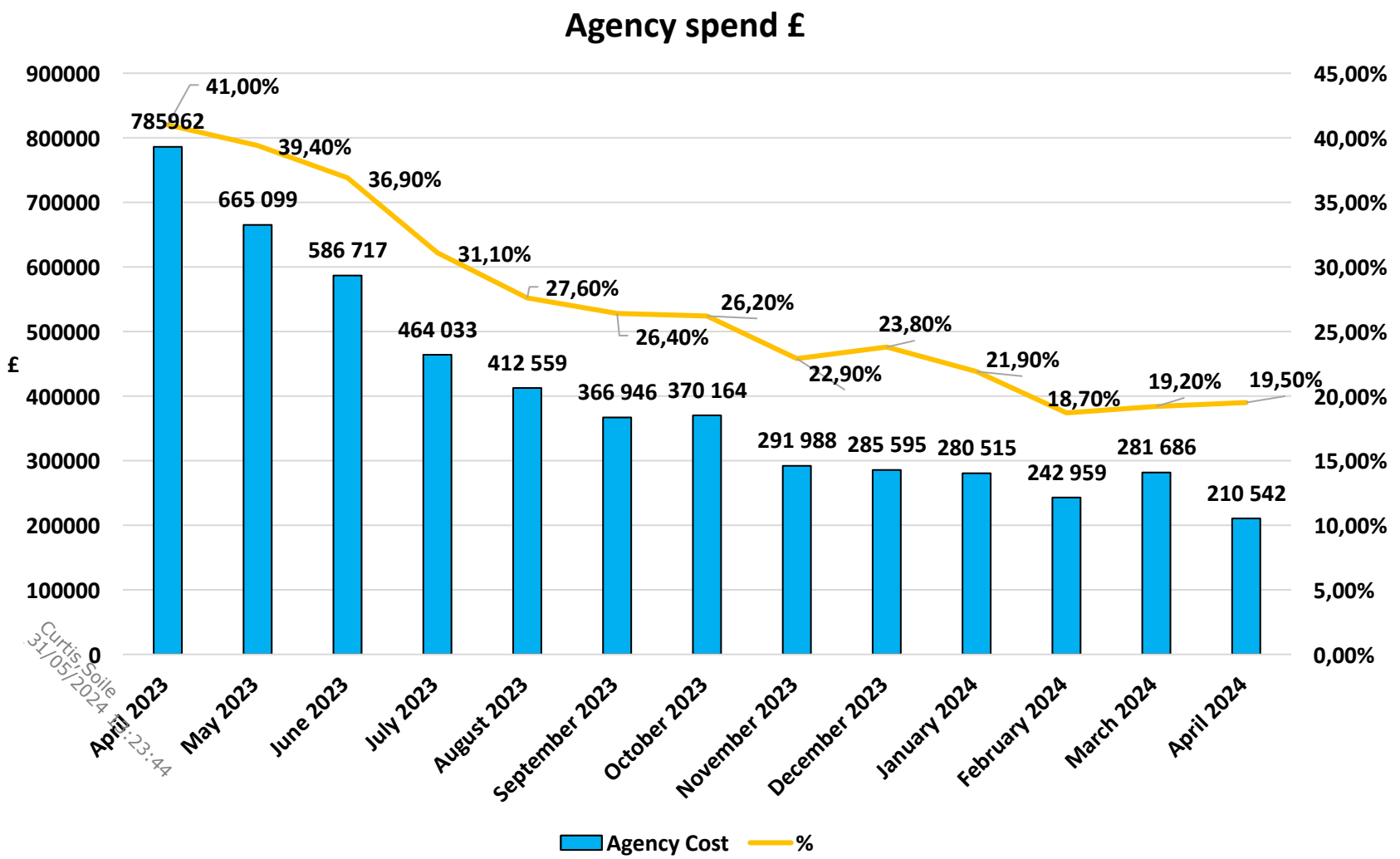


Data provided by People Analytics

5. Nursing & Midwifery Agency Spend

NHS Stockport NHS Foundation Trust

The table below illustrates the 'month on month' cost to the Trust of registered agency staff.



Data provided by NHSP

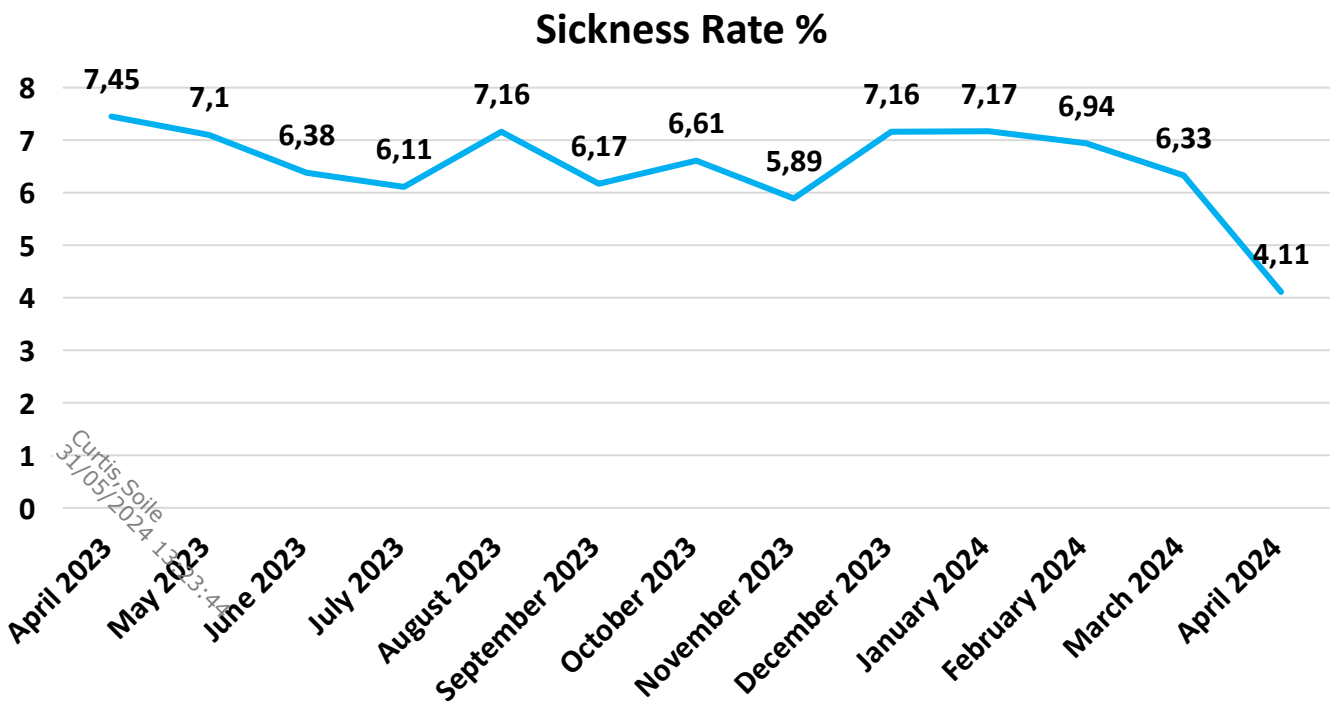
6. Nursing & Midwifery Absences

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	3.98%
RNs & RMs	6.36%
Students	0.14%



- 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

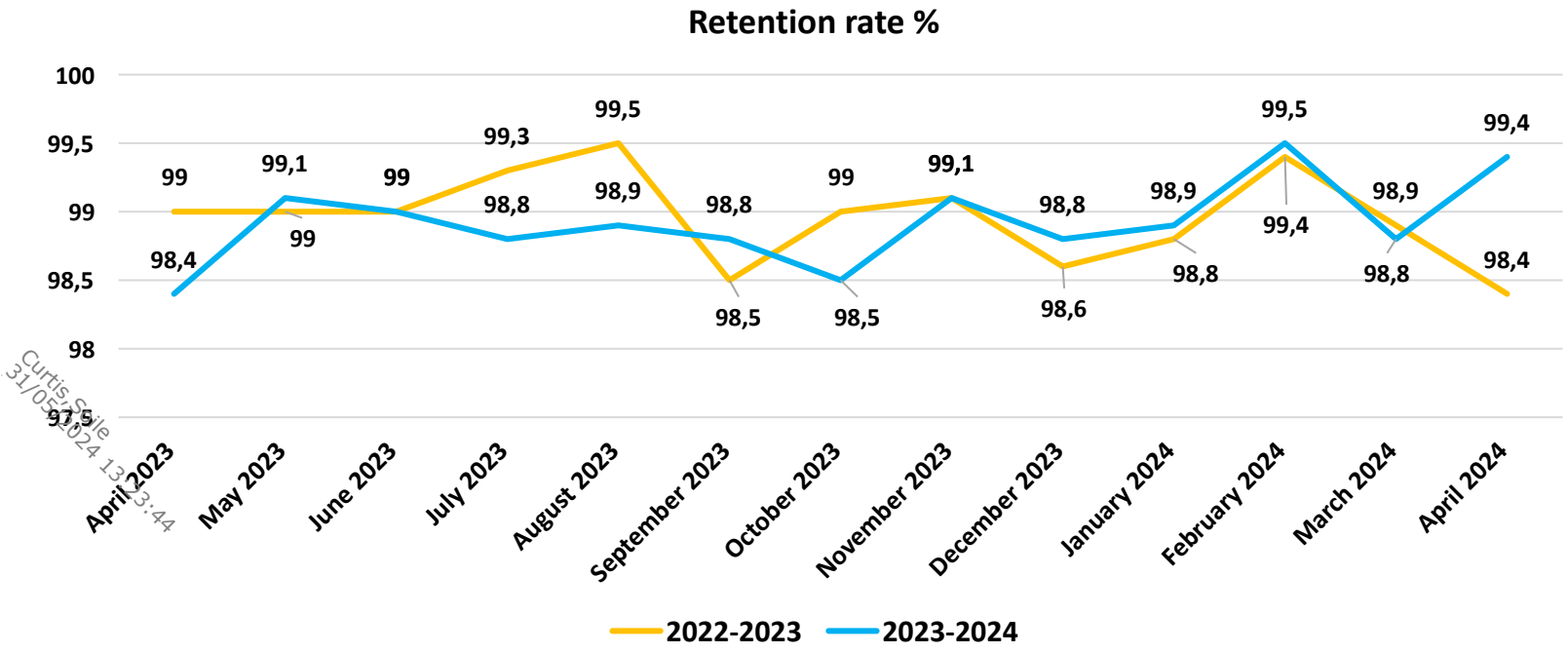
The graph illustrates the 'month on month' number of staffing shortfalls recorded by staff on Datix. Showing Stockport actively encourages staff reporting culture

Data provided by Datix

8. Nursing & Midwifery Retention

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

Retention figures are expected to improve with the recruitment of the Pastoral Care Lead who will be focusing on supporting the Trust's new starters from interview throughout the recruitment process and their initiation on the wards; supporting international RNs working as HCAs through the OSCE process. In addition, the role will also include managing the Grow & Retain our Workforce (GROW) pathway which enables RNs to internally transfer. All which contribute to improving retention. Retention and everything that contributes to it – environment and culture, flexibility and work/life balance, development, and career progression – must remain a core part of how we grow our workforce. This plan, builds on the valuable work in both the NHS People Plan and the NHS People Promise.

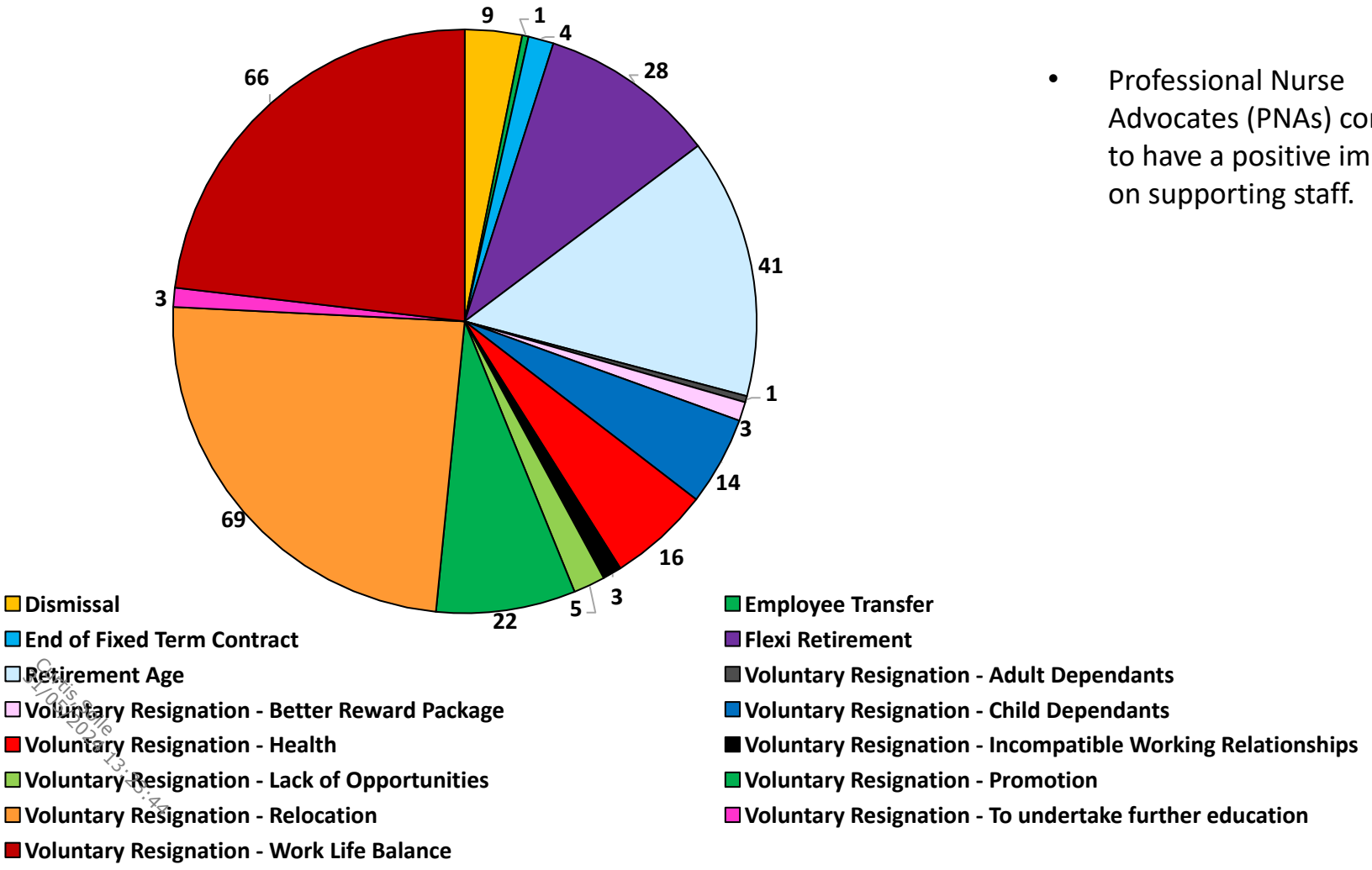


Data provided by People Analytics

9. Nursing & Midwifery – Reasons for Leaving

Stockport NHS Foundation Trust

Reasons for leaving the Trust April 2023 - April 2024



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

Data provided by People Analytics

10. Nursing & Midwifery Recruitment

NHS Stockport NHS Foundation Trust

- The focus is now on the Internationally Educated Nurses (IENs) who are currently employed as HCAs in the Trust and to support them through the Objective Structured Clinical Examination (OSCE) process. Ten HCAs will be supported through the OSCE with training provided by the OSCE Team. The start date of this process will be decided by the Learning and Education team.

- 4 Internationally Educated Midwives (IEMs) have all passed their OSCE and are working as registered Midwives in the unit numbers

- The Emergency Department and CDU held an event on 2nd March 2024 to recruit nursing staff. They recruited 3 x Band 6 RNs, 4 x Band 5 RNs, 1 Band 3 HCA and 2 x Band 2 HCAs.

- The Theatres Department held a recruitment event on the 6th April 2024. Visitors were able to have a tour of a working theatre and find out about career and training pathways. They appointed 2 x Anaesthetic and Recovery Band 5s, 6 x Scrub Band 5s, an Escort Practitioner and 2 x Theatre Assistants.

- The Pastoral Care Lead will be supporting any recruitment event going forward.

11. Nursing & Midwifery Student Engagement

NHS Stockport NHS Foundation Trust

- At the request of the Senior Lecturer, at the University of Salford, in April the Matron for Workforce & Matron for Medicine presented a "Meet the Matrons" session to 3rd year nursing students. This was an opportunity for students to ask questions about real life work experience and personal career pathway. Following the success both Matrons been invited to Manchester Metropolitan University (MMU) to facilitate a similar session.

- The session includes discussions as to what is expected of the students once they have joined the Trust as a qualified nurse, and what they should expect from us as an organisation. And discuss the process of applying for a job, provide guidance on completing application forms and advice on interview techniques. They learnt about the role of the Trust's Pastoral Care Lead who will be involved with them throughout their recruitment process to starting at the Trust, and their period of supernumerary.

A selection of comments received from the students at the April session: All 54 responses were very positive

"The Matron both put me at ease, I don't feel so scared about qualifying in January. Now I know there are people to help and support me. They gave real life examples of when to escalate and to who."

"Thank you for your insight and advice. The format of the session was conducive to good participation from the Students and Matrons"

"I appreciate your honest response to my own questions. It was a great session. Matrons aren't as scary as I once thought. You are friendly, approachable and professional"

12. Training Pathways

NHS Stockport NHS Foundation Trust

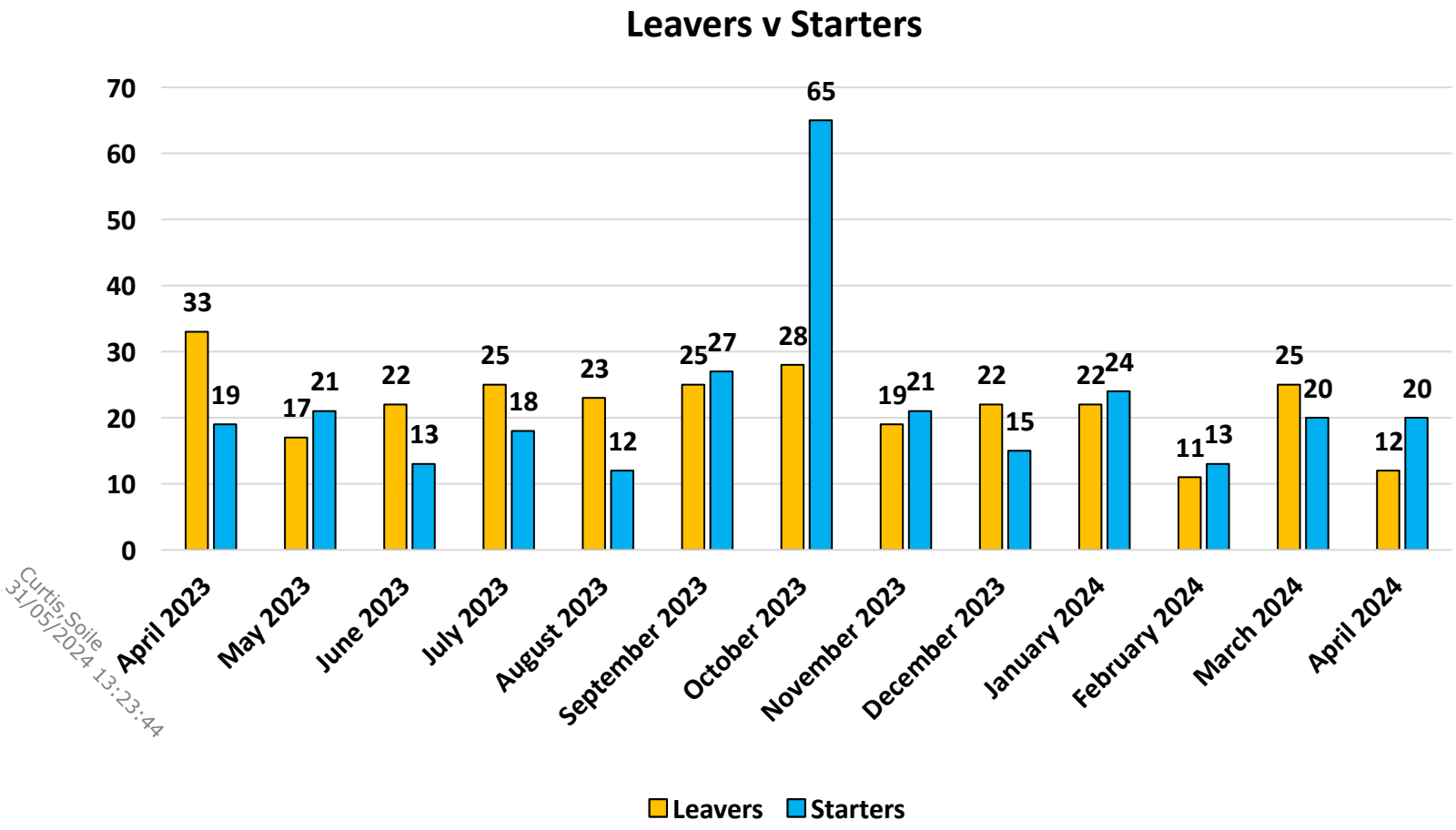
Multi-professional Cadet Programme

This initiative has been put in place in order to support future NHS workforce demand.

- In light of the large reduction in students applying to universities, this programme aims to recruit local young people and support them into careers in the NHS by offering a wide range of placement opportunities (across all professions)
- The Trust currently collaborates with The Trafford Group College (Stockport), Macclesfield College, Manchester College and the UCEN Manchester
- There are currently 84 cadets on programme who are studying on the National BTEC Level 3 programme, or the new industry T-Level qualification. These learners are between 16-19 years old
- It is anticipated that the number will increase to 120 by September 2024
- Cadets will be encouraged to either access HEI (guaranteed interviews at Universities of Salford and Bolton with agreement to complete 3 years training at Stockport NHS Foundation Trust), or access other roles within the Trust such as a HCA or administrator where they can continue to progress via apprenticeship routes
- UCEN students are adult learners studying a BSc in Health and Social Care; they will be actively looking to be recruited into HCA roles. On completion of a degree they can access the MSc Adult Nursing Programme (2 years) at the University of Bolton and be recruited into RN positions at SHH

13. Nursing & Midwifery Starters & Leavers

There was a decrease in the number of leavers in April. With the introduction of the role of Pastoral Care Lead it is expected this will continue and that going forward there will be an improvement in retention. The quality of the exit interviews does not give definitive reasons for leavers. The Pastoral Care Lead will offer to conduct exit interviews to see if this will support the transparency of answers.



Data provided by People Analytics

14. Pathology

NHS Stockport NHS Foundation Trust

Laboratory Medical

- **Microbiology** consultants remain the largest risk. There have been two 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. There are discussions for support from MFT (Manchester Foundation Trust) and an additional bank consultant post is under discussion. There will be pressure on the daily rota and on the provision of on-call. Currently this is covered but will require close management.

- **Histopathology** consultant workforce has been returned to establishment and there are interviews in May for an additional consultant.

- **Blood sciences** there is an additional day to backfill consultant clinical scientist to provide capacity for the replacement LIMS project.

Histology Laboratory

- **Biomedical Scientists (BMS)** Two additional band 6 post on 12 month contracts are at the interview stage of recruitment, these are funded via the Cancer Alliance; additionally the Band 7 senior BMS has started. 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.

- **Medical Laboratory Assistants (MLA)** – Cancer Tracker post is currently in the recruitment process.

Data provided by Pathology

14. Pathology

Stockport NHS Foundation Trust

Blood sciences

- **Biomedical Scientists (BMS), Bands 5-8s** Have had good staffing stability for a number of years, there is now a significant level of turnover which especially affects the Biochemistry Team.

- **Medical Laboratory Assistants (MLA), Bands 2-4** Two supervisors in Blood Sciences Reception have given notice, one for promotion and one leaving. There is a historic 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 principal 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.

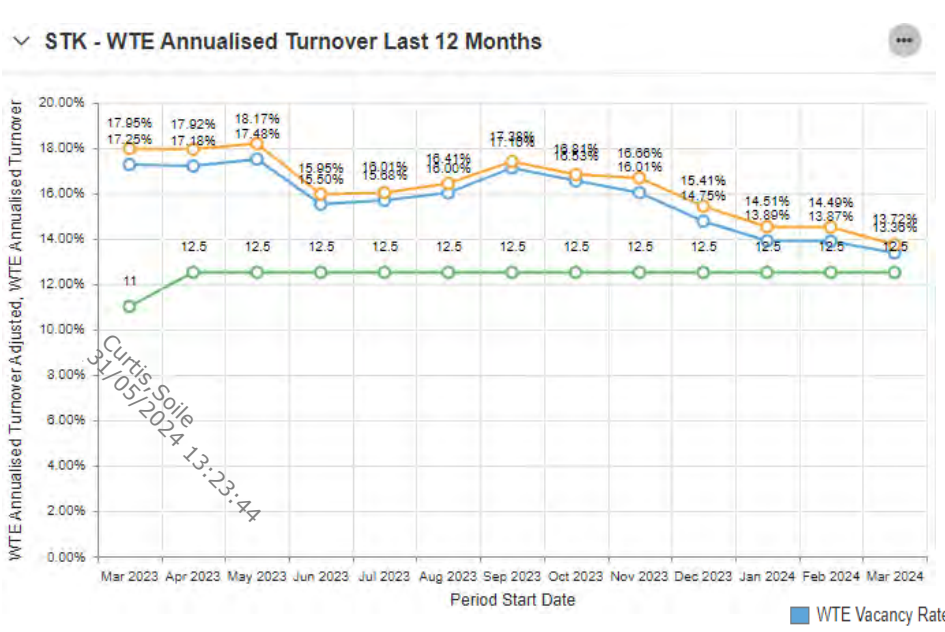
15. Allied Health Professionals (AHPs)

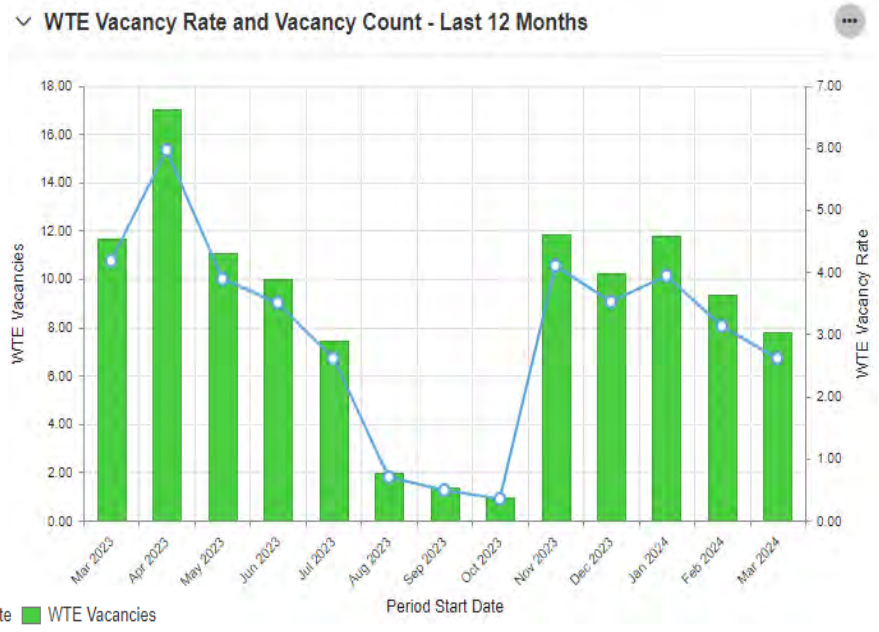
NHS Stockport NHS Foundation Trust

Recruitment continues to follow an encouraging trend with vacancies reducing from 8.79 WTE in January 2024 to 7.81 WTE in March 2024 against an establishment of 298.86 WTE.

The Assistant Directorate Manager is currently leading a scoping exercise to explore more innovative & inclusive interview/recruitment strategies than the historic face-to-face style with unseen questions. The aim is to better foster diversity, equity & representation within our services through the recruitment process. Effective use of talent pools is also enabling us to hire the best available workforce, ultimately leading to stronger & more dynamic teams.

Turnover is another success story, again sitting at the lowest in more than a 1 year. While we remain above the Trust target currently at 13.36%, the main reason for staff leaving is to pursue career development opportunities not available within the Trust, and staff on rotational posts who continue with career training and development. Exit interview feedback from staff articulate a desire to return should the right opportunity present itself.





Data provided by Integrated Therapies & Boroughwide Services

15. Allied Health Professionals (AHPs)

NHS Stockport NHS Foundation Trust

Agency Trajectory and Temporary Staffing

- Whilst work has been ongoing to reduce agency expenditure, the single remaining pressure point is within Speech and Language Therapy (SLT). The use of SLT agency staff has been essential to maintain safe staffing levels and ensure that patients in our care are not at risk due to workforce.
- Despite this, agency spends are the lowest we have seen in more than a year and continue to decline.

Job Planning / Capacity and Demand Analysis

- The job planning guidance template for AHPs in Integrated Therapies is now complete, ready to be presented to the Divisional leadership team for feedback and rolled out within the Directorate.
- The trajectory for job plans to be in place by the end of Q1 remains on track.
- Capacity/demand data collection and analysis has started in community services, with Podiatry, MSK Physio and Community Neuro-Rehab leading the way, and the plan is to drive the more complicated work around inpatient services in Q2.

Main Challenges

- Orthotics NHSP – due to the novel situation using NHSOP for Orthotics staffing, we still haven't been able to complete the onboarding process. It has been a frustrating journey for all involved, but we hope to have 2 of our new NHSP Orthotists in post by May 2024.
- SLT staffing – staffing remains a challenge but it is important to note that, at the current time, this is an improving picture.

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.)

Challenges

- Current registered vacancy inclusive of Inpatient and Outpatient areas 1.11 WTE, in addition to this there is currently a gap of 13.24 WTE on maternity leave

Current Maternity position		
WTE Actual	**Number of WTE Vacancies**	**Post WTE Recruited to TRAC**
160.48	**1.11**	**0**

Actions

- Weekly planned roster scrutiny meetings/E-Roster training sessions
- Rolling advert for Band 5/6 midwives is in place
- Recruitment day held for the 20th April for student midwives due to complete training Sept/Oct 2024

Assurance

- All shift co-ordinators have supernumerary status
- March showed we achieved 96.9% one to one care in labour. The target is 100% but this is not always achievable due to women who birth unattended at home or arrive in established labour. If it is not achieved each case is reviewed to identify any learning, for April the 1:1 care in labour is 99.6% 1 women birthed before arriving at the hospital (unplanned)
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity Support Workers Framework Working Group
- Recurrent funding confirmed for Recruitment and Retention Midwife, Band 6 Preceptor Midwife and Band 3 Maternity Support Worker Retention post – job descriptions under review
- Engaged with the International Educated Midwifery (IEM) recruitment programme. Three commenced in post, 1 IEM arrived on 28th December 2023, 1 IEM arrived January awaiting OSCE

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	238.78	227.46	-11.32
Tier 2	77.64	66.76	-10.88
Tier 1	119.62	153.98	34.36
Total	**436.04**	**448.20**	**12.16**

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

Stockport NHS Foundation Trust

Consultant Recruitment

- Medical Staffing continue to work 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 since the last report with the appointment of a number of Consultants including one in Occupational Health, a post that can be very hard to recruit to.

- We are actively working with divisions regarding recruiting Consultants in Histopathology, Microbiology, General Medicine, DMOP, Stroke and ENT.

- In 2024 Trauma and Orthopaedics recruited another Specialist Doctor and a Doctor who can work autonomously, this follows the appointment of a Specialist Doctor in Diabetes in 2023. Appointees to this role can often work autonomously which provides another option for the Trust in the recruitment of senior Doctors, especially in areas that prove difficult to recruit to.

Medical Workforce Group (MWG)

- The MWG can monitor and support in staffing, and in particular seek to assist with those difficult to fill specialties and ensure that all options are being explored.

Data provided by Medical Staffing

18. Good news

Stockport NHS Foundation Trust

- Approval of the Nursing Student Recruitment SOP
- The Theatres Department held a very successful recruitment event on the 6th April 2024 and appointed 2 A&R Band 5, 6 Scrub Band 5s, an Escort Practitioner and 2 Theatre Assistants
- 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 9.2%. We expect the May data to below 8%
- Matron for Workforce & Matron for Medicine visited the University of Salford and spoke to 3rd year nursing students about real life experience such as managing incidents, attending inquests, handling complaints & what to expect on their first working day. They also provided advice on how to apply for jobs & interview techniques.
- The Trust continues to be popular choice for students, the following are currently on placement :
    - 148 nurses
    - 57 midwives
    - 31 AHPs
    - 11 ODPS
- An alternative pathway is via an apprenticeship, currently on placement at the Trust :
    - 11 registered nurse degree apprenticeships
    - 2 Physio Therapists Level 6
    - 1 Dietitian
    - 4 Occupational Therapist

19. Going forward

Stockport NHS Foundation Trust

- Formalise the selection of and pathway for international nurses working as HCAs to qualify as Band 5 registered nurses
- Seventeen trainees have joined the NHSP Care Support Worker Development (CSWD) programme and are scheduled to start their training date to be confirmed. The CSWD's need to be allocated to wards.
- Matron for Workforce visited Manchester Metropolitan University; to discuss extending the university sessions we do at Salford into other local universities.
- Pastoral Care Lead has offered to support divisions with exit interviews

NHS Stockport NHS Foundation Trust

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	15
Meeting	Board of Directors				
Report Title	Maternity Services CQC Inspection Report & Action Plan				
Director Lead	Nicola Firth Chief Nurse	**Author**	CQC Report Action Plan – Sharon Hyde Divisional Director of Nursing and Midwifery		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	**X**
Recommendation:	**The Board of Directors is asked to:** • **Receive the Maternity Services CQC Inspection Report published in May 2024, following inspection in September 2023.** • **Receive assurance in relation to the action plan created following receipt of the report.** • **As recommended by Quality Committee, approve the action plan to be submitted to the CQC by 7th June 2024.**						

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		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	x
Financial impacts if agreed/not agreed	x
Regulatory and legal compliance	ALL
Sustainability (including environmental impacts)	X

Executive Summary

On 28 September 2023 the CQC undertook an announced inspection of maternity services covering the domains of safe and well led as part of the national maternity inspection programme.

The inspection report published 10 May 2024 rated the service as requires improvement in both safe and effective, meaning that rating remained unchanged.

The report included 3 MUST DO actions, and 4 SHOULD DO actions. An action plan in response to these recommendations is to be submitted to the CQC by no later than 7 June 2024.

This report includes:

- CQC Maternity Service Inspection Report – For Information
- CQC Maternity Service Action Plan – For assurance, noting progress against the action plan will be monitored by Quality Committee and reported to the Board of Directors.

Stockport NHS Foundation Trust

Stepping Hill Hospital

Inspection report

Poplar Grove
Stockport
SK2 7JE
Tel: 01614831010
www.stockport.nhs.uk

Date of inspection visit: 28 September 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Stepping Hill Hospital

Requires Improvement ➔➔

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Stepping Hill Hospital.

We inspected the maternity service at Stepping Hill Hospital, which delivers maternity services for Stockport NHS Foundation Trust, as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Stepping Hill Hospital provides maternity services to the population of Stockport and High Peak.

Maternity services include a maternity triage unit, a maternity ward including antenatal and postnatal care, co-located Stockport Birth Centre (midwifery led birth-unit (MLU)) consultant led delivery suite and enhanced care room, and transitional care area. The MLU has 4 individual birthing rooms, 3 of which have birthing pools and a 4 bedded bay for postnatal use when required. The MLU is located on the same floor as the maternity triage and antenatal day unit (ADU).

Between April 2021 to March 2022, there were 3250 babies born at Stepping Hill Hospital.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Our rating of this hospital stayed the same. We rated it as Required Improvement because:

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well-led as Requires Improvement.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited maternity triage, the delivery suite, 1 maternity ward which provided antenatal and postnatal care (which included 2 private rooms and a bay), the midwifery led unit (MLU), the antenatal day unit (ADU), delivery suite theatres and relevant recovery area, elective caesarean section theatres waiting area, the bereavement suite and the transitional care area provided within the neonatal unit. There was no transitional care area designated on the ward although staff told us they aimed to keep baby with mother, birthing person where possible.

We spoke with 25 midwives and 8 doctors, 3 maternity support workers and 6 women and birthing people. We received two positive feedback to our 'give feedback on care' posters which were in place during the inspection.

Our findings

We reviewed 10 patient care records, 10 observation and escalation charts and 10 medicines records. We attended handover meetings and safety huddles.

Following our onsite inspection, we spoke with senior leaders within the service. We also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement ● →←

Our rating of this service stayed the same. We rated it as requires improvement because:

- Not all staff working on the birth centre had completed training in key skills. However, staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.
- Staffing levels did not always match the planned numbers, which could put the safety of women, birthing people, and babies at risk.
- Medicines were not always managed well, and care records were not always completed in full.
- Leaders did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.
- Staff did not always risk assess woman and birthing people.

However:

- Staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.
- Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups in their local population.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- We witnessed a cohesive effective communication between professionals focusing on the needs of the woman, birthing person.
- The service-controlled infection risk well.

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service had an overall compliance rate of 94% of mandatory training compliance, against a trust target of 90%. However, there were some areas where there was lower compliance. For example, for adult basic life support (level 3) the overall compliance rate was 93%, but compliance for midwives on the birth centre was 71% and midwives working within the antenatal clinic had 87% compliance.

Data showed the combined compliance for medicines training was 94% for all midwives across the maternity service. This met the trust target. In addition to the medicines training the service facilitated a medicines management midwives competency assessment. Not all midwives had completed the assessment with 68% of delivery suite midwives and 63% of midwives completing on the triage/assessment day unit. The service told us, staff who had not yet completed the training were working to do so.

The service told us they delivered mandatory training updates on perinatal mental health training which included information on the Mental Capacity Act (1983). The training included maternal health disorders, risk assessment and referral routes. However, data showed that 81% of midwives had completed this training against a trust target of 90% compliance. In triage and the antenatal day unit, only 55% of staff had completed this training.

The trust did not provide full details of all training compliance data for obstetric medical staffing.

The service made sure that all staff received multi-professional simulated obstetric emergency training. The mandatory training was comprehensive and met the needs of women and birthing people and staff. Records showed 94% of midwives and 93% of medical staff had completed cardiotocography (CTG) training. CTG is a continuous reading of fetal heart rate via an ultrasound transducer placed on the woman or birthing person's abdomen. Ninety four per cent of staff had completed Practical Obstetric Multi-Professional Training (PROMPT) training and obstetric emergency skills and drills training. This training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Ninety-three percent of staff had completed maternity specific training relevant to their role, which included infant feeding, newborn screening, blood transfusion and pool evacuation and met the trust's targets.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Managers gave staff time to complete the training.

The service told us that the maternity training need analysis was informed by local learning from incidents, audit and staff and patient feedback. The service practice development team told us they worked closely with the maternity governance team to look at themes or trends and that they adjusted the training programmes and adapted it to include national updates and local outcome data.

Safeguarding

Most staff had completed safeguarding training in line with trust policy and national guidance. Staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.

Most staff had received training specific for their role on how to recognise and report abuse. The service training records showed that midwives received both level 3 safeguarding adults and level 3 safeguarding children training at the level for their role as set out in the trust's policy and the intercollegiate guidelines.

There was an overall midwife compliance across the service of 93% for level 3 safeguarding children's training and 96% for level 3 safeguarding adults training. Training compliance was above the service target of 90% in all areas other than the Birth Centre where 63% of midwives had completed adult safeguarding training level 3 and 80% compliance in level 3 children's safeguarding training.

Medical staff, including consultants, were not always up to date with their safeguarding training. Data showed the medical staff safeguarding training compliance was 87% and slightly below the service compliance rate of 90% for both level 3 safeguarding adults and safeguarding children training at the level for their role (August 2023).

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The service safeguarding team worked in partnership with the perinatal mental health team, who was aligned to the infant parenting service. This team provided psychological support and support with personalized care plans.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were visibly clean and had suitable furnishings which were well-maintained. We saw “I am clean” stickers were used to show equipment was clean and ready for use and saw cleaning was in progress during the visit.

The service provided evidence of daily cleaning checklists and a cleaning schedule to demonstrate all areas including the birth pools had been checked and cleaned regularly.

The service provided evidence of Legionella testing. Data provided showed the service generally performed well for cleanliness. The monthly cleaning audit from July to September 2023 showed the delivery suite and the postnatal ward scored 99% for cleanliness. Staff inspected various areas of the maternity unit to review cleanliness and shared the results with trust infection control leads for oversight and support when required.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 98%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Equipment was not always stored, checked, and maintained regularly. The bereavement room was not sound proofed impacting on the persons using it. However, staff were trained to use available equipment and managed clinical waste well.

The design of the environment did not always follow national guidance as the bereavement suite was not sound proofed. The service had a furnished bereavement room to care for bereaved mothers and their families. The room was in a quieter area of the ward but was not soundproof in line with national guidance. This meant that bereaved mothers could hear other babies crying on the ward and not in line with national recommendations.

The service otherwise had suitable facilities to meet the needs of women and birthing people's families. For example, all rooms had individual ensuite facilities. Rooms were spacious and light affording privacy and dignity and an accessible environment. We noted two birthing rooms did not have baby resuscitaire units in line with national recommendations. However, this was clearly communicated by staff on a central whiteboard. There was access to birthing pools, birth balls and stools to support movement in labour. The birth partners of women and birthing people were supported to attend the birth and provide support. The maternity unit was secure and there was a monitored entry system. The service had a mobilisation room with ‘a home from home feel’ with refreshments available to those wanting to wait to be in established labour.

The estate was outdated and was not always kept tidy. We saw holes in the ceiling in the domestic storage cupboard and the room was cluttered and with items stored on the floor including personal belongings of staff which should not have been stored in this area.

Equipment was not always serviced and maintained in a timely manner. We found an incubator stored on the postnatal ward that had not been serviced since 2021. Senior leaders confirmed this incubator had been out of use and acknowledged that it should have been disposed of. This was completed during the inspection.

The service had an equipment asset register to ensure all medical equipment was maintained and safe for use. The service electro biomedical engineering service (EBME) report August 2023 report showed that 70% of equipment had been serviced within the correct time frames and that 30% of equipment was awaiting service. This risk had been added to the trust risk register however, there were no mitigation measures shared by the service to address the issue.

Staff mostly carried out daily safety checks of specialist equipment. Records showed the neonatal resuscitation equipment on the birth centre was not always checked daily showing gaps in the checking with 6 days being missed in September 2023.

Records showed that resuscitation equipment checks on the birth centre had not always been completed. Two dates in September 2023, staff identified the clock / timer on the resuscitaire was not working and documented on the checklist, but no action had been taken at the time of the inspection to address this. It was also recorded in the same month, that the heater of the birth centre neonatal resuscitaire was not working but we did not see any evidence of actions taken. This was escalated to the staff at the time of inspection.

Maternity

The service had a clinical room accessible for staff by swipe card where sepsis, blood sugar monitoring equipment, postpartum haemorrhage (PPH) medicines and neonatal medicines were safely stored.

The service had a scavenger system for medical gases within maternity theatres. The service had completed a risk assessment. However, we found the birthing centre did not have a scavenger system and there had been limited mitigation put in place to monitor staff exposure to medical gases.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Managers completed environmental ligature and ligature point risk assessments. In clinical areas that were high risk of having individuals who were at risk of suicide and /or self-harm, staff completed an additional comprehensive environmental assessment, which were added to the incident reporting system and every month the trusts Health & Safety team reviewed them.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always complete and update risk assessments and did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff did not always use a 'fresh eyes' approach for cardiotocography (CTG). Cardiotocography is used during pregnancy to monitor fetal heart rate and uterine contractions and CTG interpretations is used as a part of a holistic review. Data from April to September 2023, showed that staff compliance with getting a 'fresh eyes' review of a CTG within safe time frames averaged 72% against a trust target of 90%. The fresh eyes audit completed in September showed compliance was 84.8%, which did not meet the trust target.

The service told us that cardiotocography (CTG) cases were reviewed at the weekly multidisciplinary (MDT) training sessions and during investigations of reported incidents. Staff told us lessons learned influenced the training and training was modified to ensure improvements in practice. Fresh eyes audits continued with general feedback to staff and management, and where appropriate additional support was provided to individual staff.

During the inspection, we saw women and birthing people who attended triage were seen and reviewed in a timely manner (within 15 minutes) although staff told us this was not always the case and that delays for medical reviews occurred. Staff in the maternity day assessment unit / triage used a red, amber, and green (RAG) rated prioritisation tool to risk assess women and people on arrival. The tool was designed to ensure that high risk women and people were seen within safe time frames and assessed at the time based on clinical indications. However, managers did not monitor arrival and wait times to make sure high-risk women were seen within safe time frames as set out in the triage guidance and in line with national recommendations. Service leaders had developed an action plan to improve triage services.

Staff told us they did not usually have a designated midwife allocated to answering the triage telephone line to ensure telephone triage was available in line with national recommendations. The service recognised this was a need and

recruitment for a telephone triage midwife was planned for December 2023. Until this additional recruitment was in place, existing midwives covered the triage when able. The service told us they planned to allocate 2 midwives to work in triage and when possible, 2 midwives, to support telephone triage. On the day of inspection, the triage telephone had a designated midwife to answer all calls.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Maternity Early Warning Score (MEWS) for women and birthing people. MEWS is a tool that identifies signs of deterioration during admission to hospital or during childbirth. The staff told us that all pregnant women from 16 weeks of pregnancy and up to 42 days postpartum who attend the maternity assessment unit did have their observations recorded on MEWS.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Newborn babies classed as a high risk were monitored using a newborn early warning trigger and track chart (NEWTT). Newborn infants that triggered on the chart were escalated for paediatric review and management. The NEWTT's observation chart was only available in paper format because this wasn't yet established on the electronic patient record.

There was no monitoring in place of NEWTT. However, the NEWTT's audit was an area of work currently being developed by the neonatal and midwifery team as part of a Quality Improvement Plan.

Staff risk assessed women and birthing people at their booking appointment (first full risk assessment at the beginning of pregnancy) and used the five elements of the 'Saving Babies Lives Care Bundle version 2. The service had oversight of the use of the saving babies lives care bundle version 2 (SBLv2) through an action plan, which was regularly updated. However, there was no evidence the service had implemented saving babies lives care bundle version 3 (SBLv3, May 2023). Following the inspection the service provided assurance explaining SBLv3 would be implemented by March 2024.

Staff used a recognised tool to monitor fetal growth during pregnancy. Leaders implemented a competency assessment to ensure clinical staff accurately plotted women's abdominal growth during pregnancy. A specialist midwife for 'saving babies lives' calculated growth retrospectively every month to see if systems accurately detected reduced growth. The service reported a 44.6% detection rate in identifying small for gestational age babies born at the service January 2023 to March 2023 compared to a national average of 43.6%.

Staff provided women and pregnant people with information on fetal movements during pregnancy. We saw staff offering and providing this information to women, birthing people in their preferred language. Staff reviewed blood screening and scan results to help inform decisions around care.

Staff used a 'sepsis 6 care bundle' and flow chart to implement care for women and pregnant people showing signs of sepsis. The service did not undertake sepsis audits to monitor compliance.

The service had 'sepsis rapid response kits' which were sealed without a list of contents, meaning staff did not know what it contained. We raised this with service leaders at the time of inspection who took action to address this.

Staff provided enhanced care for women who were critically ill. The service had an enhanced care room which enabled staff to provide a higher level of care, with vital lifesaving equipment. Staff followed the trust's 'Care of The Critically Ill Woman in Childbirth' standard operating procedures. This document included a list of roles and responsibilities for medical staff, anaesthetists, and midwives. Staff liaised with clinicians who worked outside of the maternity unit when dealing with women who needed a higher level of care or who had different medical conditions. Training records

showed that not all midwives on the labour ward were trained in caring for the critically ill woman, however there were 7 midwives who were qualified in critical care having completed the appropriate university course. Leaders told us they had an ongoing plan to train existing labour ward midwives to an enhanced level of care. All clinical staff attended a 3 yearly maternity Acute Illness Management (AIM) course and annual PROMPT training.

Theatre staff completed a World Health Organisation (WHO) checklist when women and birthing people arrived in theatre. Data collected from April 2023 to August 2023 for "labour rooms" showed that overall staff compliance of the safe use of the surgery safety checklist was 87.1% which did not meet local target of 90%. Data for "maternity theatres" and "maternity theatre risk" for this period showed both as having overall compliance of 100%, During the inspection theatre staff were observed to appropriately complete and the WHO safety checklist.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments, ligature risk assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people safe was shared when handing over care to other staff. Staff used the SBAR (situation, background, assessment, and recommendation) tool in paper form when handing over the care of women, birthing people, and babies to others. Staff told us that they also entered the SBAR information on to the electronic patient record. Staff had 2 safety huddles each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people.

There was a multidisciplinary team handover at 8.30 am daily, and doctors performed a ward round on the delivery suite every morning and evening in line with national guidance. Audits completed by the service showed occasions where ward rounds had taken place three times depending on medical shift changes and ward acuity and demonstrated a positive response to service needs.

Staff completed risk assessments prior to discharging women and birthing people into the community and ensured third-party organisations were informed of the discharge. Staff told us there were some delays to discharging women and birthing people and their babies which sometimes led to self-discharge without assurance of all required assessments and reviews had been completed.

Midwifery Staffing

The service did not have enough midwifery staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day of inspection midwifery staffing should have been 37 midwives plus 3 supernumerary coordinators for the 24-hour period. However, there were 27 midwives plus 3 supernumerary coordinators on duty.

Staff told us low staffing numbers on duty made them feel unsafe. The delivery suite staff roster for July 2023 and August 2023 showed 299 registered midwives shifts plus 3 delivery suite coordinators remained unfilled. Staffing data for the

maternity ward in July 2023 and August 2023, showed 141 registered midwives shifts remaining unfilled, and in maternity triage for this same period, there were 87 unfilled registered midwives shifts remaining. A review of the service's staff roster showed the maternity unit had 527 unfilled midwifery shifts in July and August 2023 for triage, delivery suite and in the maternity ward.

The service completed a maternity safe staffing workforce review in line with national guidance in February 2023. The "Midwifery Workforce Report" February 2023 showed the service at that time had funded clinical, specialist and management midwives' roles of 172.93 whole-time equivalent (WTE). This was above the report recommendations that midwifery staffing be 158.29 WTE, indicating a positive variance of 14.64 WTE of midwifery staff. Despite this, service leaders and staff told us at the time of inspection they did not have enough midwives because of sickness, challenges with recruitment and maternity leave.

The bi-annual maternity services highlight report dated August 2023, showed a vacancy rate of 20.8 whole time equivalent (WTE) midwives with 13.03 WTE due to commence post in Autumn 2023. This would leave a shortfall of 7 WTE. The service reported challenges in the recruitment and retention of staff but shared successful recruitment planning and several staff were awaiting start dates to bring the service to full midwifery staffing levels.

Data showed that midwifery sickness within the midwifery service was consistently being above the service target of 4%. The sickness rate in May 2023 was 8.3%.

At the time of our inspection the service had added three safe staffing risks to the maternity risk register. Risks included not being able to meet the recommendations of safe staffing within the maternity unit, risk of poor quality and unsafe care provision relating to delayed induction of labour due to increase in induction rate and the unavailability of inpatient Diabetes Specialist Nurses within maternity.

The service told us they had recognised they did not have enough staff to meet safe minimum staffing requirements despite the midwifery workforce review and had ceased further roll out of Midwifery Continuity of Carer (MCoC) in line with national guidance. MCoC is a way of delivery maternity care so that women receive dedicate support from the same midwifery team throughout their pregnancy. However, the service was still able to roll out community midwifery teams which provided enhanced care to vulnerable groups.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Records showed that between January and August 2023 there were 46 red flag incidents. In July 2023, there were 18 red flags incidents, which included 3 episodes when the service was unable to accept any admissions affecting 11 women. Staff recorded all red flags as incidents.

Data showed us that in July 2023 they provided 1:1 care in labour to 96% of women and birthing people. Leaders monitored the midwife to birth ratio via the Maternity Quality Improvement Project Dashboard. Records for July and August 2023 showed this was 26:1 and below (better than) the recommended national standard.

There was a supernumerary shift co-ordinator allocated to be on duty around the clock. Their role was to retain oversight of staffing, acuity, and capacity. However, it was not always possible for the shift co-ordinator to remain supernumerary which meant there was not always clinical oversight of the unit to keep women, birthing people, and babies safe. To support the supernumerary status of the shift co-ordinator, maternity staff had 24hr access to a senior midwifery manager on-call as well as the manager of the day rota.

Maternity

Managers accurately calculated and reviewed the number and grade of maternity support workers needed for each shift in accordance with national guidance. Service leaders told us they had a manager who walked around all clinical maternity areas 3 times a day, to enable monitoring and redeployment of staff around the unit depending on staffing, acuity and the women and birthing people's needs.

The service had a 'recruitment and retention' midwife and a locally developed a standard operating procedure to improve the retention of nursing and midwifery staff called 'Grow and Retain Our Workforce (GROW).'

Leaders described an escalation process when there were staffing issues. Managers calculated and reviewed the number and grade of midwives, maternity support workers needed for each shift in accordance with national guidance. A manager of the day (MOD) was responsible for monitoring staffing and acuity levels every 4 hours, reporting red flag incidents and escalating concerns to the matron who escalated concerns to the deputy head of midwifery. Leaders told us that during times of increased operational pressure staff would follow the 'maternity escalation procedure' and diverted women and birthing people to other maternity services. The service reported 8 service diverts between February 2023 – September 2023 and lack of staffing was the most common cause of the diverts.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice and expected to work in areas unfamiliar to them. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had professional midwifery advocates available to support midwives and staff, in addition to their managers. Midwives and managers told us the midwives had the opportunity to attend supervision sessions.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Managers supported staff to develop through yearly, constructive appraisals of their work for all midwifery registered, and unregistered staff. A practice development team had 2 practice development lead midwives supporting midwives with their learning and appraisals. Data showed 97% of staff had appraisals in the 12 months before the inspection.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep woman and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. Records showed that the service was overseen by 13.61 whole time equivalent (WTE) consultants, 11.7 WTE registrars and 12.38 WTE senior house officers (junior doctors).

A new on call rota was implemented in April 2023 which enabled twice daily ward rounds to reflect the recommendations of the most recent Ockenden (2022) report recommendations.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. This included a locum induction checklist that required sign off. Locums had to demonstrate they had fire safety training, understood the IT systems could access relevant policies, knew how to report incidents, and had completed a health and criminal declaration.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Managers supported obstetric and medical staff to develop through yearly constructive appraisals. A practice development team supported medical staff with learning and appraisals. Data showed 11 medical staff had appraisals in the 12 months before the inspection, 6 were reported as in progress and one person's appraisal had missed the year milestone by days. At time of the inspection, the service told us that the one outstanding appraisal was being arranged.

The service made sure medical staff received any specialist training for their role and ongoing support.

Records

Records were not always up to date, complete and contemporaneous. Paper records were stored securely but due to notes being spread over several paper pages and electronic systems information was not always easily available to all staff providing care.

Managers completed monthly documentation audits and data showed that record compliance varied in each area. For example, in September 2023 an audit of 10 sets of records found that all had been completed accurately. However, the same audit found that staff on the labour ward had an overall compliance of 91% and the reviewed records from the birth centre showed an overall compliance of 74.6%. This was below the trust 95% target. Risk and governance staff monitored maternity care record through case reviews and learning was shared with maternity teams.

The record audit showed medical information was not always shared across the maternity pathway. This could pose a risk to women, birthing people, and their babies. Following our inspection leaders told us that they were developing a new audit programme to develop a better reflective audit process and to improve data collection.

We reviewed 10 sets of records and found they were not always clear and complete. Notes spread over several paper pages and electronic systems created opportunity for omission, inaccuracies, and inconsistencies. This had been recognised by service leaders and was recorded on the risk register.

We found areas where documentation had not been completed in line with trust policy. This included lack of legible notes, incomplete risk assessment, record of carbon monoxide monitoring, theatre checklists, fetal monitoring, and swab counts. Data showed the lack of a robust records management had been previously identified.

Medicines

Medicines were not always stored safely and not all midwives had completed their medicines competency training to safely administer medicines. Expressed breast milk and formula milk was not stored in accordance with national guidance.

Maternity

Staff did not always complete their medicines training in line with trust policy. Leaders told us that there was a clear process for medicines training for each staff group and that midwives should complete a medicines training and competency assessment, however not all midwives had completed this medicine management competency.

Data provided by the service told us midwifery medicines training compliance overall was reported by the service as 94%, just below the service compliance level of 95%, however, the midwifery competency assessment element of the training to be completed by all midwives was reported to be between 63% and 75% in all clinical areas and 100% for midwives in specialist roles. Leaders told us there was no requirement for the competency part of this training, but they had introduced this as good practice.

During the inspection it was observed that medicines were not always stored securely. The inspection team raised these concerns during the inspection, and we were given assurances the issues identified and raised were rectified immediately.

Women and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines.

The pharmacy team supported the service and reviewed medicines prescribed.

Some staff completed medicines records accurately and kept them up to date.

The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents When things went wrong, staff apologised and gave woman and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff told us they knew what incidents to report and how to report them. Managers investigated incidents thoroughly and made sure they were reviewed within safe time frames. Data provided by the trust showed that as of September 2023 there were only 5 open incidents over 60 days since the incident was initially recorded. Managers had oversight of the outstanding incidents and provided clear rationale for the reasons why they remained open.

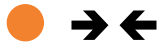
The services most recent 'Maternity Service Highlight report' (April – September 2023) stated that there were no incidents of moderate harm in July 2023 relating to patient care. However, we found examples on the maternity quality

improvement dashboard for July 2023 that could have warranted a moderate score. We noted one incident where a patient lost more than 2.5 litres of blood and required a blood transfusion and 5 reported cases of perineal trauma (also referred to as 3rd and 4th degree tears), which were not mentioned in the report. These incidents were graded as "no harm."

In the last 6 months, the trust has made one referral to the Healthcare Safety Investigation Branch (HSIB) for investigation. The service most recent 'Maternity Service Highlight report' showed that from 6 month prior to the inspection there had been one HSIB referral.

The service had 8 serious incidents reported from 1 February 2023 to 21 August 2023, which included 5 incidents where the maternity services were closed temporarily.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women, birthing people, and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. Leaders were visible and approachable in the service for women, birthing people, and staff. Leaders were well respected, and staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Maternity services were managed as part of the maternity business unit in the division of women's and children's service. The maternity service had a clear leadership structure including a senior leadership team known as "the triumvirate" which included a consultant obstetrician clinical lead, a divisional director, director of midwifery and a clinical director. The service was managed by a divisional director of midwifery and nursing and a head of midwifery. The Divisional director of midwifery and nursing was support by the chief nurse, labour ward lead obstetrician and obstetric maternity safety champion.

The service was supported by two maternity safety champions who were executive and non-executive directors. The safety champions acted as ambassadors for safety and enabled communication from 'floor to board' (in other words from the wards up to the senior management and trust board of directors). They encouraged staff to speak up so they could gather their feedback to improve on the service.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Maternity

Service leaders supported midwives in showing outstanding care, assisting with problems beyond their usual workload and duties to support refugees new to the United Kingdom. This included changing the service to meet the holistic needs of the refugees to reduce health inequalities.

Leaders regularly held meetings to review the service governance processes. Where applicable the service worked with external partner organisations. Decisions made at meetings would then be shared with frontline staff via leadership channels.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to implement them.

The service had a comprehensive vision for what it wanted to achieve and a precise and well-organised strategy to turn it into action, developed with all relevant stakeholders. The maternity strategy and vision were published in 2022 and provided a 3-year plan up to 2025. The service's main objectives were providing a safe and high-quality service, in partnership with local families, patients and communities. The strategy included investing for the future with a culture for learning, improvement, addressing health inequalities, and working with service users to include local maternity initiative for integrated working.

The vision and strategy demonstrated the service's understanding of the local population. They had developed the vision and strategy in consultation with staff at all levels, and staff could explain the vision and what it meant for women, birthing people, and babies. The strategy contained specific actions to identify and tackle health inequalities that affected the local population.

The service was part of the northwest regional maternity team who supported the Local Maternity and Neonatal System (LMNS) and maternity providers to deliver visions set out in line with national plans and guidance.

The services maternity triumvirate leadership team assessed the service against this strategy and updated the board through the patient safety group and quality committee.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families, and staff could raise concerns without fear.

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues or when things went wrong.

Maternity

Results of the 2022 NHS Staff Survey were mostly positive. Staff described a positive and friendly culture where managers and colleagues were kind, caring, and showed respect for individual differences. However, the survey showed staff had concerns about staffing and excessive workload impacting on staff taking breaks in a reasonable time frame. Staff felt that they were valued by senior management but had wished to have additional access and visibility of their senior management which was actioned by the senior leadership team. Following suggestions by staff the senior leadership now had regular walk rounds to meet staff, women, birthing people, families, and volunteers. The service regularly shared newsletters with staff. The service had introduced a 'manager of the day' (MOD), huddle meetings and a feel-good Friday initiative. Feedback, including compliments from women were shared with staff.

Leaders had recently introduced 'civility training' which promoted respectful and considerate behaviour on the part of all members of the workforce and team building events to encourage and provide a positive team working environment. Staff told us they welcomed this training.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed women and birthing peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service made plans and took action to reduce inequalities and improve outcomes, they produced a standing operating procedure (SOP) for 'Reducing inequality in Black, Asian and minority ethnic communities during the perinatal period'. They collected specific maternity data which enabled them to map services in relation to local population and deprivation utilising postcodes to level out perinatal outcomes for women and birthing people. The effectiveness of this had not yet been evaluated by service leaders at the time of inspection.

A community midwife was appointed as a designated cultural & diversity champion. They delivered mandatory training to the maternity workforce, including training which was designed to address issues relating to unconscious bias, and cultural sensitivity.

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to make a complaint or raise concerns. Staff understood the policy on complaints and knew how to handle them. Complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Women and birthing people received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes, shared feedback with staff, and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. The trust policy was to process, respond and close complaints within 25 days. Between July and September 2023, the service received 9 formal complaints, and 8 of these were managed in a timely way according to trust policy.

Maternity

The trust submitted data to the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). In WRES data 2022, 4 out of 9 metrics showed statistically significant differences between white staff and staff from ethnic minority groups. This indicated poorer working experiences for staff from "all other ethnic groups at the trust" compared to the "white staff at the trust". WRES data was discussed at the people performance committee meetings and worked into the service vision and strategy. WDES data showed notable differences between the experiences of staff with a long-term condition or illness compared to staff without. This indicated poorer working experiences for staff with long-term conditions or illnesses.

Governance

Leaders mostly operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service assessed, monitored, and improved the service through audits and then implemented actions and mitigations to reduce risks. However, there were some missed opportunities to ensure all parts of the service were monitored. For example, the service did not always recognise themes and trends and complete action plans to prevent recurrence including post-partum haemorrhage (PPH) and 3rd and 4th degree trauma. Nevertheless we found the service had a governance structure that supported the flow of information from frontline staff to senior managers.

Governance oversight needed to be improved to ensure all aspects of care were safe for women and that best practice was followed.

The senior leadership team held maternity and divisional governance meetings to plan and develop actions to improve the service. Minutes of meetings showed discussions included divisional objectives, senior medical vacancies, and performance review.

Monthly divisional governance and risk meeting were held, and this fed into the divisional quality board and trust boards. The leaders had an ongoing improvement, performance, and safety plan to give assurance through the directorate and division to the board. Leaders told us that they had strengthened the divisional governance programme.

The senior leadership team, including the executive director, had a weekly 'walk around'. This enabled them to engage with staff, women, birthing people, and their families and to seek their views to inform practice and patient care.

There were monthly maternity and women's health governance group meeting minutes which showed leaders discussed any service issues in both obstetrics and gynaecology. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service. The leaders told us they monitored the maternity improvement plan, key performance indicators, discussed incidents, baby loss, and any hot topics to improve the service. This meeting also evidenced service user feedback was obtained, however no actual action plans were reviewed at this meeting.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. We noted that induction of labour guidance (Greater Manchester & Eastern Cheshire Maternity Strategic Clinical Network Induction of Labour Guidance, Stockport NHS Foundation Trust version 1) had been updated but it was not in line with most current national guidance to promote best practice. At the time of inspection, the service did not have an agreed induction of labour guidance ratified for use, instead the service was working to a regional Greater Manchester & Eastern Cheshire Maternity Strategic Clinical Network guideline which was not owned by the service.

Management of risk, issues, and performance

Leaders did not always carry out audits to identify themes and trends to identify where improvements were needed. However, they identified and escalated relevant risks and issues.

The service did not always ensure all relevant audits had been completed and there was a lack of effective sharing of audit results to drive improvement. This meant there was a possibility that learning opportunities could be missed and failure to identify themes and trends to drive improvement.

Leaders did not identify all risks as the service did not complete local audits on the use of the neonatal early warning track and trigger tool (NEWTT) trigger system, Maternity Early Warning Score (MEWS), triage audit, sepsis or audited the safety and effectiveness of handover processes (situation, background, assessment, recommendation (SBAR) audit). All of which would inform the service and help understand areas needing improvements.

The service mostly captured performance and indicator data on their “Maternity Dashboard” to monitor and improve outcomes. This included the recording of the perineal trauma rate of 3rd and 4th degree trauma/ tears which the service reported to NHS Digital National Maternity Dashboard. In September 2023 the service reported 34 incidents of 3rd or 4th degree tears per 1000 births, which was significantly higher than the national average of 24 incidents per 1000 births reported by NHS Digital. Data provided by the service showed the service was consistently above the national rate with the highest rate reported in 2023 with 43 per 1000 births compared to national average of 26 per 1000 births.

The leadership team did not always oversee timely completion of required actions to make changes where risks were identified including action identified relating to infection prevention control, and record keeping.

The service provided a clinical audit programme for 2023 to 2024 to indicate the current status of compliance with national audits. The programme included the use of antenatal risk assessments and smoking cessations audits, as well as national audits such as the national maternity and perinatal audit. However, the clinical audit programme showed were no completed audits for each quarter of 2023 to 2024 and the service did not provide evidence to show recent audits had been completed. The service told us there were current delays with submitting information to national audits due to service pressures. Following the inspection, the service told us they were consistently submitting to the National Pregnancy in diabetes audit and the most recent report was published in October 2023.

Leaders told us they reviewed and audited data about Avoiding Term Admissions to the Neonatal Unit (ATAIN). Data showed that between April and June 2023, there were 32 babies admitted to the neonatal unit and the audit identified 6 avoidable neonatal unit admissions. ATAIN was previously audited by the service for the period between January 2023

and March 2023 where the review concluded there were 29 admissions to the neonatal unit of which 3 were potentially avoidable. The service had created an action plan (dated 1st August 2023); which showed all actions has been completed. However, despite actions that had been taken to reduce admissions to the neonatal unit due to respiratory distress syndrome (RDS), this continued to be an ongoing theme of avoidable admissions since January 2023.

The maternity dashboard included details of reducing smoking during pregnancy. Data from September 2022 to August 2023 showed staff compliance for carbon monoxide (CO) screening at booking was consistently above the service target of above 95%. The number of women and birthing people smoking at booking had decreased significantly by delivery each month from November 2022 to August 2023. CO screening was also audited through the 'saving babies lives' action plan. The plan identified that in June 2023, CO monitoring at 36 weeks compliance was 89.6%, which did not meet the service target of 95%. However, the service identified that there had been a sustained improvement in monitoring of CO at 36 weeks and the service had been above 80% compliance for the last 6 months. The service reported that further work was ongoing improve compliance and reach the target of 95%.

The service audited cardiotocograph (CTG) fetal monitoring and fresh eyes in line with guidance and Ockenden recommendations. Where issues were identified, action plans were in place to monitor and improve the quality of the service. The 10 care notes we reviewed, were completed in full in relation to CTG monitoring.

Leaders monitored readmissions to the obstetric unit and women and birthing people re-attending the service within 30 days of delivery. Records showed that during July 2023 there were 23 readmissions from 239 registerable births (9.6%) compared a national average of 3.3% showing the service to have a higher than national readmission rate. These readmissions were not recorded on the service maternity dashboard. The service did not have action plans to reduce women, and persons postnatal readmissions.

Staff did not always report post-partum haemorrhages (PPH) on the electronic incident recording system. The NHS national maternity dashboard reports "major obstetric haemorrhage" as a volume of 1500 millilitres (mls) or more, however the service reported on their local dashboard "massive post-partum haemorrhages" of only of 2500mls or more.

The service told us that their top risks included staffing, delayed induction of labour and delayed caesarean sections due to poor theatre capacity. The risk register showed mitigating actions and forward planning with clear dates for review. Between April 2023 – August 2023 there were 13 days of multiple episodes when inductions of labours and augmentation of labours were delayed, including delays to high-risk pregnancies and delays to category two emergency caesarean sections. We saw in one case the delay was more than 4 hours despite national guidance of "performing category 2 caesarean birth (which is not immediately life-threatening) as soon as possible, and in most situations within 75 minutes of making the decision" to proceed with a caesarean birth. We also found one occasion where there was a 3-hour delay in a woman, birthing person having an instrumental delivery and 5 cases during this time frame when women did not receive 1-1 care in labour.

Service leaders recognised a problem with patient flow through the unit which affected the service. The service told us they had a 'Manager of the Day' to have oversight, ease pressures and effectively manage these issues by visiting areas 3 times a day.

The service had reported 46 delays in care from January 2023 to August 2023 due to staffing and acuity but there was no evidence the service followed the maternity escalation policy and operational pressures escalation guidance to reduce delays for all these incidents. No risk assessment tool was seen to have been completed in the cases of delays in care during the inspection.

Maternity

The service had a low rate of stillbirth compared with the national average and there were robust processes for recording and managing investigations through the national standardised Perinatal Mortality Review Tool (PMRT) pathway. The PRMT tool supported objective, robust and standardised reviews of baby deaths to provide answers for bereaved parents. When improvements were required, these were implemented swiftly by service leaders.

The service worked to co-produce a homebirth emergency training day with the local ambulance service which provided an opportunity for professionals to collaborate and learn together and improve patient care. The training day was also open to external professionals working within the local maternity and neonatal system.

Service leaders told us they had implemented "Stockport Accreditation & Recognition System" (StARS) is designed to measure the quality of care provided by individuals and teams throughout the trust it incorporates key clinical indicators and supports the service in improving standards and providing evidence for the CQC 14 fundamental standards evidenced in action plans.

Information Management

The service collected data and analysed it. Staff could mostly find the data they needed to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. However, staff used several paper and electronic systems and patient records were not always complete which impacted finding and analysing accurate data.

The service collected data and analysed it. They had a live dashboard of performance data which was accessible to senior managers. Key performance indicators were displayed for review and managers shared this information with the regional Greater Manchester and Eastern Cheshire Strategic Clinical Networks.

Staff could mostly find the data they needed to understand performance, make decisions and improvements. However, as records were not always completed in full, this impacted on leadership ability to monitor performance. The service used paper records, electronic patient record system and clinical computer systems, staff told us that they had ongoing concerns regarding the systems. Although staff told us information and data needed could be mostly found, the service recognised risks with the systems and there was an ongoing action to review the digital information systems. The service had a digital strategy and relevant personal employed to improve digital provision in line with national guidance.

The service provided all maternity staff with digital news updates via "Maternity DigiNews", giving updates on the digital transformation and quality improvements with the aim of alleviating issues and risk in information management.

Data and notifications were consistently submitted to external organisations as required including NHS Digital.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local maternity voices partnership (MVP) to contribute to decisions about care in maternity services. Local MVP co-chairs told us they had a positive working relationship with staff and a positive appetite for

change and improvement at the service. MVP meeting minutes showed progress against strategic actions on the workplan which covered a comprehensive task list. This included but was not limited to engagement, patient information, and strategy group meetings. MVP representatives were invited and attended service meetings including perinatal mortality reviews, perinatal mental health meetings, and maternity & maternal voice meetings.

The service work collaboratively with the MVP to develop a closed communication group using technology to improve communication within the network. The aim was to improve maternity services and encourage positive service development between the maternity service managers and the MVP.

The MVP representatives told us they had been working to develop a more inclusive organisation which represented the local population. They told us they worked with partners and families to make sure the voices of women, birthing people and their family were heard. The MVP aimed to build links with community leaders, vulnerable groups and hard to reach groups within the local community to breach the gaps in health inequalities.

The MVP representatives informed us they had identified a disconnect between the maternity services and women and birthing people with a pregnancy loss prior to 16 weeks gestation. It was their aim to improve this and ensure that the voices of these women and birthing people were heard.

The service made interpreting services available to women and birthing people and collected data on women and birthing people's ethnicity. This was considered in their care planning, and in the review of incidents and outcomes. Leaders understood the needs of the local population and tailored services according to them.

The service worked with local stakeholders to improve maternity outcomes and experiences of women and people using the service. The was a focus on people who faced inequality because of their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation, and disability.

We received two responses to our give feedback on care posters which were in place during the inspection. Both responses were positive.

Learning, continuous improvement and innovation

Staff told us they were committed to learning and improving services. Leaders supported staff to develop and to innovate the service, implement changes and improvements to meet service needs.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Staff told us the service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

Staff told us there were several quality improvement programmes in progress including a focus on health inclusion, inequalities, and deprivation which had led to development of new community outreach clinics and partnership working with local refugee populations.

Midwives and leaders worked collaboratively with the local agencies where women, people and babies were being supported with a multi-agency approach to meet all essential needs such as housing, health, and community support. The service recognised the benefits of developing this model of enhanced care and the community midwives provided continuity of care where required.

Maternity

The service community midwives had been recognised for a unique service of providing safe and equitable care with enhanced care pathways and engagement. This service ensured there was an interpretation service at each and every contact they had with vulnerable women and birthing people. The enhanced pathway included provision of care and support for woman, baby, and the wider family. The service provided evidence of excellent service user feedback.

The service was a finalist at the Heath Service Journal awards 2023, recognising the midwifery service working to support refugees. One midwife and team of community midwives received recognition for their work with refugees in Stockport, specifically focused on promoting equality and diversity for staff and patients, tackling health inequalities, improving outcomes, experience, and health. This group of community midwives provided support to other vulnerable groups including pregnant teenagers, pregnant substance misuser with a large awareness drive on alcohol use and mental health needs adapting Midwifery Continuity of Carer MCoC to “enhanced care” adapting personalised care case by case including labour care when able.

Two individual midwives and the perinatal mental health team in 2022 received awards from chief midwifery officer. The service had received a recognition award for the ‘maternity perinatal mental health team’, for their “walk into wellbeing” initiative to provide support to new parents during and beyond the pandemic. The service maternity leadership team were recognised nationally for their work in reducing term admissions to the neonatal unit in September 2022.

Community midwives had specifically focused on promoting equality and diversity for staff and patients, tackling health inequalities, improving outcomes, experience, and health. This group of community midwives provided support to other vulnerable groups including pregnant teenagers, pregnant substance misuser with a large awareness drive on alcohol use and mental health needs adapting Midwifery Continuity of Carer MCoC to “enhanced care” adapting personalised care case by case including labour care when able.

The service had received a recognition award for the ‘maternity perinatal mental health team’, for their “walk into wellbeing” initiative to provide support to new parents during and beyond the pandemic. The service maternity leadership team were recognised nationally for their work in reducing term admissions to the neonatal unit in September 2022.

Outstanding practice

We found the following areas of outstanding practice:

- Midwives at this service have recognised the need to develop an enhanced care pathway to support refugees and other vulnerable groups such as pregnant teenagers and women and pregnant people living with addiction. Midwives have won awards and recognition nationally in creating this service. The midwives have also implemented a transport service to ensure women and birthing people who lived in areas that had difficult access to the hospital, could attend scans and appointments more easily to reduce missed appointments.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

Stockport NHS Foundation Trust Maternity Services

- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (e)
- The services must ensure staff comply with systems in place to ensure risks are identified and acted upon in a timely manner. This includes but not limited to compliance with accurate interpretation and escalation of electronic fetal monitoring. Regulation 12 (2) (a) (b)
- The service must ensure there are effective governance systems and processes to identify and manage incidents, risks, issues, and performance and to monitor progress through completion of audits, action plans and oversight of improvements and reduce the recurrence of incidents and harm including postpartum haemorrhage PPH and perineal tears & trauma. Regulation 17 (2) (a) (b)

Action the trust SHOULD take to improve:

Stockport NHS Foundation Trust Maternity Services

- The service should ensure staff on the birth centre complete all mandatory training.
- The service should ensure stored breast and formula milk is labelled and stored correctly and in line with national guidance.
- The service should continue to minimise and mitigate the impact of short staffing.
- The services should continue to review and improve patient record keeping ensuring all staff have easy access to patient information they need.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors, one obstetric specialist advisor, and two midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care

CQC Action Plan

Stockport NHS Foundation Trust

BLUE	Action successfully achieved.
GREEN	Successful delivery of the action is on track and seems highly likely to remain so; there are no major outstanding issues that appear to threaten delivery
AMBER	Successful delivery of the action is likely to be off track, however with corrective action and management attention issues are resolvable and achievement of action feasible.
RED	Successful delivery is significantly behind schedule/ off track and no progress has been made, and/or progress has been made but the timescale has not been achieved.

Version 1: 15.5.2024

Must Do 1: The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (e)							
Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence Available
Resus Trolley Birth centre/Triage -Daily checks to be completed and documented by ward manager/ shift leader.	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round. Where none compliance is identified this will be incident reported.		Matrons/Ward managers		
Resuscitaires Birth centre/Triage Daily checks to be completed and documented by ward manager/ shift leader.	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round. Where none compliance is identified this will be incident reported.		Matrons/Ward managers		

Resus Trolley Delivery Suite Daily checks to be completed and documented by ward manager/ shift leader on the Delivery suite	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round. Where none compliance is identified this will be incident reported.		Matrons/Ward managers		
Resuscitaires Delivery Suite Daily checks to be completed and documented by ward manager/ shift leader on the Delivery suite	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round.		Matrons/Ward managers		

			Where none compliance is identified this will be incident reported.				
Resus trolley Ward M2 Daily checks to be completed and documented by ward manager/ shift leader.	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round. Where none compliance is identified this will be incident reported.		Matrons/Ward managers		
Resuscitaire Ward M2 Daily checks to be completed and documented by ward manager/ shift leader.	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walk round. Where none compliance is identified this will be incident reported.		Matrons/Ward managers		
Antenatal Clinic Resus Trolley Daily checks to be completed and documented by ward manager/ shift leader on the Antenatal clinic	100% of daily checks will be completed and documented	**31 May 2024**	Assurance received during fortnightly peer review walkround.		Matrons/Ward managers		

			Where none compliance is identified this will be incident reported.				

Must Do 2: The services must ensure staff comply with systems in place to ensure risks are identified and acted upon in a timely manner. This includes but not limited to compliance with accurate interpretation and escalation of electronic fetal monitoring. Regulation 12 (2) (a) (b)

Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence
Monthly fresh eyes audit to take place in relation to cardiotocography (CTG)	Minimum 90% compliance each month	**31 May 2024**	Fresh eyes audit is reported within the audit system 'AmAT'. Audit outcome to be reported to the Divisional Quality Group.		Sarah Young		
Monthly NEWTT's audit to be introduced.	Minimum 90% compliance each month.	**31 May 2024**	NEWTT's audit to be reported within the audit system 'AmAT'. Audit outcome to be reported to the Divisional Quality Group.		Sarah McManus		
Monthly SBAR audit to be introduced	Minimum 90% compliance each month.	**31 May 2024**	SBAR audit is reported within the		Sarah McManus		

			audit system 'AmAT'. Audit outcome to be reported to the Divisional Quality Group.				
Monthly MEWS audit to be introduced	Minimum 90% compliance each month.	**31 May 2024**	MEWs audit is reported within the audit system 'AmAT'. Audit outcome to be reported to the Divisional Quality Group.		Sarah McManus		
Service to continue to comply with ongoing national audit submissions including but not limited to the national pregnancy in diabetes audit and national maternity and perinatal audit.	All submissions to national audit completed and reported via Clinical Effectiveness Group	**31 May 2024**	Assurance in relation to national audits will be shared at Divisional Quality Group and Clinical Effectiveness Group		Diabetes specialist midwife Obstetric Lead Audit lead		

Must Do 3: The service must ensure there are effective governance systems and processes to identify and manage incidents, risks, issues, and performance and to monitor progress through completion of audits, action plans and oversight of improvements and reduce the recurrence of incidents and harm including postpartum haemorrhage PPH and perineal tears & trauma. Regulation 17 (2) (a) (b)

Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence
Correlation of PPH incidents and 3/4th degree tear incidents	All PPH incidents and 3rd and 4th	**31 May 2024**	Failsafe reported through risk		Sarah Karsa Steph Bray		

to make sure numbers are consistent within dashboard and incident reporting system	degree tears are reported within Datix. Total numbers each month on the RCOG dashboard and incident system are consistent.		and governance meeting				
Shared learning of PPH themes across MDT	Record of all learning and actions from reviewed PPH >1500mls Share via safety huddles and PROMPT study days. Outcome of QI project.	**31 May 2024**	Reduction in PPH >1500MLS Monitored through RCOG dashboard		Sarah Karsa Suzanne Whitehead		
Shared learning of 3rd and 4th degree tears themes across MDT	Record of all learning and actions from reviewed 3rd and 4th degree Share via safety huddles and PROMPT study days.	**31 May 2024**	Reduction in 3rd and 4th degree tears. Monitored through RCOG dashboard		Sarah Karsa Suzanne Whitehead		
Should Do 1: The service should ensure staff on the birth centre complete all mandatory training.							
Action	Measure of	**Deadline**	Assurance	RAG	Action Lead	Progress Update	Evidence

	Success			Status			
All staff on the birth centre to complete all statutory and mandatory training within required timescales.	Minimum compliance to training is at 90%.	**31 May 2024**	Assurance received through monthly training report and monthly HR update meeting.		Helen Hurren Maternity Training Team		
All relevant staff on the birth centre to complete Adult Safeguarding Training Level 3	Minimum compliance to training is at 90%	**31 May 2024**	Assurance received through monthly training report and monthly HR update meeting.		Helen Hurren Maternity training team		
All relevant staff on the birth centre to complete Children's Safeguarding Level 3.	Minimum compliance to training is at 90%	**31 May 2024**	Assurance received through monthly training report and monthly HR update meeting.		Helen Hurren Maternity training team		
Should Do 2: The service should ensure stored breast and formula milk is labelled and stored correctly and in line with national guidance.							
Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence
Introduction of daily checks of the storage of breast and formula milk to include safe labelling and storage, within the daily checklist.	100% compliance	**31 May 2024**	Assurance received during fortnightly peer review walkround. Where none		Matron/Ward managers		

			compliance is identified this will be incident reported.				
Should Do 3: The service should continue to minimise and mitigate the impact of short staffing.							
Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence
Manager of the day to monitor daily staffing and undertake ongoing weekly staffing review. Timely roster completion.	Safe staffing levels across Maternity unit	**31 May 2024**	Report x 3 daily MOD report. Compliance with roster KPI's Maternity red flags monitored through risk and governance meetings. Reduced Vacancy rate. Reduction in maternity unit diverts related to staffing.		Divisional Director of Midwifery/ Deputy HOM		
Ongoing Recruitment and Retention plan to inform safe staffing across Maternity	Safe staffing levels across Maternity unit Turnover rates in line	**31 May 2024**	Reduced sickness Reduced vacancy rate		Divisional Director of Midwifery/ Deputy HOM/R&R midwife		

	with Trust targets. Reduced sickness levels due to work related stress.						

Should Do 4: The services should continue to review and improve patient record keeping ensuring all staff have easy access to patient information they need.

Action	Measure of Success	Deadline	Assurance	RAG Status	Action Lead	Progress Update	Evidence
Monthly record keeping audit is completed and where compliance is less action plans to be in place and monitored through directorate risk and governance meeting.	Minimum compliance to audit is at 90% in each area.	**31 May 2024**	Record keeping audit is reported within the audit system 'AmAT'. Audit outcome to be reported to the Divisional Quality Group.		Matrons/Ward managers		

NHS Stockport NHS Foundation Trust

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	16
Meeting	Board of Directors				
Report Title	Quality Strategy Annual Progress Report 2023/2024 & 2024/25 Objectives				
Director Lead	Nic Firth Chief Nurse	**Author**	Wendy Oakes, Quality Matron Carole Sparks, Assistant Chief Nurse		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	Board of Directors is asked to acknowledge the content of the report and the progress made to date against the Quality Strategy objectives for 2023/24 and the Objectives set for 2024/25.					

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
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
	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 provides Quality Committee with the end of year (2023-2024) update against the Trust Quality Strategy (2021-2024). It also includes Objectives for 2024-25.

The strategy outlines how the Trust will be driving change on our improvement journey to deliver on our ambition to:

• Start well – Improve the first 1,000 days of life

• Live well – Reduce avoidable harm

• Age well – Reduce avoidable harm

• Die well with dignity – Improve the last 1,000 days of life

There have been objective measures set with tangible outcomes for certain elements of the strategy, e.g. there have been annual targets set for reduction of Falls/Infection Prevention Control/Sepsis and Pressure Ulcers. The RAG score is attached to show the achievement for the year 2023-2024.

For other metrics it is recognised that a longer programme of work is required to enable achievement of the desired outcome, this may include achievement of national standards or programmes of work, or implementation of a revised care pathway for example. Again, the RAG score applied will reflect progress since the implementation of the Quality Strategy in 2021 to current date.

In addition, the historical narrative has been retained with the report to highlight progress made over time.

The quality objectives for 2024-2025 are also included. There have been objective measures set with

tangible outcomes for certain elements of the strategy, e.g. there have been new annual targets set for reduction of Falls/Infection Prevention Control/Sepsis and Pressure Ulcers. Again, for other metrics the desired outcome, may include achievement of national standards or programmes of work, or implementation of a revised care pathway for example.

1. Purpose

1.1 We have made improvements to many services over the last few years, and we are clear in our commitment to continue to strive to deliver excellent, safe, effective and compassionate treatment and care.

1.2 Our goal is to be recognised as an outstanding organisation, and we aim to demonstrate that the care and treatment delivered by all our staff is of the best quality possible. We want to make sure that the high quality and safe care we aim to provide is recognised externally by our partners and colleagues because it has become business as usual. The Quality Strategy 2021-2024 describes the blueprint for our journey; it makes our objectives clear and sets timescales and performance indicators along the way.

This report describes progress against the Quality Strategy objectives for the year 2023/24 and the Objectives for 2024/25.

2. Introduction / Background

2.1 In February 2020, the Trust underwent an unannounced Care Quality Commission (CQC) inspection of our Urgent and Emergency Services, Medical Care, Maternity and Services for Children and Young People between 28 January to 27 February 2020. The report was published May 2020 and found the Trust to be “Requires Improvement”, overall.

2.2 At times we need to be responsive, reactive, and agile, taking immediate actions however, we need to make sure that these actions are sustainable and have a long-term positive impact. Our Quality Strategy builds on the work our teams have done to date and complements the new governance and assurance infrastructures that have been established since its inception.

3. Matter under consideration

3.1 Driving change on our improvement journey

To deliver on our ambition to:

- Start well – Improve the first 1,000 days of life
- Live well – Reduce avoidable harm
- Age well – Reduce avoidable harm
- Die well with dignity – Improve the last 1,000 days of life.

3.2 Quality Metrics Year End Update (2023/2024)

Metric	Measure	Update	
Start well – improve the first 1,000 days of life			
Reduction of perinatal mortality in line with the national ambition to halve the rates of still births, neonatal and maternal deaths and intrapartum brain injuries by 2025.	Full compliance of all 5 elements of Saving Babies Lives Care Bundle version 2 (SBLCBv2).	**Year End Update May 2024** Fully compliant with SBLCBv2	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Remain fully complaint with SBLCBv2. SBLCBv3 launched June 2023 and includes a 6th element on the management of pre-existing diabetes in pregnancy. As part of the 3 year delivery plan for maternity and neonatal services, the trust is responsible for implementing the new version by March 2024. Compliance will be monitored through Quality Committee	
		Year 2 (2022-2023) **December 2022** Fully compliant in all 5 elements, trust compliance monitored through Quality Safety and Improvement strategy group. Awaiting the launch of SBLCBv3 to benchmark against, no date yet for launch	
		September 2022 Fully compliant in all 5 elements, trust compliance monitored through Quality Safety and Improvement strategy group.	
		Year 1 (2021-2022) Fully compliant in all 5 elements, trust compliance monitored through Quality Safety and Improvement strategy group.	

Metric	Measure	Update	
Reduction in the number of women smoking at the time of delivery (SATOD).	To achieve the national target of 6% for SATOD.	**Year End Update May 2024** Average SATOD rate at year end is 5.8%	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Average SATOD year to date is 5.9%	
		Year 2 (2022-2023) **December 2022** Average SATOD year to date is 7.8%	
		September 2022 Average SATOD year to date is at 7.6%	
		Year 1 (2021-2022) Average SATOD is 8.4% for 2021-2022	
NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.	Full compliance with all 10 safety actions of CNST.	**Year End Update May 2024** Fully compliant with Year 5 CNST, submitted to Trust Board and the ICB Board 1st February 2024	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Fully compliant with all 10 safety actions for CNST year 4. The service is currently working towards CNST year 5, due to be submitted to MIS 1st February 2024 following Trust Board and ICB Board approval	
		Year 2 (2022-2023) **December 2022** Continue to work towards Year 4 submission, due to be submitted to MIS 2nd February following Trust Board and ICB approval.	
		September 2022 Working toward year 4 submission for January 2023.	

Metric	Measure	Update	
		Year 1 (2021-2022) Full compliance achieved of all ten standards. Year 4 relaunched 6th May 2023, declaration to board is due January 2024	
Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision Is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.	75% of the services BAME/ vulnerable women to be booked onto COC pathway.	**Year End Update May 2024** Year end average of both the services ethnic minority women and women in the bottom decile of deprivation at 29 weeks booked onto a CoC pathway is 64%. The Trust remains committed to the development of MCoC. In the absence of national targets for MCoC the trust continues to establish a model of AN and PN continuity for all women and families including a named midwife, a low risk offer for intrapartum care utilising the birth centre, a successful home birth service and enhanced MCoC offer to the most vulnerable families including young parents and asylum seekers.	RAG SCORE AMBER
		Year 3 (2023-2024) Interim Update **November 2023** The trust remains committed to the development of MCoC. In the absence of national targets for MCoC the trust continues to establish a model of AN and PN continuity for all women and families including a named midwife, a low risk offer for intrapartum care utilising the birth centre, a successful home birth service and enhanced MCoC offer to the most vulnerable families including young parents and asylum seekers. Average year to date; 57% of the services ethnic minority women at 29 weeks booked onto a CoC pathway. 68% of the services women in the bottom decile of deprivation at 29 weeks booked onto a CoC pathway.	
		Year 2 (2022-2023) **December 2022** All trusts received a letter from NHSE on 21 September 2022 regarding essential and immediate changes to the national maternity programme in light of the continued workforce challenges that maternity services face. As a result, there is no longer a national target for Midwifery Continuity of Carer (MCoC), this will remain in place until all maternity services in England can demonstrate sufficient safe staffing levels to do so.	

Metric	Measure	Update	
		The trust can meet the safe minimum staffing requirements for existing MCoC provision, including our vulnerable team, however has ceased further roll out of planned teams as outlined in our trajectory as this is dependent on further investment and recruitment of midwifery staffing. A single plan is expected from the national team at the end of March 2023 which is expected to provide further information and an update of plans for MCoC.	
		September 2022 **Average year to date;** 49.3% of the services BAME population booked onto a CoC pathway. 55.4% of vulnerable women booked onto a CoC pathway.	
		Year 1 (2021-2022) 54.6% of the services BAME population booked onto a CoC pathway 67.2% of vulnerable women booked onto a CoC pathway.	
The Ockenden report was published in 2020 and highlighted immediate and essential actions for maternity services to put in place.	To be compliant against all immediate and essential actions.	**Year End Update May 2024** Fully compliant with all Ockenden immediate and essential actions	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** The trust continues to be fully complaint with the immediate and essential actions and is working towards the 4 themes to be concentrated on in the 3 year delivery plan	
		Year 2 (2022-2023) **December 2022** The trust continues to work towards the 15 IEA's from the final Ockenden report. A national single plan is due in Spring 2023 which will incorporate Ockenden, East Kent	
		September 2022 The trust are compliant with the 7 Immediate and Essential actions (IEA's) following recruitment of 2 consultants and the introduction of LMS reporting template for MDT training. The trusts are working towards full compliance of the 15 IEA's highlighted in the final Ockenden report.	

Metric	Measure	Update	
		Year 1 (2021-2022) Out of the 7 Immediate and Essential actions (IAE's) the trust remain partially compliant with . **Staff training and working together** • Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week **Fully compliant** - Monday to Friday **Partially Compliant** - Saturday and Sunday until the new consultant commences June 2022, further interviews planned for May 22 this will enable full compliance. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year **Compliant -** Multi disciplinary team training. **Partially Compliant** Report to LMS 3 times per year – Submission document in draft with LMS awaiting final ratification due in May 22	
Avoiding term admissions into the neonatal unit	To have < 4% of all term births being admitted to the neonatal unit.	**Year End Update May 2024** Year end 5.6%, weekly MDT continues to review all babies admitted to NNU plus 37 weeks to establish any learning for those avoidable admissions.	RAG SCORE AMBER
		Year 3 (2023-2024) Interim Update **November 2023** Quarterly audits in line with CNST continue to be submitted to the LMNS. Action plan is in place to continue to reduce the number of term admissions to the neonatal unit.	
		Year 2 (2022-2023) **December 2022** Review MDT embedded in practice Audits undertaken in line with CNST requirements and shared with the LMNS	
		September 2022 MDT review commenced of all term admissions to review themes and action learning. Clear Governance process identified	

Metric	Measure	Update	
		Year 1 (2021-2022) Working towards compliance- MDT review commenced of all term admissions to review themes and action learning	
Implementation of the neonatal critical care review.	Expert neonatal workforce Enhancing the experience of families.	**Year End Update May 2024** The consultant gap has been recruited to, with an interim plan in place to support the rota until successful candidates commence in post. (September 2024)	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** The nursing workforce are fully compliant to BAPM standards, a business case has been submitted to support the junior medical rota, the Consultant gap is now out to recruitment.	
		Year 2 (2022-2023) **December 2022** Compliant to BAPM for nursing staff, identified gaps for medical staff remain with action plan in place.	
		September 2022 Neonatal Network review completed, still awaiting Neonatal Critical care review.	
		Year 1 (2021-2022) Still awaiting date for review, preparation on going	

Metric	Measure	Update	
To reduce unnecessary hospital admissions for children and young people particularly those who have long term conditions such as Asthma, Diabetes and Epilepsy.	Supporting CYP and their families to maintain wellness and manage their health needs within the community setting.	**End of Year Update May 2024** The focus for GM 2024/2025 in line with Core20PLUS5, continues to be Asthma, Epilepsy, Diabetes, Oral Health and Mental Health.	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Identified NHSE funding levelling up monies for Epilepsy funding as yet not released – this will help support the teams to achieve BPT	

Metric	Measure	Update	
		Year 2 (2022-2023) **December 2022** Diabetes transition pilot underway. Transition working group established.	
		September 2022 Benchmarking service against NICE Guidance. Service review ongoing.	
		Year 1 (2021-2022) Working closely with GM to review data and pathways. New Nice guidance for CYP with epilepsy under review.	
To ensure that transition of care for young people to adult services meets their needs and ensures continuity of high care.	Seamless transition to adult services.	**End of Year Update May 2024** Epilepsy and Diabetes transition work continues with support from transformation services. The Diabetes transition team have successfully recruited to a transition specialist nurse and youth worker as part of the supported project with NHSE.	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** The transformation team are supporting the wider teams to review and develop robust pathways to support transition of care for young people to adult	
		Year 2 (2022-2023) **December 2022** Virtual ward develop across the paediatric, medical and community teams as part of this is an ongoing project	
		September 2022 Diabetes teams, Adults and Paediatrics have been awarded funding from GM to commence Transition pilot.	
		Year 1 (2021-2022) Particular focus across GM for SEND, clear focus on ICS forward plan and strategy	
For neonatal unit to become a Baby Friendly accredited unit.	Aim to achieve stage 1 of the accreditation	**End of Year Update May 2024** Preparation continues for the Baby friendly accreditation, alongside the	RAG SCORE AMBER

Metric	Measure	Update	
	process.	Maternity services. This is an external assessment with no confirmed date for assessment at present. The Neonatal Unit achieved Green in the Family Integrated Care re accreditation in December 2023.	
		Year 3 (2023-2024) Interim Update **November 2023** Re accreditation December 2023 for Ficare.	
		Year 2 (2022-2023) **December 2022** Accredited January- strong Amber for re assessment September	
		September 2022 Accreditation taking place in October 22	
		Year 1 (2021-2022) Work continues in preparation, support from NN network	

Metric	Measure	Update	
Live well / Age well – Reduce avoidable harm			
Pressure ulcers	**2023/24** 5% reduction on final 22/23 figure – no more than 87 pressure ulcers	**End of Year Update May 2024** We ended the year 2023/24 at **16.3% under trajectory** and met the reduction target in the acute setting. We had 77 pressure ulcers through the year; the trajectory allowed us to have no more than 87, which was a 5% reduction on 2022/23 figures.	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** We are currently 23% under trajectory to meet the reduction target for this year in the acute setting. We have had 33 pressure ulcers at the end of quarter 2; the trajectory allows us to have no more than 43 at this point.	
	2022/23 10% reduction	**End of Year 2 Achievement 2022/2023** At the end of the year, there were 92 pressure ulcers acquired in the acute setting. We achieved an **8% reduction** against the target set to reduce by 10%.	
		Year 2 (2022-2023) **December 2022** We are currently 5% over trajectory to meet the reduction target for this year in the acute setting.	
		September 2022 We are currently 10% **over** trajectory to meet the reduction target for this year in the acute setting.	
		Year 1 (2021-2022) 28.6% reduction of pressure ulcers within the acute setting	

Metric	Measure	Update	
Falls	**2023/24** 10% reduction in the overall number of falls 10% reduction in lapses of care/areas of concern. Measured these as a rate per 1000 bed days.	**End of Year Update May 2024** Total Number of Falls: 651 Rate of 2.82 / 1000 bed days – 83% Reduction of 17 %	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Rate of falls at end of October 2023 is ahead of trajectory at 2.91 per 1000 bed days. Rate of lapses in care at the end of October 2023 is also ahead of trajectory at 1.24 per 1000	
	2022/23 10% reduction Target 2022/2023 is 10% reduction which equates to **4.66** per 1000 bed days	**End of Year 2 Achievement 2022/2023** 2022/23 target (10% reduction) = 4.66 / 1000 Bed days 2022/23 End of Year Rate = 3.78 / 1000 Bed Days 2022/23 total falls number = 882 Which is a **reduction of 27%** compared to 2021/22	
		Year 2 (2022-2023) **December 2022** Rate of falls at end of December 2022 is ahead of trajectory at **3.96** per 1000 bed days	
		September 2022 Rate of falls to end of July 2022 – **4.27** per 1000 bed days	
		Year 1 (2021-2022) Not Achieved – 6.55% increase in the overall number of falls per 1000 bed days	

Metric	Measure	Update	
Falls with moderate harm	**2023/24** 5 % reduction in those causing moderate and above harm. This equates to **0.09** per 1000 bed days	**End of Year Update May 2024** Total number of moderate and above harm falls: 4 Rate of 0.02 / 1000 bed days **Reduction of 82%**	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Rate of falls with moderate and above harm at the end of October 2023 is 0.03 per 1000 bed days and we are ahead of trajectory.	
	2022/23 10% reduction Target 2022/2023 is 10% reduction which equates to **0.12** per 1000 bed days	**End of Year 2 Achievement 2022/2023** 2022/23 target (10% reduction) = 0.12 / 1000 Bed days 2022/23 End of Year Rate = 0.10 / 1000 Bed Days 2022/23 total falls mod harm or above number = 22 Which is a **reduction of 23%** compared to 2021/22	
		Year 2 (2022-2023) **December 2022** Rate of falls with moderate or above harm remains at **0.09** per 1000 bed days	
		September 2022 Rate of falls with moderate harm at end of July 2022 – **0.09** per 1000 bed days	
		Year 1 (2021-2022) 6.67% Decrease per 1000 bed days	

Metric	Measure	Update	
Sepsis	Improvement in timely recognition of sepsis	**End of Year Update May 2024** Rolling 12-month position (to end April 2024) Timely recognition of sepsis = 97%	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Rolling 12 month position (to end Oct 2023) Timely recognition of sepsis = 97%	
		Year 2 (2022-2023) **December 2022** Rolling 12 month position (Jan- Dec 2022) Timely recognition of sepsis = 96% End of year achievement Rolling 12 month position (04/22-03/23) Timely recognition of sepsis = 95.1% compared to 94.1% achieved previously	
		September 2022 Rolling 12 month position (09/21-08/22) Sepsis triggers reviewed on time = 96%	
		Year 1 (2021-2022) 24% Improvement in timely recognition (*Dataset for 2020-2021 incomplete as automated data collection not implemented until 09/2022)	
	Improvement in timely antibiotic treatment for sepsis	**End of Year Update May 2024** Rolling 12-month position (to end April 2024) Timely antibiotic administration = 75% *(NICE guidance updated end Jan 2024 changing criteria to recognise risk level due to sepsis for adults in acute hospital setting. The guidance recommends clinicians determine timing of antibiotics according to risk level. There is work underway through the Sepsis Steering Group to develop a trust SOP for sepsis underpinned by latest NICE guidance. Quality metrics will be reviewed as part of this project and the intention is to align with quality measures set by AQUA).*	RAG SCORE RED
		Year 3 (2023-2024) Interim Update **November 2023** Rolling 12 month position (end Oct 2023) Timely antibiotic administration =74%	

		Year 2022/2023 Achievement Rolling 12 month position (04/22-03/23) Achieved 76.5% compared to 83.1% - No improvement The implementation of full electronic recording of interventions in Patientrack for Sepsis Six went live as planned. As yet the scope to support the burden of manual auditing of records has not yet been fully realised due to limited BI resources. This continues to impact on the number of audits undertaken and a representative sample size.
		Year 2 (2022-2023) **December 2022** Rolling 12 month position Jan- Dec 2022 Timely antibiotic administration = 79% **Sepsis6 Go Live 24/1/23 –** full electronic recording of interventions in Patientrack
		September 2022 Rolling 12 month position (09/21-08/22) Sepsis treatment on time = 81%
		Year 1 (2021-2022) 2% Improvement (*Dataset for 2020-2021 incomplete as automated data collection not implemented until 09/2022)

Metric	Target	Year End	End of Year Update May 2024	RAG SCORE
				RED
CDI	40	81	It continued to be another challenging year from an IPC perspective, with the Trust only achieving the national trajectory for Klebsiella and the internal trajectory for MSSA. In comparison with other Trusts within Greater Manchester Stockport fared well. It is understood that there will be no National trajectories for 2024-25, Trusts will be asked to provide assurance against the IPC Board Assurance Framework (BAF). Stockport has set internal trajectories based on their local intelligence and provided divisional trajectories which will be monitored through the Quality & Safety Improvement Strategy Group	
MRSA	0	1		
MSSA	24	22		
E Coli	46	74		
Pseudomonas	3	9		
Klebsiella	22	15		

Metric	Measure	Year End	Year 2 2022/2023 Achievement
CDI	41	75	**Overall Results Year 2 2022-2023** All HCAI trajectories were not achieved which compared/reflected other hospitals/peers across Greater Manchester. All Divisions have reviewed their IPC action plans to assist the Trust in achieving the 2023/2024 National trajectories. **December 2022** With exception of Klebsiella, all HCAI are over trajectory **September 2022** 2022-23 thresholds have been set by NHSI, To date the trust is over proposed threshold for all the HCAIs
MRSA	0	5	
MSSA	18	28	
E Coli	49	94	
Pseudomonas	3	7	
Klebsiella	23	26	

Metric	Measure	Year End	Year 1 2021/2022 Achievement
CDI	40	77	Our internal ambitious targets were not achieved; however, action plans are in place for 2022-23 to address the matters.
MRSA	0	2	
MSSA	10	19	
E Coli	34	39	
Pseudomonas	2	3	
Klebsiella	12	11	Achieved

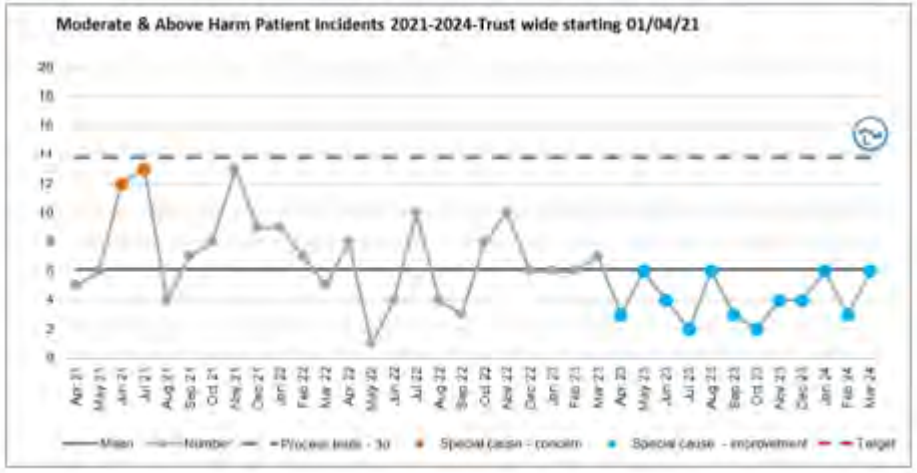
Metric	Measure	Update	
Mortality: Hospital Standardised Mortality Ratio (HSMR)	Latest position - Rolling 12 month period (less than 100)	**End of Year Update May 2024** Stockport's mortality rate is now reported as “within expected range" and is currently in the green zone. All other GM Trusts are reported in the green zone except for Bolton and Tameside, who are in the amber zone. The HSMR index is currently 103.1 for the period March 2023 to February 2024. This is currently 12.5 points higher than the GM peer median, and 3.9 points higher than the national median. This is a shift decrease of 2.4 from the previous month and the Trust no longer has the highest mortality rate.	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** In the latest period Aug-22 to July-23 the Trust has a HSMR (56 CCS groups) of 108.48. This is an improvement on the previous month (110.58) but is still rated ‘above expected’. The large discrepancy between SHMI and HSMR may be explained by palliative care coding. SHMI does not adjust for palliative care coding while HSMR does. If we remove the adjustment for specialist palliative care from the HSMR model our relative risk goes down to 98.43 and is considered ‘as expected’ , this is also more in line with the SHMI.	
		Year 2 (2022-2023) **December 2022** No further update	
		September 2022 No further update	
		Year 1 (2021-2022) 1.12 We have recently changed our reporting tool from CHKS to HED and in taking this step, our calculated mortality ratios have risen to slightly over the expected values.	
Mortality: Summary Hospital-level Mortality indicator (SHMI)	Latest position - Rolling 12 month period (less than 100)	**End of Year Update May 2024** Stockport's mortality rate is reported as "within expected range" and is currently in the green zone. All other GM Trusts are also reported in the green zone. The SHMI index is currently 92.7 for the period February 2023 to January 2024. This is currently 8.5 points better than the GM peer median, and 5.5 points better than the national median. This is a shift decease of 0.2 from the previous month and is the lowest mortality rate in GM.	RAG SCORE GREEN

	< = 1 (Jan 2021-Dec 2021)	**Year 3 (2023-2024) Interim Update** **November 2023** In the latest period July-22 to Jun-23 , the Trust has a SHMI of 95.94 and a banding of band 2 this result shows that deaths are 'as expected'. There are 142 SHMI diagnosis groups used within the SHMI model, there are no SHMI diagnosis groups identified as outliers.
		Year 2 (2022-2023) **December 2022** No further update
		September 2022 No further update
		Year 1 (2021-2022) Achieved Over the last 12 months we have had 50,265 provider spells. Of them we have had 1540 observed death (from 1565 expected deaths), giving us a summary hospital-level mortality indicator (SHMI) 0.98. Of the 142 different diagnosis groups, SNHSFT appears not be an outlier with the SHMI as expected. This is also found to be true with patients who have died from Covid-19.

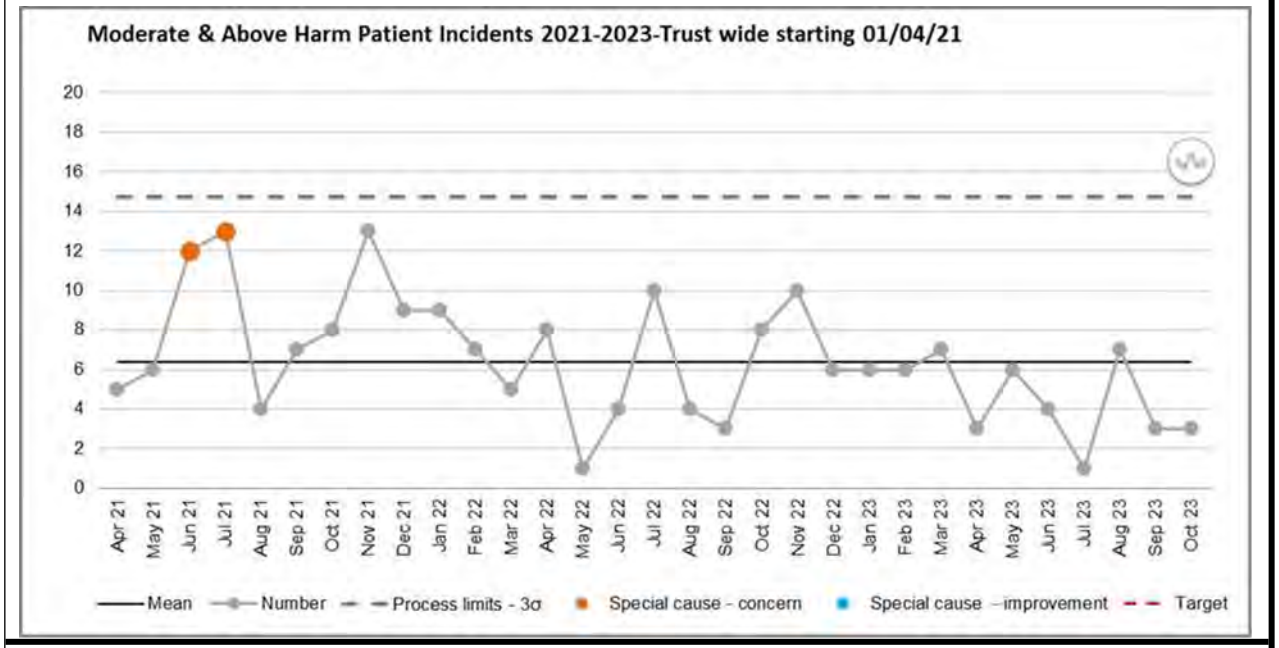
Metric	Measure	Update	
Number of Incidents reported relating to moderate or severe harm	Reduction in incidents reported	**End of Year Update May 2024** There were 49 Moderate or Above Harm Patient incidents in the full financial year 2023/24. We have successfully reduced the number of Incidents reported relating to moderate or above harm by 32.88%, this is in comparison to the 73 reported	RAG SCORE GREEN

in the previous full financial year (2022/23). This reduction is on a back drop of increased incident reporting overall.

Patient Incidents Reported	FY 2022/23	FY 2023/24	# Change	% Change
Moderate (short term harm caused)	60	43	-17	-28.33%
Severe (permanent or long term harm caused)	10	4	-6	-60.00%
Fatal (caused by the Incident)	3	2	-1	-33.33%
Total	73	49	-24	-32.88%

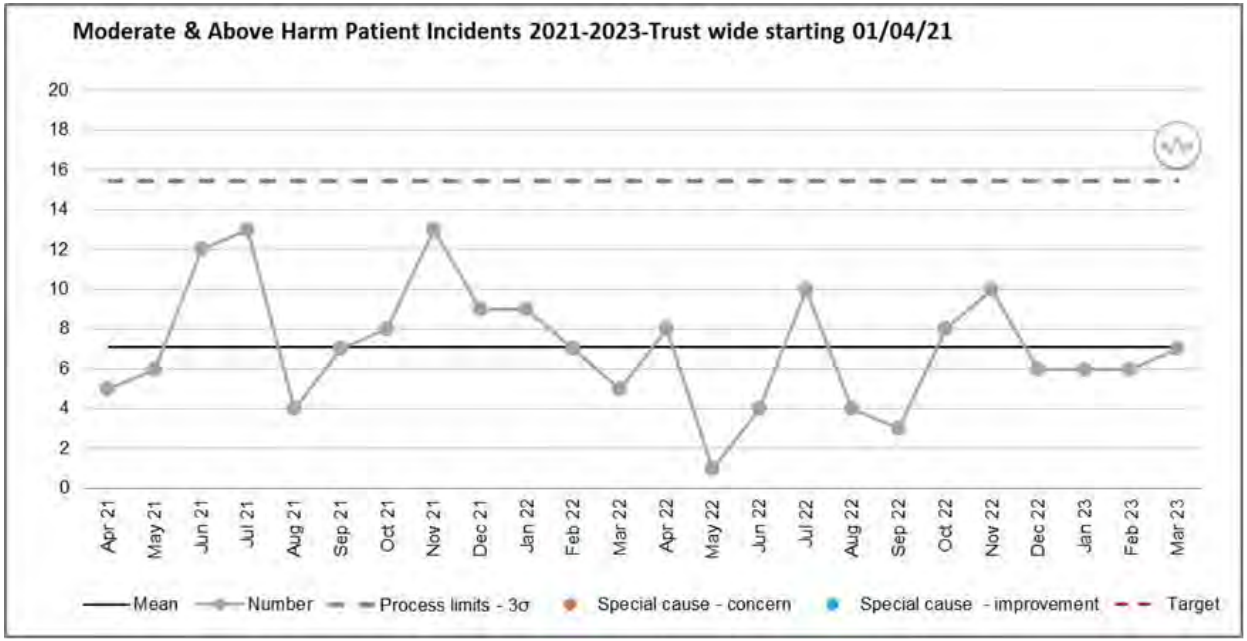


Year 3 (2023-2024) Interim Update
November 2023
There have been 27 Moderate or Above Harm Patient incidents so far in financial year 2023/24.
We are on track to reduce the number (and proportion) of Incidents reported relating to moderate or above harm, with 73 having been reported in the previous full financial year (2022/23). This reduction is on a back drop of increased incident reporting overall.

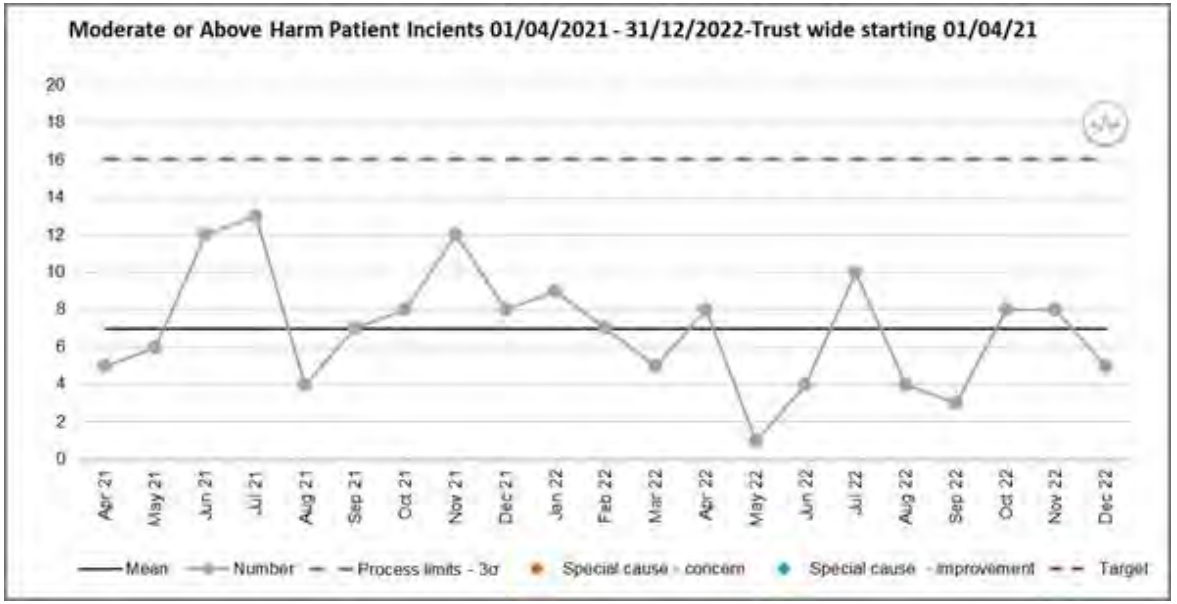


Year 2 (2022-2023)
End of year update 2022/23
There were 73 Moderate or Above Harm Patient incidents in the full financial year 2022/23.
We have successfully reduced the number of Incidents reported relating to moderate or above harm by 25.51%, this is in comparison to the 98 reported in the previous full financial year (2021/22). This reduction is on a back drop of increased incident reporting overall.

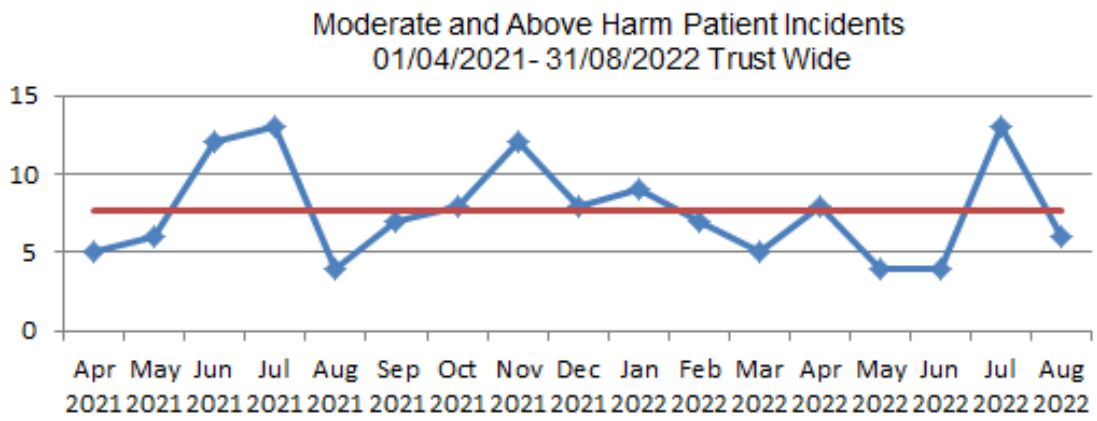
Patient Incidents Reported	FY 2021/22	FY 2022/23	# Change	% Change
Moderate (short term harm caused)	73	60	-13	-17.81%
Severe (permanent or long term harm caused)	18	10	-8	-44.44%
Death (caused by the Incident)	7	3	-4	-57.14%
Total	98	73	-25	-25.51%



Year 2 (2022-2023)
December 2022
There have been 51 Moderate or Above Harm Patient incidents so far in FY 2022/23.
We are on track to reduce the number of Incidents reported relating to moderate or above harm, with 96 having been reported in the previous full financial year (2021/22). This reduction is on a back drop of increased incident reporting overall.

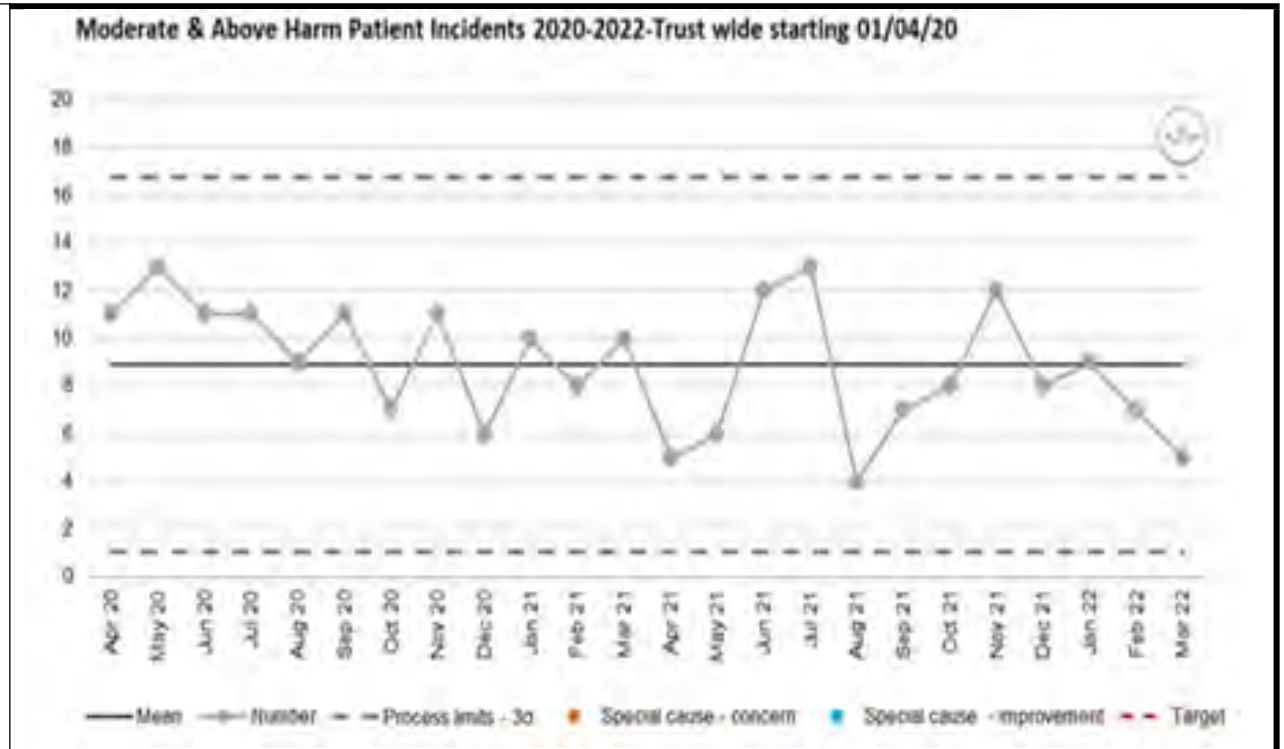


September 2022



Year 1 (2021-2022)

Patient Incidents Reported	FY 2020/21	FY 2021/22	# Change	% Change
Moderate (short term harm caused)	99	72	-27	-27.27%
Severe (permanent or long term harm caused)	15	17	2	13.33%
Death (caused by the Incident)	4	7	3	75.00%
Total	118	96	-22	-18.64%



Metric	Measure	Update	
Die well – Improve the last 1,000 days of life			
Reduce admissions to hospital in the last 90 days of life through use of advance care plans and enhanced clinical management plans shared with primary care	Establish baseline and determine uptake	**End of Year Update May 2024** Dashboards related to 3 or more admissions in last 90 days and last year of life now in place on GM Intelligence Hub / GM Tableau for all Integrated Care Board (ICB) Localities within Greater Manchester including Stockport. Work continues to provide as up to date data as possible with trends. Advance Care Planning training continues to be provided within SNHSFT.	RAG SCORE AMBER
		Year 3 (2023-2024) Interim Update **November 2023** Dashboards continue to be developed in Stockport that will be rolled out in GM to facilitate further benchmarking across ICB to include Population Level Provider Activity – last 90 days. Potential of auditing patients presenting to ED within last 90 days of life discussed to capture key themes and future actions	
		End of Year 2 2022-2023 Dashboards continue to be developed in Stockport that will be rolled out in GM to facilitate further benchmarking across ICB to include Population Level Provider Activity – last 90 days. Potential of auditing of patients presenting to ED within last 90 days of life discussed to capture key themes and future actions	
		Year 2 (2022-2023) **December 2022** Dashboard has required a BI update and just finalising clinical validity of new dashboard.	
		September 2022 Stockport wide palliative dashboard on tableau and benchmark admissions in the last 90 days of life against GM and England results	
		Year 1 (2021-2022) Stockport wide palliative dashboard on tableau and benchmark admissions in the last 90 days of life against GM and England results	

Metric	Measure	Update	
Implement use of GM electronic palliative care coordination system (EPaCCs) in community and secondary care	Determine and agree implementation date	**End of Year Update May 2024** EPaCCS has gone live across Stockport Locality including in Primary Care and at St.Ann's hospice. A technical issue is being worked through to enable SNHSFT to go live with the Specialist Palliative Care and District Nursing services. EPaCCS training has already been delivered, by the Consultant in Palliative Medicine and the GP Educator, to the Specialist Palliative Care team, Primary Care, District Nursing staff, Cancer Specialist Nurses and COPD team. Further discussions are underway within the Trust, with the support of the Deputy Medical Director, around training for specific areas within Acute including ED / Acute.	RAG SCORE AMBER
		Year 3 (2023-2024) Interim Update **November 2023** Stockport locality T&F Group monthly meetings with full implementation and training plan in place. Launch provisionally scheduled for end of November 2023, awaiting sign off from GM	
		End of Year 2 2022-2023 No further updates at this time	
		Year 2 (2022-2023) **December 2022** T+F group met 23rd January with project management support from locality IMT	
		September 2022 Not achieved as awaiting CCG to recruit project manager	
		Year 1 (2021-2022) Not achieved as awaiting CCG to recruit project manager	

Improve quality of palliative care monitoring in District Nurse teams through use of IPOS palliative outcome scale	Establish baseline and determine 5 reduction	**End of Year Update May 2024** The focus of the District Nursing (DN) teams has been on the Stockport Accreditation and Recognition Scheme (StARS) which encompasses quality standards relating to the care of the dying patient. 7 out of 7 Primary Care Network (PCN) DN teams have achieved a GREEN status for the quality of their end of life care. Care of the Dying documentation audits are completed monthly to monitor the quality of documented care and a quarterly report shared with District Nursing staff. There is an IPOS function in Community EMIS (the patient electronic record) and we are re-engaging with the BI team to understand the opportunities for reporting.	RAG SCORE AMBER
		Year 3 (2023-2024) Interim Update **November 2023** No further updates at this time.	
		End of Year 2 2022-2023 No further updates at this time.	
		Year 2 (2022-2023) **December 2022** Further meetings planned with BI re: reporting.	
		September 2022 Reporting mechanism in place and first quarter reported.	
		Year 1 (2021-2022) Partially achieved as teams have implemented IPOS however reporting mechanism awaiting business intelligence development	

Metric	Measure	Update	
All Learning from Death reviews completed from a palliative care perspective	Implement learning from learning from death reviews	**End of Year Update May 2024** LFD reports and learning shared at LFD Review Group and at the Trust P&EoLC Group. **Q3 = 7 x Learning from Deaths (LFDs) undertaken by SPCT** Areas of good practice include: • Exploring the reversible but with a realistic view of likely prognosis. • It was discussed with the lady's family what her pre-morbid state was, especially with regard to capacity. • Concerns raised by daughter regarding patient not managing at home were acknowledged and a capacity assessment was completed as per her request. Patient died peacefully on ward with family present. • Timely recognition of dying and communicated to patient and family. Peaceful death with family present. Some attempts were made to try and get him home. Clear conversations about risk feeding and the consequences after he pulled his NG tube out. Areas for improvement: • It appears, on reading the notes, that there was no evidence of a capacity assessment or a best interests decision meeting. Patient was unlikely to have the capacity to make complex decisions about her care. • Appears to be little consideration of the likelihood that patient might be dying until the last few hours of his life. No documentation to indicate that the patient's wishes and preferences were actively sought or considered during admission. Syringe pump potentially commenced prematurely. • Patient stated that he wanted to go home to die, 5 days before his death. No team or took overall responsibility to coordinate the discharge so by the time it was decided who would coordinate this, he was too ill to transfer and he did not get his wishes. Review of medications issued - seems to have had a lot of morphine in many forms without any coordinated or managed approach for symptom control.	RAG SCORE GREEN

		3 x Score 2 LFD review. Referred for departmental Mortality and Morbidity (M&M) Review: • Did not recognise the early signs of dying. Did not document that we had involved the patient in decisions about treatments, interventions and references and wishes for care. • No evidence of advance care planning or involvement of patient in her care. AMU/ED would have been much better supported had there been discussions with patient about what she wanted during her last could of admissions that was then passed on the ED/AMU. This was potentially an admission that the patient would not have wanted. • Despite 3 admissions in last month of life, there was nothing in last set of notes to evidence any understanding of what the patient wanted from treatment or what she was prepared to tolerate or her preferred place of death. This resulted in a short last admission which was managed well by AMU but there is an argument that this might have not been where the patient would have wanted to die. **Q4 = 9 x Learning from Deaths (LFDs) undertaken by SPCT** Areas of good practice include: • End of life – recognised in a timely way • Good & detailed discussions with patient and family; re decline, ceilings of treatment and dying (2) • Facilitated preferred place of death • Attempt to establish patient's preferred wishes for care through discussions with family • Symptoms responded to promptly and in line with GM Palliative Pain and Symptom Control Guidance. • Changing clinical picture acknowledged and family informed. • Escalation plans and ceilings of treatments reviewed and adjusted in a timely way. Areas for improvement: • Evidence/documentation re mouth care	

		• Decisions around passing of an NG tube were difficult and robust evidence of a Best Interest decision was difficult to find • The patient's voice is silent in the records. • There is no evidence that capacity was assessed nor that decisions made in compliance with the principles of the MCA. 1 x Score 2 LFD review. Referred to departmental M&M review: • Late recognition of dying even when blood gases hugely deranged • Symptoms not well managed in last 2-3 days of life	
		Year 3 (2023-2024) Interim Update **November 2023** 9 Learning from Death (LFDs) datix reviews completed in Q2 2023/24. Outcomes reported via LFD Report, LFD review group and newly established Palliative and End of Life Care Steering Group. Areas of improvement noted regarding recognition of decline and likelihood of dying. Recording of capacity assessments and the application of principles of the Mental Capacity Act where they relate to best interest decision making are areas where we could do better	
		End of Year 2 2022-2023 As above – no further updates	
		Year 2 (2022-2023) **December 2022** 12 Learning From Deaths (LFDs) datix reviews completed per quarter. Outcomes reported to LFD review group and via LFD newsletter. Common themes are late recognition of dying and absence of advance care planning leading to possible avoidable hospital admissions.	
		September 2022 78% of patients with IPOS scores x 2 reduced their pain score whilst under care of the team.	
		Year 1 (2021-2022) Complete	

Metric	Measure	Update	
End of life care role specific training %	All teams > 85%	**End of Year Update May 2024** Trust Level 1 EoLC training compliance = 89% (End of March 2024) Trust Level 2 EoLC training compliance = 81% (End of March 2024) Divisional compliance monitored by each Division and at the Trust Palliative and End of Life Care Group and shows and upward trend.	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** Compliance for role specific EOLC Level 1 = 79.78% and EOLC Level 2 = 78.33%. DNA rate 50%. Compliance monitored by each division.	
		End of Year 2 2022-2023 Compliance for role specific EOLC Level 1 = 71.4% and EOLC Level 2 = 75.2%. DNA rate 50-75%. Compliance monitored by each division.	
		Year 2 (2022-2023) **December 2022** Compliance for role specific EOLC Level 1 = 77% and EOLC Level 2 = 76%. DNA rate 50-75%. Compliance monitored by each division.	
		September 2022 Complete	
		Year 1 (2021-2022) Not achieved – Overall 65.9% Compliance Monitored by each Division	

Metric	Measure	Update	
Review complaints associated with end of life care	Implement learning from review of complaints	**End of Year Update May 2024** Divisional Palliative and EoLC Reports shared at the Trust P&EoLC Group; these reports include complaints related to EoLC. With regard to the Division of Integrated Care and the Specialist Palliative Care team. Complaints that have been reported whereby the incident is related to an EoL patient: Q3 complaints = 12 and Q4 complaints = 7 Themes from formal complaints in Q3 & Q4: • Transfers between wards prior to death • No side rooms available when patient dying • Pressure ulcer acquired • Pain relief • Medication/syringe driver • Process after death • Breaking bad news to patient without family present • Treatment • Explanation of DNACPR • Communication with family • Lost property • Lack of covid-19 testing	RAG SCORE GREEN
		Year 3 (2023-2024) Interim Update **November 2023** (Q2 – July – Sept 2023) Incidents that have been reported whereby the incident is related to an EOL patient: Incidents = 77 incidents and 8 Learning from Deaths (LFDs) (Q2 – July – Sept 2023) Complaints that have been reported whereby the incident is related to an EOL patient: Complaints = none received	

		End of Year 2 2022-2023 Following local and national audit outcomes and feedback from bereavement surveys, a robust outcome driven process of ward accreditation and recognition has been implemented collaboratively between the Specialist Palliative Care Service and the Trust Quality Team to align national and local standards in inpatient settings.
		Year 2 (2022-2023) **December 2022** 1 formal complaint received in Q3 and managed through Trust complaints team with learning shared across teams. 9 other feedback received through Beechwood bereavement feedback service and responded directly by SPCS.
		September 2022 Compliance Monitored by each Division
		Year 1 (2021-2022) Overall numbers and themes monitored by Integrated Care Quality Board. A more robust process for shared learning needs to be developed across the organisation.

Quality Objectives for Achievement in Year 4 (2024/2025)

Quality Objectives	Outcome Measure / Achievement	Progress / Achievement	RAG
Start well – improve the first 1,000 days of life			
Reduction of perinatal mortality in line with the national ambition to halve the rates of still births, neonatal and maternal deaths and intrapartum brain injuries by 2025.	Full compliance of all 6 elements of Saving Babies Lives Care Bundle version 3 (SBLCBv3).		
Reduction in the number of women smoking at the time of delivery (SATOD).	To achieve the national target of 6% for SATOD.		
NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.	Full compliance with all 10 safety actions of CNST (Year 6)		
Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision Is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.	75% of the services Black Minority Ethnic vulnerable women to be booked onto COC pathway.		
The Ockenden report was published in 2020 and highlighted immediate and essential actions for maternity services to put in place.	To be compliant against all immediate and essential actions.		
Avoiding term admissions into the neonatal unit	To have < 4% of all term births being admitted to the neonatal unit.		
Implementation of the neonatal critical care review. Expert neonatal	This is an external review. The local		

Quality Objectives	Outcome Measure / Achievement	Progress / Achievement	RAG
workforce Enhancing the experience of families.	target is to maintain our Green Standard in family integrated care		
To reduce unnecessary hospital admissions for children and young people particularly those who have long term conditions such as Asthma, Diabetes and Epilepsy. Supporting CYP and their families to maintain wellness and manage their health needs within the community setting.	Continue monitoring and maintain service provision and support for CYP living with long term health condition. The focus for GM 2024/2025 in line with Core20PLUS5 continues to be asthma, epilepsy, diabetes, oral health and mental health.		
To ensure that transition of care for young people to adult services meets their needs and ensures continuity of high care. Seamless transition to adult services.	To monitor and continue to further develop our transition pathways.		
For neonatal unit to become a Baby Friendly accredited unit.	Aim to achieve stage 1 of the accreditation process.		
Live well / Age well – Reduce avoidable harm			
Pressure ulcers – *Targets for both Acute and Community are the same*	1.No reduction target for Cat 2-4. To focus on reducing lapses in care, timely investigation and action plans 2. Reduce lapses in care by 20% (ie no more than 30% of overall pressure ulcers to lapse in care 3. Aspirational Target – No Category 3 or 4 as a direct result of a lapse in care		
Falls	1. 5% Reduction in overall number of falls per 1000 bed days 2. 5% Reduction in lapses in care		
Falls with moderate harm	No increase in falls with moderate		

Quality Objectives		Outcome Measure / Achievement	Progress / Achievement	RAG
		or above on previous year – Total number 4 (2023/2024)		
Sepsis		1. Timely Recognition 90% 2. Timely Administration of Antibiotics 90%		
Infection Prevention and Control		Internal trajectories (Possibly no National targets)		
CDI	73 (10% reduction)			
MRSA	0 (Zero)			
MSSA	19 (15% reduction)			
E Coli	70 (5% reduction)			
Klebsiella	13 (10% reduction)			
Pseudomonas	8 (10% reduction)			
Mortality: Hospital Standardised Mortality Ratio (HSMR)		Ratio of < = 1		
Mortality: Summary Hospital-level Mortality indicator (SHMI)		Ratio of < = 1		
Number of Incidents reported relating to moderate or severe harm – *superseded /replaced by implementation of Patient Safety Incident Response Framework (PSIRF)*		1.Implement the Patient Safety Incident Response Framework and Stockport Patient Safety Incident Response Plan 2.Comply with Duty of Candour Regulations and engage compassionately with those involved in patient safety investigations.		
Die well – Improve the last 1,000 days of life				
Reduce admissions to hospital in the last 90 days of life through use of advance care plans and enhanced clinical management plans		1.Agree, at the Trust Palliative and End of Life Care Steering Group,		

Quality Objectives	Outcome Measure / Achievement	Progress / Achievement	RAG
shared with primary care	how best to utilise the GM Dashboard to drive reductions in admissions. NOTE: Dashboards related to 3+ admissions in last 90 days and last year of life now in place on GM Intelligence Hub / GM Tableau for all Integrated Care Board (ICB) Localities within Greater Manchester including Stockport. Work continues to provide as up to date data as possible. 2. Continue to provide Advanced Care Planning training within SNHSFT; agreeing a training target for the relevant cohort of practitioners.		
Implement use of GM electronic palliative care coordination system (EPaCC) in community and secondary care	1.Establish a 'Go Live' date and agree a rollout plan for the Specialist Palliative Care and District Nursing Services (now Primary Care and St. Ann's Hospice have gone live). 2. Agree and implement a training programme for clinicians in Urgent Care, Acute and Speciality services to promote the use of the GM EPaCC to improve patient shared care planning with Primary Care.		

Quality Objectives	Outcome Measure / Achievement	Progress / Achievement	RAG
Improve quality of palliative care monitoring in District Nurse teams through use of IPOS palliative outcome scale	1. Increase use of IPOS for 25% of patients with recognised deterioration in condition on the DN caseload. (13% achieved in 2023/24.)		
All Learning from Death reviews completed from a palliative care perspective	1.Specialist Palliative Care Service target to complete 10 LFD reviews a month. 2. Increase the number of non-medical practitioners involved in LFD reviews, to strengthen the Trust MDT approach to learning from deaths.		
End of life care role specific training %	Achieve 90% compliance (in line with the Trust target for all other role specific training).		
Review complaints associated with end of life care	1.Divisional complaints associated with end of life care are reviewed to identify learning and develop action plans to improve practice. Divisional learning and action plans reported and monitored at i) Divisional Quality meetings and ii) at the Trust Palliative and End of Life Care Steering Group		

Meeting date	6th June 2024	**Public**		**Agenda No.**	17
Meeting	Board of Directors				
Report Title	Health & Safety Annual Report 2023/24				
Director Lead	Nicola Firth Chief Nurse	**Author**	Mike Craven Health & Safety & Risk Manager		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	**The Board of Directors is asked to receive and confirm 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.**					

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
	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
	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
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
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

	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	N/A
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	Throughout paper
Sustainability (including environmental impacts)	N/A

Executive Summary

This report provides the Board of Directors with a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2023/2024.

Data provided in the report is reviewed via standing monthly and quarterly reports at the Health & Safety Joint Consultative Group and assurances provided to the Quality Committee, by submission of a key issue report following each meeting.

1. PURPOSE

(Note: The Health & Safety & Risk Manager left the Trust in May 2023, having produced and developed objectives and action plans for 2023/24; his successor was appointed and took up post at the end of June 2023. The new Health & Safety & Risk Manager has a wealth of experience on the field of health, safety and risk, going back to the late 1980s and covering the communications, retail, education, local government, leisure, construction and social housing sectors, but had no previous experience in the NHS. This annual report looks at the objectives set by the outgoing manager – and is primarily a review of objectives agreed at the beginning of 2023/2024 - whilst also looking at the reviews completed by the new post-holder.)

1.1 The purpose of this report is to provide the Trust Board with a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2023/2024.

1.2 The Chief Nurse continues to be the director with delegated responsibility for Health & Safety whilst the Deputy Director of Quality Governance has taken over the position of Chair of the Health & Safety Joint Consultative Group (H&S JCG).

1.3 In addition to the progress made within the reported period, the H&SJCG had recommended a series of objectives for the 2022/2023 period – carried over to 2023/24 - that sought to further enhance the level of corporate responsibility the Trust attaches to its Health and Safety function.

1.4 Continuing objectives for 2023-2024 were to;

- Develop and implement a robust Health and Safety Management System that delivers continuous improvement
- Ensure a Healthy and Safe working environment for staff, patients and visitors
- Develop and maintain a culture of safety that promotes; openness, continuous improvement, research, innovation and positively acts upon learning

The objectives were reviewed by the incoming Health & Safety & Risk Manager, in consultation with divisional governance leads, and with staff-side partners, thus:

1.5 Key General Objectives:

- To keep our employees safe and healthy at work
- To keep those affected by what we do protected from harm caused by our activities
- To protect the Trust and its people from the potential threat of legal (both, criminal – enforcement – and, civil – liability claims) action and financial loss.
- To build and enhance a positive Health & Safety Culture

- To ensure that Health & Safety aligns with the Trust values that, “We Care, We Respect, We Listen”.

1.6 Specific Objectives (to support the above)

- Provide effective governance and oversight of Health & Safety.
- Maintain a safe and healthy working environment for all.
- Provide and maintain safe equipment, plant and machinery.
- Minimise the number of RIDDOR-reportable, lost-time, and foreseeable / avoidable workplace accidents.
- Provide effective Health & Safety training.
- Increase the level of staff involvement in Health & Safety
- Maintain (and enhance) an effective Health & Safety Management System
- Reduce incidence of, and harm (actual and potential) caused by identified key challenges

2. INTRODUCTION

2.1 This report provides analysis of the delivery of KPI’s for health and safety management throughout the Trust for the financial year 1st April 2023 to 31st March 2024. The Health and Safety at Work etc. Act 1974 provides a legislative framework to promote, stimulate and encourage excellent health and safety at work standards with delegated responsibility through the Chief Executive to implement systems that ensure Trust staff and contractors, work in a safe and compliant manner to protect themselves, patients and visitors from significant or avoidable harm.

2.2 In progressing the Health and Safety strategy of health and safety throughout the Trust, the Health, Safety and Risk Manager continues to observe the ISO 45001:2018 standard as a framework for our organization to document and improve our operational practices in order to prevent work-related injury and ill-health.

2.3 Compliance with ISO 45001:2018 will help the Trust to achieve its objectives and demonstrate that its health and safety management system is effective. The Trust’s management system will help to translate its corporate objectives to prevent incidents into a systematic and ongoing set of processes that are supported by the use of appropriate methods and tools that can reinforce commitment to proactively improving performance.

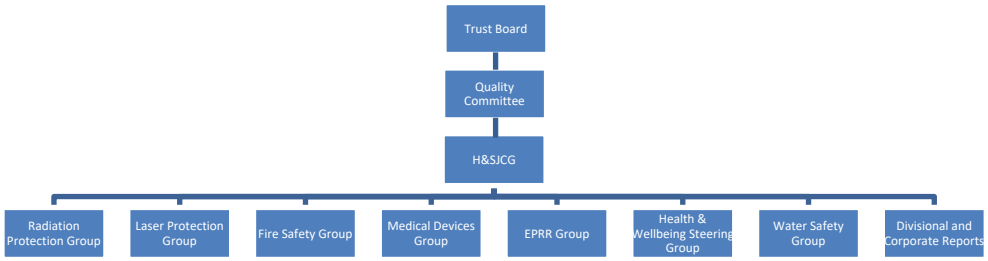
2.4 The Figure below illustrates ISO 45001 for the development of the health and safety management system, which uses the plan, do, check and act cycle to implement the process approach that delivers management system objectives, stakeholder requirements and staff safety;

2.5 Health and Safety Joint Consultative Group and supporting groups

2.5.1 The H&SJCG has been established to plan, manage and monitor organisational compliance with statutory health and safety requirements and specific NHS duties. In this way compliance with external organisational requirements such as the HSE are managed.

2.5.2 The H&SJCG receives reports from its sub-committees and ratifies policies approved at sub-committee level.

2.5.3 The H&S supporting committees are structures as follows:



3. DELIVERY OF THE KPI'S WITHIN THE HEALTH AND SAFETY STRATEGY

3.1 Audit and Inspection

An annual programme was developed to identify what audit activity is required for the forthcoming year, and to ensure any areas of concern are addressed as soon as possible and that all regulatory requirements are met. The following methods of audit and inspection were to be carried out:

3.1.1 Safety Management System (HSMS)

3.1.2 An annual audit of the HSMS was carried out by the Health and Safety and Risk Manager and presented by the Health & Safety & Risk Manager through regular

progress reports, with a final, closing report being submitted to H&S JCG in March 2024. This audit is a methodical and documented assessment of the trust's systems and processes relating to Health and Safety Management. It is measured against the ISO 45001 criteria. And addresses the following factors;

- The strengths and weaknesses of the current system
- How the system performs within the aims of the trust
- If the trust is fulfilling its legal obligations
- If a proper performance review system is in place

3.1.3 A report on the annual audit will be presented at the March 2025 Annual Meeting of the H&JCG.

3.1.4 Monthly inspections commenced from Q1 2021/22. These are completed by each ward/department and captured using the AMaT system currently being used for clinical audit, fire safety etc. Following consultations, and discussions at the H&S JCG, these inspections moved to quarterly with effect from 01/10/2023 (Q3, 2023/24)

3.1.5 The KPI for all Divisions and Corporate function was to achieve 100% proactive monitoring in accordance with agreed plan. Commencing Q1 2021/22.

3.1.6 The compliance rates for financial year 2023-2024 for each Division and Corporate function were as follows:

	Audits Completed	% Completion	% Completion 22/23	% Completion 21/22
Trust Level	883/1125	78.49%	63.90%	51.07%
Corporate Services	81/136	59.56%	65.55%	70%
Emergency Department	6/15	40.00%	2.30%	10%
Estates & Facilities	123/136	90.44%	81%	81%
Integrated Care	171/247	69.23%	43.90%	43.30%
Medicine	169/175	96.57%	84.37	46.30%
Surgery GI & Critical Care	148/160	92.50%	76.66%	49.70%
Women, Children & Diagnostics	84/112	75.00%	68.88%	50.10%
Clinical Support Services	101/144	70.14%	N/A	N/A

3.1.7 The overall Trust compliance of completion of the audits was 78.49%, a significant increase on 63.90% in 2022/23 and 51.07% in 2021/22.

3.1.8 Audit completions will remain as a KPI within the 2024-2025 Health and Safety Strategy.

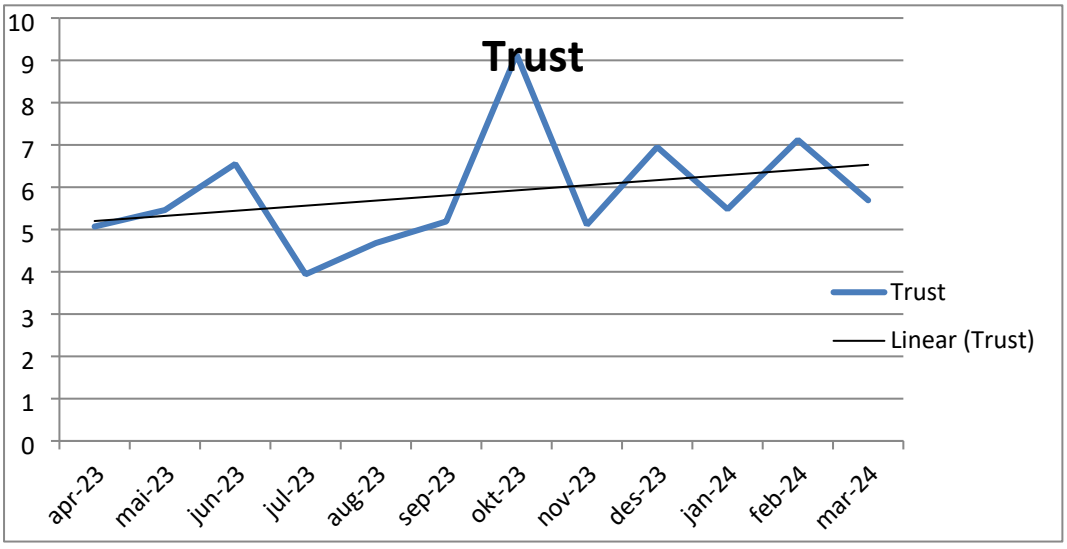
3.2 Safety Metrics

3.2.1 By the end of Quarter 4 2024, target reductions of 10% in incidents of 'harm' to staff were required for all Divisions and Corporate functions in relation to slips, trips and falls, needle-stick/sharps, physical assaults, moving and handling and collision/contact with objects.

3.2.2 These reductions have been reviewed for 2024-2025 as follows:

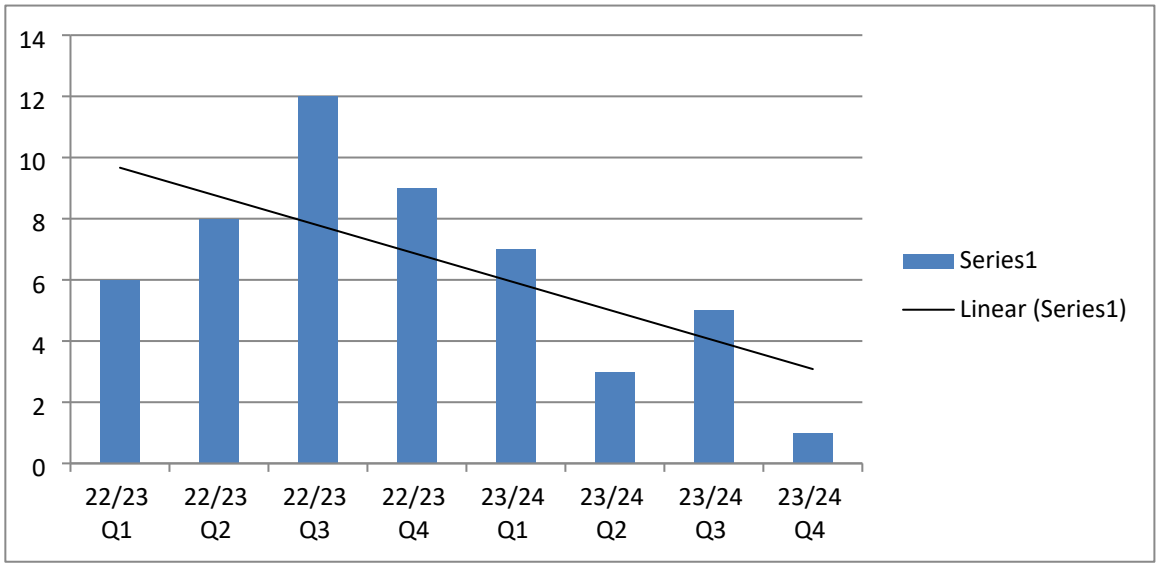
- slips, trips and falls (10%)
- needle-stick/sharps (10%
- physical assaults (25%)
- moving and handling (20%)
- collision/contact with objects (10%).

3.2.3 By the end of Quarter 4 a target to *'achieve a month by month reduction in Lost time Injury Incidence Rate'*. As the graph below shows there was no definite trend in the reduction, or indeed increase, of injury incidence rate during 2023-2024. There were periods in the year where all Divisions and corporate functions had an increase or decrease in the same month; however this does not provide any clear indicators why this was and did not happen consistently to draw any conclusions.



3.3 RIDDOR Reporting

3.3.1 In financial year 2023-2024 there were 16 incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). This compares to 35 for 2021-2022.



(Note: Previous annual reports may be seen to have been flawed, in that they have shown the statistics for "RIDDORs" based on the date on which the report was submitted, not the date of the actual incident. Given that, (a) RIDDOR allows some reports to be submitted up to 15 days after the accident and, (b) the Trust has had a history of late reporting – sometimes by several weeks/months – this has not provided an accurate picture of when reportable accidents have occurred. The data and graph in section 3.3.1 above corrects this.)

3.3.2 By the end of Quarter 4 a target to ensure '*All serious incidents (RIDDOR and potential claims) are investigated within agreed timescales and lessons learned are communicated'.* At the time of writing this report there were 2 RIDDOR investigations overdue. All RIDDOR reportable incidents had been investigated at Level 1 and lessons learned communicated within their respective Divisions and at the H&SJCG via Divisional and Corporate function reports.

(*Note: The Level 1 reporting format was geared towards to investigation of patient incidents. The process and format was reviewed during 2023/24, and RIDDORs related to employees are now reported in a more appropriate manner and format.)*

3.4 **Claims**

3.4.1 By the end of Quarter 4 a target to *achieve a reduction of EL and PL claims relating to workplace safety.* In 2022-2023, 8 Employers Liability claims and 6 Public Liability claims were received by the Trust. In 2023-2024, 6 Employers Liability claims and 3 Public Liability claims were received. An overall decrease of 5 claims received by the Trust for 2023-2024.

3.4.2 By the end of Quarter 4 a target to ensure all significant Health and Safety Hazards identified within the Trusts Duty Holders Matrix to be included within the Trusts Risk Register.

3.4.3 Assurances were sought from Duty Holders throughout 2023-2024, with the updates provided being added to the Matrix. In order to get a better understanding of assurance, the Health & Safety & Risk manager will meet with Duty Holders in early 2024-2025 to complete a full review of the Matrix.

3.4.4 One area of risk includes:

COSHH – The Trust COSHH Policy has been reviewed and updated. A new "COSHH Working Party" has been set up to replace the defunct "COSHH Committee". The working party will report back to the H&S JCG.

3.6 Legal Compliance

3.6.1 A target to provide assurance that the trust is either fully compliant with H&S legal requirements or has a SMART action plan in place to address noncompliance.

3.6.2 The Trust now has in place a legal register. This is currently being populated with evidence of compliance against respective legislation and for E&F HTM compliance, and where gaps are identified actions are put in place to rectify. At the time of writing this report there are no risks relating to non-compliance identified.

3.7 Consultation and Communication

3.7.1 Safety, including monitoring of the Duty Holder's Matrix is a continuous standing agenda item on Divisional and Directorate governance meetings. Meetings between staff-side representatives and the Health, Safety and Risk Manager were held monthly. Bulletins and briefings are sent out periodically to all staff to raise awareness of specific Health and Safety topics.

3.8 Safety Culture

3.8.1 As outlined in the Health and Safety plan a Safety Climate survey was to be carried out in 2021-2022. This was not carried out in the period and will be added to the Health and Safety Plan for 2024-2025.

3.9 Health and Safety Joint Consultative Group (H&SJCG)

3.9.1 For 2023-2024 the following targets were set in relation to the H&SJCG;

- 100% Monthly H&SJCG meetings held according to Terms of Reference.

- 100% staff side representation from all Business Groups.
- 80% membership attendance at H&SJCG.
- 100% Senior Management representative attendance for all business groups.

3.9.2 100% of meetings were not held there was one meeting cancelled in July 2023. The reasons for the cancellation were the absence of key attendees, and the new Health & Safety & Risk Manager only having taken up employment with the Trust one week prior to the scheduled meeting.

3.9.3 100% Staff-side representation was not achieved during 2023-2024 although, whilst only representation from Unison attended meetings during 2022-2023, Chartered Society of Physiotherapists (CSP) representation also attended in 2023-2024.

3.9.4 Whilst there was staff-side representation at all but one of the meetings, five of the ten meetings were inquorate due to an insufficient number of staff side representatives being in attendance; the “Staff Side Coordinator” was unable to attend any of the meetings, and the “Unison Coordinator” was only able to attend two of them. Recruitment of members will remain a priority and will be included in 2024-2025 KPI’s.

3.9.5 100% senior management attendance was achieved. It was decided that one senior Manager will attend meetings on behalf of all Divisions.

3.9.6 A significant review of the H&S JCG Terms of Reference was carried out at the end of 2023/2024. For 2024-2025, the main H&S JCG meetings will move from monthly to quarterly (May, August, November and February), with an AGM in March. These quarterly JCG meetings will be supported by two “Collaborative Forums” – one attended by the Health & Safety & Risk Manager and Divisional Governance, the other attended by the Health & Safety & Risk Manager and Staff Side representatives – both meeting on a quarterly basis. The main aims of the Collaborative Forums will be to increase staff side involvement and practical involvement in Health & Safety issues.

3.10 Health and Safety Training

3.10.1 As of March 2023 the compliance of mandatory Health and Safety training was as follows:

	Fire Safety	Health, Safety and Welfare	Moving and Handling - Level 1	Moving and Handling - Level 2	Conflict Resolution
Stockport NHS Trust	94.94%	94.53%	93.29%	87.44%	93.72%

Clinical Support Services	97.77%	97.35%	96.87%	91.85%	96.80%
Corporate Services	94.52%	94.93%	93.93%	86.21%	94.12%
Emergency Department	89.72%	89.72%	90.91%	83.67%	88.79%
Estates & Facilities	95.43%	96.05%	96.67%	100.00%	96.67%
Integrated Care	96.59%	95.88%	96.45%	87.11%	95.70%
Medicine & Urgent Care	92.34%	91.76%	78.44%	83.62%	88.69%
Surgery	92.81%	91.59%	86.01%	86.75%	90.27%
Women & Children	96.86%	96.86%	97.23%	93.83%	97.11%

3.10.2 Significant progress has been made in 2023/24, and as of March 2024, the compliance with mandatory Health & Safety training is as follows:

	Fire Safety	Health, Safety and Welfare	Moving and Handling - Level 1	Moving and Handling - Level 2	Conflict Resolution
Stockport NHS Trust	98.05%	96.75%	95.52%	91.22%	96.52%
Clinical Support Services	98.99%	98.49%	98.15%	92.68%	98.49%
Corporate Services	98.93%	97.33%	97.24%	92.59%	96.79%
Emergency Department	96.48%	95.59%	91.14%	79.05%	96.48%
Estates & Facilities	94.27%	94.47%	94.26%	100.00%	95.45%
Integrated Care	98.88%	98.11%	96.03%	93.44%	97.68%
Medicine & Urgent Care	96.84%	94.35%	88.82%	91.75%	94.80%
Surgery	98.41%	96.08%	94.31%	88.35%	95.33%
Women & Children	99.53%	98.46%	98.14%	95.17%	97.39%

3.10.3 A summary of the improvement in training compliance levels from March 2023 to March 2024 can be summarized as follows:

	Green	Amber	Red	Higher in 2023	Higher in 2024
Mar 23	17	16	12	6	39
Mar 24	29	13	3		
Difference	+12	-3	-9		

3.10.4 A target of 100% senior leaders training was not achieved in 2023-2024. This was due to the fact that no courses were delivered in the period. Further courses will be planned for 2024-2025.

(Note: The Health & Safety & Risk Manager is in contact with Institution of Occupational Safety & Health (IOSH) with regards to the possibility of IOSH training courses to be delivered in-house – with a significant potential cost savings for the Trust – or for in-house training to become IOSH-accredited and will report back on this in the next Annual Report.)

4 HEALTH AND SAFETY PLAN 2022 – 2024

4.1 An independent audit of the health and safety arrangements of the Trust was carried out in September 2020. The aim was to assess compliance of current health and safety arrangements in place and to carry out a gap analysis and identify areas for improvement. The methodology used was to compare against a recognised ISO standard for Health & Safety (ISO45001). From the findings of the audit a Health and Safety Plan was developed to address gaps identified.

4.2 A summary of the progress of the Health and Safety Plan and Roadmap since its adoption in 2022 is as follows:

Indicator	Update
Develop a Health and Safety Manual using ISO45001 as a foundation.	The health and safety manual was been partially written by the previous Health & Safety & Risk Manager, and continues to be progressed by the new post-holder.
Initiate a triannual independent audit of safety management in line with ISO 45001	To be looked at in 2024/25 when new initiatives and arrangements have been implemented and bedded-in, and the Health & Safety Joint Consultative Group (guided by the Health & Safety & Risk Manager) is satisfied that The Trust is completely ready for an independent audit.
Carry out a gap analysis of Trust compliance against the NHS Workplace Health and Safety Standards 2022.	Work is ongoing and will continue in 2024/25, with the H&S JCG receiving regular progress reports. (Note. The two newly formed H&S Collaborative Forums - H&S & Staff-Side, and H&S & Divisional Governance - will have a greater practical involvement.)

Populate the trust legal register.	This is an ongoing piece of work that will remain on the Health and Safety plan indefinitely. Estates and Facilities are populating parts of the register in relation to areas within their control.
Raise awareness of the Health & Safety Policy using a campaign targeting at all levels to: Engage with duty holders, accounting officers and front line teams so that they know their individual and collective responsibilities;- Clarify expectations of all employees, visitors and contractors	The trust Health and Safety Policy was reviewed, updated and re-issued in February 2024.
Safety audit and inspection: - Update the Health and Safety audit matrix in this document.	Health and Safety audits are now embedded. Frequency of the audits was changed from monthly to quarterly from October 2024, with additional “H&S walkabouts” promoting increased staff-side and trade union involvement being promoted.
Update and approve a Safety Management Strategy to: - Shape the Board’s goals and ambition for safety management; - Support the adoption of a proactive, anticipatory safety culture; - Drive demonstrable improvement in safety outcomes.	The Health and Safety Strategy was written and approved.
Review the Duty Holders Matrix setting out (for each identified hazard arising from the Trust’s undertakings and primary activities undertaken by the Trust and contractors): - The hazard, who might be harmed and how; - Who the duty holder is; - Who the responsible person for implementation is; - How the hazard is controlled; - Updated evaluation of risk; and - Who to contact for advice.	Duty holder’s matrix is now embedded and updated quarterly. In 2024/25, the Matrix will be reviewed and further questions asked on assurance.
Obtain written confirmation from new Duty Holders and responsible officers that confirm they: - understand and agree to the responsibilities assigned to them for the oversight and management of specific safety hazards; - are clear on their obligations for planning, implementation, monitoring and assurance for each duty assigned to them	As above
Undertake specific ‘safety climate survey’ to assess and evaluate safety culture, and benchmark results with Other NHS Trusts and IOSH Healthcare Group.	This was not completed due to having an agreed method of delivery. This will remain on the Health and Safety Plan 2024-2025.

Explore ways to make safety more prominent within the Trust's organisational values and behaviours	This is an ongoing piece of work that will remain on the Health and Safety plan indefinitely.
Review and confirm responsible persons/Manager training provision for safety management. Where any gaps are identified a personal development plan is developed and agreed with relevant line managers	This is an ongoing piece of work that will remain on the Health and Safety plan indefinitely.
Review the role and contribution of the Health & Safety Consultative Group, using this opportunity to: - Secure operational representation at senior level; - Secure involvement of Communications Officer; - Secure input from Service Improvement Specialist; - Develop, review and approve safety management plan; and - Oversee safety management performance	This was carried out within an annual review of the Terms of Reference in both March 2023 and March 2024. The 2024 review changed the Group meetings frequency from monthly to quarterly, whilst introducing an AGM, and two quarterly "collaborative forums" (H&S & Staff Side Reps, and H&S & Divisional Governance)
Develop, approve and establish an annual Safety Management Plan subject to annual review that: - Flows directly from the safety risks incorporated into the Duty Holders Matrix above; - Identifies resource requirements for implementation and records the Board's decision on those resource requirements; - Sets clear safety management goals and objectives for the year ahead as prioritised within the Safety Management Strategy - Annual Safety Management Plan is based on a systematic review of safety performance using a balanced mix of leading and lagging key performance measures	This was completed in 2022-2023 and will require a review for 2024-2025.
The following leaders to undertake and successfully complete accredited IOSH training commensurate with their role in effective safety management: - Board of Directors - Deputy Director of Quality Governance - Business Group Directors - Directors of major corporate functions	This was delivered, however this will need to be repeated to ensure newly appointed leaders are trained.
Review the content and frequency of Health & Safety training provided to all staff on induction and through routine refresher courses to ensure that: - The training provided to all members of staff is sufficient and meets organisational needs and safety priorities;	This was not completed. This needs to remain on the Health and Safety plan for 2024-2025.

Determine and agree budget requirements to implement the safety management plan: - Ensure appropriate linkage between Safety Management and Capital Expenditure Plans	This is ongoing.
Each Business Group and major corporate function will establish and maintain a local safety management plan and determine relevant safety performance measures	Complete – annual reviews required.
Develop, agree and implement a suite of suitable leading and lagging safety performance measures in to test specific risks control strategies and procedures	Complete - annual reviews required.
Identify and implement a system which links staff absence reported as work related to incident investigation and Occupational Health activity.	Workforce and OD now supply data relating to work-related absence and costs.
With the contribution of the Health & Safety Consultative Group, HR, Occupational Health and Health and Wellbeing Group explore ways to reduce; • Work-related stress within the Trust. • Violence and aggression to staff• Sharps injuries • Moving and Handling Injuries • Slips and Falls	This is ongoing.

4.3 The Plan will be fully reviewed in 2024/2025

5 CONCLUSION

5.1 This report highlights the significant level of H&S focussed activity that has been undertaken during the 2023-2024 period, to improve the management of health and safety in the Trust.

5.2 The H&SJCG continues to promote every facet of the Trusts H&S Strategy while measuring each outcome against the declared objectives and associated metrics. This essential group is supported by the Trust Executive Management while also receiving key information and assurances from its key sub groups, in support of a safe and compliant Health and Safety management system.

Meeting date	6th June 2024	**Public**	**X**	**Agenda No.**	18
Meeting	Board of Directors				
Report Title	Transformation Annual Report 2023/24				
Director Lead	Angela Brierley, Director of Transformation	**Author**	Hannah Silcock, Assistant Director of Transformation		

Paper For:	**Information**	**X**	**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors are asked to review and confirm the Transformation Annual Report 2023/24					

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	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 this paper is to provide an update to the Board on service transformation initiatives across both Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust.

This paper describes a number of service transformation initiatives that have led to, or are leading to, improvements whilst continuing to build and nurture a culture of continuous improvement. It should be noted that several of these have also contributed to supporting wider organisational effectiveness that is often difficult to capture. Across Stockport Foundation Trust (FT) 22 improvement schemes have taken place over the last 12 months. 12 of these schemes have been completed and are continuing to show good progress within the relevant teams. 10 are currently active, with 2 of these having recently commenced.

Examples of some of the improvements made include:

- Digital Health Development Programme - Stockport have also implemented a virtual ward, which to date has seen 1350 patients referred via both step-up and step-down pathways, leading to Stockport's Virtual Ward saving approximately 4145 bed days and £1.2million saved.
- Medicolegal pathway improvement project - We have seen a reduction in informal complaints of 71% between July and October 2023 and an increase of over 40 additional GDPR requests completed each month.
- District Nursing Efficiencies and Productivity Project – A new rapid response team proof of concept pilot was established, and over 1000 people have now been seen through this pilot, and receiving

positive feedback from our patients and our staff. A new capacity and demand tool has also been established, and presented to the Greater Manchester Community Services Forum to share learning. This tool is now enabling the team to review and respond to their referrals and ensure timely interventions, whilst being responsive to changing demand as necessary.

In addition, this paper highlights how we effectively use our transformation resources to support operational and clinical colleagues in a variety of ways to demonstrate our high-quality services and high performing teams across both organisations.

The Board has previously received reports relating to progress with the service transformation programmes across the organisation. These programmes are discussed and monitored through the monthly Service Improvement Group, which is chaired by the Chief Executive.

The Board are asked to note the work that has been undertaken to date.

TRANSFORMATION TEAM ANNUAL REPORT

2023-24

Prepared By:

Hannah Silcock

Assistant Director of Transformation

Date:

April 2024

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Message from the Transformation Leadership Team

Angela Brierley
Director of Transformation

Hannah Silcock
Assistant Director of Transformation

We are thrilled to introduce our 2023/24 Annual Report, which describes continuous improvements during an exciting and challenging year for both organisations, and the whole of the NHS.

Our joint Transformation Annual Report for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust celebrates some remarkable improvements for both organisations throughout the year.

The Transformation Team have empowered, supported and celebrated our vibrant and diverse organisations to make improvements across wide reaching areas, in order to support our clinical and operational colleagues to drive continuous improvements.

We are really proud of our team, and the flexibility and agility team members have demonstrated whilst supporting a number of transformation programmes to support improvements for our patients and staff.

As we look towards the year ahead, we will build on our successes – continuing to strengthen our improvement offer through our Continuous Improvement Strategy, increasing our focus on education and training to build capability and capacity across both organisations.

We hope you enjoy reading about some of our achievements from 2022/23. We are looking forward to seeing our progress develop and grow into 2024/25.
If you have any questions about the work we do please get in touch:

Stockport: transformation.team@stockport.nhs.uk
Tameside: servicetransformation@tgh.nhs.uk

Transformation Team

The last 12 months have been a busy period for the Transformation Team, across both sites. The team are now working to a new and improved structure, to use our resources more effectively, allowing for opportunities for career progression which speaks to our NHS People Promise.

Additionally, our "ADOPT Continuous Improvement" strategy has been developed and approved. Implementation plans are in place with a particular early focus on our training packages to build capability and capacity across both organisations.

Finally, we have introduced a Transformation Communications and Promotions Officer role to the team, to support both organisations to celebrate their improvements and successes, using a variety of media options.

Alongside these opportunities to develop ourselves as a team, we have continued to support both organisations with their improvements and transformation programmes, provided training to our staff, and hosted 2 successful events to celebrate improvement successes.

It has been an incredible 12 months in the Transformation Team, alongside the vast improvements that have been occurring across both sites. We look forward to the changes made this year, propelling us forward in 2024-25.

Our year in Numbers

13 Time in motion studies

38 Storyboards

12 Lumina Spark Sessions

7 Away Days

45 Workshops

17 Newsletters

122 Process mapping sessions

28 Training Sessions

22 Completed schemes

16 Active schemes

12 Podcasts

14 Leaflets

16 Learn & Shares

12 Surveys

1 Website

11 Courses attended

46 Presentations

226 Visuals

14 Award Submissions

14 Events

28 Videos

11 Sprints

12 Business Cases

4 Accreditations

Tameside & Glossop
Transformation Schemes 2023-24

Tameside and Glossop Transformation Programme 2023-24

Division	Corporate				Clinical Support Services			
Scheme	Cancer Improving Outcomes	Patient Safety Framework	Sepsis	Hospital @ Night	Outpatients	Pharmacy	Pathology	Virtopsy
Objective	To implement best timed pathways, for faster diagnosis. Support prevention and early identification of cancer and implement patient led follow up pathways.	To successfully implement the Patient Safety Incident Response Framework across T&GICFT and Stockport NHS Foundation Trust.	To be able to recognise and diagnose sepsis sooner and improve our care for those diagnosed with sepsis.	To introduce a Hospital @ Night team with the ultimate goal of improving the safety of patients at night by the standard of right people, right place, right time.	To introduce new virtual outpatient pathways, reduce follow up appointments and improve patient experience and efficiency of Trust outpatient services.	To review current processes & improve patient experience. To improve staff well being and provide education to colleagues on pharmacy procedures.	The aim is to improve results turnaround times, review skill mix, recruitment, culture, capacity and demand mapping and futureproofing the service.	To reduce invasive autopsies carried out within the organisation, and reduce the autopsy backlog.

Division	Surgery / Women and Children			Medicine and Urgent Care				
Scheme	Children, Young People & Families (Phase 2)	Theatre Quality and Safety Improvement	Maternity Improvement	Urgent and Emergency Care Improvement	Ward Standards Project	Inpatient pathways	Delirium	Cardiology Improvement Project
Objective	Health Visiting and School Nursing services to be complaint with the modernised, national Healthy Child Programme and the core offer is to be consistent across Tameside.	To improve Theatre utilisation to improve efficiency, ensure substantive workforce development to meet demand, and improve culture, health and wellbeing of the Theatres workforce.	To implement Ockenden actions and recommendations, reduce staff turnover and improve staff retention. To deliver Maternity Safety Standards and improve patient experience.	To support the organisation with patient flow through the department, effective processes and developing digital solutions.	To support the delivery of plans through a range of approaches from writing business cases to having the capacity to investigate options to fully understand the impacts.	To review our capacity and flow of the organisation, focusing on reduced length of stay and readmissions.	To improve delirium diagnostic accuracy and identification. To develop clear pathways, education and awareness.	To improve our efficiencies and productivity within the service, whilst looking for new ways of working that will improve patient experience.

The Tameside & Glossop Transformation Team have been involved in 16 improvement schemes in 2023-24. 10 of these schemes have been completed and are continuing to show good progress within the relevant teams. 6 are currently active, with 2 of these having recently commenced with more schemes commencing imminently.

Tameside & Glossop

Completed Transformation Schemes

Maternity Improvement Programme

The Maternity Improvement Programme has focused on issues raised nationally through the Ockenden Reports, alongside local priority areas for improvement.
Through this programme, we have seen the following key benefits for our service users and staff:

- Ockenden actions compliance = 100%.
- Maternity Safety Standards compliance = 100%.
- Essential Training has improved from 46% compliance Feb 23 to 95% Dec 23.
- Mandatory Training has improved from 21% compliance April 23 to 94% Dec 23.
- A new website has been developed: tamesideandglossopmaternity.nhs.uk.
- Maternity Theatres business case has been approved.
- Successfully recruited more midwives by redesigning our recruitment methods.
- Intentional rounding tool has been introduced and embedded.
- We are currently working towards Baby Friendly Accreditation.

Pharmacy Improvement Project

The pharmacy project aimed to improve the patient experience by improving flow, creating a better environment for patients, improving communications and manage patient expectations. Additionally, they sought to improve team morale and communications across clinical teams.
Improvements within the team include:

- Increased communications with patients, including posters in waiting areas and a story wall installed in the Pharmacy waiting room to improve communications and help patients understand the checks a prescription goes through.
- A prescription box has been installed for out of hours drop offs.
- Trustwide communications including updates to the intranet page, Meet the Team through the Trust communications channels.
- A discharge trolley has been implemented to ensure more timely turnaround times for discharge medications on the wards.

Tameside & Glossop

Completed Transformation Schemes

Patient Safety Incident Response Framework (PSIRF) Implementation

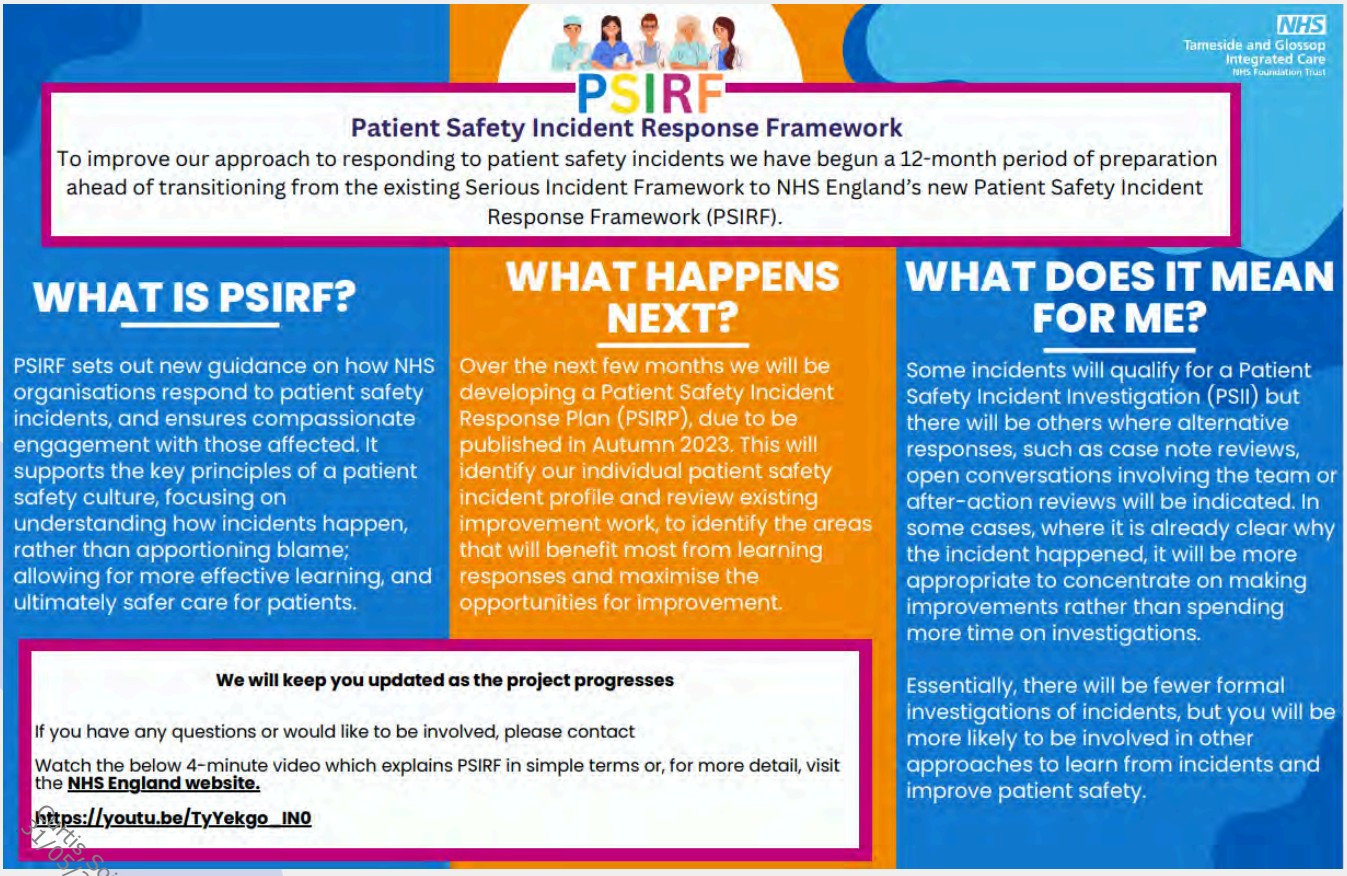
The PSIRF is a national framework that supports the development and maintenance of an effective patient safety incident response system, replacing the Serious Incident Framework (2025). It integrates 4 key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

As part of this area of work, a Patient Safety Incident Response Plan has been developed identifying the local priorities.

Drop-in sessions have taken place to inform all staff of what PSIRF is and what it means. Patient safety syllabus training level one is now live on ESR for all staff to complete. Level two training is currently being compiled. A second round of PSIRF drop-in sessions are underway for staff who are investigating officers.

PSIRF will take a few years to fully embed however the rollout is well underway.



Tameside & Glossop

Completed Transformation Schemes

Virtopsy Implementation Project

"Virtopsy is an incision free procedure, using imaging methods that are used in clinical medicine such as CT and MRI imaging in the field of autopsy to find the reason for death".

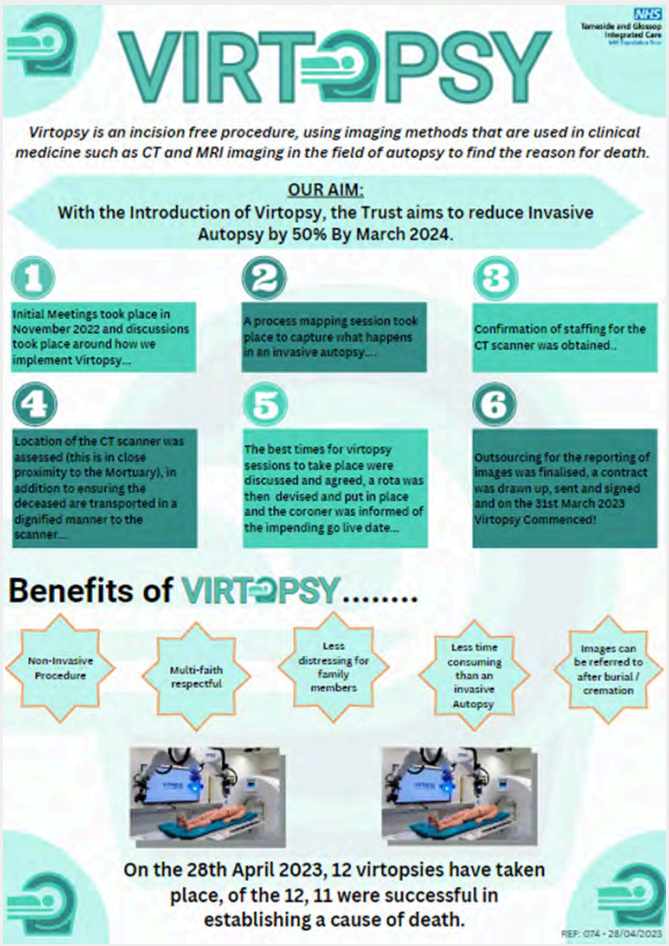
The aim of our virtopsy project was to reduce invasive autopsy by 50% by March 2024 and reduce autopsy backlog from 1 week to an average of 3 days.

Benefits of Virtopsy:

- Less time consuming than an invasive autopsy.
- Less distressing for family members.
- Multi-faith respectful.
- Images can be referred to after burial / cremation.

Virtopsy went live on 31st March 2023 at Tameside & Glossop ICFT. So far, we have completed 330 virtopsies. With the introduction of Virtopsy, invasive post-mortems had reduced by 31% and the turnaround time for invasive post-mortems has reduced dramatically from up to 15 working days to 1-2 working days.

In the initial stages of introduction, 3 virtopsies were carried out per week, this has now been increased to 9, equating to nearly 50%, and therefore achieving the ambition of the service.



Pathology Improvement Project

The Pathology Improvement Project was developed to focus on improving staff experience and wellbeing; improve our processes; improve communications; and improve education and awareness. Significant developments and improvements made. Some of these include:

- A departmental shared vision has been produced and circulated following a series of away days.
- Weekly huddles were introduced within the department, and a closed-loop communication approach applied to matters that may arise.
- Rebranding of the service to the "Department of Laboratory Medicine" occurred, to reflect the multi-profession staffing within the team.
- A staffing review saw a new staffing strategy produced to support recruitment and the introduction of an apprentice biomedical scientist and T-Level student commencing in January 2024.
- A re-organisation of lab space occurred to support productivity.
- Senior team members, in conjunction with the Medical Director, have worked with GP colleagues to reduce the % of paper diagnostic requests being sent to the department. There was a notable reduction from 9.7% to 2.9% with a projected numerical value of 25,000 in a 12-month period. This has impacted massively on the staff, releasing time and boosting team moral.

Tameside & Glossop

Completed Transformation Schemes

Hospital at Night

With the key objectives of "right people, right place, right time" this project aimed to improve the safety and quality of care of patients overnight; improve the working experience of the clinical teams overnight; and improve the education; and training in the out of hours setting.

To do this the below work occurred:

- An analysis of workforce and workload during out of hours was completed.
- A review occurred into the clinical informatics offer to support safety and effective provision of care.
- An evidence-based business case for a hospital at night team was developed.

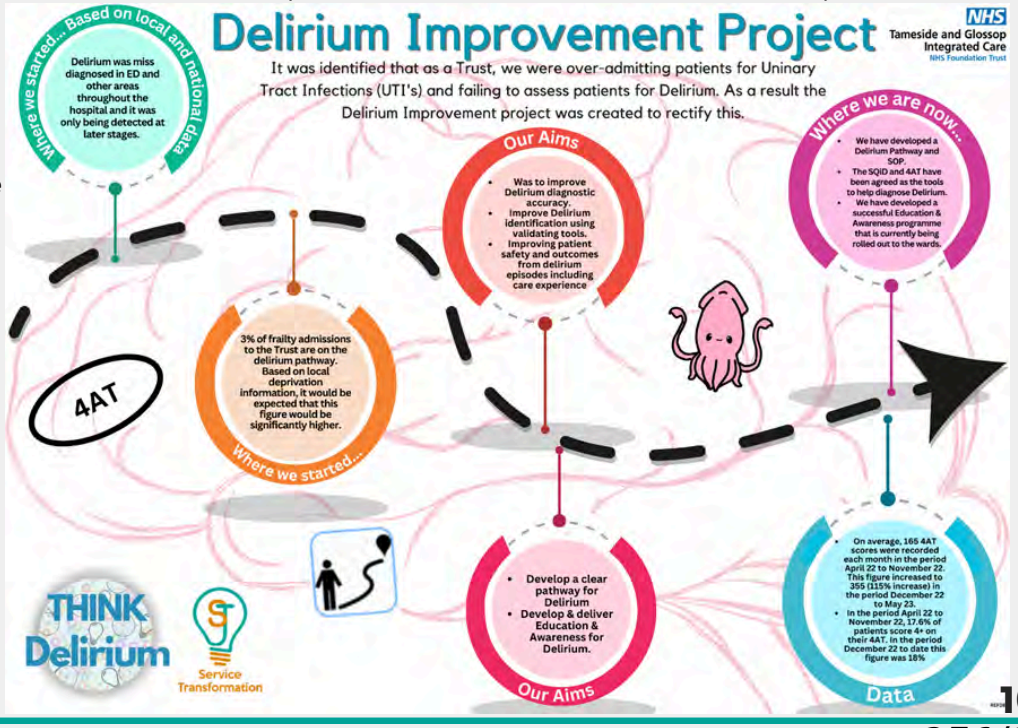
The foundations of this work are now complete and the work placed on hold until the our new EPR system is implemented.

Delirium Improvement Project

It was identified that, as a Trust, we were an outlier for over admitting people with urinary tract infections (UTI's) and were below standards in assessing patients for delirium. The aims of this project were to improve diagnostic accuracy; implement a validated tool for identification of delirium; embed a clear pathway and raise awareness through education.

Key achievements include:

- The implementation of the 4AT as part of the ED CAS card to improve diagnostic accuracy.
- ·CFS, NEWS2 & 4AT now being captured in ED 70 hours per week over 7 days, via Frailty SDEC.
- ·On average, 165 4AT scores were recorded each month in the period April 22 to November 22. This figure increased to 352 (113% increase) in the period December 22 to May 23.
- ·In the period April 22 to November 22, 17.6% of patients score 4+ on their 4AT. In the period December 22 to date this figure was 17.3%.
- Delirium identification tools have been agreed and developed to improve identification of Delirium.
- Delirium pathway has been developed and implemented.
- SOP for Delirium has been ratified and implemented.
- A communications campaign was launched to provide education and awareness.



Tameside & Glossop

Completed Transformation Schemes

Outpatient Transformation Programme

The aims of the Outpatient Transformation Programme were to embed Advice & Guidance; review referral and booking processes; improve utilisation; and launch Patient Initiated Follow Up (PIFU). Key achievements include:

- Above planned activity for Advice and Guidance, the successful launch of Advice and Refer in Cardiology and the development of Advice and Guidance on ward boards.
- A full DNA benchmarking exercise completed, leading to a review of all outpatient letters to ensure compliance against the locality average reading age. There has been a text message validation process across specialties and the implementation of a text message reminder service and a portal letter service.
- Divisions have worked to review utilisation, and reviewed all specialties in line with pre-covid Royal College of Physicians guidelines, and clinics have been amended as required.
- There has been a significant uptake in PIFU, notably within the Division of Medicine, with various communications strategies launched across all divisions to include PIFU Week(s); visuals for patients and professionals; development of a Trustwide PIFU Standard Operating Procedure; and implementation of electronic clinic outcome sheets.

Additionally, the Outpatient Transformation Programme benefitted from a patient representative throughout the duration of the programme, which added significant value to the outcomes and actions.

Children, Young People & Families (CYPF) Improvement Programme

Following the success of the CYPF Phase 1 programme, a 2nd phase was launched to continue the momentum of improvement within the services. The second phase set out the following ambitions:

- Health Visiting Team to be compliant with national and local KPIs, set for the 5 mandated contacts.
- Health Visiting and School Nursing resources to be aligned to reflect the differing indices of multiple deprivation (IMD) across Tameside.
- Health Visiting and School Nursing services to be complaint with the modernised, national Healthy Child Programme and the core offer is to be consistent across Tameside.
- Cared for Children Team review to be completed and the revised model is implemented.

Each domain has now been met and practice embedded.

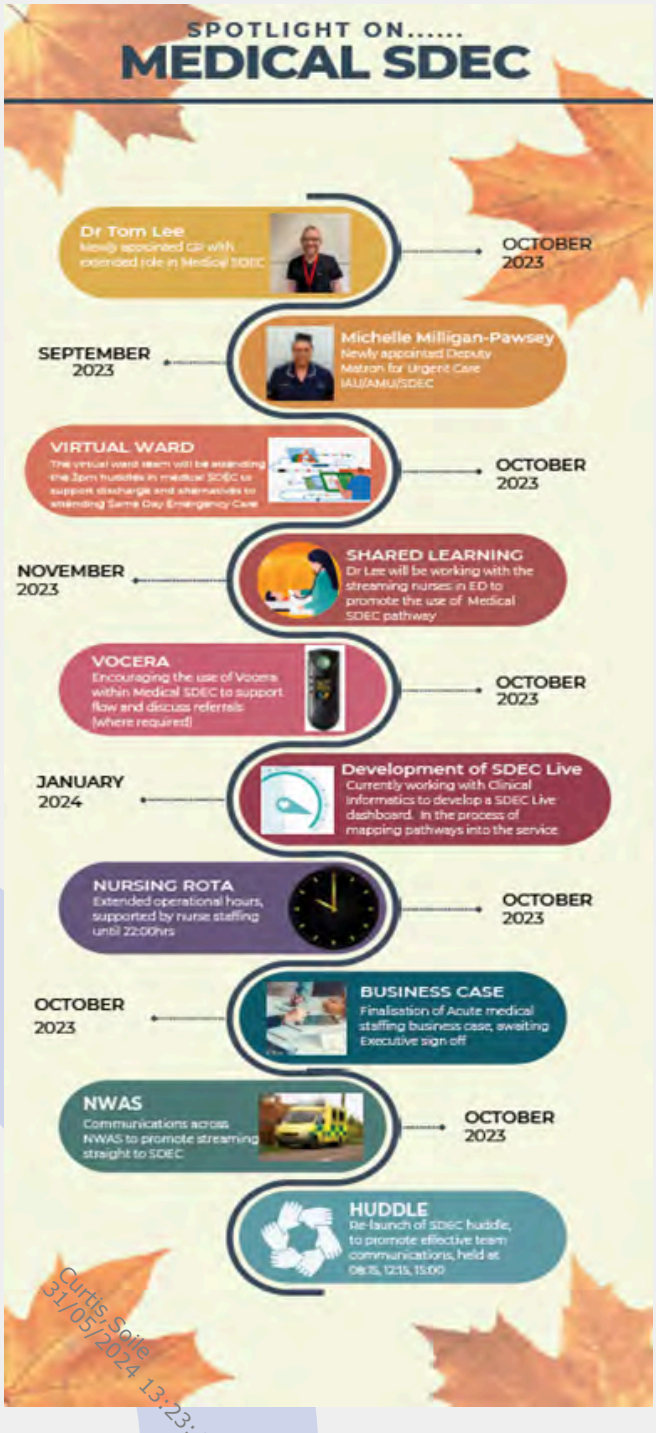
CYPF remains a key focus for the Trust, and next steps are currently in development to support a phase 3 to the programme.

Tameside & Glossop

Completed Transformation Schemes

Urgent & Emergency Care Transformation Programme

The Urgent & Emergency Care Programme aims to provide our patients with the right care, in the right place, at the right time. It aims to benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.



Over the last 12 months there has been a key focus on:

- Front door streaming.
- Ambulance Turnaround.
- Medical Same Day Emergency Care (MSDEC).
- Urgent Treatment Centre (UTC).

There has been significant investment into the education and training of the Digital Health streaming function, to support the effective streaming away from the front door. Clinical Pathways and inclusion criteria have been reviewed, to be in line with best practice guidelines. Communications have been improved between the front door and MSDEC by introducing Vocera devices and adopting a pull model into the service.

Following a successful nursing business case, we now have enhanced opening hours with criteria nurse-led discharging introduced to reduce unnecessary admissions.

Through a 'missed opportunities review', there is now further engagement with NWAS to increase the number of direct referrals. This work has begun and has had significant engagement to date.

Furthermore, the electronic Manchester Triage Screening launched and an audit of UTC attendances and engagement with Digital Health, with bookable appointments now implemented.

Planning has now commenced for a full system approach, with our partners, to improved Urgent and Emergency Care starting and ending in the community, with ongoing improvements to our Urgent and Emergency Care services at the hospital, as well as our inpatient flow processes. Taking a systemwide approach to our patients journey to access urgent support, will support a greater transformational piece of work for our population.

Tameside & Glossop

Active Transformation Schemes

Theatres Quality & Safety Programme

As the NHS continues to address the backlog of elective procedures exacerbated by the COVID-19 pandemic, enhancing theatre facilities is essential for increasing surgical capacity and efficiency. Through 10 different workstreams, our Theatre Improvement Programme is dedicated to improving theatre utilisation; developing a substantive workforce to meet demand; achieving a reduction in overspend; and improving the culture, health and wellbeing in the wider theatres team.

Key achievements to date include:

- Number of lists and 4 hour sessions have increased by 5.86% and 7.89% respectively with an increase in Elective Lists of 9.22% and Elective 4hr sessions of 4.21%.
- Number of cases increased by 12.18% (15.04% for Elective) with average cases per 4hr session increasing from 2.05 in 2022 to 2.13 in 2023 for all cases and from 2.21 in 2022 to 2.43 in 2023 for Elective.
- Elective Touchtime Utilisation in December was 92% increasing from an average of 88% between September and November and a significant improvement on the reporting TT Utilisation of 83% in December 2022.
- Elective Capped Utilisation was 86%. This is not only a significant improvement on the 79% reported for December 2022 but the highest reporting Capped Utilisation in both 2022/23 and 2023/24.

Sepsis Improvement Programme

The Sepsis Improvement Programme went live in February 2024, with an aim to improve our recognition of sepsis and improved processes for those diagnosed with sepsis. Despite being in its infancy, this programme has:

- Recruited 31 Sepsis Fellows from junior and middle grade Doctors. The launch date for this programme is 1st May 2024.
- Delivered sepsis training to the new rotation of Emergency Department Junior Doctors.
- Planned Sepsis Month (April 2024) for the Emergency Department.
- Accepted to be in phase 1 of the national Martha's Rule implementation.
- Reviewed and launched the Sepsis Bundles in line with latest Sepsis Trust Guidance.
- Engaged with Ward Managers to identify areas for improvement.
- Promoted Sepsis SIMS training.

A Power BI dashboard is in the process of development in line with agreed KPI's, alongside a balance scorecard, and a sustainability review taking place.

Tameside & Glossop

Active Transformation Schemes

Ward Standards Improvement Project

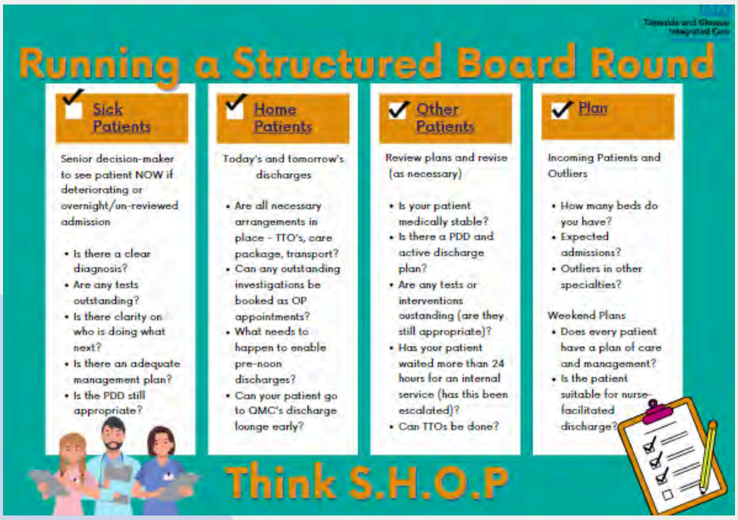
The Ward Standards Improvement Project was tasked with improving the quality and safety of the care delivered to patients, ensuring they receiving the right care in the right place. To do this successfully the group focused on the below areas of work to improve:

1) Processes for patients with a length of stay more than 7 days – A new process has been implemented for patients who are medically fit and awaiting discharge. These patients are reviewed weekly and issues are highlighted to enable correct escalation. Additionally, Multidisciplinary Team ward rounds have been trialled, to review patients and help to support flow for long stay patients.

2) Criteria Led Discharge - A policy has been written to support criteria-led discharge in the Trust, and awaits enablers for implementation. There is also a focus on improving utilisation of step down transfers to the Trusts virtual ward.

3) 7 Day Discharge Standards – Using soft intelligence, focusing on the effectiveness of consultant led weekend ward rounds and the limitations of medical golden discharge patients to understand the areas for improvement and focus.

4) Implementing the SHOP model & SAFER Principles – The SAFER Patient Flow Bundle is a practical tool that reduces delays for patients in adult inpatient wards (excluding maternity). The SHOP model focuses on running a structured Board Round and safety of patients in our care. This project has focused on embedding these models and identifying and supporting wards struggling to enact these. SAFER stickers have been implemented for use on ward rounds and newly appointed sepsis fellows are supporting the embedding of the SHOP model.


Running a Structured Board Round
Sick Patients
Senior decision-maker to see patient NOW if deteriorating or overnight/un-reviewed admission
• Is there a clear diagnosis?
• Are any tests outstanding?
• Is there clarity on who is doing what next?
• Is there an adequate management plan?
• Is the PDD still appropriate?
Home Patients
Today's and tomorrow's discharges
• Are all necessary arrangements in place - TTO's, care package, transport?
• Can any outstanding investigations be booked as OP appointments?
• What needs to happen to enable pre-noon discharges?
• Can your patient go to QMC's discharge lounge early?
Other Patients
Review plans and revise (as necessary)
• Is your patient medically stable?
• Is there a PDD and active discharge plan?
• Are any tests or interventions oustanding (are they still appropriate)?
• Has your patient waited more than 24 hours for an internal service (has this been escalated)?
• Can TTOs be done?
Plan
Incoming Patients and Outliers
• How many beds do you have?
• Expected admissions?
• Outliers in other specialties?
Weekend Plans
• Does every patient have a plan of care and management?
• Is the patient suitable for nurse-facilitated discharge?
Think S.H.O.P


Think S.A.F.E.R
S enior Review
All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A ll Patients
Will have an Expected Discharge Date and Critical Criteria for Discharge, set by assuming ideal recovery and assuming no unnecessary waiting.
F low
Of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
E arly Discharge
33% of patients will be discharged from base inpatient wards before midday.
R eview
A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days - also know as 'stranded patients') with a clear home first mind set.

Cardiology Improvement Project

The Cardiology Improvement Project has set an ambition to develop a one-stop model for Cardiology. This will mean that when a patient attends their Cardiology clinic appointment, they will also receive their diagnostics and results/next steps on the same day.

Additional aims of this scheme include the development of a Pacemaker Home Monitoring Service; developing a Physiologist-led service; develop spirometry training and education.

The outcomes of this project will have notable patient experience and outcome benefits. Additionally, it should support some efficiency savings.

Tameside & Glossop

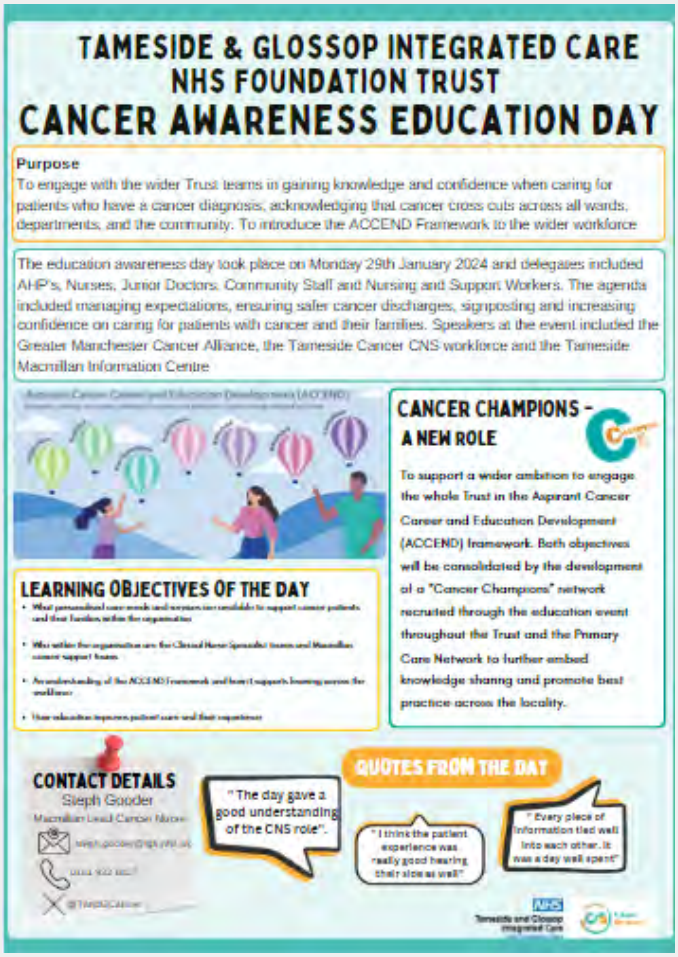
Active Transformation Schemes

Improving Cancer Outcomes Programme

This scheme of work has been designed as a direct response to the NHS Long Term Plan. As part of the NHS strategy, 3 key ambitions for cancer are prevention & early identification; faster diagnosis & standardised care (FDS); personalised care.

Key areas of development over the last 12 months include:

- A new one-stop model for HPB cancers aiming for diagnosis by day 21.
- Review of Urology service complete.
- Gynaecology pathways process mapped and improvements being implemented.
- Head and neck clinics reviewed and actions taken to review timings and radiology support.
- Reviewing opportunities for Artificial Intelligence in the lung pathway.
- Health Needs Assessments in place for all tumour groups.



- Infoflex implemented in Breast and Colorectal pathways to support improved governance around patient stratified follow ups.
- Cancer application developed for patients to access more information about their care.

Inpatient Pathways Improvement

Inpatient pathways is a new scheme, aiming to look at the capacity and flow of the organisation. Key areas of focus will be around embedding criteria-led discharge; reviewing allocation processes for beds; bed modelling; preventing avoidable admissions; reducing readmissions and length of stay; and improving our pharmacy and take home medication processes.

Initial areas of focus include monitoring patients with COPD and how their relevant pathway impacts on readmissions and length of stay. Working with both acute, and community teams, to help streamline these processes and improve quality of care for our patients.

This work will feed into our wider Urgent & Emergency Care Delivery Programme.

Stockport Transformation Schemes 2023-24

Stockport Transformation Programme 2023-24

Division	Corporate		Medicine				Women & Children's				System
Scheme	Cancer Improving Outcomes	Medicolegal Pathway	Diabetes	Respiratory Outpatients	Haematology	Medical Theatres	Antenatal Pathway Review	Children's, Young People & Families	ADHD pathway redesign	Gynae SDEC	Frailty
Objective	To improve our efficiencies in time to diagnosis, and ensuring personalised care and follow ups.	To improve processes to ensure the organisation meets compliance with the UK GDPR Subject Access Request timescales.	To review the internal Stockport FT adult diabetes services and pathways services for patients living with diabetes.	To improve efficiency of Respiratory Outpatient Service in light of high demand and limited services.	To improve patient experience and maximise the services productivity by enhancing the efficiency and responsiveness of the Haematology Service.	To ensure theatre usage is maximised within ophthalmology & ENT services by reviewing the patient journey from pre-op to post-op care.	Ensure safety of service users of the antenatal services & timely review for women on scan pathways.	To improve pathways that our patients under the age of 18 access, including supporting their transition to adult services.	To improve the ADHD pathway by brining all services in-house, making efficiencies and improving experience.	To complete a service review on Jasmine Assessment Unit against national Gynae SDEC standards to develop a Stockport Gynae SDEC service model.	To support a system wide approach to improving Stockport's frailty offer, including a standardised approach to identifying frailty & developing clear pathways.

Division	Integrated Care			Clinical Support Services		Surgery					
Scheme	Digital Health Development	District Nursing Redesign	Advanced Practice Future Model	Outpatients	Endoscopy	Pain Management EBCD	Pain Management EBCD phase 2	Elective Bookings Admin Review	Surgery Out of Hours	Theatres Efficiency & Productivity	Opioid Stewardship
Objective	To increase our digital offer so patients can be treated in the right place through implementing a new LCAS 111 pathway, a virtual ward & increased support to care homes.	To review and redesign the District Nursing team and processes to make efficiencies, contributing to improved patient care and staff engagement.	To develop the model for Advanced Clinical Practitioners, improving efficiencies and productivity within the service.	To improve patient experience of their outpatient journey, enhancing the efficiency of Trust outpatient services.	To ensure that the utilisation of endoscopy sessions are fully maximised.	To identify opportunities to maximise efficiency of current practices for triage and initial appointment, through a co-designed model of practice.	To expand the success of phase 1 by identifying opportunities to improve the remainder of the patient journey, through a co-designed model of practice.	To deliver a fully centralised elective booking and scheduling structure for surgical specialties across the Trust.	To improve the provision of out of hours medical staffing and support in the surgical division, improving effective flow of patients from ED to SAU.	To ensure theatre usage is maximised by reviewing the patient journey from pre-op to post-op care.	To maximise peri-operative patient opioid management pathways in line with national guidelines

The Stockport Transformation Team have been involved in 22 improvement schemes in 2023-24. 12 of these schemes have been completed and are continuing to show good progress within the relevant teams. 10 are currently active, with 2 of these having recently commenced.

Stockport have been holding a transformation waiting list for support and allocation for the full 12 months, showcasing the culture for improvement that exists across the organisation.

Stockport

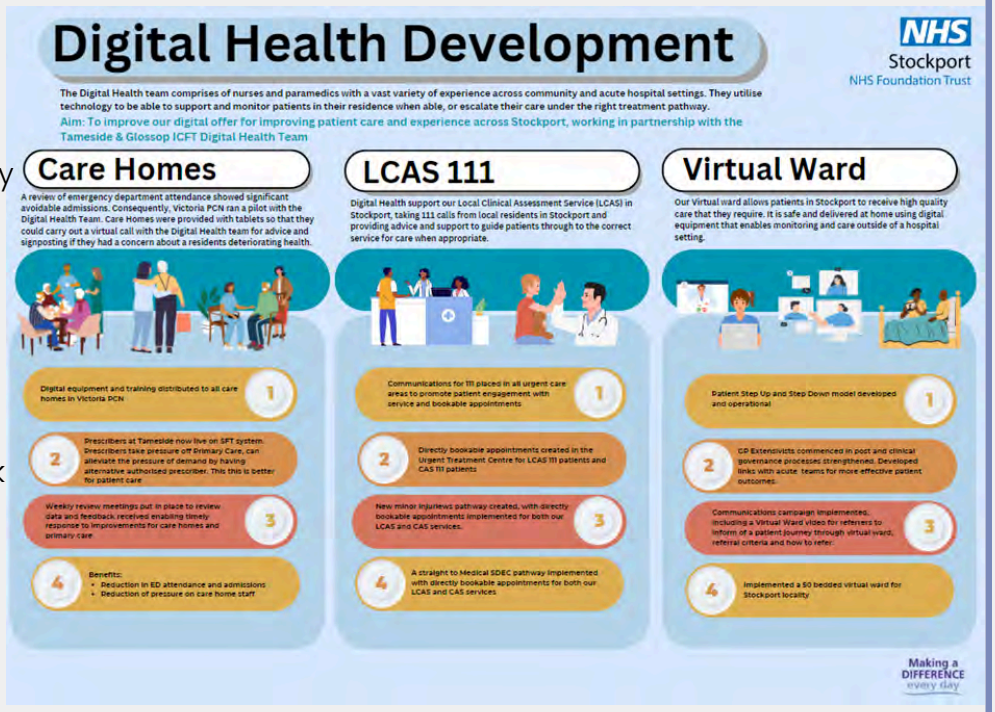
Completed Transformation Schemes

Digital Health Development Programme

The Digital Health Development Programme has focused on implementing the Tameside Digital Health team, to support people living in Stockport in 3 key projects: Local Clinical Assessment Service (LCAS) 111 service; Virtual Ward; Care Home pilot project.

Implementation of LCAS 111 occurred in September 2022. Since then, work has been ongoing to roll out the service and streamline pathways, to ensure patients can be seen by the most appropriate service and reduce avoidable attendances to the Emergency Department. Directly bookable appointment slots now exist with both our Urgent Treatment Centre and Medical Same Day Emergency Care Unit. A new Minor Injury Pathway with bookable appointments has also been created.

Stockport have also implemented a virtual ward, which to date has seen 1350 patients referred via both step-up and step-down pathways, leading to Stockport's Virtual Ward saving approximately 4145 bed days and £1.2million saved.



Finally, Digital Health have participated in a care home pilot across Victoria Primary Care Network, supporting care homes with deteriorating patients to seek advice and the best care for their residents. Benefits of this pilot include reduced ED attendances, improved staffing levels in care homes and reduced pressure on primary care.

Medicolegal Pathway Improvement

The Medicolegal pathway improvement project was undertaken to streamline processes and pathways; provide clear clarification on roles and responsibilities within the team; and ensure Subject Access Requests (SARs) are completed in a timely manner to meet the UK General Data Protection Regulation (GDPR) Standards.

Some of the achievements through this project include:

- Cleanse of backlog completed.
- Processes reviewed and streamlined.
- Clear roles and responsibilities established.
- Activity log dashboard created to support management and tracking on SARs.
- Utilised Egress for solicitors to ensure timely and secure communications.

Through the project, we have seen a reduction in complaints, a reduced backlog and SARs now being recorded in a timely manner.

Stockport

Completed Transformation Schemes

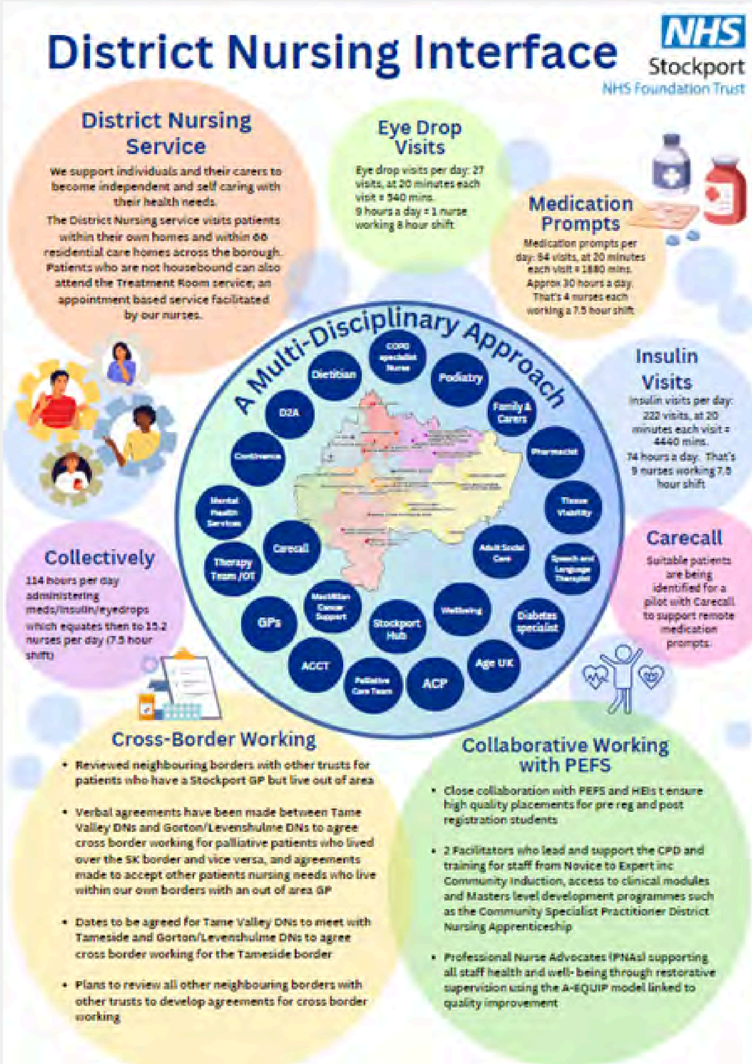
District Nursing Efficiencies & Productivity Project

This programme aimed to improve efficiencies and productivity within the District Nursing Team. It sought to create a better working model for our staff, including improved wellbeing; improved staff turnover rates; and investment in staff to retain within our service, whilst supporting continuous improvements to patient care.

The programme outcomes included:

- The implementation of two six-month secondment roles for the Rapid Response Team proof of concept.
- Centralised recruitment for the service with a workforce profile completed.
- Capacity & Demand Tool developed to allow for improved daily resource allocation.
- Deferral Guide developed to ensure safe deferrals of home visits.
- Pharmacy reviews introduced for polypharmacy and insulin dependent patients.
- Boundaries and cross border working agreed with neighbouring trusts.

The success of the District Nursing Improvement Project was widely communicated and celebrated, including at the Greater Manchester Community Services forum.



District Nursing Interface
NHS
Stockport
NHS Foundation Trust
District Nursing Service
We support individuals and their carers to become independent and self caring with their health needs.
The District Nursing service visits patients within their own homes and within 66 residential care homes across the borough. Patients who are not housebound can also attend the Treatment Room service; an appointment based service facilitated by our nurses.
Eye Drop Visits
Eye drop visits per day: 27 visits, at 20 minutes each visit = 540 mins.
9 hours a day = 1 nurse working 8 hour shift
Medication Prompts
Medication prompts per day: 94 visits, at 20 minutes each visit = 1880 mins.
Approx 30 hours a day. That's 4 nurses each working a 7.5 hour shift
A Multi-Disciplinary Approach
Dietitian
Podiatry
D2A
Family & Carers
Pharmacist
Continence
Tissue Viability
Mental Health Services
Carecall
Adult Social Care
Therapy Team /OT
Speech and Language Therapist
GPs
Macmillan Cancer Support
Stockport Hub
Wellbeing
Diabetes specialist
ACCT
Palliative Care Team
ACP
Age UK
Insulin Visits
Insulin visits per day: 222 visits, at 20 minutes each visit = 4440 mins.
74 hours a day. That's 9 nurses working 7.5 hour shift
Carecall
Suitable patients are being identified for a pilot with Carecall to support remote medication prompts.
Collectively
114 hours per day administering meds/insulin/eyedrops which equates then to 15.2 nurses per day (7.5 hour shift)
Cross-Border Working
Reviewed neighbouring borders with other trusts for patients who have a Stockport GP but live out of area
Verbal agreements have been made between Tame Valley DNs and Gorton/Levenshulme DNs to agree cross border working for palliative patients who lived over the SK border and vice versa, and agreements made to accept other patients nursing needs who live within our own borders with an out of area GP
Dates to be agreed for Tame Valley DNs to meet with Tameside and Gorton/Levenshulme DNs to agree cross border working for the Tameside border
Plans to review all other neighbouring borders with other trusts to develop agreements for cross border working
Collaborative Working with PEFS
Close collaboration with PEFS and HEIs t ensure high quality placements for pre reg and post registration students
2 Facilitators who lead and support the CPD and training for staff from Novice to Expert inc Community Induction, access to clinical modules and Masters level development programmes such as the Community Specialist Practitioner District Nursing Apprenticeship
Professional Nurse Advocates (PNAs) supporting all staff health and well- being through restorative supervision using the A-EQUIP model linked to quality improvement

Antenatal Improvement Project

The Antenatal Improvement Project aimed to improve patient safety and patient experience through an improved antenatal journey, leading to a reduction in missed appointments or scans, consequently improving outcomes for both mother and baby. Specific focus was placed on the antenatal clinic and ultrasound scan department.

Through the project, the following was achieved:

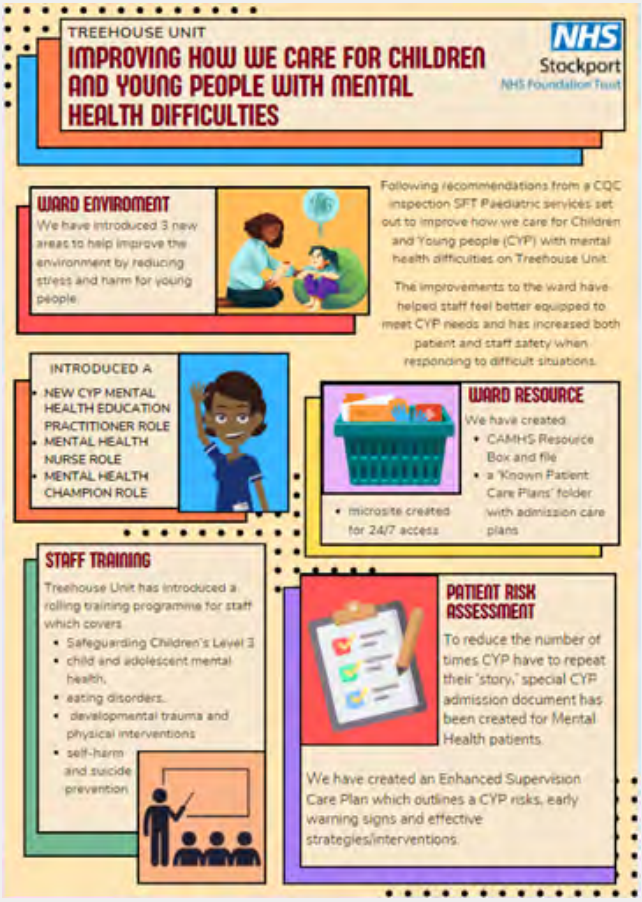
- A Gold Standard pathway was created, leading to the scanning department reviewing their vetting processes to support women getting more timely appointments.
- A reduction in DNA's through introducing the Trust nudge texting, improved signage for the clinic and an improved check-in system.
- Improved communications, including the creation of a daily electronic list, between the scanning department and antenatal clinic.
- Patients are now provided with their next appointment upon leaving their appointment.
- Improved coding of clinic outcomes, providing better data quality.

Stockport

Completed Transformation Schemes

Children, Young People & Families (CYPF) Improvement Programme

The CYPF programme provided an opportunity to review, integrate and streamline pathways across a variety of children's services to improve access to services and enhance the efficiency and responsiveness of services for children, in line with national objectives sets from the NHS Long Term Plan and Every Child Matters / The Healthy Child Programme.



The programme aimed to define robust, safe, effective and streamlined pathways to improve our services for patients under the age of 16/18. It did so through 6 key workstreams:

- School Nursing – where a new universal model has been implemented.
- Early Years Autism – SACS-R screening for children aged 11-22months has been implemented.
- Paediatric Mental Health – Mental Health assessments on admission have been embedded.
- Children's Safeguarding – Direct referral pathways to school nurses and Health Visitor teams established.
- Epilepsy Transition – Future transition model pathway scoped.
- Paediatric Speech and Language Therapy servic
- Collaborative work and agreement with GM ICB / SMBC /SFT Speech & Language Therapy Service to utilise Balance System Framework approach.

The success of this programme has led to a further phase 2 currently being scoped and established.

Advanced Clinical Practice Future Model

The advanced clinical practice future model project focused on revising our advanced clinical practice (ACP) model within our community integrated care division. The aim was to deliver a model of ACP that offered senior clinical assessment to patients within both proactive and reactive care to support out of hospital urgent care and neighbourhood model development.

This project has seen the following achievements:

- Staff engagement carried out from outset to enable staff to support the design of the new model.
- Engaged with system partners and stakeholders to understand the challenges and opportunities of the service and identify their requirements.
- ACP strategy developed and implementation plan initiated.
- ACP neighbourhood workforce co-located to enhance peer support, communication and collaboration within the team.
- New model agreed and organisational change process initiated.
- Referral pathways reviewed and streamlined.

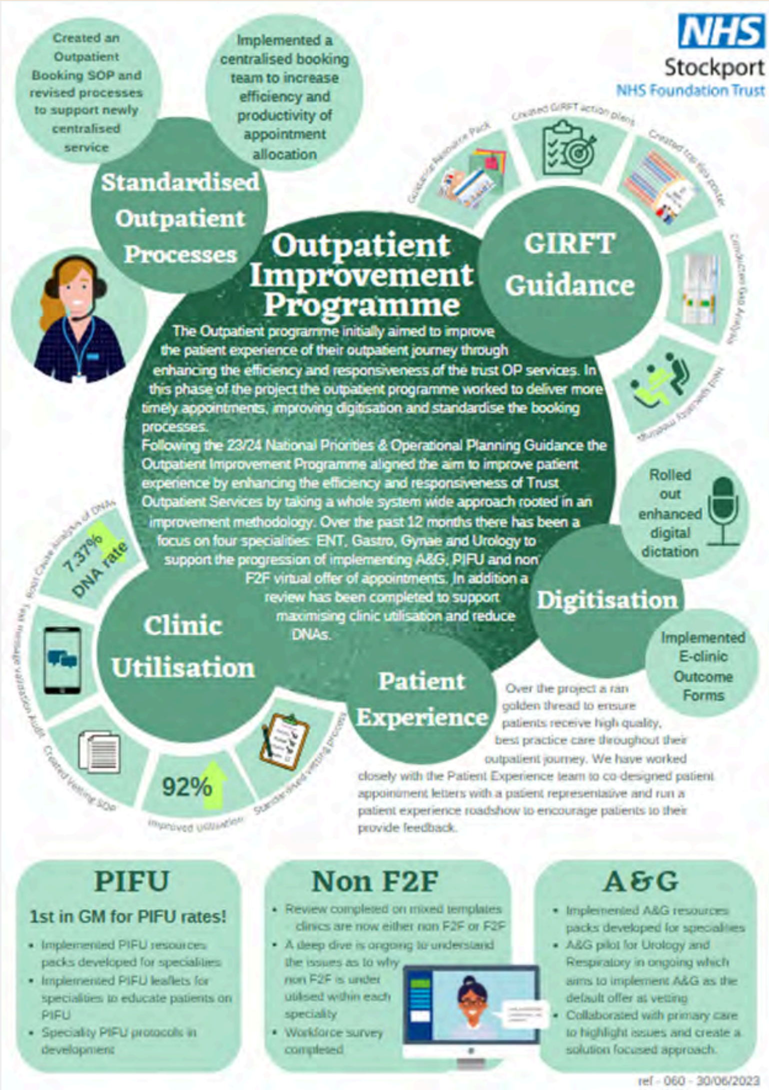
Stockport

Completed Transformation Schemes

Outpatients Improvement Programme

The Outpatient Improvement Programme focused on the significant challenge of an increasing demand for outpatient services, alongside supporting the national elective recovery initiative following the Covid pandemic. A combined, collaborative and innovative approach was key to support outpatient waits and demand.

The aim was to improve patient experience by enhancing efficiency and responsiveness of the Trust's outpatient services by taking a whole system wide approach in line with the Long Term Plan and Operational Planning Guidance priorities.



NHS
Stockport
NHS Foundation Trust
Created an Outpatient Booking SOP and revised processes to support newly centralised service
Implemented a centralised booking team to increase efficiency and productivity of appointment allocation
Standardised Outpatient Processes
Outpatient Improvement Programme
The Outpatient programme initially aimed to improve the patient experience of their outpatient journey through enhancing the efficiency and responsiveness of the trust OP services. In this phase of the project the outpatient programme worked to deliver more timely appointments, improving digitisation and standardise the booking processes.
Following the 23/24 National Priorities & Operational Planning Guidance the Outpatient Improvement Programme aligned the aim to improve patient experience by enhancing the efficiency and responsiveness of Trust Outpatient Services by taking a whole system wide approach rooted in an improvement methodology. Over the past 12 months there has been a focus on four specialities: ENT, Gastro, Gynae and Urology to support the progression of implementing A&G, PIFU and non F2F virtual offer of appointments. In addition a review has been completed to support maximising clinic utilisation and reduce DNAs.
GIRFT Guidance
Created GIRFT action plans
Created top tips poster
Guidance Resource Pack
Rolled out enhanced digital dictation
Digitisation
Implemented E-clinic Outcome Forms
Patient Experience
Over the project a ran golden thread to ensure patients receive high quality, best practice care throughout their outpatient journey. We have worked closely with the Patient Experience team to co-designed patient appointment letters with a patient representative and run a patient experience roadshow to encourage patients to their provide feedback.
Clinic Utilisation
7.37% DNA rate
Root Cause Analysis of DNAs
Created Vetting SOP
92%
Improved utilisation
PIFU
1st in GM for PIFU rates!
Implemented PIFU resources packs developed for specialities
Implemented PIFU leaflets for specialities to educate patients on PIFU
Speciality PIFU protocols in development
Non F2F
Review completed on mixed templates clinics are now either non F2F or F2F
A deep dive is ongoing to understand the issues as to why non F2F is under utilised within each speciality
Workforce survey completed
A&G
Implemented A&G resources packs developed for specialities
A&G pilot for Urology and Respiratory in ongoing which aims to implement A&G as the default offer at vetting
Collaborated with primary care to highlight issues and create a solution focused approach.
ref - 060 - 30/06/2023

Key programme outcomes included:

- New patient clinical validation of waiting lists initiative (6 week rolling programme) to ensure patients on the waiting lists still require a speciality outpatient appointment to enable prioritisation of those patients at most clinical need and risk.
- Patient Initiated Follow Up (PIFU) appointments usage increased across specialities following an increased education and communications campaign.
- Implemented advice & guidance (A&G) at triage and vetting, in line with the GIRFT speciality guidance. Our Urology directorate completed a successful pilot whereby A&G became the default offer for all new urgent and routine referrals. Following the success of the pilot, the change of practice has remained and other specialties such as Respiratory have now commenced a similar pilot.
- Revised and updated clinic templates across all the specialities to maximise clinic utilisation, alongside the implementation of the centralised booking team to support standardisation and maximise productivity.
- Co production with patients to redesign patient appointment letters to ensure they are clear and easy to understand.

Respiratory Outpatients Improvement Project

Alongside our Outpatients Improvement Programme, we also completed a targeted Respiratory Outpatients project, acknowledging some specific and targeted issues within this area. This enabled deeper support and faster resolution to improve our services. Alongside the aims and objectives of the main outpatients programme being implemented, this project also reviewed processes and pathways for lung function appointments, and supported the transition of clinical systems from Evolve to ERS. Root cause analysis deep dives, time in motion studies and workforce surveys contributed to the success in outcomes of this project.

Stockport

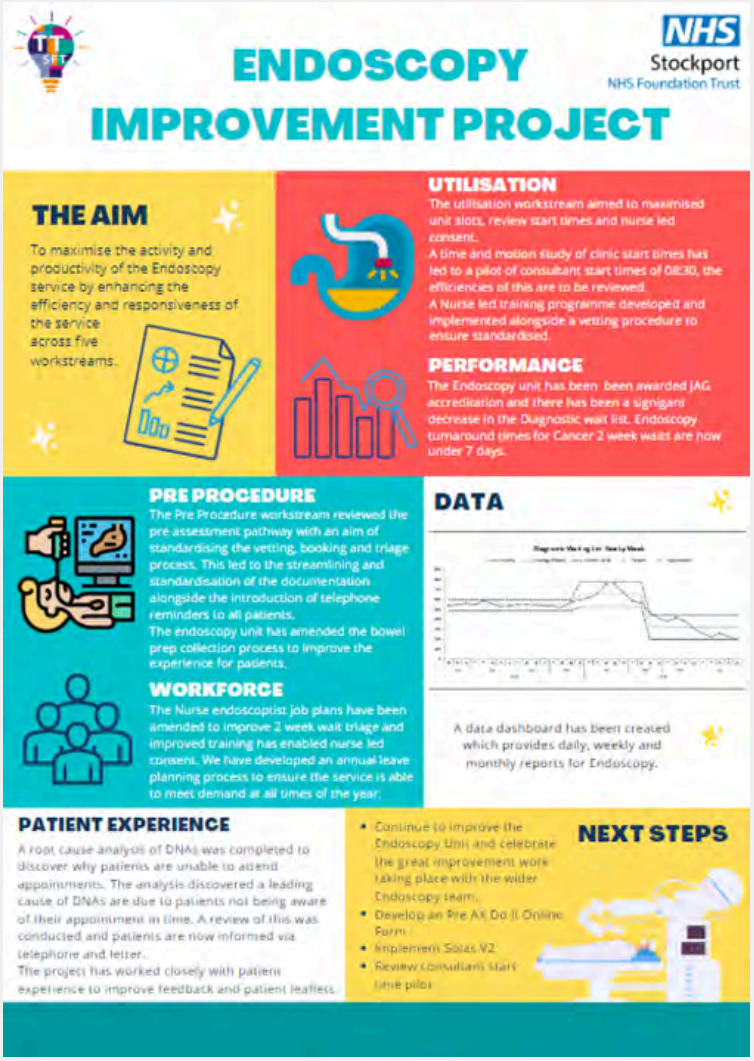
Completed Transformation Schemes

Endoscopy Improvement Project

The Endoscopy Improvement Project vision and aim was to improve the efficiency, productivity and patient experience while meeting the growing demand of the service. The quality improvement initiative has supported the endoscopy unit to achieve Joint Advisory Group (JAG) Accreditation and compliance of DM01, whilst supporting the elective recovery national initiative.

The project objectives focused on the multifactorial reasons causing the inefficiencies across the service, focusing on: pre-procedure pathways; utilisation and efficiency; workforce; patient experience.
The initiative enabled the team to work smarter, improving efficiency and increasing productivity.

The project has resulted in multiple improvements which have been sustained. The backlog from the covid pandemic has reduced from over 5000 patients to 0 by January 2024, resulting in patients being able to access the service in a timely and efficient manner. It has also helped prioritise those in need of endoscopy, supporting the cancer national targets for faster diagnosis.



Surgery Out of Hours Improvement Project

This programme aimed to improve the provision of Out of Hours medical staffing in the Surgical Division. Through reviewing the current service model, staffing and patient flow areas of efficiencies and improvement were identified. Workload audits, workforce ratio modelling and benchmarking were completed alongside process mapping for our eTask out of hours tasking. This helped to understand and complete improvements made within this programme, which include:

- Introduction of a weekend handover proforma for patients.
- An update of the Same Day Emergency Care (SDEC) Standard Operating Procedure (SOP).
- A business case developed for additional Out of Hours Surgery staffing.
- The programme outcome was a business case for additional Out of Hours Surgery staffing, which included the data and evidence gathered as part of the Transformation programme was developed.

Stockport

Completed Transformation Schemes

Diabetes Improvement Programme

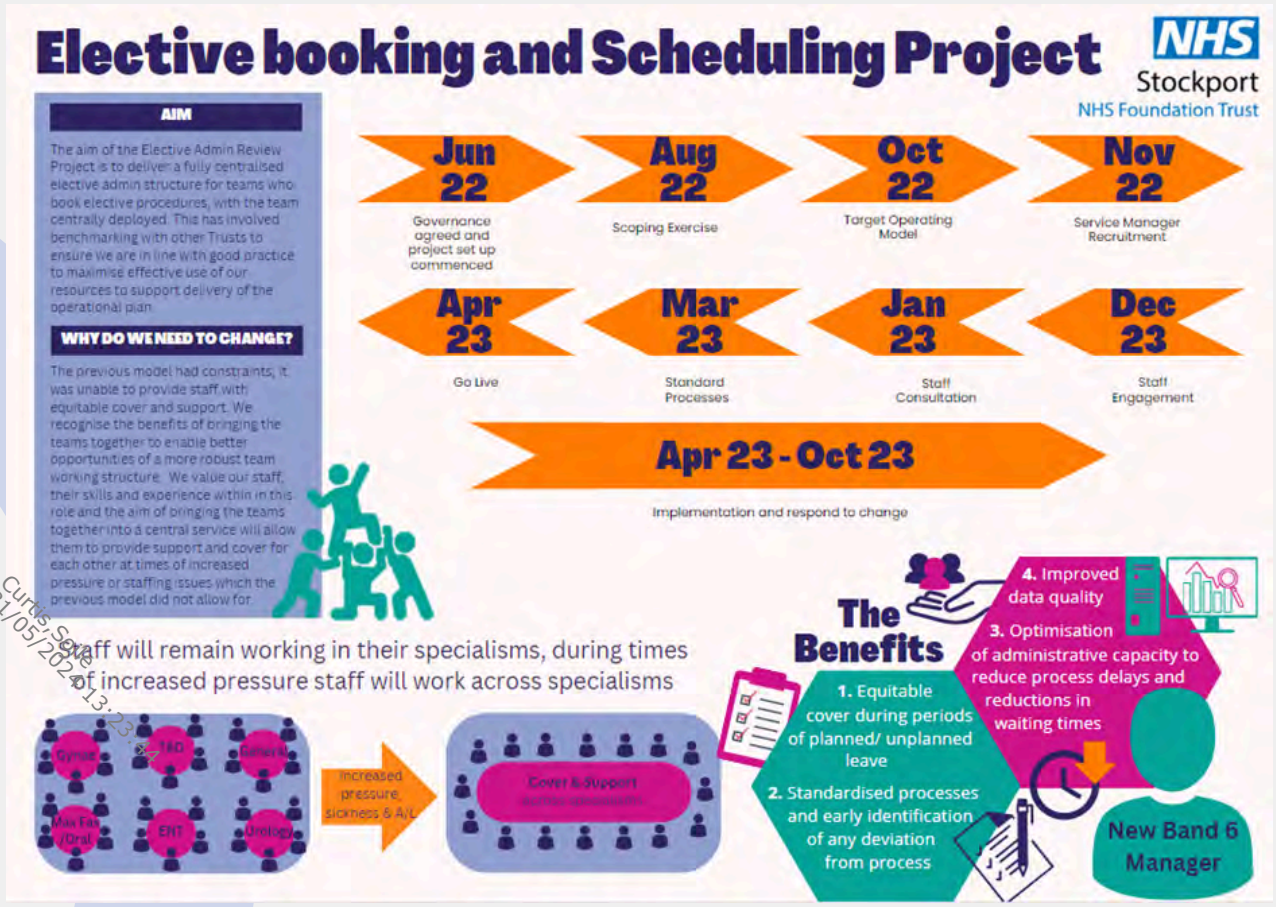
As a Stockport Locality, 4 transformation priorities have been set by the Provider Partnership Board. These are: Cardiovascular Disease; Frailty; Alcohol Related Harm; and Diabetes,

Internally at Stockport FT, we have therefore been reviewing our diabetes pathways and our compliance against national guidance and best practice. Key areas for development have been highlighted as:

- Structured education.
- Meeting diabetic pump demand.
- Diabetes in children & young people.
- Diabetic foot clinic.
- Type 1 & Type 2 Pathways for adults with diabetes.

Elective Booking & Scheduling Project

This project supported the centralisation of the booking and scheduling service for teams that book elective procedures. A new operating model was defined and the team now operates as a single team who are centrally managed and co-located. The new system supports cross-cover of specialisms during times of pressure or leave.
A new dashboard became operational in September 2023, to support the team in monitoring their performance against set KPI's, supporting effective and robust performance reporting of the centralised service.



Stockport

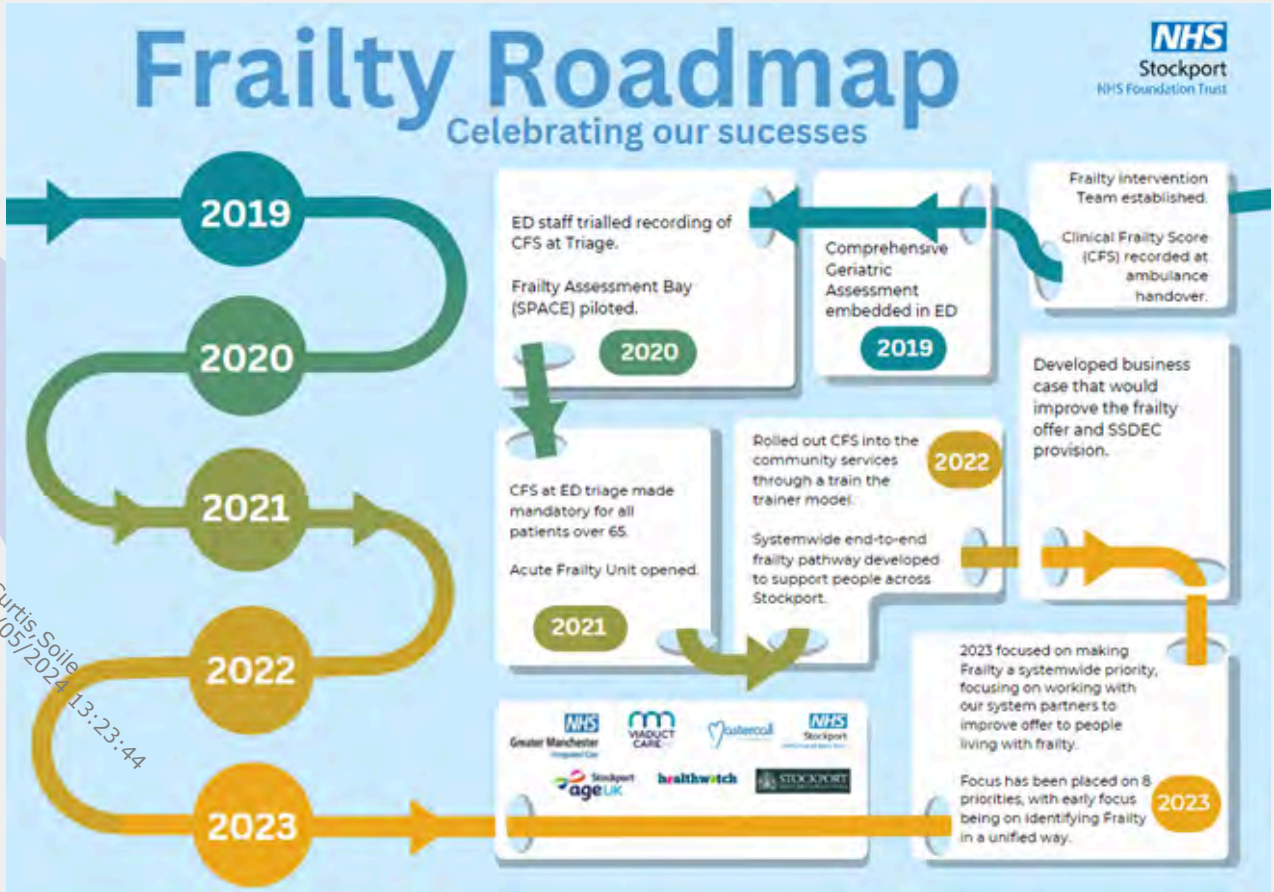
Active Transformation Schemes

Frailty Programme

Frailty is an area highlighted as a system priority through Stockport's Provider Partnership Board. System partners have come together and built a programme based on the "Joining the dots: A blueprint for preventing and managing frailty in older people". 8 workstreams were consequently developed.

The programme aims to introduce a standardised approach to recording Frailty through the Rockwood Clinical Frailty Score (CFS) across the system. Data is now available to track progress at Stockport FT. Work is ongoing to review opportunities for data collection to monitor the improvements in the wider system.

Additionally, the group seeks to ensure assessment of holistic needs are occurring and people are cared for on the most appropriate pathway, alongside work to prevent hospital admission and support people to be treated in the most suitable setting for them.
Key successes to date include:
-Agreement to the use of the Rockwood Clinical Frailty Score across all parts of the system.
-An exercise benefits video produced for people living with Frailty was published in conjunction with service users and the University of Manchester – In conversation with Jan - Dr AG strength research (full) (youtube.com).
-Care Home Pilot complete, implementing increased MDT support and supporting improved Advanced Care Planning.
-Launched the Keep On Keep Up (KOKU) application across Stockport, a digital strength & balance programme to prevent physical decline and frailty.
-Frailty core capabilities training framework created against the Core Skills Framework.



Stockport

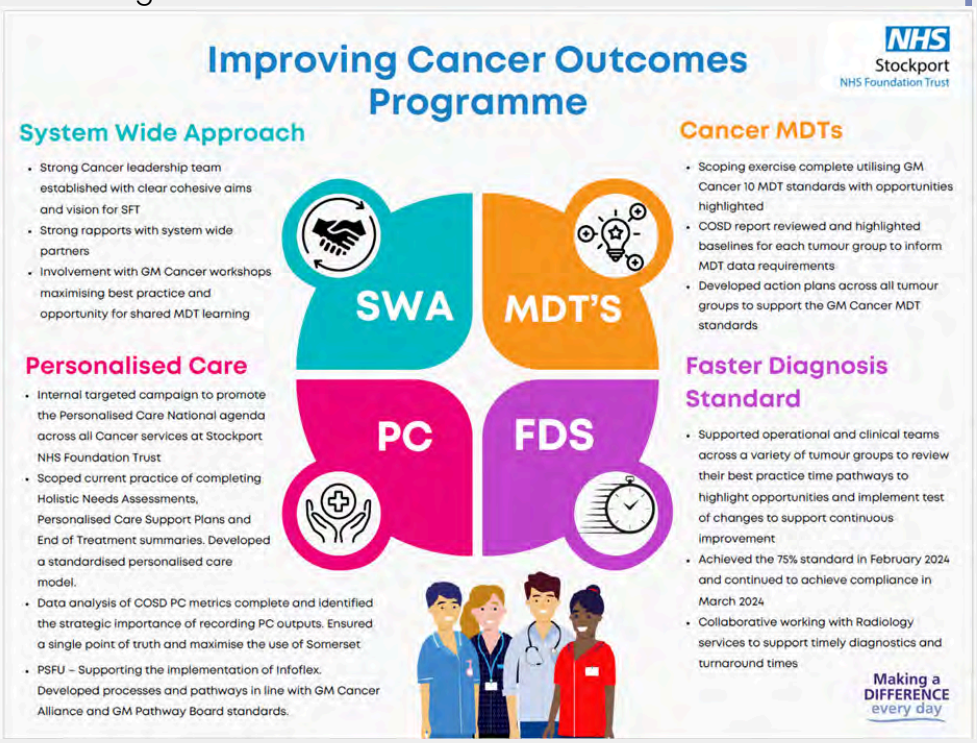
Active Transformation Schemes

Improving Cancer Outcomes Programme

Over the past 12 months the focus and priority has remained on the Faster Diagnosis Standard (FDS) pathways and performance; Personalised Care (PC); and reviewing the Trust cancer multidisciplinary team meetings against the Greater Manchester Cancer Alliance cancer MDT standards to ensure we continue to deliver high quality care in a timely manner.

Through continuous improvements cycles and transformational changes implemented across a number of different processes and pathways, the Cancer FDS performance has improved and is now meeting and exceeding the national 75% target.

Additionally, over the past year there has been an internal targeted campaign to promote the PC national agenda across all cancer services at Stockport NHS Foundation Trust. Initial scoping of current practice has been completed and a standardised model has been developed to ensure every patient diagnosed with Cancer is offered a Holistic Needs assessment and a Personalised Support Care Plan is completed.



Haematology Improvement Project

This project has enabled a whole service review reviewing the competing demands the Haematology team support. The aim of the project is to maximise the efficiency and productivity of the Haematology Service, ensuring we achieve high quality patient care and meet the demand of the service across the different multifaceted services Haematology provide.

The project continues to support continuous improvement methodology and key successes to date include:

- Agreed single point of referral process to Laurel Suite.
- Escalation pathway revised and agreed.
- Updated job planning for Haematology CNS's to support MDTs and patients diagnosed with cancer.
- Pilot plans developed to implement Advice & Guidance model at triage.
- Agreed single point of referral pathway to ensure safe and timely referrals to the Haematology Service from neighbouring specialities within inpatient and outpatient setting.

Stockport

Active Transformation Schemes

Theatres Efficiency & Productivity Programme

The aim of this programme is to optimise surgical care pathways and theatre utilisation, ensuring efficiency to enable sustainable elective recovery. Despite many challenges, through this programme there have been some key achievements. These include:

- Improved working across divisions and directorates to enhance theatre utilisation.
- A targeted communications campaign to ensure everyone is aware of the improvement work happening with the programme, alongside how utilisation is measured.
- Business case development for My Pre-Op.
- Time in motion studies to identify areas of inefficiency and how to make system lean.
- Loan kit process reviewed.
- Coordinator's checklist developed to aid surgical flow.

We are currently reviewing our programme aims and objectives based on new national recommendations.

Medical Theatres Improvement Project

The Medical Theatres Improvement Project focuses on ophthalmology and oral surgery. Pathways have been reviewed and mapped to identify bottlenecks and challenges to the services. This supported the development of four key workstreams with the aim to improve efficiencies and productivity. Some of the key improvements to date include:

- Increase in slots for theatre lists and injection lists for Stockport Eye Centre.
- New processes devised for late cancellation backfill.
- Patient letters reviewed and information leaflets developed.
- Pre-operative clinic improvements made for appointments, including criteria development for whether a face to face or telephone appointment is needed.
- Time in motion studies completed and pathways mapped to highlight areas for improvement, including through the Theatreman system.

Stockport

New Transformation Schemes

Attention-deficit hyperactivity disorder (ADHD) Pathway

The overarching aim of this programme is to improve patient access to ADHD services by developing a single service to improve patient experience, quality and cost efficiencies.

Objectives include reviewing patient pathways and commissioning funding streams to improve patient waiting times; improve patient experience; and develop streamlined patient pathways including a single service commissioning tariff.

Gynaecological Same Day Emergency Care (SDEC) Service model Project

The Gynaecology SDEC service model project aims to complete a service review on the Jasmine Assessment Unit against the national Gynaecology SDEC standards, with a view to developing the Stockport NHS Foundation Trust Gynaecology SDEC service model.

The project will seek to review the service delivery models; theatre processes and pathways; and explore opportunities for advice and guidance and bookable 111 slots. Workforce skill mix, training and education and job planning is also to be reviewed to ensure an effective service.

Pain Phase 2 - Experience-Based Co-Design (EBCD)

This project aims to transform the journey for patients accessing our pain management service, through an EBCD approach, utilising the views of staff, patients and families who use the service. The project was launched at the team away day with a brainstorming workshop with staff to identify the current service offer, what works well, the challenges and improvement opportunities. Recruitment has also commenced for patients, families, and service users with lived experience to support with the project. Q exchange funding was received to support this project, which will be used to fund an EBCD facilitator. Recruitment for this has commenced and should help drive the project forward.

Opioid Stewardship Improvement Programme

Our Opioid Stewardship Improvement Project seeks to reduce the risk from opioid use across the trust with particular focus on peri-operative opioid prescribing. Looking at our processes pre and post operative, alongside patient education, this project aims to increase adherence to post-surgical opioid prescription guidelines, improve patient experience and increase utilisation of our peri-operative clinic. Additional financial benefits of this project are also being reviewed, alongside our quality and benefit markers.

Continuous Improvement Strategy

Over the last 12 months, the Transformation Team have been busy working on a Continuous Improvement Strategy for both organisations. Engagement with our staff has been integral to the development of our strategy. Seeking the opinions and voices of our workforce on various key matters that will support us to develop a culture of continuous improvement across the organisations. Through this co-production, we can ensure we are building a strategy we can implement and embed. Through this engagement key themes emerged which have helped shape our vision.

This strategy sets out our shared ambitions over the next 3 years, guiding our priorities to make the best use of our resources. It aims to embed a culture of continuous improvement and provide our workforce with the skills, knowledge and support required to continue to deliver cutting edge services. In doing so, we will facilitate a culture that directly improves outcomes for our patients, our workforce, the organisations as a whole, and for our populations.

Below you can see the principles for our ADOPT Continuous Improvement Strategy:

ALIGN
to our strategic ambitions
DEVELOP
a continuous improvement culture
ORGANISATIONAL PARTNERSHIPS
to deliver sustainable change
PEOPLE
placed at the heart of our plans and engagement
TRAIN
Our people to deliver improvement

Progress

ADOPT Continuous Improvement

Align

A review against current strategic alignments have occurred at a local, regional and national level. This includes review against the NHS IMPACT Framework. Our strategy and alignment to NHS Impact has been shared nationally upon request.

Develop

A Promotions and Communications Lead has been made a permanent role within the team to support in in sharing improvement successes widely through a range of avenues. A Transformation Event has also been held on both sites, to celebrate the array of improvements that have occurred.

Organisational Partnerships

We have worked with our system partners to be involved in improvement initiatives through both localities Provider Partnership Boards and Neighbourhood Transformation Networks. We have also held shared learning events across both organisations, to support improvement.

People

We have commenced a review into how we will improve the co-production within our schemes, to ensure an array of opportunities to get staff, patient and carer voices into our improvement journey, whilst ensuring flexibility in this approach to meet the needs of the programme.

Train

We have reviewed our training opportunities, to align with our new strategy, creating a new "ADOPT" methodology. A training matrix to support people at different levels of their improvement journey has been drafted and initial training modules on existing cohorts (Aspire leaders at TGH & Preceptorship at SFT) trialed.

Communications & Promotions of Improvement

Last year, we reported a trial of a new role within our team, to support communications and promotions of improvement occurring across both organisations. Following the success of this role, this year, we are pleased to say, following a restructure within the team, we have been able to make this a permanent role.

This role has quickly gained momentum, and is contributing to an energy within both Trusts to promote and celebrate their improvement journeys and successes through a variety of ways, including:

- Videos
- Animations
- Posters
- Campaigns

Additionally, this role has supported the execution of successful Transformation events held at both organisations.

Looking internally, we have also been able to improve our training provided, and have successfully launched 2 podcast seasons, with a third recorded and soon to be release.

Feedback for the support offered by this role includes:

"Congratulations for Transformation Talks. I have recently joined the NHS and Stepping Hill Hospital. I am an avid podcast listener and couldn't keep myself from our Trusts 1st Podcast." (JCF)

"The visual posters are excellent - great idea to personalise and share! Glad you've been getting some good feedback locally too!" (GIRFT National Team)

"Just a quick thank you for supporting the very last minute MADE video. We are very grateful for the quick support, turnaround and quality of the video" (Operational Support Team)

Testimonies

"The entire Transformation team are beyond excellent, since I joined the organisation they have been by my side supporting me to explore the services I lead and helped me deliver change, transformation and most importantly better care to our patients and the residents of Stockport.

Nothing is ever too much trouble, and they are so accessible and friendly whenever I ring or email with a problem, they always have a solution. The team are always professional and always have a compassionate and kind approach to their work, they are a highly skilled and experienced team and I am grateful for their support. I couldn't do my job without them and they are a huge cog in our system that makes our clinical work so much easier.

Thank you team Transformation for everything."

(Corporate Nursing)
MADE Award Nomination

"Thank you to the Transformation team for their support in our endoscopy project, helping the team to move forward with their improvements and also providing the tools to continue."

(Divisional Director)

"The support that the team have given to this very complex change process has been superb. They have been a constant support and innovator to the project and has been able to really delve into the PSIRF methodology and requirements. Through research and linking with other organisations, learning from early adopter sites has paid dividends to the project. Given the large scale / change that PSIRF requires this is not something that the Governance team could have delivered without the support of the Transformation Team. I would like to offer my thanks to the team for all the support."
(Assistant Director of Integrated Governance & Patient Safety)

"I would recommend the Transformation team to support any project. They were dedicated, helpful and extremely supportive and have made the whole process a lot easier to navigate. The team understood our issues and concerns and addressed them individually rather than as a whole as this helped us to really detail down to the areas that need more support. They have set us on the right pathway of improvement which helps us to focus on next steps. Really enjoyed working with the whole team!"

(Directorate Manager)

"A massive thank you for today's workshop! It was amazing to see the energy and enthusiasm around the table to kick start these conversations and finally getting a start on this enormous project! You were fantastic in keeping us in check! We can definitely do this!"

(Divisional Director)

Contact

Name	Position	Contact
Hannah Silcock	Assistant Director of Transformation	hannah.silcock@stockport.nhs.uk
Angela Brierley	Director of Transformation	angela.brierley@tgh.nhs.uk

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	19
Meeting	Board of Directors				
Report Title	Annual Self Certification: Continuity of Services 7 – Availability of Resources				
Director Lead	John Graham, Chief Finance Officer	**Author**	Rebecca McCarthy, Company Secretary Kay Wiss, Director of Finance		

Paper For:	**Information**		**Assurance**		**Decision**	**X**
Recommendation:	**The Board of Directors is asked to:** - **Approve the self-certification for Licence Condition - Continuity of Services 7: Availability of Resources, as reviewed and recommended by Audit Committee.**					

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
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
	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	N/A
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

The NHS Provider Licence ('the licence') was introduced in 2013 for all NHS foundation trusts. It sets out conditions that providers must meet to help ensure that the health sector works for the benefit of patients, now and in the future, and serves as the legal mechanism for formal regulatory intervention. Following enactment of the Health and Care Act 2022, the licence was modified, and an amended licence came into effect on 1st April 2023.

The requirement for self-certification, previously in relation to General Condition 6 and Corporate Governance Statement FT4 of the licence, was removed from the new licence to reduce duplication with other reporting mechanisms, such as the NHS Oversight Framework, Annual Report and Annual Governance Statement. However, with respect to the 'Continuity of Services 7 - Availability of Resources' the self-certification requirement remains in place and is to be approved by a resolution of the Board of Directors.

The Board must select one of the three prescribed statements as set out in the licence.

Audit Committee reviewed the statements at its meeting on 23rd May 2024, and recommends the following for approval by the Board of Directors:

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.

1. Introduction and Context

1.1 The NHS Provider Licence ('the licence') was introduced in 2013 for all NHS foundation trusts. It sets out conditions that providers must meet to help ensure that the health sector works for the benefit of patients, now and in the future, and serves as the legal mechanism for formal regulatory intervention.

1.2 Following enactment of the Health and Care Act 2022 (the Act), and a period of consultation, the licence was modified, and an amended licence came into effect on 1st April 2023 and now forms part of the oversight arrangements for NHS foundation trusts, independent sector providers and NHS trusts. The revisions to the licence included technical amendments in line with the Act 2022, alongside conditions to support effective system working and consideration of the triple aim, health inequalities and climate change.

1.3 The requirement for self-certification, in relation to General Condition 6 and Corporate Governance Statement FT4, was removed within the new licence to reduce duplication with other reporting mechanisms and oversight arrangements incorporated in the NHS Oversight Framework, Annual Report and Annual Governance Statement.

1.4 However, within the new licence there remains a requirement for self-certification with respect to Continuity of Services 7: Availability of Resources. Boards should confirm that they understand clearly the declarations being made and retain copies of those declarations should they be the subject of an audit by NHS England.

2. Continuity of Services 7 (CoS 7) – Availability of Resources

2.1 An NHS Foundation Trust is required to always act in a manner calculated to secure that it has, or has access to, the required resources.

2.2 The new licence continues to require Trusts, not later than two months from the end of each Financial Year, to certify as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, including a statement approved by a resolution of the Board of Directors.

The Board of Directors must select one of the three statements, as detailed below, and provide a statement of the factors taken into account in making the relevant declaration.

2.3 The three statement options are:

a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

Or

b) “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.

Or

c) “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.

2.4 In considering an appropriate declaration, Board members should note that ‘Required Resources’ are defined as follows:

- management resources,
- financial resources and facilities,
- personnel,
- physical and other assets

2.5 Factors to consider as part of the declaration include:

- the Trust’s financial plan 2024/25 developed in line with national guidance and as part of the Greater Manchester Integrated Care System (ICS)
- the submission for the Trust is a £46.1m deficit which includes CIP of £24.6m.
- the Going Concern assessment presented to Audit Committee (to be agreed by the Board, June 2024)
- the implications of any planned or potential services changes in the context of resource availability to accommodate/service such changes,
- the likelihood of any unplanned changes emerging during financial year 2024/25, including the on-going effects of industrial action
- the implications of inflation across all services, some of which may be beyond the control of the organisation to influence.

2.6 Audit Committee reviewed this matter at its meeting on 23rd May 2024 and supported a recommendation to the Board of Directors that the following statement was adopted:

b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to 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.

Meeting date	6th June 2024	**Public**	X	**Agenda No.**	20
Meeting	Board of Directors				
Report Title	Going Concern Assessment 2023/24				
Director Lead	John Graham, Chief Finance Officer	**Author**	Lisa Byers, Associate Director of Financial Services		

Paper For:	**Information**		**Assurance**		**Decision**	**X**
Recommendation:	**The Board of Directors is asked to:** - **Approve the declaration, as recommended by Audit Committee, that, in accordance with International Accounting Standard 1 and the NHS Foundation Trust Annual Reporting Manual (ARM) 2023/2024, 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 2023/2024.**					

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
	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	N/A
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

This paper sets out the considerations for the declaration of going concern status for Stockport NHS Foundation Trust based on the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2023/24, as considered by Audit Committee at its meeting on 21st May and recommended to the Board of Directors.

1. Purpose

1.1 The International Accounting Standard 1 (IAS 1) requires the Trust to assess its ability to continue as a Going Concern as part of preparing the Annual Accounts.

1.2 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis. The process for considering Going Concern should be proportionate in nature and depth to the risk being faced by the entity.

1.3 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

1.4 This paper will set out the considerations for the declaration of going concern status for Stockport NHS Foundation Trust based on the criteria set out in the NHS Foundation Trust Annual Reporting Manual and as reviewed and recommended by the Audit Committee, asks the Board of Directors to support the recommendation.

2. Current Situation

2.1 When concluding whether or not the accounts for 2023/24 should be prepared on a going concern basis, IAS1 requires that the Board of Directors will need to consider which of the following scenarios are most appropriate:

- The Trust is a going concern and it is appropriate for the accounts to be prepared on the going concern basis;
- The Trust is a going concern but there are material uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view;
- The Trust is not a going concern and the accounts will need to be prepared on an appropriate alternative basis.

2.2 The NHS Foundation Trust Annual Reporting Manual (ARM) 2023/24 sets out that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

2.3 The Trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise; these should be discussed with NHS England. Where the continued provision of services in the

public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

3. Recommendation

3.1 Based on the criteria set out in the NHS Foundation Trust Annual Reporting Manual (ARM) 2023/2024 the Audit Committee supported the following declaration on going concern status to the Board of Directors:

3.2 *After making enquiries, the Directors have a reasonable expectation that the services provided by Stockport NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.*

Meeting date	6 June 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					

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 April-May 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	9 May 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 the role specific training was within target, with all other metrics below target. It was noted, however, that performance continued to improve on staff turnover noting HCA's the group of staff with highest turnover. The Committee considered that the mandatory training metric whilst on track could be further interrogated to identify individual teams or staff members issues and compliance over time. This triangulates with a theme identified in the maternity CQC report reflecting poor compliance in a small team where a high proportion of staff were absent from work but mitigation for safety were in place. It was agreed to explore the reporting of the time to hire metric going forward, to ascertain whether median or modal reporting would be more appropriate to ensure the metric was not skewed by any significant outliers. The Committee received and noted the report, current performance and the actions being taken to continue to drive improvement.
Advanced Clinical Practitioner Strategy	The Committee received an Advanced Clinical Practitioner (ACP) Strategy for 2024-2029, highlighting the vision, mission and strategic ambitions to develop the ACP role over the next five years. Committee members welcomed the strategy, but stressed the need for a stronger correlation with the Trust's Equality, Diversity & Inclusion (EDI) Strategy and the inclusion of a section on value added benefits. The Committee supported the strategy in principle, subject to the caveats described above.

Item	Key issues and matters to be escalated
Workforce Race Equality Standard Report	The Committee received the Workforce Race Equality Standard (WRES) Report which trusts were required to publish on an annual basis. The Committee noted the headlines, benchmarking information and actions agreed to cascade key messages with staff and external stakeholders. The Committee acknowledged areas of improvement and noted that the Trust's Equality, Diversity & Inclusion (EDI) Strategy and Organisational Development Plan would support improvements in WRES performance. The Committee reviewed and confirmed the Trust's 2024 WRES performance data ahead of its publication by 31 May 2024.
Workforce Disability Equality Standard Report	The Committee received the Workforce Disability Equality Standard (WDES) Report which trusts were required to publish on an annual basis. The Committee noted the key headlines and benchmarking information. The Committee heard about actions to further improve confidence of staff to declare disabilities, acknowledging that cultural change and the development of psychological safety took time to embed. It was noted that the Trust's EDI Strategy and Organisational Development Plan would support improvements in WDES performance. The Committee reviewed and confirmed the Trust's 2024 WDES performance data ahead of its publication by 31 May 2024.
Ethnicity Pay Gap Report	The Committee received the Ethnicity Pay Gap Report, noting that there was no statutory requirement to publish ethnicity pay gap information, but it was a requirement in the Trust's EDI Strategy and the North West Anti-Racist Framework. The Committee heard that the issues highlighted in the report would be considered alongside the EDI Strategy and the Organisational Development Plan.
Employee Relations and Exclusions Activity	The Committee received a report providing a summary of employee relations case activity 1 October 2023 and 31 March 2024. The Committee noted information regarding: - Employee relation cases by type and division - Employment tribunals information - Activity by case type - Ethnicity information. The Committee heard that there had been an increase in BAME and disabled colleagues entering the disciplinary process, and the reasons for this would be further explored.
Widening Participation	The Committee received a report which provided an update on widening participation and vocational learning offer, providing career opportunities for communities across Stockport, particularly from underrepresented and deprived areas.
Freedom to Speak Up Report	The Committee received a report providing an overview of Freedom to Speak Up activities since the previous report.

Item	Key issues and matters to be escalated
	The Committee 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 Committee noted 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.
Staffing Approval Group (SAG) & Quality Impact Assessment (QIA) Assurance	The Committee received a report, noting that it had been agreed that the Terms of Reference for the SAG would be shared with each of the Board Committees, alongside the Quality Impact Assessment (QIA) process, a key feature of the Stockport Trust Efficiency Programme (STEP) (CIP) to assess impact of schemes to service delivery and quality and safety impact for patients or staff. The Committee noted that the QIA process had also been shared and discussed with the Board of Directors on 7 March 2024, when receiving update on the development of CIP Plan for 2024/25. The Committee received and confirmed the report highlighting key operational systems and processes in place to support the Trust in its duty to exercise functions effectively, efficiently and economically, and have regard to likely effects of the decision in relation to the quality of services provided to individuals and on quality of care delivery.
Standing Committees	The Committee received and noted the following key issues reports: • People Engagement & Leadership Group • Equality, Diversity & Inclusion Group • Education Governance Group

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	16 May 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, however it was acknowledged that the Trust's performance compared favourably against GM peers across all metrics. The Committee noted improvements in month against the following standards: • Referral to treatment (RTT) standards with good reductions in overall wait times and 52-week breaches • Cancer waiting times with a continued improvement to the 28-day faster diagnosis performance • Theatre utilisation remained on an upward trajectory and benchmarked favourably. The Committee heard that performance had deteriorated in relation to: • Diagnostics, relating to the loss of MR capacity. It was noted that recovery was anticipated by June 2024. • Patients waiting over 12 hours in the Emergency Department (ED). The Committee noted significant challenges in this area due to high levels of attendance and high acuity of patients. The Committee was pleased to note that the improvement in cancer performance had been recognised by regional and national teams, and as a consequence NHS England has stepped the Trust down from Tier 1 oversight for the cancer 62-day standard. The Director of Operations briefed the Committee on the impact of the Emergency & Urgent Care Centre (EUCC) building works disruption on the theatre complex, acknowledging the quality, operational and financial impact of this matter. The Committee heard that a planned closure of the main theatres was put in place for a five-week period from mid-April to mid-May 2024, to ensure the current phase of the building works could be completed in a timely way. In doing so, mitigating actions had been put in place, with operations moved to another available theatre where possible, and plans to ensure patients would be rebooked within a short time scale after the shutdown period. The Committee heard that recovery was planned between now and

	June 2024.
GM Productivity Overview	The Committee received a report including a productivity pack that had been developed at GM Integrated Care Board (ICB) level to support performance and financial turnaround, providing a summary of key metrics and enabling a regional and national comparison for improvement purposes. The Committee heard that the productivity pack was routinely considered at the Financial Improvement Group and Operational Management Group, as well as being presented to the F&P Committee on a quarterly basis. It was noted that each domain was reviewed by the appropriate lead director for accuracy, areas of improvement and deterioration, to drive next steps. The Committee heard that the Trust was ranked 7th best performing Trust in the North West, from a possible 31 trusts, and 3rd best performing acute trust in the North West, from a possible 17 trusts.
Stockport Q1 Tiering Status	The Committee received a report and associated letters providing an update on the Trust's tiering status as part of the national elective recovery programme. The Committee heard that the Trust had committed to eliminate 65+ week RTT waits by the end of September 2024, with a significant caveat for a requirement for mutual aid. In recognition of this, the Trust has remained in Tier 1 monitoring for elective care. The Committee was pleased to note that the Trust had been removed from Tier 1 support relating to cancer due to considerable improvements made in reducing the 62-day pathway backlog and improving faster diagnosis standard performance. The Committee welcomed the improvement and noted that the Trust was not currently being monitored as part of any tiering process for cancer.
Operational Divisions – Performance Review Framework	The Committee received a report on the Trust's approach to the operational performance assurance framework, providing a connection from Board to Ward and maintaining a line of sight to key organisational risks. The Committee noted the key domains covered by the framework and the change in approach in 2024/25, which now incorporated a Senior Leadership Engagement Event at the start and two points of the year and improved arrangements to support the completion of the operational planning submission. The Committee agreed that the way in which the performance of operational and corporate teams was being monitored and challenged should be further explored to ensure parity.
Finance Report – Month 1 Position	The Committee received the Finance Report for Month 1 2024/25. The Committee heard that overall, the Trust position at Month 1 was a deficit of £5.0m which was in line with plan, with a forecast year-end deficit of £46.1m, 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 1 of £1.0m had been delivered. The Committee heard that the Trust had maintained sufficient cash to operate during April, however this was following revenue support of £5.4m in month. It was noted that the Capital Plan for 2024/25 was £42.5m, however this was non-compliant and was being reviewed by GM.

	The Committee noted the following key risks to delivery of the financial plan: • Cash • Pay awards • Industrial action • STEP target • ERF The Committee thanked colleagues for the delivery of the 2023/24 Financial and Capital Plans, recognising the significant efforts in this area. The Committee heard that a review of loss-making services would be part of the review by the Integrated Care Board (ICB) on the appropriateness of the financial system. It was noted that while the scope of the review was awaited, it was expected to identify what was in our gift / what was in GM's gift / structural deficit. The Committee agreed the Board action would be closed.
Opening Budgets	The Committee received an Opening Budgets report, noting that the report reflected the current submitted plan which may be subject to change. It was noted that a shortened version of the report would be presented to the Board of Directors in June 2024, by which time further clarity on final figures was expected. The Committee received and noted the Opening Budgets 2024/25 report and recommended it to the Board of Directors for approval in June 2024.
Costing Submission 2023/24 – Pre-Submission Planning Report	The Committee received and noted the Costing Submission 2023/24 - Pre-Submission Planning Report and confirmed the systems and processes in place as sufficient to provide assurance on the plan to complete the mandated costing submissions for 2023/24.
Cost Improvement Programme (CIP) Unpalatable Schemes	The Committee received a comprehensive report providing an overview of work that was taking place to deliver the CIP plans for 2023/24 and develop the CIP plans for 2024/25. The Committee received an overview of the quality impact assessment (QIA) process for schemes considered for 2023/24 and 2024/25, details of the unpalatable schemes approved in 2023/24, the thematic approach to the unpalatable CIP schemes being considered for 2024/25, highlighting a line of sight into the robustness and scale of the CIP schemes being considered. It was noted that the CIP plans linked with the GM ICS review on structural deficit and the plan to reconsider the allocation of funding.
Annual Procurement Programme	The Committee received the Annual Procurement Programme and Progress Report, highlighting the procurement activities undertaken during the year.
Staffing Approval Group (SAG) & Quality Impact Assessment Assurance Report	The Committee received a report, noting that it had been agreed that the Terms of Reference for the SAG would be shared with each of the Board Committees, alongside the Quality Impact Assessment (QIA) process, a key feature of the Stockport Trust Efficiency Programme (STEP) (CIP) to assess impact of schemes to service delivery or patients or staff. The Committee noted that the QIA process had also been shared and discussed with the Board of Directors on 7 March 2024, when receiving update on the development of CIP Plan for 2024/25.

	The Committee received and confirmed the report highlighting key operational systems and processes in place to support the Trust in its duty to exercise functions effectively, efficiently and economically, and have regard to likely effects of the decision in relation to the quality of services provided to individuals and on quality of care delivery.
Green Plan Progress Report	The Committee received a report providing an update on progress made against the Green Plan, including current challenges and future opportunities. The Committee heard that a new Sustainability Manager was in post across this Trust and Tameside & Glossop Integrated Care NHS Foundation Trust, noting plans to establish a joint Green Plan Group across the two Trusts, and a joint Green Plan from January 2025.
Digital Strategy Progress Report	The Committee received a report providing a 6-monthly update on the delivery of the Trust's Digital Strategy, which was approved by the Board of Directors in December 2021. The Committee agreed to receive an interim update report on outcome measures at its next meeting.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Estates Strategy Steering Group • Digital & Informatics Group The Committee approved the Terms of Reference and Work Plans 2024/25 for Capital Programmes Management Group and Digital & Informatics Group.

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Susan Moore
	23rd April & 28th May 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
Patient Story	Quality Committee listened to a patient story read and presented by the Chief Nurse. • A positive reflection by an inpatient • Support for a child in the community by School Nursing
Learning from Deaths Report April 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. An issue was identified with regard to, action the prescribing of Heparin (VTE Prophylaxis) post operatively when indicated as part of the post-operative check list. Improved post-operative processes had been introduced to reduce the likelihood of recurrence.
StARS Progress Report April 2024	Overview of current assessment ratings, including recent achievement of '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. The Assistant Chief Nurse confirmed that currently, all Divisions had independently reached the Trust targets to achieve 50% Green/Blue clinical areas and no more than 25% Red outcomes. Triangulating this report with the Patient Safety Group Key Issues Report, the committee queried ongoing concerns with E3. Assurance that the Patient Safety Group continued surveillance of E3 with confirmation there were no matters for escalation at this time.
Patient Safety Incident Framework (PSIRF) Reporting April 2024	The Deputy Director of Quality Governance presented an update on Implementation of the Patient Safety Incident Response Framework which went live at the end of March. Work continues on training and embedding process' despite current workforce challenges. It was noted that PSIRF is a significant shift from the preceding SI Framework. The Quality Committee reviewed and confirmed the roles of responsibilities of the Trust Board, or those with delegated responsibility, including Members of board quality sub-committees, in relation to PSIRF.
Patient Safety Incident Quarterly	The purpose of this quarterly paper is to provide Quality Committee with assurance that lessons are learned and improvements to practice implemented, as a result of

Report: Quarter 4 2023/24 (January 2024 to March 2024)	incidents, inquests, claims and complaints reported via the Trust's incident reporting system (Datix) for Q4 2023/24. To Note: • There were 6004 incidents reported at a rate of 103 incidents reported per 1000 bed days. • 'Pressure ulcers and skin conditions', 'Administrative Processes (Excluding Documentation)', and Patient 'Behaviour' were the types of incidents reported at the highest rate per 1000 bed days. • There were 12 serious incidents reported via StEIS. • There were 60 new inquests opened, which was a 36.3% increase compared to the Q3 2023/24, (41). • There were no Prevention of Future Death Reports received from HM Coroner during Q4 2023/24. • Communication remains the top theme regarding formal complaints. • The complaint response rate was 95.2% • The PHSO contacted the Trust in relation to 4 new requests for information. • The PHSO concluded 5 cases in Q4 2023/24. There are currently 11 ongoing cases that we are awaiting a decision for. Incident 113176 relates to follow up on bowl cancer pathway and triangulates with Finance and Performance Assurance Committee.
Trust Integrated Safeguarding Group Key Issues Report April 2024	The Trust Integrated Safeguarding Group Key Issues Report from March 2024 was presented to Quality Committee including update on: - Terms of reference & Work Plan 2024/25 - Young Persons Experience Audit - Independent review of GMMH - Divisional Safeguarding Assurance Report - Adult Safeguarding Integrated Report - Children Safeguarding Integrated Report - Children in our Care Report - Maernity Safeguarding Report - 20 Week Gestation Joint Assessment - Stockport Accreditation and Recognition Scheme (StARS) – Safeguarding - Security Report - PREVNT - SAR/DHR/Rapid review & Safeguarding Children Child Death & Serious Incident Summary - GM Safeguarding Assurance Action Plan - Risk Register Assurance Report The Children in Our Care Team (Previously Children Looked After) had limited capacity. Action to address this was to be clarified at a future meeting.
Quality & Safety Integrated Performance Report April & May 2024	**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 Chief Nurse confirmed that, any patient who gets an infection 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. Work ongoing with AQuA on sepsis antibiotic administration noting NICE guidelines are under review.
Maternity CQC Report	On 28 September 2023 the CQC undertook an announced inspection of maternity services covering the domains of **safe and well led as** part of the national maternity inspection programme. The inspection report published 10 May 2024 rated the service as requires improvement in both safe and effective, meaning that rating remained unchanged. The report included 3 MUST DO actions, and 4 SHOULD DO actions. An action plan in response to these recommendations is to be submitted to the CQC by no later than 7 June 2024. The report includes: • CQC Maternity Service Inspection Report – for information • CQC Maternity Service Action Plan – for assurance* These are to be presented to Board on the 6th June 2024 *Note the action plan is not populated for this submission but is an ongoing live document operationally that has progressed or completed many of the actions. Ongoing monitoring continues through Maternity neonatal Champions, The Mat. Neo. Quadumvirate and Quality Committee.
Maternity Services **- Maternity Services Highlight Report** **- Perinatal Mortality Maternity Services** **May 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. There is an ask that the below reports relating to safety actions from CNST Year 6 are reported to Trust Board monthly/ or subcommittee, bi-monthly and quarterly. Following an action from a previous Quality Committee significant assurance was gained on the specifics of smoking in pregnancy with SFT working to and achieving a stretch target.
RCOG Guidance May 2024	The RCOG have published guidance regarding the 'Involvement of the Police and external agencies following abortion, pregnancy loss and unexpected delivery' in response to concerns regarding an increasing number of police investigations following later gestation abortion and pregnancy loss, and the impact this can have on patients.

	The RCOG and Faculty of Sexual and Reproductive Healthcare (FSRH) stated that it is not in the public interest to investigate a patient who is suspected of ending their own pregnancy.
Key Issues Reports April & May 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. • Health & Safety Joint Consultative Group (JCG) – Key Issues Report • Patient Safety Group Key Issues Report • Patient Safety Group Key Issues Report • Patient Experience Group Key Issues Report • (March) • Clinical Effectiveness Group Key Issues Report Of note: The Deteriorating Patient Group data suggested 65% of high escalation observations were missed in December 2023. on further review, it was understood that this related to observations missed within the timeframe, but not missed in entirety. Further confirmation was received at the subsequent Quality Committee that this does not presents lapses in care or patient harm but was in respect of the reporting rules. Care and treatment in real time are prioritised over input reporting. Patient Safety Group identified shortfalls in funding for some medical devices
Mental Health Plan Progress Report May 2024	Presented to the Committee by Divisional Director of Nursing and Medical Director: Work continues with growing relationships with Pennine Care, now due for a timely review with Director of Strategy
PLACE Report May 2024	Presented to the Committee by Estates and Facilities Matron: This fully digital report is undertaken by community volunteers in Autumn 2023. It Identified 309 area of failings mostly relating to the Trusts Estate and Privacy and dignity (which includes non-person centred measures) The report is to be shared and accessible from Trust intranet/shared drive.
Annual Health & Safety Report May 2024	Presented to the Committee by Chief Nurse: This report provides Quality Committee with a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2023/2024. By the end of Quarter 4 2024, target reductions of 10% in incidents of 'harm' to staff were required for all Divisions and Corporate functions in relation to slips, trips and falls, needle-stick/sharps, physical assaults, moving and handling and collision/contact with objects. These reductions have been reviewed for 2024-2025 as follows: • slips, trips and falls (10%) • needle-stick/sharps (10% • physical assaults (25%) • moving and handling (20%) • collision/contact with objects (10%).

Annual Quality Account	Presented to the Committee by Chief Nurse: This report will be presented at Board.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell
Date of Meeting	**21st May 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
Risk Management Committee Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at March, April and May 2024. The report illustrated to the Committee that the Trust is facing a number of significant risks that it is in the process of mitigating and presented the opening risks for 2024/25. The Committee received clarification about the two new clinical risks and an action was taken to refer these to the Quality Committee. The Committee asked for assurance on risk 1004 that appropriate mitigations were evidenced Breach of Regulatory Reform (Fire Safety) Order 2005. There was a discussion on the existing risk appetite of the Trust and the Committee were informed about a recent risk training workshop. At this workshop focus was given on how to use risk scores to reflect risk appetite within the Divisions.
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 The Committee were asked to consider how the 'patient/customer' voice was heard within the Audit Committee and considered that the feedback from Committees did provide the opportunity for this.
Internal Audit 2023/24 Plan Progress Report 2024/25 Annual Plan Summary Head of Internal Audit Opinion Curtis Soile 31/05/2024 13:23:44	The Committee received: • Internal Audit Plan Progress Report • Internal Audit Reports • Follow up Tracker Update The Committee were assured that the Internal Audit Plan for 2023-24 was almost complete with five reports finalised (see below) and the Quality Spot Checks report at final stages with the Draft Report issued. Performance indicators all rated green. The Committee received the final reports for: • Outpatient Booking Process – Substantial Assurance

	The Committee asked for assurance how the Divisional learning from the report recommendations can be translated to organisational learning. It was confirmed that these will be addressed in by the Director of Operations in performance meetings. The Committee also asked for clarification on the recommendation on Capacity Planning for Outpatients. It received assurance that this recommendation was related to the documentation of the process. • ESR/Payroll – Substantial Assurance • Staff Wellbeing – Substantial Assurance • Medical Staffing – Substantial Assurance • BAF Review - Standards Met The Follow Up Tracker for Recommendations was discussed, and it was agreed that future reports will pull out separately recommendations overdue to give the Committee greater assurance on progress. There was a discussion on the planning of the CIP Review that is carried over to the 2024-25 financial year. The Committee agreed that this will concentrate on process and a review of one Divisional area. The scope will be sent to the Audit Committee for final agreement. The Committee reviewed an update to the Internal Audit Plan for 2024/25 with changes made for the CIP review and NICE guidelines. There was a query regarding the priority order of the EDI Review in 24-25 from the Freedom to Speak Up Review – with the latter planned for 25-26 and how this linked to risk scores. The Committee were assured that a recent self-assessment of Freedom to Speak Up did not highlight any major concerns. An action was agreed to take this back to the Risk Committee to review risk in this area and a further action to refer also to the People Committee. The Committee was assured that the Head of Internal Audit Opinion will be ready to issue by the 28th June deadline and this will give substantial assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. There were no concerns that this opinion will change once the final report for Quality Spot Checks was issued.
Anti-Fraud Annual Report Anti-Fraud Plan 2024/25	The Committee received the Anti-Fraud Annual Report 2023-24 and an update on the status of current investigations. The Committee were given assurance that the Trust had not incurred any financial losses on Fraud Prevention notices issued during March 24 – Q1 2024-5 to date. The Committee were updated on the Counter Fraud engagement visit and were assured that this was a very positive meeting with useful feedback and learning.
Annual Review of Conflicts of Interest Policy Curtis Soile 31/05/2024 13:23:44	The Committee received a report of the Annual Review of Conflicts of Interest. The Committee received assurance that considerable work had been undertook by the Corporate Affairs team to cross reference declarations of interest to Companies House for accuracy. The report identified improved compliance with the completion of declarations of interest from 87% in 22-23 to 98% in 2023-24.

	The Annual Review highlighted the improvement in the outcome of the Conflicts of Interest Review from limited assurance to substantial assurance. The Committee also noted that further targeted training and development is planned with the Workforce and Consultant teams.
Waiver Report October 2023 to March 2024	The Committee received the Waiver Report and accompanying appendix of individual waivers from October 2023 to 2024. The Committee received assurance that the number of waivers identified especially to Estates and Facilities reflected a thorough formalised process by the Procurement team and included waivers where sole suppliers existed and/or off framework suppliers provided better value. To provide further assurance future waiver reports will be updated to identify separately the above categories and highlight waivers that were in place due to urgency/late procurement and breach of Standing Financial Instructions. The Committee were also informed of improved governance around breaches of SFIs which will require completion of new documentation. These breaches will also be reported to the Audit Committee at future meetings.
Accounting Policies 2023/24	The Committee received an update to the accounting policies note to be included in the 2023/2024 Annual Accounts. It received assurance that the changes were prepared in accordance with the latest NHSE, DHSC and HM Treasury guidance. The Committee approved the accounting policy note for inclusion in 2023/24 financial statements.
Annual Self Certification: Continuity of Services 7 – Availability of Resources	The Committee received a report to consider the self-declaration on the availability of resources with respect to Continuity of Services. The Committee considered the report and supported a recommendation to the Board of Directors that the Trust will have the Required Resources available but noting specific risks surrounding this declaration.
Draft Annual Report and Accounts 2023-24	The Committee received draft versions of the following: • Draft Annual Governance Statement; • Draft Annual Report; • Draft Annual Accounts; • Key Accounting Issues Report; • Going Concern Assessment The Committee considered and noted the key accounting issues relevant to the 2023/24 Annual Accounts. The Committee reviewed and noted the Draft Annual Report. The Committee recommended the AGS to the Board of Directors for approval. The Committee reviewed and noted the draft Annual Accounts and received assurance on the final accounts processes and timetable to deliver audited accounts by the 28th June 2024. The Committee supported the declaration that the Trust continued to adopt the going

	concern basis in the preparation of the accounts. The Committee agreed to provide any comments on the Draft Annual Report and Annual Accounts to the Company Secretary by the 30th May 2024 to meet the timelines towards completion of the audit and submission to NHSE.
External Audit Progress Report National Publications Report	The Committee received a progress report on the Annual Report and Accounts audit for 2023-24. It received assurance that working papers were of good quality and that there was proactive engagement with the Trust. There were no matters to bring to the attention of this Committee meeting. The Committee received a summary of national publications but there were no specific reports highlighted as needing attention.

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			✓									
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
Communications & Engagement Strategy Progress Report	Head of Communications	Paper			✓						✓			
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									✓			

Report	Presenter	Format	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Transformation / Continuous Improvement Strategy Report (Opening & Mid-Year)	Director of Transformation	Paper			✓						✓			
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					✓						✓	
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					✓							
Draft 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	Jun 24	Jul 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										
Chief Executive	Karen James	Y	Y	Y										
Chief Finance Officer/Deputy Chief Executive	John Graham	A	Y	Y										
Medical Director	Andrew Loughney	Y	Y	Y										
Chief Nurse	Nic Firth	A	Y	A										
Director of Operations	Jackie McShane	Y	Y	Y										
Director of People & OD	Amanda Bromley	Y	Y	Y										
Director of Strategy & Partnerships*	Paul Buckley	Y	Y	Y										
Director of Communications & Corporate Affairs*	Caroline Parnell	Y												
Senior Independent Director/Non-Executive Director	Louise Sell	Y	Y	Y										
Non-Executive Director	Samira Anane	Y	Y	A										
Non-Executive Director	Tony Bell	Y	Y	Y										
Non-Executive Director	Beatrice Fraenkel	Y	Y	A										
Non-Executive Director	David Hopewell	Y	Y	Y										
Non-Executive Director	Mary Moore	A	Y	Y										
*Non-Voting														
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**										
Key														
Y	= Present													
A	= Apologies													
A(D)	= Attended as Deputy													