NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

28 FEBRUARY 2018

Your Health. Our Priority.

Board of Directors Meeting - 28 February 2018

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Stockport NHS
NHS Foundation Trust

Board of Directors Meeting
Wednesday, 28 February 2018

Held at 1.30pm in Lecture Theatres, Pinewood House, Stepping Hill Hospital

AGENDA

Time			Enc	Presenting
1330	**1.**	Apologies for absence		
	2.	Declaration of Interests		**A Belton**
	3.	Opening Remarks by the Chair		
1335	**4.**	Patient Story		**E Rogers**
	5.	**OPENING MATTERS**		
1350	5.1	Minutes of Previous Meeting: 31 January 2018	✓	**A Belton**
1355	5.2	Chair's Report	✓	**A Belton**
1400	5.3	Chief Executive's Report	✓	**H Thomson**
1405	5.4	Key Issues Reports from Assurance Committees • Finance & Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
1415	6.1	Urgent Care Quality Improvement Update	✓	**S Toal**
1435	6.2	Performance Report	✓	**S Toal**
1450	6.3	Stockport Together Progress Report	✓	**C Drysdale**
	7.	**QUALITY**		
1510	7.1	Medical Leadership Development	✓	**C Wasson**
1515	7.2	The Bawa-Garba Case	✓	**C Wasson**
1530	7.3	Safe Staffing Report	✓	**A Lynch**
	8.	**GOVERNANCE**		
1535	8.1	Draft Strategic & Corporate Objectives 2018/19	✓	**H Thomson**
1545	8.2	Corporate Risk Register	✓	**A Lynch**
	9.	**CONSENT AGENDA**		
1555	9.1	• National Joint Registry Annual Report • Diabetes Care	✓ ✓	

10. DATE, TIME & VENUE OF NEXT MEETING

10.1 Thursday, 29 March 2018, 1.15pm in Lecture Theatre B, Pinewood House, Stepping Hill Hospital.

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public on Wednesday 31 January 2018 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr M Sugden	Non-Executive Director
Mr P Buckingham	Director of Corporate Affairs
Mrs A Lynch	Director of Nursing & Quality
Mr H Mullen	Director of Support Services
Mr F Patel	Director of Finance
Mrs J Shaw	Director of Workforce & OD
Mrs H Thomson	Interim Chief Executive
Ms S Toal	Chief Operating Officer

In attendance:

Mrs S Curtis	Membership Services Manager
Ms C Drysdale	Managing Director, Stockport Neighbourhood Care
Dr S Krishnamoorthy	Associate Medical Director
Mrs K Bentley	Patient
Ms K Brown	Sister
Ms C Dent	Matron
Mrs E Rogers	Matron for Patient Experience

13/18 Apologies for Absence

Apologies for absence had been received from Mr J Sandford, Ms A Smith and Dr C Wasson. The Chair welcomed Dr S Krishnamoorthy, who was deputising for the Medical Director, and Ms C Drysdale to her first Board meeting since her appointment as Managing Director of Stockport Neighbourhood Care.

14/18 Declaration of Amendments to the Register of Interests

Mrs C Barber-Brown advised the Board of her role as an Interim Executive Director with the Greater Manchester Transformation Unit. The Director of Corporate Affairs confirmed that this entry had already been included on the Register of Interests.

15/18 Patient Story

The Board of Directors welcomed Mrs K Bentley (patient), Mrs E Rogers (Matron for Patient Experience), Ms K Brown (Sister) and Ms C Dent (Matron) to the meeting. The Chair reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board providing real and personal examples of the issues within the

Trust's quality and safety agendas. Mrs K Bentley advised the Board that in January 2016, she had undergone successful Sacroiliac joint fusion surgery at Stepping Hill Hospital following years of debilitating back pain and briefed the Board on how the surgery had transformed her life. She commented that before surgery, she could not bend to tie her shoe laces and now she was training for a marathon. Mrs K Bentley advised that Mr Tandem, who had performed the operation, had been fully trained in advance of the surgery as her operation had been the first of its kind at the hospital and in the North West. Mrs K Bentley commented that she could not fault her care at the hospital, including on Ward D5, and gave examples of how the surgery had completely transformed her and her family's life. She noted that the manufacturers of the meta-rods used in the operation had contacted her as the operation had been such a success and that she had also been asked if she would consider being an ambassador for the surgery.

The Director of Nursing & Quality thanked Mrs K Bentley for sharing her moving story which, she noted, was a great example of tenaciousness of a member of staff who had changed Mrs K Bentley's and her family's life with positive support of the organisation. Ms K Brown noted that she was proud to have been part of the success story. The Chief Operating Officer noted that one of the positive outcomes of the treatment from the Trust's point of you was that Mrs K Bentley no longer had long term health needs.

Mrs K Bentley, Mrs E Rogers, Ms K Brown and Ms C Dent left the meeting.

The Board of Directors:

- Received and noted the Patient Story.

16/18 Minutes of the previous meeting

The minutes of the previous meeting held on 30 November 2017 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

17/18 Report of the Chair

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. He wished to record the Board's appreciation to colleagues in the Emergency Department for their exceptional efforts in the testing circumstances. The Chair advised that the agenda for today's meeting had been revised in order of priorities and also included a consent agenda for items for noting. He also noted his attendance at an Active Recovery Service event at the Stockport Town Hall on 24 January 2018 and welcomed the increased sight on developments.

The Chair referred the Board to Annex A of the report which included a document detailing the separation of responsibilities between the Chair and Interim Chief Executive and the Board of Directors consequently approved the adoption of the document. The Chair also noted that an updated summary of relevant Lead

Responsible Officers following recent changes in Board membership had been included at Annex B of the report for information.

The Board of Directors:

- Received and noted the Report of the Chair and approved adoption of a Chair & Chief Executive Responsibility document included at Annex A of the report.

18/18 Report of the Chief Executive

The Interim Chief Executive presented a report which provided an update on national and local strategic and operational developments. She referred the Board to s2 of the report which detailed the latest position with regard to Healthier Together developments. The Interim Chief Executive noted that the programme was beginning to gather some pace following a period of slow progress. She then referred the Board to s3 of the report and provided an overview of ongoing work with Stockport Metropolitan Borough Council (SMBC) and KPMG LLP with regard to Shared Services. The Interim Chief Executive advised that the departments that had been prioritised, due to being deemed suitable to explore shared service options, were Human Resources, Information Governance and Information Technology. The Board noted that Mrs C Anderson was providing Non-Executive oversight in this area and that the final report would be considered by the People Performance Committee at its meeting on 22 February 2018.

The Interim Chief Executive then referred the Board to s4 of the report and provided an overview of Alliance Provider Board developments. She advised that the appointment of an independent GP to chair the Alliance Provider Board would be advertised and noted that a separate report on the subject of Stockport Together business cases was included later on the Board agenda. In response to a question from Mrs C Barber-Brown regarding s4.1b of the report, the Director of Support Services provided further clarity with regard to a review of the Stockport Together financial commitments for 2018/19 which was led by the Managing Director of Stockport Neighbourhood Care. In response to a further question from Mrs C Barber-Brown regarding s4.1c of the report, the Director of Support Services reported that the Alliance Provider Board had agreed that the Stockport system should not accept a reduction in the level of Digital Funds previously allocated to them and noted that the Stockport system was collectively taking this issue forward.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

19/18 Key Issues Reports

The Chair advised that the Committee Key Issues Reports had been adapted to provide a more focused method of reporting under the headings of Alert, Assure and Advise.

<u>Quality Assurance Committee</u>

Dr M Cheshire briefed the Board on matters considered at a meeting of the Quality Assurance Committee held on 16 January 2018. He reported that the Committee had

been advised of work to ensure Board line of sight on claims against the Trust and had noted two high value litigation claims with a potential risk to Trust reputation. Dr M Cheshire advised that in reviewing the Quality Metrics, the Committee had been alerted to both incidence of Inpatient Falls, which exceeded the target for the year of <17, and incidence of Pressure Ulcers in an acute setting, which exceeded the zero tolerance target. In response to a question from the Chair, the Director of Nursing & Quality advised that one of the outcomes of the Quality Improvement Event held on 30 January 2018 had been that more focus would be given to Falls and Pressure Ulcers. Dr M Cheshire reported that the Committee had taken positive assurance from the following subject areas: work being undertaken to evidence progress against the Trust's Quality Improvement priorities for 2017/18; the Safe, High Quality Care Report which related to the Improvement Plan in response to findings of the CQC inspection; and a Learning from Deaths report.

Dr M Cheshire advised the Board that an annual review of the Committee's Terms of Reference had been completed together with a self-assessment of effectiveness. He noted that outcomes of the review were detailed under a separate agenda item but advised the Board in particular of the Committee's intention to both re-title the Committee to Quality Committee and adopt a monthly meeting cycle. Dr M Cheshire also advised the Board of plans to adapt the approach to reporting of key issues from the Quality Governance Committee, soon to be re-titled Quality Governance Group, to provide the Quality Committee with line of sight on elements where further work was required. Finally, Dr M Cheshire noted that the Committee had reviewed a comprehensive and robust Quality Governance Framework which was recommended to the Board of Directors for approval.

<u>Finance & Performance Committee</u>

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Performance Committee held on 24 January 2018. He reported that the Committee had considered a progress report on the Electronic Patient Record (EPR) Project and had been alerted to factors which had the potential to result in further delays to system roll-out. Mr M Sugden advised that work to identify solutions was being undertaken and the subject would be reported to the Board in February 2018. In reply to a question from the Chair regarding expectations in this area, the Director of Support Services advised that the Trust was seeking legal advice regarding Intersystems' adherence to contract and provided an overview of associated implications due to the postponement of the EPR 'go live' date. He noted that the Board report referred to by Mr M Sugden would be considered at the private Board meeting in February 2018 due to its 'commercial in confidence' nature. Mrs C Barber-Brown advised that herself and Mr M Sugden had met with the Director of Support Services to discuss the EPR issues from an assurance perspective.

Mr M Sugden noted the Committee's concerns when reviewing the draft Operational Plan for 2018/19 and alerted the Board to delays in completing the Plan, primarily as a result of current operational pressures and availability of definite data on which to base plans. Mr M Sugden commented that the national planning guidance was anticipated to be published imminently with the likelihood that draft Operational Plans would be required for submission in late February 2018. He noted that the Finance & Performance Committee would review and refine the process for future years.

Mr M Sugden noted that linked to the above, the Committee had been alerted to the absence of national planning guidance as a factor impairing meaningful discussion with commissioners on contract arrangements for 2018/19 and that it had been agreed that this matter should be initially escalated to Chief Executive-level for resolution. He reported that the Committee had considered the continuing challenge to performance against the A&E 4-hour standard but noted that this item would be covered during consideration of the Integrated Performance Report.

With regard to assurance, Mr M Sugden advised that the Committee had noted a low level of assurance on the overall delivery of the 2017/18 financial plan in the final quarter and noted concerns relating to the ability of the Medicine & Clinical Support Business Group to deliver its financial recovery plan. Mr M Sugden reported that a key factor affecting the position was delivery of the in-year cost improvement programme and advised that there remained a low level of assurance on achievement of the cost improvement programmes for 2017/18 and 2018/19. He commented that the Director of Finance would be presenting a progress report on this subject at the Committee's next meeting.

Mr M Sugden advised the Board that progress was being made with the planned Service Reviews and noted that the Committee had requested a further report at its next meeting to provide assurance on both levels of efficiencies, and timescales for delivery, resulting from the Service Reviews completed to date. Mr M Sugden concluded his report by advising the Board of a worsening trend with regard to reference costs and noted that the Committee would be receiving 6-monthly reports on the Trust's use of outputs from benchmarking systems.

<u>People Performance Committee</u>

Mrs C Anderson briefed the Board on matters considered at meetings of the People Performance Committee held on 21 December 2017 and 25 January 2018. With regard to the December meeting of the Committee, Mrs C Anderson advised that the Committee had proposed that an Allied Health Professionals (AHP) Staff Story report be presented at the Board meeting on 28 February 2018 to provide an overview of key achievements by the staff group, including associated improvements with regard to timely discharges. She also advised that the Committee had approved a revised Statutory & Mandatory Training Key Performance Indicator of 90% to enable greater alignment with other trusts in Greater Manchester.

With regard to the Committee meeting held on 25 January 2018, Mrs C Anderson advised that the Committee had been alerted to a number of 'red' rated actions in the Health Education England North West (HEE NW) 'Other Issues' Action Plan. The Director of Workforce & OD advised that she had met with the Deputy Medical Director and the Director of Medical Education to review the 'red' rated actions which had subsequently been updated. She advised that the final Action Plan would be signed off by the Executive Team prior to its submission to HEE NW.

Mrs C Anderson reported that in reviewing the Workforce Flash Results, the Committee had been alerted to vacancy issues which were 'masked' by the overall vacancy rate presented in the report. She advised that the vacancy rate figure would be split between nursing and medical staff in future reports and that the Committee had also requested that forecast information be included going forward.

With regard to the Flu campaign, Mrs C Anderson reported that the Committee had received positive assurance that the Trust was on track to achieve the CQUIN target for 70% of frontline staff to have received the Flu vaccination. She noted, however, that in the interest of patient safety, the Committee had requested that further work be undertaken to ensure a greater uptake of the vaccination by staff as well as joint working with the Stockport Together partners to improve uptake of the vaccine in the community. In response to a comment from Dr M Cheshire, the Director of Workforce & OD advised that a report on lessons learnt would be prepared at the end of the season by the Flu Strategy Group for consideration by the People Performance Committee.

Mrs C Anderson advised the Board that the Committee had taken positive assurance from the following reports: the Trust's Freedom to Speak Up arrangements; 2018/19 Nursing & Midwifery Retention Plan; and a Medical Appraisal & Revalidation Report.
Mrs C Anderson reported that the Committee had noted an improved position on agency expenditure in Month 9. She noted that while this had been the case in 3 of the 4 previous months, the level of expenditure would be negatively influenced by deployment of additional winter funding to enhance staffing levels. Mrs C Anderson concluded her report by advising the Board that NHS Employers were undertaking a consultation on a National Workforce Strategy and that Committee members were requested to provide any comments on the document to the Deputy Director of Workforce by 9 March 2018.

The Board of Directors:

- Received and noted the Key Issues Reports.

20/18 Trust Performance Report – Month 9

The Chief Operating Officer presented the Performance Report which summarised the Trust's performance against the NHSI Single Oversight Framework for the month of December 2017, including the key risks to delivery. She advised that the report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. The Chief Operating Officer advised that there were two areas of non-compliance in month which were the non-achievement of the Accident & Emergency (A&E) 4-hour target and the Cancer 62-day standard. She noted that the Trust had remained compliant with the Referral to Treatment (RTT) standard in month.

The Chief Operating Officer briefed the Board on an improved position in the areas of Discharge Summary and Clinical Correspondence. She advised that the introduction of a Clinical Correspondence typing hub had been a success and noted that staff were requesting to work there. On a less positive note, the Chief Operating Officer reported an increased number of cancelled operations in December 2017 due to a shortage of beds. With regard to the RTT standard, the Chief Operating Officer advised that the position was likely to be negatively influenced by cancelled elective work and associated administrative pressures.

In response to a question from Mrs C Barber-Brown, who queried whether the Trust could take any mitigating actions with regard to the risk to RTT performance, the Chief

Operating Officer advised that this issue would be built into any recovery plans but was dependent on the duration of the current pressures. The Chief Operating Officer briefed the Board on the successful 'Home for Christmas' event which had resulted in a significant improvement in discharges in the lead up to Christmas. The Associate Medical Director noted that one of the key interventions and successes during this event had been the adoption of a 7-day service approach in Medicine. The Chief Operating Officer advised that since Christmas, there had been unprecedented pressure within the system from an urgent care demand and capacity perspective due to a higher acuity of patients. She reported that to accommodate this demand, the Trust had opened 30 additional medical beds and had converted a surgical ward to medicine and stopped all non-urgent elective surgery. The Chief Operating Officer advised the Board that for the next four weeks, the Trust had commenced an intensive performance programme and created ward-based multi-disciplinary discharge teams to help expedite a safe discharge of patients.

In response to a question from Mrs C Barber-Brown regarding partnership working, the Chief Operating Officer noted that while certain aspects worked well, concerns remained regarding the provision of discharge support by primary care. The Managing Director of Stockport Neighbourhood Care advised that the Stockport system had made a commitment to take shared accountability for urgent care. In response to a question from Mrs C Barber-Brown, the Chief Operating Officer and the Director of Nursing & Quality briefed the Board on the Trust's plans in the event of further outbreaks of flu. In response to a question from Dr M Cheshire, the Interim Chief Executive noted a surge in 12-hour breaches due to the unprecedented pressure within the system from urgent care demand which had resulted in longer waits.

In response to a comment from Dr M Cheshire regarding the high number of ambulance deliveries at the Trust compared to other trusts in the Greater Manchester, the Chief Operating Officer noted that this was due to the Trust's geographic location. In response to a question from the Chair, the Chief Operating Officer advised that a report detailing a review of winter plan effectiveness and outcomes of the current 4-week intensive performance programme would be presented to the Board for consideration at the meeting on 29 March 2018. The Managing Director of Stockport Neighbourhood noted that the report would include lessons learned regarding complex discharges.

With regard to the Finance section of the report, the Director of Finance reported that in-year plans showed significant amounts of unidentified or red rated schemes which added major pressure to the Trust's ability to deliver the in-year and next year's financial plan. He also noted a shortfall in the delivery of recurrent Cost Improvement Programme. With regard to Financial Sustainability, the Director of Finance advised that the Trust's Use of Resources score under the Single Oversight Framework was a 3 which was in line with the plan. He referred the Board to Chart 69 of the Integrated Performance Report and noted that based on the latest cash flow forecast, the requirement for a working capital support facility loan was now likely to be delayed until April 2018.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 9 compliance standards

- Noted the future risks to compliance and corresponding actions to mitigate
- Noted the key risk areas from the Integrated Performance Report.

21/18 Review of Integrated Performance Report

The Director of Support Services presented a report which updated the Board on progress made to date with regard to a review of the Integrated Performance Report (IPR). He thanked Mrs C Griffiths, Improvement Director, and Executive Team colleagues for their support during the process and noted that the key difference would be in the narrative of the IPR which would also include forward looking actions. The Director of Support Services briefed the Board on the content of the report and noted that a draft version of the IPR had been included in Appendix 1 of the report to provide an overview of the proposed design. In response to a comment from the Chair, the Director of Support Services clarified that the information included in the draft IPR was illustrative rather than actual.

A number of Board members commended the new format of the IPR which they found to be clear, concise and which would facilitate improved triangulation between quality, performance and finance. In response to a question from Dr M Cheshire, the Director of Support Services noted that the new IPR was anticipated to launch on 1 April 2018, with the first new style IPR presented to the Board at its meeting on 24 May 2018. The Director of Nursing & Quality noted that in the meantime, the Quality Committee would continue to review the IPR in a 'shadow' form. The Chair commented on the need to ensure consistency with regard to RAG rating and encouraged the inclusion of 'amber' rating. The Director of Support Services advised that a further progress report would be considered by the Board on 29 March 2018.

The Board of Directors:

- Received and noted the Review of Integrated Performance Report.

22/18 Stockport Together Benefits Realisation Update Report

The Managing Director of Stockport Neighbourhood Care presented a report which described progress with the implementation of the Stockport Together Business Cases and outlined the approach to benefits realisation and measurement for 2018/19. She briefed the Board on the content of the report and noted that the strategic system vision was to provide a truly joined up, high quality, sustainable, modern and accessible health and care system, described under the brand name of 'Stockport Together'. The Managing Director of Stockport Neighbourhood Care reported that the focus of Stockport Together was to provide highly integrated approaches for the 15% of the population with chronic health needs who were most at risk of hospitalisation. She noted that the delivery of the Stockport Together programme was underpinned by a number of business cases which had been approved, in draft, by all Provider and Commissioner Boards in July 2017 and advised that the Stockport Neighbourhood Care senior leadership team had been appointed in October 2017 to deliver these business cases.

The Managing Director of Stockport Neighbourhood Care then referred the Board to s4 of the report and provided an overview of progress regarding deployment of the Stockport Together Integrated Service Solution (ISS) which was anticipated to take

place by the beginning of March 2018. The Managing Director of Stockport Neighbourhood Care noted that due to the complexity and scope of the system transformation, as well as winter pressures, it was possible that the deployment of some of the workstreams would be staged and the associated benefits realisation consequently affected. She commented, however, that as some of the schemes achieved a roll out prior to March 2018, it would be expected that some benefits would be realised before June 2018. The Board was advised that a maturity assessment, which was being undertaken to understand the associated impact, was due to conclude in February 2018. The Managing Director of Stockport Neighbourhood Care noted that, in addition, a recovery plan would be produced to mitigate risks.

In response to a question from the Associate Medical Director, the Managing Director of Stockport Neighbourhood Care advised that some example metrics had been included in Appendix 1 of the report. In response to a question from Dr M Cheshire regarding the target dates, the Managing Director of Stockport Neighbourhood Care acknowledged that the aim for the programme to be fully operational by June was ambitious, which had prompted the need for a maturity assessment. Dr M Cheshire queried if in the interest of safety, the Board could have sight of any key problem areas with regard to patient flow. The Managing Director of Stockport Neighbourhood Care advised that work had commenced to map interdependencies of business cases and noted that this piece of work had culminated in a complex view. She welcomed suggestions with regard to the way in which the information could be triangulated.

In response to a question from Mr M Sugden with regard to the possibility of building outcomes of the maturity assessment in the 2018/19 contract, the Director of Finance advised that the Managing Director of Stockport Neighbourhood Care had been asked to report any associated financial impacts following the maturity assessment. He noted that the full benefit of the business cases could only take effect when they had all been implemented. In response to a comment from Mr M Sugden, who raised a concern regarding the quality of output in such a short timescale, the Managing Director of Stockport Neighbourhood Care acknowledged the concern and noted that the maturity assessment would help prioritise the schemes. In response to a question from Mrs C Barber-Brown who queried why the staff fill rate information differed from the presentation given at the earlier Strategy session, the Managing Director of Stockport Neighbouring Care apologised for the contradicting information which would be rectified for future reports.

The Managing Director of Stockport Neighbourhood Care referred the Board to s4.2 of the report and noted that despite significant challenges with regard to the implementation of some of the workstreams, there had also been progress made against a number of the schemes. She provided an overview of ongoing progress with regard to Core Neighbourhoods; Borough Wide Services / Intermediate Tier; and Enablers. The Chief Operating Officer, Mrs C Barber-Brown and Mrs C Anderson raised concerns regarding the measurement of progress, which they felt provided a false sense of assurance in its current form. The Managing Director of Stockport Neighbourhood Care commented that the report was intended to provide a strategic oversight and transparency with regard to challenges. She acknowledged the comments, however, and agreed to review the report to ensure it provided greater clarity and granularity going forward.

In response to a question from Mrs C Barber-Brown, the Managing Director of Stockport Neighbourhood Care advised the Board of the development of an outcomes framework and metrics which would provide clarity with regard to benefits, outcomes and underpinning actions. She advised that the Board would receive monthly Stockport Together progress reports until further notice.

The Board of Directors:

- Received and noted the Stockport Together Benefits Realisation Update Report.

23/18 Corporate Objectives 2017/18 – Progress Report

The Interim Chief Executive presented a report which provided an update on progress with regard to the Corporate Objectives for 2017/18 as at the end of Quarter 3. She briefed the Board on the content of the report and noted that a full list of strategic objectives, corporate objectives for 2017/18, progress updates and RAG ratings had been included in Appendix 1 to the report. The Interim Chief Executive referred the Board to s3.2 of the report and provided an overview of two 'red' rated corporate objectives, C3 and C10, which related to Healthier Together and the CQC inspection respectively.

The Board of Directors:

- Received and noted the Corporate Objectives 2017/18 Quarter 3 update report.

24/18 Quality Governance Framework

The Director of Nursing & Quality presented a Quality Governance Framework report. She advised that the Quality Governance Framework had been considered and recommended for Board approval by the Quality Committee on 16 January 2018. The Director of Nursing & Quality briefed the Board on the content of the report and advised that the Quality Governance Framework set out the structures and processes at and below Board level to ensure achievement of quality, safety and experience standards. She thanked Mrs C Griffiths, Improvement Director, for her help in the process. The Director of Nursing & Quality referred the Board to page 13 of the Quality Governance Framework and briefed the Board on the new Committee structure. In response to a question from Dr M Cheshire, the Director of Nursing & Quality confirmed that issues relating to medicines harm would be considered by the Safer Medicines Practice Group.

In response to a question from the Chair, the Director of Corporate Affairs noted that each Committee and Group detailed in the Committee structure of the Quality Governance Framework would be subject to Terms of Reference and an annual review of effectiveness. In response to a further comment from the Chair, the Director of Corporate Affairs agreed to circulate a copy of the Quality Governance Framework to the Council of Governors for information.

The Board of Directors:

- Received and noted the report and approved the Quality Governance Framework.

25/18 Safe High Quality Care Improvement Plan – CQC Action Plan

The Director of Nursing & Quality presented the Safe High Quality Care Improvement Plan for review by the Board of Directors. She advised that the plan had been developed in response to the 'must do' and 'should do' actions from the Care Quality Commission (CQC) Report published on 3 October 2017 and was included for reference at Annex A of the report. The Board noted that the plan had been submitted to the CQC on 19 December 2017. The Director of Nursing & Quality advised that a draft Safe High Quality Thematic Plan had also been included for reference at Annex B of the report. She advised that the aim of the Thematic Plan was to facilitate monitoring of CQC actions and provide a framework for assurance across the 16 CQC domains.

The Director of Nursing & Quality advised that the initial 'RAG' rating of the action plan had been amber but noted that some of the actions were now rated green. She advised the Board that regular progress reports against both the Improvement Plan and the Thematic Plan would be presented to the Quality Committee together with any items for escalation to the Board. The Director of Nursing & Quality noted that consideration would be given to publishing the Safe High Quality Care Improvement Plan on the Trust's website. The Director of Corporate Affairs commented that in effect the Plan had already been published on the Trust's website as it was included in the Board meeting pack. In response to a question from Mrs C Barber-Brown, the Director of Nursing & Quality briefed the Board on the key risk areas in the action plan, which included management of health records and management of diabetes.

The Board of Directors:

- Received and noted the Safe High Quality Care Improvement Plan – CQC Action Plan Report.

26/18 Maintaining Safe Staffing Levels

The Director of Nursing & Quality presented a report which provided an overview of actual versus planned staffing levels for the month of December 2017. She briefed the Board on the content of the report and advised that Registered Nursing and Midwifery vacancies across the Trust equated to 187.6 whole time equivalents. The Director of Nursing & Quality reported that average fill rates for Registered Nurses, Registered Midwifes and non-registered care staff remained above 90% for both day and night duty. The areas reporting suboptimal registered staff levels below 90% included five medical wards, one surgical ward and one area in Child & Family. The Board noted that temporary staff had been utilised in the clinical areas to support safe staffing levels.

The Director of Nursing & Quality reported that recruitment initiatives were not providing sufficient results to address the underlying vacancy rates and noted that the levels recruited only supported the monthly turnover. She advised that from May 2018, the Safe Staffing report would become part of the Integrated Performance Report and noted that a 12 month Strategic Staffing Review report would be presented to the Board in March 2018. The Director of Nursing & Quality referred the Board to s3.4 of the report and provided an overview of activities regarding retention and

advised that the Trust was supported by NHSI in this area. The Director of Workforce & OD made reference to the Trust's Nursing & Midwifery Retention Plan and noted that the Trust's target was to increase retention by 2%. In response to a comment from the Chair who noted the national interest regarding nursing retention, the Director of Nursing & Quality briefed the Board on local and Greater Manchester-wide actions in this area. In response to a question from Mrs C Barber-Brown, the Director of Nursing & Quality advised that the role of a housekeeper was being considered as part of the strategic staffing reviews.

The Board of Directors:

- Received and noted the Safe Staffing Report and the measures in place to ensure patient safety.

27/18 Corporate Risk Register

The Director of Nursing & Quality presented the Corporate Risk Register. She advised that considerable amount of work was still ongoing to ensure the robustness of the Risk Register, which included a review of the framework and structure. The Director of Nursing & Quality advised that she had met with Mr J Sandford to discuss the Risk Management Framework which would support the delivery of the Corporate Risk Register.

Mrs C Anderson advised that the People Performance Committee had considered the Corporate Risk Register at its meeting on 25 January 2018 and reported that Committee members had noted a number of improvements compared to previous versions of the Risk Register while acknowledging that further work was required to improve the content and presentation of the document. In response to a question from the Chair, the Director of Nursing & Quality advised that it was anticipated that an improved version of the Risk Register would be available for consideration by the Quality Committee at its meeting on 13 March 2018.

The Board of Directors:

- Received and noted the Corporate Risk Register.

28/18 Board Assurance Framework

The Interim Chief Executive presented the Board Assurance Framework (BAF) 2017/18 to the Board of Directors for consideration and approval. She advised that the BAF, which had been included for reference at Annex A of the report, had been reviewed by the relevant risk owners and updated accordingly. The Interim Chief Executive noted that there had been no movements in residual risk scores sine the last review by the Board. She advised the Board that work had commenced to review the Strategic Objectives in conjunction with the work being carried out to prepare a revised Trust Strategy. The Board noted that any resultant amendments to the Objectives would form the basis for content of a 're-opened' BAF for 2018/19. The Interim Chief Executive advised that in addition, the Director of Nursing & Quality was currently assessing the feasibility of a revised format for the BAF with the aim of ensuring correlation between Framework content and associated high level risks. She reported

that outcomes of this work would be shared with Board members for consideration in due course.

In response to a question from Mrs C Anderson who queried the risk rating of 16 for the A&E 4-hour target compliance (SO3), which she noted appeared to be too low, the Chief Operating Officer apologised that the risk rating had not been amended since the previous meeting and agreed to update it. Mrs C Barber-Brown noted that it was important to ensure correlation between the risk ratings and Corporate Objectives to ensure consistency. In response to comments from Mr M Sugden, who queried the degree of assurance provided by current content, the Director of Corporate Affairs noted that the content reflected the risk to the strategic objectives previously agreed by the Board. He advised that work was in progress to both review the strategic objectives for 2018/19 and revise the format of the Board Assurance Framework.

The Board of Directors:

- Considered and approved the content of the Board Assurance Framework at Annex A but noted that SO3 required review.

29/18 Consent Agenda

a) GM Theme 3&4 Quarterly Report

The Board of Directors received and noted a GM Theme 3&4 Progress Report.

b) Terms of Reference – Quality Assurance Committee

The Board of Directors approved revised Terms of Reference for the Quality Committee and noted outcomes of an assessment of Committee Effectiveness.

30/18 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next scheduled meeting of the Board of Directors would be held on Wednesday, 28 February 2018, at 1.15pm in Lecture Theatres, Pinewood House.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
9/16	24 Nov 16	340/16	Strategic Risk Register	Mrs J Morris advised that all risks would be transferred to the new Datix system by the end of December 2016 and suggested that once implemented, Ms C Marsland would provide a presentation to the Board with regard to the new system. **Update on 27 Jan 2017** – A presentation would be provided to the Board in April 2017. **Update 27 Apr 17** – The Board noted a delay to implementation of the Datix system and agreed that the presentation would be provided on 29 June 2017. **Update 26 Jun 17** – Mrs J Morris advised that due to the revised Board meeting date, Ms C Marsland had been unable to attend the meeting as she was at an inquest. It was noted that the presentation would be deferred to the July Board meeting. **Update 27 Jul 17** – The Chief Executive advised the Board that the Trust was looking to procure an external trainer to provide training on the new Datix system. It was noted that the presentation to the Board would be arranged as soon as practicable. **Update 28 Sep 17** – The Chief Executive advised the Board that the Trust had procured an external trainer for a 6 month period to provide training on the new Datix system and noted that the Board would receive a presentation on the new system at the October meeting. **Update 27 Oct 17** – The Chief Executive noted her disappointment that due to the unavailability of fit for purpose risk management information, the Board was not able to consider a Strategic Risk Register at the meeting. A number of Board members noted their concern and disappointment with regard to this position. The Director of Nursing & Quality advised that mitigating actions were underway in this area and agreed to provide a status update to the Board prior to the next meeting. In response to a comment from Mr M Sugden, it was agreed to amalgamate the outstanding presentation on the Datix system with a presentation on the Post-Implementation Review of the Surgical &	J Morris (Director of Nursing) A Lynch (Dir of Nursing & Quality) A Lynch (Dir of Nursing & Quality)/ H Mullen (Dir of

				Medical Centre. **Update 30 Nov 17** – The Director of Nursing & Quality briefed the Board on the current status of the Risk Register. She noted that whilst a risk management system was in place which could successfully be used as a live tool, it was not possible at this stage to produce a printable version of the Risk Register. A number of Board members noted their frustration with regard to this ongoing issue. The Director of Nursing & Quality advised that following the launch of the new risk management system on 1 December 2017, the Risk Register would be considered at the Quality Governance Committee in December 2017 and the Quality Assurance Committee and the Board of Directors in January 2018. **Update 31 Jan 18** – Corporate Risk Register on agenda. Action complete.	Support Services)
13/17	26 Jun 17	170/17	Stockport Together – Outline Business Cases	Board members agreed to receive presentations on key enablers at the Board of Directors meetings in August / September 2017: • Workforce – August • IM&T and Information Governance – September **Update 28 Sep 17** – The Director of Corporate Affairs agreed to liaise with the Director of Support Services and the Director of Workforce & OD with regard to the scheduling of these presentations. **Update 30 Nov 17** – The Director of Corporate Affairs advised that the presentations were scheduled for the Board meeting on 31 January 2018. **Update 31 Jan 18** – Presentations delivered at the Board Strategy session on 31 January 2018. Action complete.	J Shaw (Dir of Workforce & OD) / H Mullen (Dir of Support Services) / P Buckingham (Dir of Corporate Affairs)
17/17	28 Sep 17	220/17	Finance & Performance Key Issues Report	Mr M Sugden reported that the Committee had considered the Trust's cash position and had noted the likelihood that the Trust would require additional cash investment in December 2017. He advised that relevant approval documentation would be prepared for consideration by the Board of Directors in November 2017. **Update 30 Nov 17** – It was noted that this subject had been considered at a private Board meeting and would be further considered by the Board by the end of January 2018. **Update 31 Jan 18** – The Board noted that the potential requirement for additional cash investment had been postponed and agreed to close the	F Patel (Director of Finance)

				action.	
18/17	28 Sep 17	221/17	Trust Performance Report – Month 5	The Interim Provider Director made reference to the increased capability of neighbourhood teams and 7-day working and noted that the Board of Directors would receive a report regarding the Implementation Plan of the Stockport Together Programme at the meeting in October 2017. **Update 27 Oct 17** – The Interim Provider Director noted that following discussions at the most recent Alliance Board, a single report would be prepared for all providers which would be presented to this Board on 30 November 2017. He noted, however, that the Board might benefit from a "walk through" of the report beforehand. **Update 30 Nov 17** – The Interim Provider Director noted that the Board had considered a report on benefits realisation at the private Board meeting on 30 November 2017 and had agreed that a subsequent report would be presented to the public Board meeting on 31 January 2018. **Update 31 Jan 18** – Report on agenda. Action complete.	K Spencer (Interim Provider Director)
20/17	28 Sep 17	225/17	Draft Alliance Provider Agreement	In response to a question from the Chair, the Interim Provider Director advised that he would provide an update with regard to the risk and gain share agreement at the next Board meeting. **Update 27 Oct 17** – The Interim Provider Director advised that he had written to all Directors of Finance with regard to the risk and gain share agreement and noted that the issue would be discussed at the Locality Finance Meeting on 6 November 2017. **Update 30 Nov 17** – The Director of Finance reported that this issue was yet to be resolved as a legal agreement. The Interim Provider Director noted that he would ensure that a risk and gain share agreement was in place by 28 February 2018 at the latest.	K Spencer (Interim Provider Director)
22/17	27 Oct 17	256/17	Board Assurance Framework	Mr J Sandford commented that, in general, the BAF provided the necessary assurance against the Trust's key risks. He noted, however, that this was not the case in areas where the Trust was failing to achieve progress or risks were not being managed appropriately in which case the Board would need to be sighted on associated recovery plans in order to gain the necessary assurance. It was subsequently proposed that the Audit Committee would consider this issue further and make any necessary	Mr J Sandford

				recommendations to the Board. **Update 30 Nov 17** – Mr J Sandford advised that the Audit Committee would consider this issue at its next meeting. **Update 31 Jan 18** – The Director of Corporate Affairs advised that the Audit & Risk Committee would consider the Risk Management Framework, including the Board Assurance Framework, at its meeting on 6 February 2018. The Board agreed to close this action.	
23/17	30 Nov 17	273/17	Quality Improvement	In response to a question from the Chair, the Director of Nursing & Quality reported that the Quality Governance Framework would be presented to the Quality Assurance Committee on 16 January 2018 and the Board of Directors on 31 January 2018. **Update 31 Jan 18** – On agenda. Action complete.	A Lynch (Director of Nursing & Quality)
24/17	30 Nov 17	278/17	Trust Performance Report – Month 7	The Board of Directors agreed to receive a presentation at a future meeting from Dr L Elliott on the subject of Enhanced Case management. **Update 31 Jan 18** – The Managing Director of Stockport Neighbourhood Care agreed to liaise with the Director of Corporate Affairs to arrange this presentation.	K Spencer (Interim Provider Director) C Drysdale (Managing Dir, SNC)
25/17	30 Nov 17	279/17	Financial Recovery Plan	The Board noted that the agency checklist would be completed for review by the Board of Directors on 31 January 2018. **Update 31 Jan 18** – The Director of Workforce & OD advised that the agency checklist would be reviewed by the Board on 28 February 2018.	J Shaw (Dir of Workforce & OD)
26/17	30 Nov 17	280/17	Review of Integrated Performance Report	In response to a question from the Chair regarding timescales, the Director of Support Services advised that the Board would receive a progress report on 31 January 2018. **Update 31 Jan 18** – On agenda. Action complete.	H Mullen (Director of Support Services)
01/18	31 Jan 18	20/18	Trust Performance Report – Month 9	In response to a question from the Chair, the Chief Operating Officer advised that a report detailing a review of winter plan effectiveness and outcomes of the current 4-week intensive performance programme would be presented to the Board for consideration at the meeting on 29 March 2018. The Managing Director of Stockport Neighbourhood noted that the	S Toal (Chief Operating Officer)

				report would include lessons learned regarding complex discharges.	
02/18	31 Jan 18	21/18	Review of Integrated Performance Report	The Director of Support Services advised that a further progress report would be considered by the Board on 29 March 2018.	H Mullen (Director of Support Services)

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

Corporate objective ref:	**Summary of Report** The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities
Board Assurance Framework ref:	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:	Nil

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

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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities. As previously, the report provides brief information since the previous Board meeting in relation to:

- Notable events
- Matters concerning the development of the Board itself
- My own engagements and visits on behalf of the Trust
- Any significant regulatory developments that as Chair I have been involved in
- A forward look to significant events or possible developments.

2. NOTABLE EVENTS

2.1 The Trust has continued to experience an extremely challenging winter period with significant pressure on Urgent Care performance. I would like to again thank our colleagues and partners for their continued professionalism and dedication in such testing circumstances.

2.2 The Urgent Care agenda featured heavily during what will be the first of a series of 'Leaders' Summits' held on Friday, 9 February 2018. The Summit was attended by the respective Chairs and Chief Executives from the Trust, Stockport Metropolitan Borough Council and Stockport CCG and was used to consider ways in which individuals are able to work together as system leaders across the local health and social care economy. The attendees re-committed to the Stockport Together programme and recognised a need to both accelerate the realisation of benefits from the programme and re-affirm a shared sense of the ultimate destination for the programme. It was agreed that the Summit approach will be a regular forum and representatives from Viaduct Care and Pennine Care NHS Foundation Trust will be invited to attend future meetings.

3. BOARD DEVELOPMENT

3.1 The Board held a half-day development session on Thursday, 8 February 2018, which was based on the recommendations arising from a Review of Undertakings. The discussion focused on; progress with preparation of a revised Strategy, financial planning and development of a medium-term financial strategy, service reviews and the provision of Quality information. The Board plans to undertake an externally-facilitated Development Day on Friday, 27 April 2018.

3.2 Board members should note that Mrs J Shaw, Director of Workforce & OD, will be leaving the Trust with effect from 31 March 2018 having accepted the offer of a similar position at the South Manchester site of Manchester University NHS Foundation Trust. Work is currently underway to recruit an appropriate replacement and this is likely to be on an interim basis to facilitate substantive appointment by an incoming Chief Executive.

3.3 The recruitment process to appoint a substantive Chief Executive is continuing, and Board members are requested to note that the deadline for applications has been extended to 28 February 2018. I have either met or spoken with a number of potential candidates

although, at the time of writing, it is difficult to assess the strength of the final field of candidates given both the extended deadline for applications and the number of similar opportunities available in the NHS both regionally and nationally.

4. CHAIR ENGAGEMENTS

4.1 A summary of the Chair's recent activities is as follows:

2 February 2018	Met with Mrs J McCall, recently appointed Chair of Tameside & Glossop Integrated Care NHS Foundation Trust
9 February 2018	Participated in the Stockport Leaders' Summit
13 February 2018	Visited the Hazel Grove Community Clinic
16 February 2018	Attended an Equality, Diversity & Inclusion event at the Trust – Celebrating LGBT
27 February 2018	Scheduled to attend a meeting with Stockport NHS Watch and a 'Working across Stockport' event for Non-Executive Directors from various sectors to consider opportunities for joined up working

5. REGULATORY DEVELOPMENTS

5.1 A system level inspection will be conducted by the Care Quality Commission in April 2018. Consequently, it is important that system leaders use the time provided by the Leaders' Summits to consider progress with preparatory work.

6. FORWARD LOOK

6.1 We anticipate that outcomes from the 2017 Staff Survey will be published in the near future and, clearly, the outcomes will be of great interest to the Board. It is expected that a report on this subject will be included on the agenda for the Board of Directors meeting on 29 March 2018.

6.2 With regard to the Board meeting in March 2018, Board members have recently considered the benefits of an adjustment to Board days which would result in the meeting held in public taking place in the morning, rather than the afternoon. We will look to introduce revised arrangements on 29 March 2018 and further details will be promulgated in due course.

6.3 In addition, we are also looking to schedule a Council of Governors meeting in March 2018 to provide Governors with the opportunity to express views on both a draft Operational Plan 2018/19 and a revised Trust Strategy.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Board of Directors' Key Issues Report

Report Date: 28/02/18		**Report of:** Finance & Performance Committee
Date of last meeting: 21/02/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Month 10 Finance Report • Month 10 Operational Performance Report • Agency Utilisation Report • CIP 2017/18 Progress Report • Service Reviews - Progress Report • Draft Operational Plan • GDPR Briefing Report • EPR Progress Report
	Alert	• The Committee reviewed the Month 10 Operational Performance Report and Board members will be fully aware of the continuing challenge to performance against the A&E 4-hour standard. The Committee was advised of a number of 12-hour breaches in January 2018 and noted that analysis of these incidences will be reported to the Quality Committee and, subsequently, to the Board. In view of continuing pressures, the Committee is only able to report a low level of assurance on attainment of a performance level of 85% against the 4-hour A&E standard by 31 March 2018. • Board members should note that, while a consequent impact on RTT performance did not materialise in January 2018, the Cancer 62-Day standard was not achieved. The Committee noted the contributory factors of complex patient pathways and a low patient denominator. • The Committee received an update on preparation of the draft Operational Plan for 2018/19 and noted that there remained a significant amount of work to be completed in advance of consideration by the Board and subsequent submission to NHS Improvement by 8 March 2018. The Committee identified the need to define timescales for the production of clear programmes to implement Plan content and to set out how assurance on progress would be reported to relevant Committees and the Board. • In considering financial elements of the draft Operational Plan, the Committee requested that a proposal to fund Business Groups at outturn for 2018/19 be reviewed, with a final proposal being underpinned by supporting analysis. It was also noted that the Board should make clear its expectations on the management of costs within budgeted levels when approving revenue budgets on 29 March 2018.

	Assurance	• The Committee considered a report on delivery of the in-year cost improvement programme and noted that, despite a number of mitigating actions being taken, there is likely to be a shortfall of circa £3.3m against the £15m target for 2017/18. Consequently, there remains a low level of assurance on achievement of the cost improvement programme for 2017/18. Board members should note that the relatively low proportion of recurrent savings will impact financial plans for 2018/19. In addition, the Committee currently has only a low level of assurance on the identification and status of plans for the 2018/19 programme. • With regard to the Month 10 Finance Report, the Committee is able to report a more positive position with financial performance ahead of plan in January 2018. Consequently, there is currently a high level of assurance on overall delivery of the 2017/18 financial plan as the financial position for the Business Groups has remained stable, despite under-performance against the Medicine and Surgical Business Groups financial recovery plans.		
	Advise	• The Committee can advise the Board that improvements in agency expenditure continued in Month 10 with costs maintained within the agency ceiling. As a result the forecast level of overshoot against the £12.1m agency ceiling for the year has reduced from £1.2m in Month 9 to £0.4m at Month 10. The Committee considered current performance in the context of a revised agency ceiling of £10.5m for 2018/19 and noted that current levels of expenditure indicate that delivery within the ceiling will be achievable in 2018/19 despite a reduction of circa £1.6m. • The Committee considered a report which detailed progress with the EPR Project and noted an overall amber status for the programme with continued uncertainty on a potential 'go-live' date for system roll-out.		
2.	Risks Identified	• Delivery of the 2017/18 CIP • Preparation of the 2018/19 CIP • Completion of a robust Operational Plan		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Malcolm Sugden, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Urgent Care Quality Improvement: Update		
Report of:	Chief Operating Officer	**Prepared by:**	Deputy Chief Operating Officer

REPORT FOR UPDATE

Corporate objective ref: -----	**Summary of Report** This paper is intended to provide a performance update from the MADE Event and an overview of the improvement work being undertaken by the Urgent Care Cabinet as a result. The improvement work is focused on 4 key work streams, they include: - The Urgent Treatment Centre - Patient Flow - Transfer processes - Community Capacity The Board is asked to note the work being done and the progress to date.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☒ Not required	

Attachments:

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

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1. INTRODUCTION

This paper is intended to provide an update on performance from the MADE Event and an overview of the improvement work being undertaken by the Urgent Care Cabinet as a result.

2. PERFORMANCE UPDATE

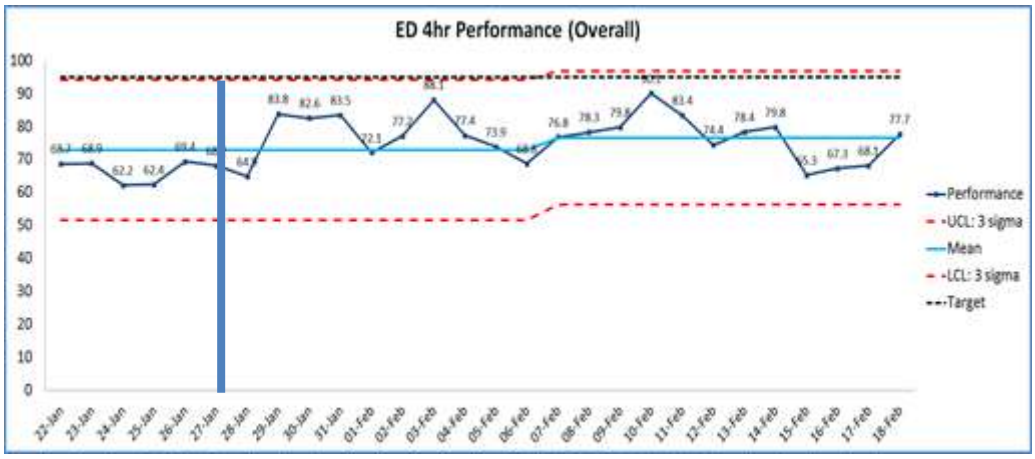
A four week MADE (Multi Agency Discharge Event) Event started across the hospital from Monday 29th January. The MADE Event consists of multi-disciplinary discharge teams (discharge teams) made up of a consultant, a senior nurse, a therapist, a discharge team member, an executive team member and administrative support working across clusters of wards to challenge and support the teams. The teams visited the ward areas every morning and reviewed each patient, asking questions about length of stay, expected date of discharges, blockages to discharge to help to expedite their discharge. This initiative was supported by colleagues from NHSI, the GM Partnership and NWAS, as well as the Stockport Together partner organisations.

The following charts indicated the outcomes of the MADE Event, and also, where possible, plot performance back to the start of the CEEPFIT initiative and Home For Christmas 2017.

ED Performance

This chart plots daily performance against the 4 hour standard, indicating when the MADE event began and the overall increase in daily performance, until the 15th Feb when there was a consistent deterioration

Chart 1

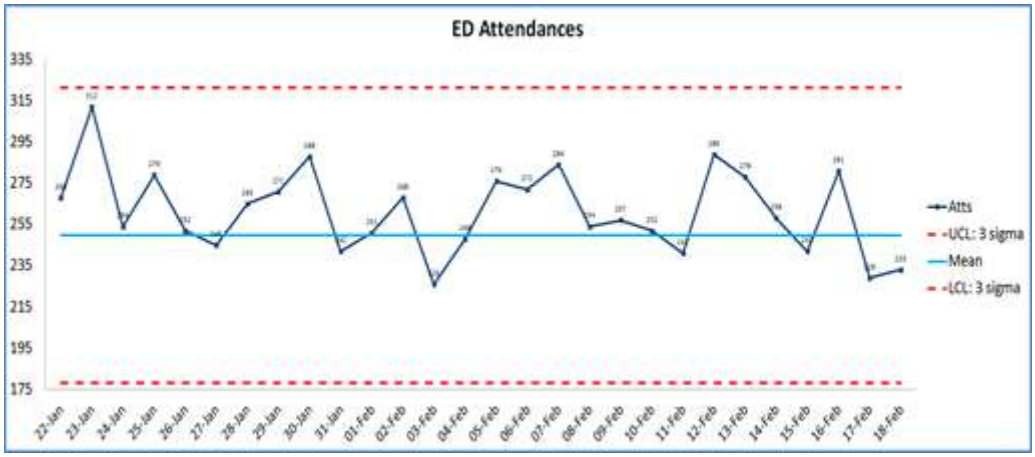


To understand why performance has consistently deteriorated, it is important to analyse the key factors that influence this, namely the number of attendances, the number and timing of discharges and the length of stay.

Number of ED Attendances

Chart 2, overleaf plots the number of daily attendances to the ED Department and clearly shows a reduction in attendances since the start of the 2017, it must be noted that attendances for January 2018 were 9.5% higher than January 2017.

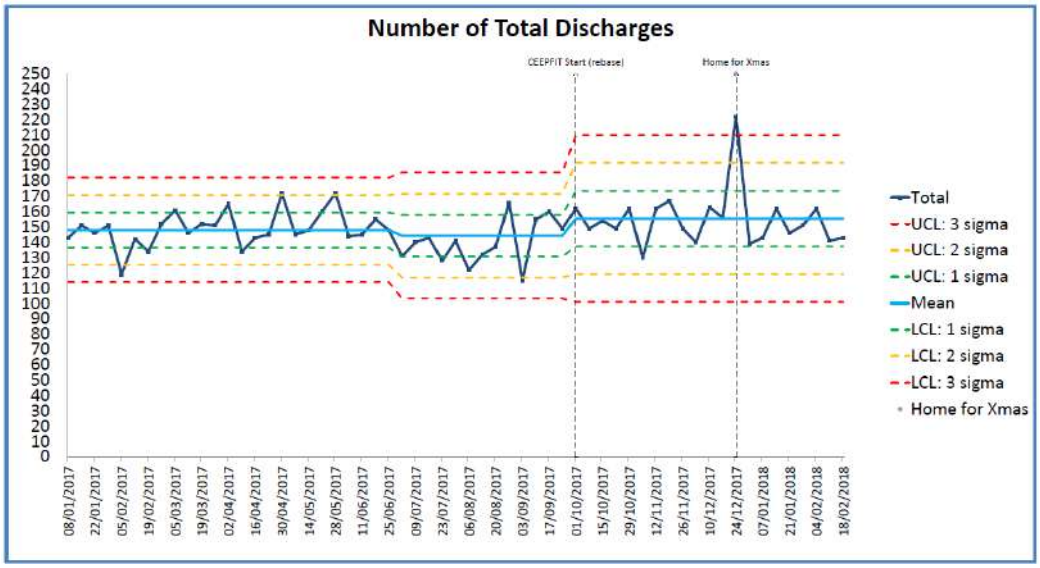
Chart 2



Number of Discharges

Chart 3 shows that the Home For Xmas week had a significant impact on the number of discharges as previously reported, however it also shows that the step change following the implementation of the CEEPFIT project was predominantly maintained until recent weeks, aligned with the overall deterioration in Urgent Care performance.

Chart 3



Timing of Discharges

Chart 4 tracks the percentage of discharges before 12 pm, indicating an upward turn in the proportion, but this must be considered in the context of the reduction in numbers of discharges in recent weeks plotted in Chart 3.

Chart 4

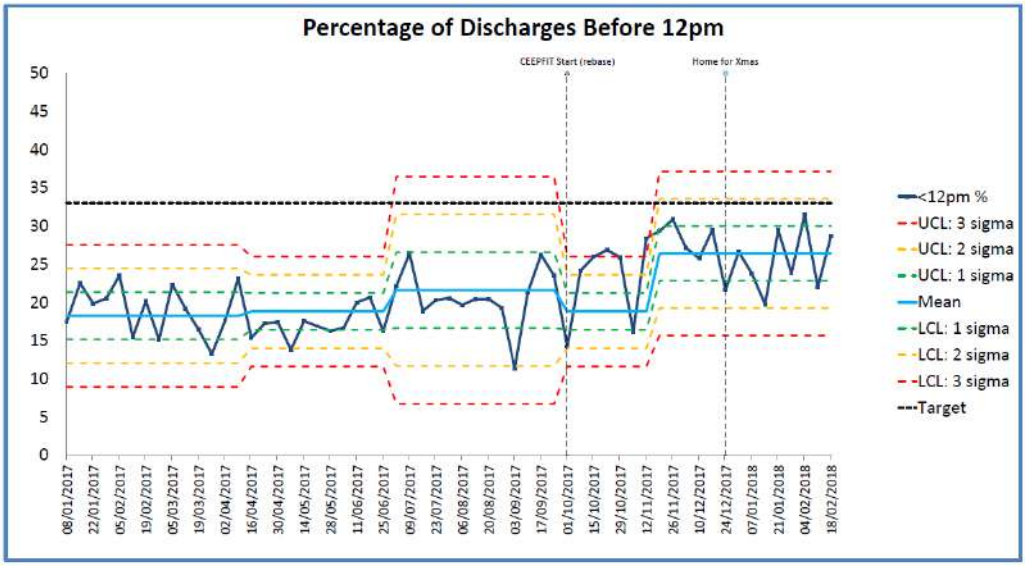
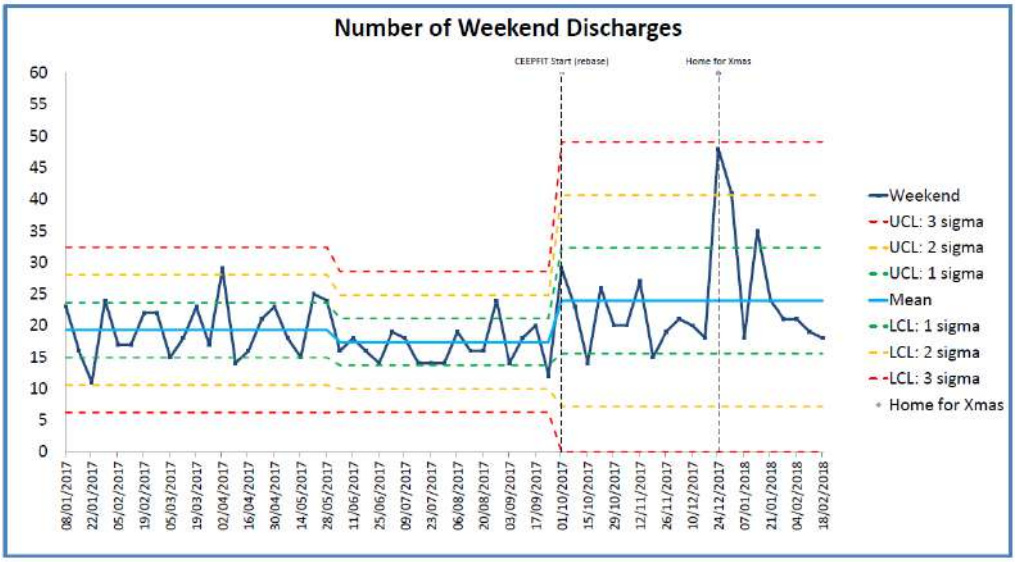


Chart 5 shows further evidence of the reducing numbers of discharges, here highlighting the number of weekend discharges. This is important to note as the numbers of weekend discharges have a clear impact on ED performance at the start of the week when flow is a particular challenge.

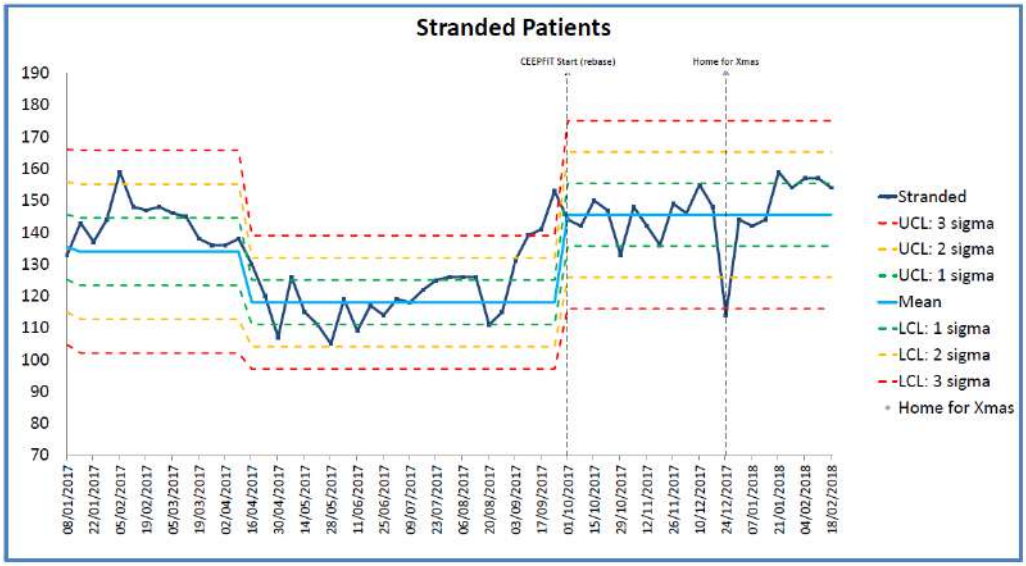
Chart 5



Length of Stay/ Stranded Patients

Chart 6 is the final piece of analysis needed to give the broader context to the deterioration in ED performance. The chart plots the number of patients with a length of stay greater than 7 days – so-called "Stranded Patients". It is clear from this chart that the number of patients falling into this cohort has increased significantly since Christmas, having spiked at the end of January '18. In addition to the higher number of "Stranded" patients, a large proportion of this group are classified as Medically Optimised Awaiting Transfer (MOAT). A recent point prevalence study has indicated that approximately 38% of Medical Beds are occupied by a MOAT patient.

Chart 6



Following the findings of the MADE Event and having noted the drop in overall performance, the reduction in attendances, the recent reduction in discharges both during the week and at the weekend, aligned to the increase in the patients staying in the hospital beyond 7 days, particularly those classified as MOAT, it has been decided to review the focus of the Stockport System Urgent Care Plan. The following sections describe the improvement work to be undertaken.

3. URGENT CARE IMPROVEMENT WORK

The Stockport System Urgent Care Delivery Board (UCDB) has been in existence for the past two years having previously existed as the System Resilience Group. The UCDB brings together the key stakeholders in Urgent Care from across the Stockport System and its key responsibility has been the delivery of the System Urgent Care plan. Over the past two years, the UCDB has variously been monthly, weekly and bi-weekly, however following a recent review at the start of 2018, it has been decided to be a monthly meeting with a three-times monthly Urgent Care Cabinet (UCC) in the intervening weeks. The UCC is intended to be the "operational" board focused on the delivery of Urgent Care Improvement work, with the UCDB remaining a strategic decision making function. The UCC membership includes the Medical Director, the Chief Nurse and the Chief Operating Officer from the Foundation Trust, in addition to leads from Primary Care, the CCG and PMO support.

In addition to the review of the function of the two groups, a decision has been taken to consolidate the focus of the Urgent Care plan into 4 key work streams, they are:

- The Urgent Treatment Centre
- Patient Flow
- Transfer processes
- Community Capacity

Each of these streams of work has a designated Senior Responsible Officer (SRO) and will have a Task & Finish Group to focus on the delivery of the required changes. In addition, a dashboard of System Metrics is in development through collaborative working between each of the Business Intelligence teams from the partner organisations. The first version of the dashboard will be available in March '18. This dashboard will allow the correlation of cause and

effect between interventions outside of the hospital and their impact on the hospital and vice versa.

4. KEY WORKSTREAMS

i. Single Point of Entry

This stream of work is tasked with the implementation of an Urgent Treatment Centre in the Stockport System and a review of attendances to the existing Emergency Department, including working in partnership with colleagues from NWAS, Primary Care and other intermediary services. Central to this will be understanding why we are currently an outlier across Greater Manchester for Ambulance attendances and the admission rate to the hospital from the Emergency Department based on the current model for Assessment Units. The mandate for this improvement has been set out by the Greater Manchester Health & Social Care partnership, by them stating in each locality of GM by Quarter four of 18/19 there will be in:

"An Urgent Treatment Centre…(e.g. CCG footprint) that will receive referrals from General Practice, A&E, NWAS, NHS 111 and 'walk ins' - it must be primary care led and open 12 hours a day"

The requirements for each centre are that they will be:

- Clinically lead by Primary Care
- Open for a minimum of 12 hours per day
- Provide pre-booked same day and "walk-in" appointments
- Accept appointments from A&E, NHS111, NWAS and General Practice
- Provide access to diagnostics
- Co-located in the community or with a hospital
- Have access to the full clinical record.

The work stream is currently at the scoping stage, having brought together the key stakeholders involved in what is both a clinical and capital development. Work has started on potential design options, the further development of the clinical model and the implications from a Business Intelligence and Performance perspective as the new service model will have an impact on metrics used for benchmarking such as Admission Rate, Mortality and Attendance Rate.

ii. Patient Flow

This work stream is the most established, building on the work that has been done to date through the CEEPFIT project. The work stream is made up of 4 projects:

1. Patient flow from AMU to Specialty Medicine/ Specialty In-Reach
2. Stranded Patients
3. General Internal Medicine (GIM) 7-day working
4. Skills and training

There are some clear required deliverables associated with the work being done through each of these four projects, in addition to clearly delineated performance indicators:

Deliverables:

- To re-launch SAFER patient flow bundle & Dressed is Best campaign within hospital
- To establish a buddying system with exemplar wards and an Executive sponsor assigned to each ward
- To introduce a review process for all stranded patients using a Grand Round methodology.
- To increase provision of services across 7 days.
- To review and re-launch the discharge policy, including clear standard roles and responsibilities.
- To improve access to "Out Of Area" services that currently create bottlenecks in flow.
- To develop and embed suite of patient flow KPIs across all ward areas.
- To increase completeness and adherence to Estimate Date of Discharge (EDD) through the application of Clinical Criteria for Discharge (CCD).

Measurables:

- Pull patients from assessment units before 10am (10 patients by 10am).
- 33% of patients to be discharged before midday.
- Reduce to 35% from 47% the number of patients with a length of stay of more than 7 days.
- An increase in the number of weekend discharges (up to 50 for the whole weekend).

iii. Transfer Processes

The stream is aimed at consolidating the work already started through the implementation of the Integrated Transfer Team (ITT) by streamlining patient pathways to services outside of the hospital, with a particular focus on patients classified as DToC or MOAT. In addition to the pathways for patients moving across the System, the work will be looking at how the ITT works and interacts with teams across the organisation, including the newly implemented Clinical Site Management Team.

As with the Patient Flow project work, there are clear deliverables for this stream, they include:

- The merger of the Stockport Council Choosing & Purchasing team with the ITT to allow for closer working between the two. This approach has worked to great effect with the implementation of the "Activation Centre" as part of the Stockport Neighbourhood Care OPEL Level 3 response.

- To scope out and develop an IT solution for the ITT to use to better enable patient flow and communication. The ITT currently use a number of different systems because their members work for a number of different organisations therefore they frequently have to rely on paper systems and lists.

- The Trusted assessor approach is to be revisited with a view to full implementation across all of the Specialty Medical wards. This will include a full communication strategy to ensure a shared awareness of the process, there is robust clinical governance and there is a robust and regular feedback loop to the Trusted Assessors themselves where it is not working. In addition, ongoing support will be given to hospital Trusted Assessors with a focus on

building relationships not solely focusing on process to help closer working with the ward teams.

- Designated Social Worker to be based in care homes to build trust and liaise with the hospital to encourage and support the use one single trusted assessment.

- To build effective and robust processes with out of area discharge teams to ensure unnecessary delays are minimised.

iv. Community Capacity

This work stream is building on that done in 2017 to apply the SAFER model and the principles of effective patient flow to the Intermediate Tier beds in the Community. The focus of this work is drive down the length of stay, predominantly in Intermediate Tier beds, to improve their throughput and effectively create greater step down and step up opportunities to either facilitate discharge or avoid admission to hospital. One of the key objectives of this work will, much like the Transfer Processes project, be to drive down the number of DToC and MOAT patients in the hospital. This will include the introduction of three-times weekly SAFER meetings whereby the whole team, including those from Borough Care will be involved in discharge planning for each patient. There is robust evidence from previous project work that this is an effective way of reducing the Intermediate Tier length of stay having seen it drop by up to 35% in the past. A further key element of this work stream is the review of the usage of Bluebell beds, including the use of 25% of the existing bed base as Intermediate Tier beds to promote flow across the system.

5. RECOMMENDATION

The Board is asked to note and support the refreshed approach being taken to the Urgent Care Delivery Board, the Urgent Care Cabinet and the System Urgent Care plan.

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Report to:	Board of Directors	**Date:**	28th February 2018
Subject:	Trust Performance Report (reporting period : Month 10 2017/18)		
Report of:	Chief Operating Officer	**Prepared by:**	Joanne Pemrick Head of Performance

REPORT FOR APPROVAL

Corporate objective ref:	N/A
Board Assurance Framework ref:	N/A
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed X Not required

In relation to month 10 performance, the following are the key issues to note:

- A&E performance was 71.6% in January which is non-complaint with the National standard.
- RTT remained compliant with standard this month, achieving 92.1%.
- At the point of reporting close, the Cancer 62 day standard is not predicted to achieve standard in January. Latest performance is 83.9%.
- In the ten months so far this financial year the Trust has lost £23.1m. The planned deficit was £23.9m so this is ahead of plan because of additional external resources. The average loss per day is £75,000 to the end of January.
- The overall variance from plan to date is due to a combination of factors:
  - CIP behind plan (adverse)
  - 2016/17 late notice STF payment and Tranche 1 winter funding (favourable)
  - Clinical income performance (favourable)
  - Capital financing savings as capital spend is behind plan and cash balances are higher than planned (favourable)
- The Trust is now able to give an increased level of assurance on having closed the gap in the forecast out-turn in the final quarter highlighted in previous reports and maintain the NHSI submission forecast of a maximum £26.2m loss (excluding the £0.4m STF for 2016/17 and £0.8m Tranche 1 winter funding).
- Bank and agency costs January 2018 accounted for 11.4% (£1.97M) of the £17.2984M total pay costs. This is a 1.43% increase from the position reported in December 2017 (£1.78M).
- The in-month unadjusted sickness absence figure for January is 4.66%; a decrease of 0.19% compared to December.

The summary of all the key issues to note are detailed in section 1.1 of the report.

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

1. Introduction

This report provides a summary of performance against the NHSI Single Oversight Framework for the month of January 2018, including the key issues and risks to delivery. It also provides, in section 4, a summary of the key risk areas from the Trust Integrated Performance Report which is attached in full in Annex A.

1.1 Key issues to note:

Operational Performance

- A&E performance was 71.6% in January which is non-complaint with the National standard and the 90% improvement trajectory plan.
- RTT remained compliant with standard this month, achieving 92.1%.
- At the point of reporting close, the Cancer 62 day standard is not predicted to achieve in January. Latest performance is 83.9%.
- Elective cancelled operations on the day was above the threshold target of 0.85%

Workforce

- Bank and agency costs January 2018 accounted for 11.4% (£1.97M) of the £17.2984M total pay costs. This is a 1.43% increase from the position reported in December 2017 (£1.78M).
- The in-month unadjusted sickness absence figure for January is 4.66%; a decrease of 0.19% compared to December.

Finance

- In the ten months so far this financial year the Trust has lost £23.1m. The planned deficit was £23.9m so this is ahead of plan because of additional external resources. The average loss per day is £75,000 to the end of January.
- The overall variance from plan to date is due to a combination of factors:
    - CIP behind plan (adverse)
    - 2016/17 late notice STF payment and Tranche 1 winter funding (favourable)
    - Clinical income performance (favourable)
    - Capital financing savings as capital spend is behind plan and cash balances are higher than planned (favourable)
- The Trust is now able to give an increased level of assurance on having closed the gap in the forecast out-turn in the final quarter highlighted in previous reports and maintain the NHSI submission forecast of a maximum £26.2m loss (excluding the £0.4m STF for 2016/17 and £0.8m Tranche 1 winter funding). This has been possible as the overall business group positions have remained stable despite the under achievement of the recovery plans, which is being offset by updated financing calculations which represent a one-off in-year saving to the Trust.

1.2 Future risks to compliance against the Single Oversight Framework

Future risks to compliance with the framework are:

- ED
    - Speed and pace required to deliver cultural change associated with large scale transformation across the Stockport System.
    - Sustained increase in high acuity demand over the winter period
    - Failure to divert current ED attends to alternative pathways of care ie falls service and other assessment areas.
    - On average, 38% of Medical beds are occupied by medically optimized patients awaiting transfer, as indicated by the point prevalence audit.

- RTT
    - Redirection of Clinical resource away from elective activity to support the urgent care pathway has resulted in reduced Outpatient activity in certain specialties.

- The admitted backlog has increased from 311 to 344 following cancellation of routine elective operations due to winter pressures. Depending on when this activity can be rescheduled, the RTT performance may be adversely affected during the coming weeks.

- Cancer
  - Bed pressures affecting the ability to expedite or undertake additional theatre sessions may impact on cancer performance in future weeks.

2. Compliance against Single Oversight Framework

The table below shows performance against the indicators in the Single Oversight Framework that came into effect 1st October 2016. The forecast position for next month is also indicated by a red (non-compliant) or green (compliant) box.

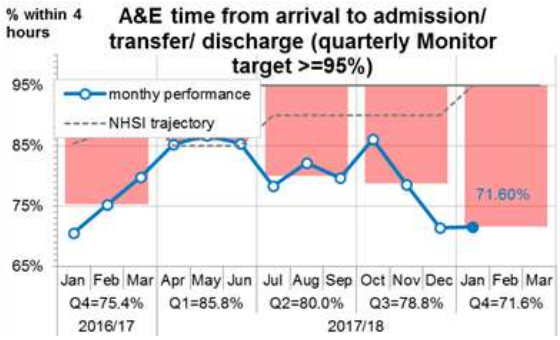
*=latest

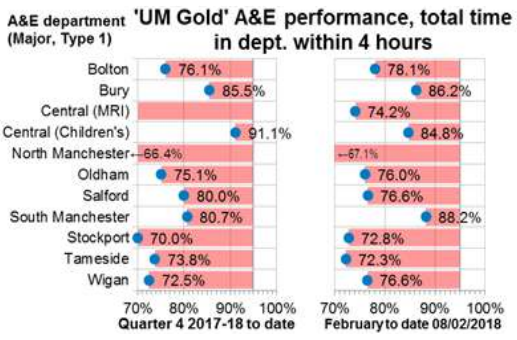
	Standard	Monitoring Period	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18 (f/cast)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate: Patients on an incomplete pathway	92%	Monthly	92.5%	93.3%	92.7%	92.8%	92.7%	92.1%	91.7%	92.1%	92.0%	92.9%	92.4%	92.4%	92.1%	
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	Monthly	85.3%	86.7%	85.3%	85.8%	78.3%	82.1%	79.7%	80.0%	86.1%	78.6%	71.5%	78.8%	71.6%	
All cancers: Maximum 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	Monthly	91.9%	77.1%	85.0%	83.7%	85.9%	90.8%	85.9%	87.7%	83.3%	86.2%	80.5%	83.7%	83.9%*	
All cancers: maximum 62-day wait for first treatment from: NHS Cancer Screening Service referral	90%		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Maximum 6-week wait for diagnostic procedures	99%	Monthly	99.6%	99.8%	99.8%	99.7%	99.4%	99.3%	99.8%	99.5%	99.8%	99.9%	99.9%	99.9%	99.9%	

3. Month 10 2017/18: Performance against Single Oversight Framework

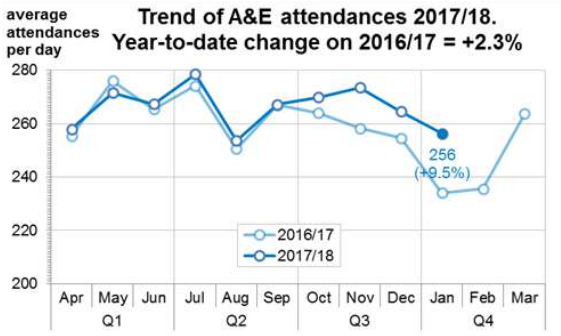
There were two areas of non-compliance against the regulatory framework in month 10:

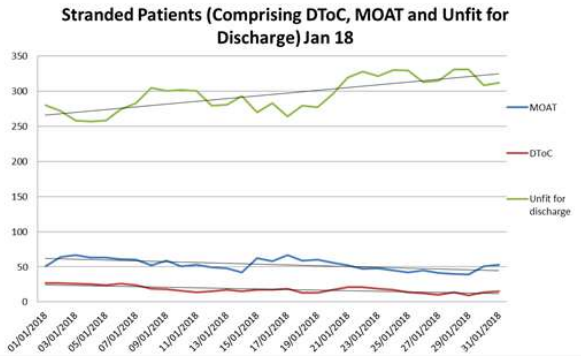
i) A&E 4hr target



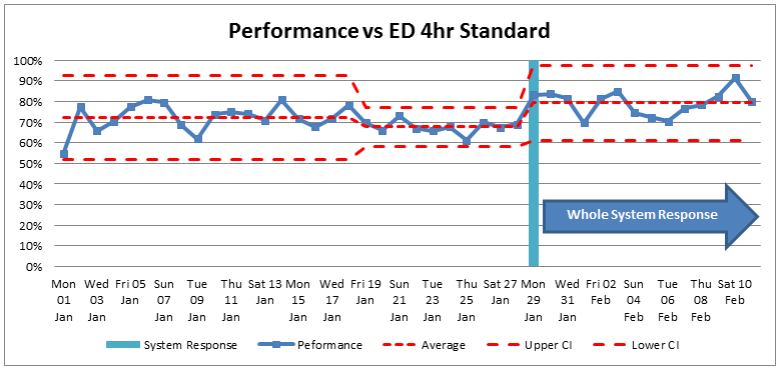


Performance against the 4hr standard was 71.6% in January; however this has begun to improve following the instigation of the Whole System Response work. The two charts above highlight the deteriorating trend for the Trust since October 17, however also highlight that every provider in Greater Manchester has been in a similar position for their Type 1 ED performance.





Notwithstanding the evident deterioration in performance, the improvement in performance since the Whole System Response work has begun must be acknowledged. Average daily performance from 01/01/17 to 29/01/17 was 70.6%, since then it has increased to 79.1% - evidently this is still some way short of the expected performance, however this must be considered in the context of the work being done to de-escalate the additional bed capacity that has been opened for Winter, meaning that performance is improving as the bed base is reducing.



It must be noted, that despite the improvement in performance against the 4 hour standard, there have been 52 breaches of the 12 hour standard in January. This is significantly higher than any month in recent years', and coincided with an acute rise in the prevalence of flu cases and demand for side-rooms. Despite this, time to be seen has improved, reflecting faster assessment and decisions to admit which provides earlier plans of care, keeping patients safer. At the time of writing, of the investigations undertaken to date, no patient harm has been identified as a result of a wait beyond 12 hours.

ii) Cancer 62 day standard

The latest position for the month of January is 83.9%. At the time of writing the 62 day standard is not expected to achieve in month.

45 patients were treated on the 62 day pathway in January, which is a slight increase on the December position but remains comparatively low to the year average of 49 and the early autumn months of 60 and 62 treatments respectively.

The 7 patients that were treated beyond day 62 were a mixture of diagnostic delays, complex pathways and patient initiated delays. At the time of writing, no patient has been identified as result of the delay to their treatment.

Improvements in the colorectal pathway are due to come into effect early March as patients will have the ability to book their radiological procedure straight from clinic prior to leaving the hospital. In

addition, the straight to test model will commence following successful recruitment. This will reduce the time taken for first diagnostic test.

A cancer strategy is being compiled which will describe the Trusts approach and plans to deliver on the Greater Manchester Cancer review recommendations, the Find Out Faster standard and the revised National Cancer Waiting time data set.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**
  The HCR process and performance rate is discussed on a weekly basis at the Elective Performance meeting, chaired by the Head of Performance. The focus for this meeting is on process issues and how the operational management teams can alleviate them to improve performance against the required standard. The issues identified remain those that have cause sub-optimal performance for a number of months, namely; lack of real time ADT, gaps and lack of consistency in the junior doctor workforce (particularly due to reliance on locum staff) and the number of patients outlying due to ongoing pressures in the Urgent Care flow.

Daily performance reporting is now in place supported by the Performance Team to ensure that all of the operational management teams have a full picture of the work required from their medical teams and each are tasked with ensuring the documents are completed in a timely manner.

- **Clinical Correspondence**
  While the performance against this metric continues to vary, significant progress has been made with the longest waiting letters by those specialties working as part of the Correspondence Hub.

  At the time of writing there are no letters older than 14 days still waiting for the specialty teams in the Hub. This is notable progress and will provide the basis for further improvement as the next phases of development of the Hub are worked through. It is anticipated that now the longest waiting letters have all been typed, the letters in the 14 to 7 day bracket will start to reduce and performance against this specific metric will improve.

- **Patient Experience**
  Overall in January, the trust scored 91.9% extremely likely or likely to recommend on the Friends and Family Test. The ED score slipped slightly from 88.9% to 87.5%. Positive comments received related to the excellent quality of care provided in the department, by compassionate staff who were working extremely hard. Negative comments continue to be related to long waiting times however there were many comments where patients have commented that they were always kept informed.

4.2 Performance

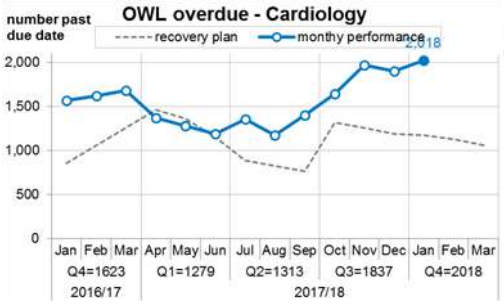
- **Cancelled operations on the day (Non-clinical reasons)**
  In January 55 cancellations were reported on the day for non-clinical reasons.

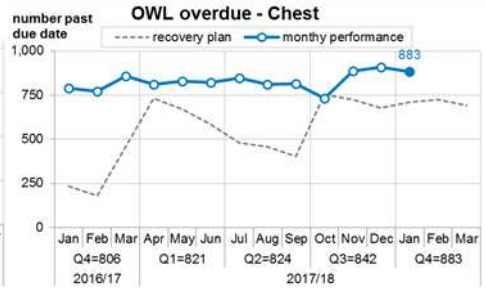
  Overall, the most common reasons for cancellation were no bed availability (18 cases) which reflects the impact of the ongoing winter pressures. 7 cases were cancelled due to no HDU bed availability, and 7 due to surgeon sickness on the day.

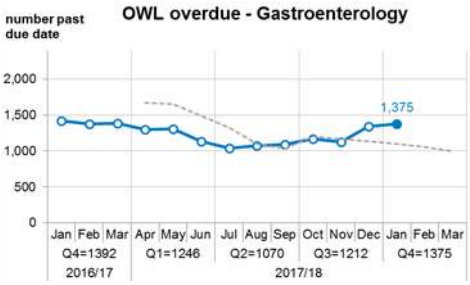
- **Outpatient Waiting Lists:**
  Ophthalmology is continuing along trajectory. Gastroenterology has deviated from plan due to the requirement to divert Consultant time to provide adequate Medical cover to the increased

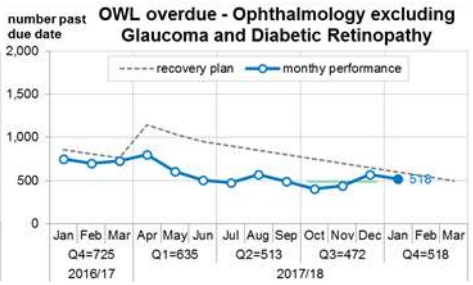
Medical bed base during winter. As these escalation beds have now closed, full clinic capacity can now be resumed.

Clear challenges remain in both Cardiology and Respiratory Medicine.









To recover the position for the two non-compliant specialties will be very challenging due to their significant workforce challenges from both a medical and nursing perspective. The long standing reliance on locum medical staff has resulted in a disproportionate number of patients referred for follow-up appointments and a lack of standardisation across the clinical workforce.

To be able to resolve the outpatient waiting list issues in each of these specialties will also require the intervention of the Stockport Together Outpatient Programme, and the close partnership working with Primary Care through the Neighbourhood teams to agree how best to manage these sizeable cohorts of patients.

4.3 Finance

- **CIP**

  To the end of January £9.5m (63%) of CIP has been actioned towards the year-to-date target of £10.7m (71%), so is £1.2m behind plan. £11.3m (75%) of the £15.0m full year annual CIP has been achieved.

  Recurrent CIP remains unchanged from last month at £6.1m (41%), and this £8.9m shortfall places considerable pressure on the 2018/19 financial position and this is another driver of the structural budget deficit.

  A further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.

- **Financial sustainability**

  The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for January 2018 and our actual performance is in line with this.

  For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

- **Agency Ceiling**
  Agency expenditure in January was £0.9m, increasing total agency costs to date to £10.3m, which is 6% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £0.7m.

- **Elective Income**
  Elective income has shown an improvement again in January as the annual plan had already assumed a higher level of cancellations due to winter pressures than have actually occurred; 77 patient operations were cancelled in January due to lack of bed capacity in the hospital. However this will not continue as a further 90 elective patients have already been cancelled for February, and this was not expected in the plan. Overall elective income is £2.6m behind the annual plan but slightly ahead of the recovery plan.

  Inpatient income is behind plan by £1.2m, and day case activity is £1.4m adverse. The Trust has spent £1.9m on waiting list initiatives and £1.3m on out-sourcing in ten months, but this is not solely on elective work and includes out-sourced radiology reporting.

  Elective activity continues to the main contributor to this deficit year, with activity 2,472 spells below planned levels. Both day case and inpatient activity is below plan by 1,746 and 726 spells respectively. As a result, the overall elective income is £2.6m adverse to plan. Urology is the main specialty adverse to plan and is 395 spells below its patient target. Endoscopy is 759 cases behind plan, ENT 321, pain 175 and orthopaedic hands 221 behind plan.

4.4 Workforce

- **Statutory and Mandatory training**
  The statutory and mandatory training compliance is 88.33% for January, a marginal decrease from December's performance.

  Following the presentation of the error report an action plan has been produced which is scheduled to be presented at a Quality Summit Committee.

  The learning and development team are continuing work in partnership with the Business Groups to ensure system and user error / queries are addressed.

  E-learning clinics are offered on a weekly basis; supplemented by telephone support and user guides.

- **Appraisals**
  The Trust's total appraisal compliance for January 2108 is 93.76%. A decrease from December's data which was 94.37%

  During January the Learning and Development team have continued their partnership working with the Business Groups to validate appraisals and rectify any anomalies, ensuring accurate data recording. Increased support continues to be focused on areas 90% and below.

- **Efficiency**
  Bank & Agency costs
  Bank and agency costs in month (January 2018) account for 11.4% (£1.97M) of the £17.2984M total pay costs. This is a 1.43% increase from the position reported in December (£1.78M).

  The Medicine & CS Business Group bank and agency spend has increased by £100k from December 2017 to £0.77M in January 2018, and continues to have the highest spend on bank and agency equating to 39.12% of the Trust overall bank and agency spend and 4.46% of the Trust total pay-bill, predominantly attributable to clinical vacancies.

- **Sickness Absence**
  The in-month unadjusted sickness absence figure for January 2018 is 4.66%; a decrease of 0.19% compared to the adjusted December 2017 figure of 4.85%. The sickness rate for comparison in January 2017 was 4.19%. The 12-month rolling sickness percentage for the period February 2017 to January 2018 is 4.10%.

  The top three reasons for absence in January 2018 are: cough/cold/ influenza/asthma at 25.45% (a large percentage increase of 16.23% from December 2017), Back/Musculoskeletal Problems including injury/fracture at 25.40% (a 0.69% decrease from December 2017). Stress has moved down to third place at 30.18% (a large percentage decrease of 8.34% from December 2017).

5. Recommendations

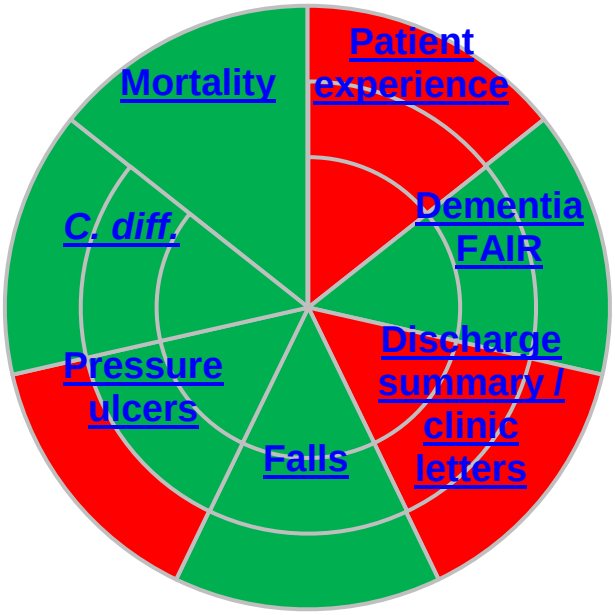
The Board is asked to:

- Note the current position for month 10 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report.

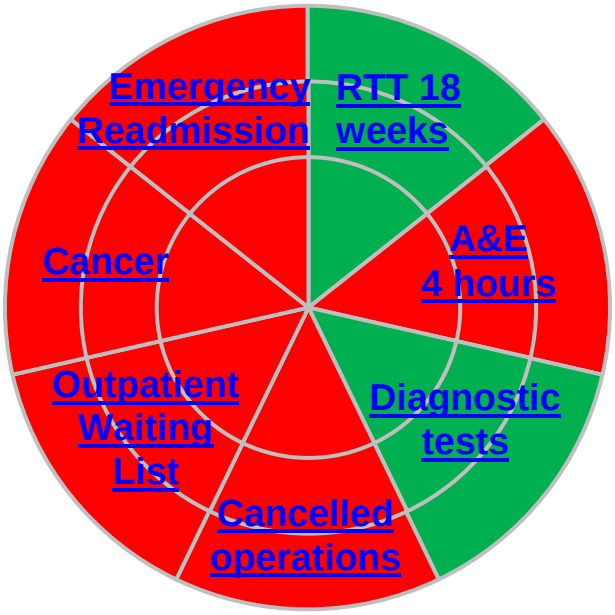
Integrated Performance Report January 2018

Stockport NHS Foundation Trust

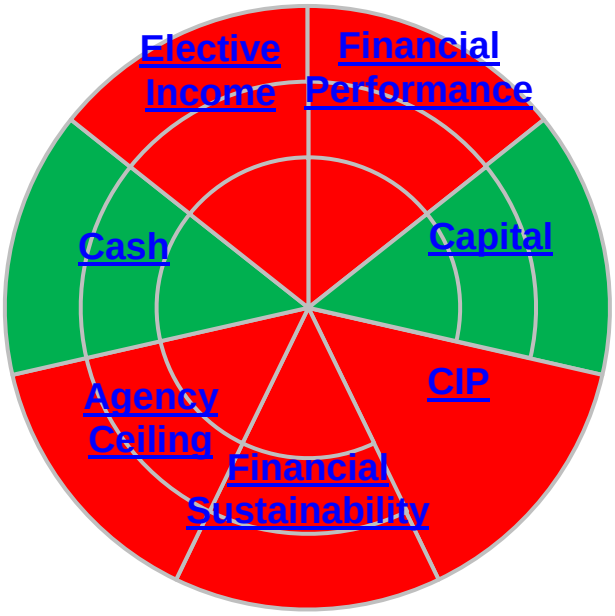
1. Quality



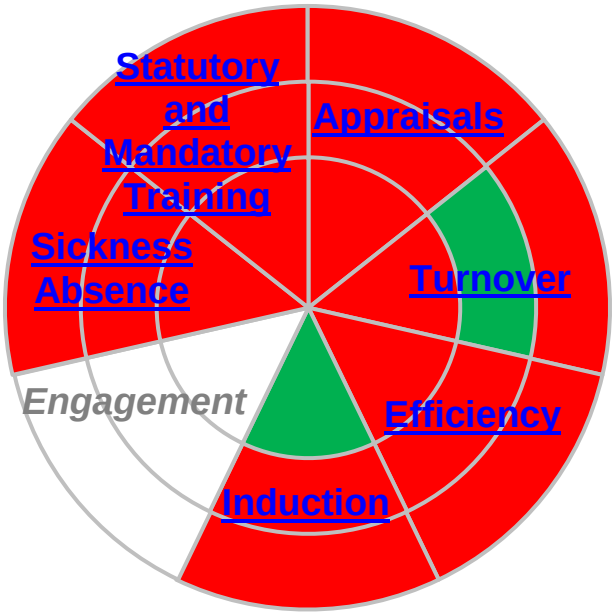
2. Performance



3. Finance



4. Workforce



Key to wheels:

Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month. Mortality is assessed on the latest 12 months, CIP (Cost Improvement Programme) on the year-to-date.

Your Health. Our Priority.

Integrated Performance Report

Changes to this month's report January 2018:

No changes to this month's report

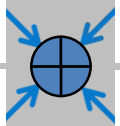
Key to indicators:

Monitor indicators (in Risk Assessment Framework): M
Monitor indicators for which we have made forward declaration: M

Corporate Strategic Risk Register rating (current or residual): 15
Risks rated on severity of consequence multiplied by likelihood, both based on a scale from 1 to 5. Ratings could range from 1 (low consequence and rare) to 25 (catastrophic and almost certain), but are only shown for significant risks which have an impact on the stated aims of the Trust, with an initial rating of 15+.

Data Quality: Kite Marking given to each indicator in this report 
This scoring allows the reader to understand the source of each indicator, the time frame represented, and the way it is calculated and if the data has been subject to validation. The diagram below explains how the marking works.

Filled Trust Data	**Blank** National Data	**Filled** Validated	**Blank** Unvalidated
Filled Automated	**Blank** Not Automated	**Filled** Current Month	**Blank** Not Current Month



Patient Experience

In the month of January we had a total of 4620 responses for the Friends and Family test, and 92% of patients stated that they were extremely likely or likely to recommend the Trust.

January Results broken down:

Area	Response rate	Variance on previous month (RR)	% Extremely likely / likely to recommend	Variance on previous month (% Rec)
ED inc children's ED	20%	+1%	87%	-2%
Inpatients	30%	+1%	94%	-2%
Maternity (Birth)	52%	+12%	98%	+2%
Outpatients	37%	+3%	92%	+1%
Daycase	35%	+2%	95%	-1%
Community	23%	-3%	89%	-2%

Chart 1

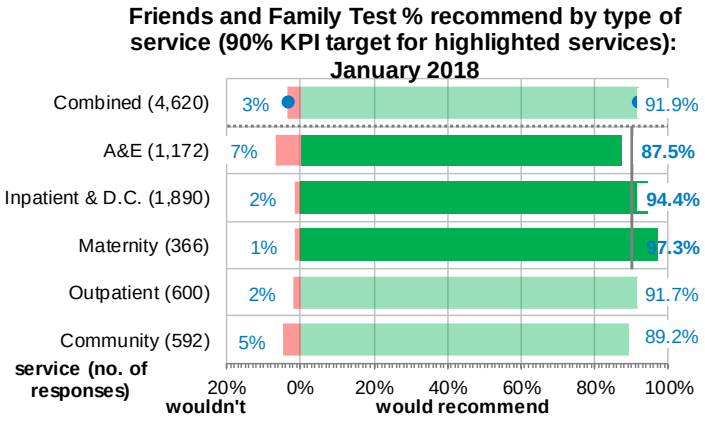


Chart 2

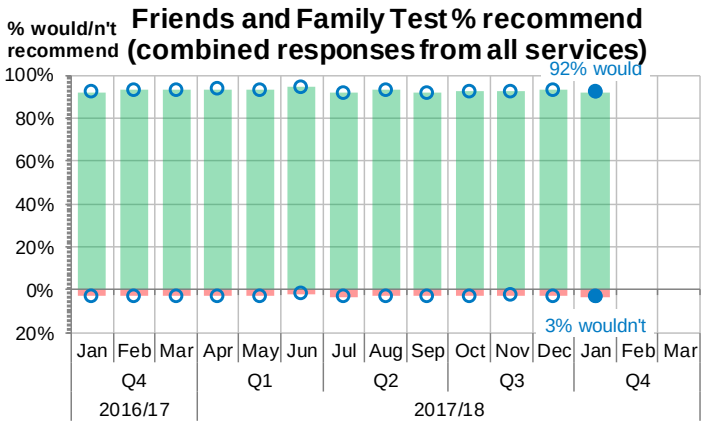
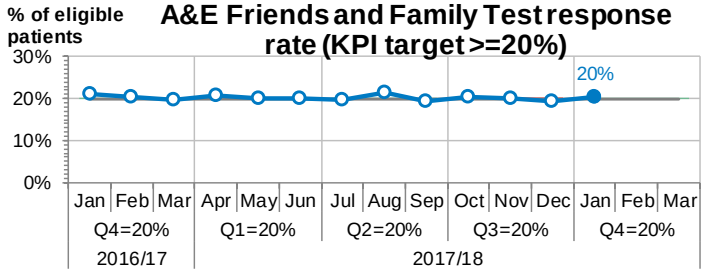


Chart 3



Maternity all stages: response rate = 35%, change from last month +8%

Maternity all stages: % extremely likely / likely to recommend 96%, an increase of 2%.

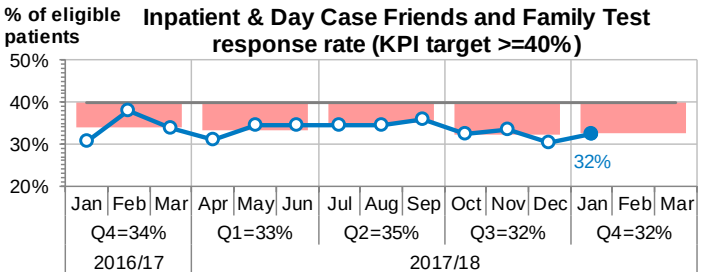
Feedback Themes (acute):

ED (adult) Positive comments received related to the excellent quality of care provided in the department, by compassionate staff who were working extremely hard. Negative comments continue to be related to long waiting times however there were many comments where patients have commented that they were always kept informed.

Inpatients (adults) Positive comments continue to be related to kind and considerate staff who treat patients with dignity and respect, there were many general positive comments centered on privacy and dignity. Negative comments continue to relate to the lack of nursing staff in some areas and the lack of staff to talk to about worries or fears.

Maternity: All comments received were positive relating to fantastic, caring and knowledgeable staff who delivered compassionate and competent care. There were many comments referring to the high standard of care provided to mothers.

Chart 4



Outpatients: Positive comments continue to be related to friendly and helpful staff who communicate well with patients regarding clinic updates. Negative comments continue to relate to long waiting times.

Paediatrics (inpatients) All comments received were extremely positive relating to professional, caring staff who provide family centered care.

Daycase: Positive comments related to caring and professional staff who deliver care to a high standard. There were very few negative comments however there were a few relating to long waiting times and poor communication.

IPad Inpatient Surveys

In January 223 inpatient iPad surveys were undertaken, which is an increase of 46 when compared to the number completed in December. .

All wards have log in access to review / undertake iPad surveys and this continues to be encouraged.

All results can be seen via the trust Corporate Information System (CIS) and continue to be sent to wards on a monthly basis in more detail as a report. Using a RAG rating system the results via CIS are presented in a format which enables an overall trust wide view of where performance is good and where targeted focus is required.

Overall, the trust scored 86% positive responses in January which is an increase of 1% when compared to December.

Results in January have shown significant improvements in relation to quality of the patient food in particular the temperature and having an adequate choice on the menu. There has also been a significant improvement in the completion of property lists with an increase of 15%.

There have been further improvements where patients feel the Portering and Cleaning staff are courteous, where patients haven't been bothered by noise at night from both staff and other patients, the overall care that patients have received and being treated with privacy and dignity.

Less positively results have deteriorated relating to patients feeling that they didn't received assistance with eating or drinking when required, not receiving enough emotional support or feeling like there was someone to talk to about worries or fears and the cleanliness of the toilets and bathrooms.

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Dementia

Chart 5

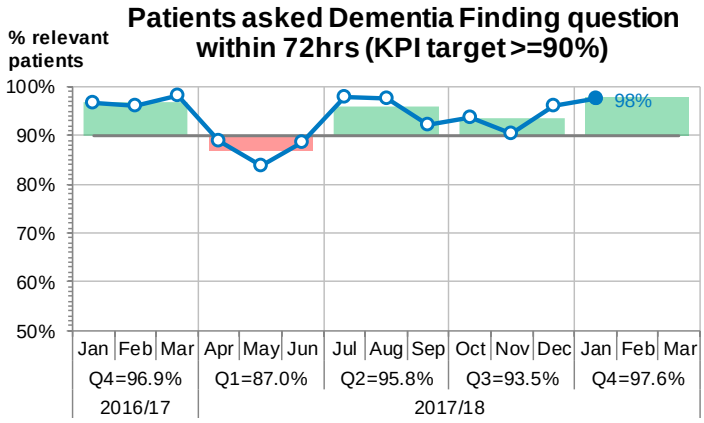
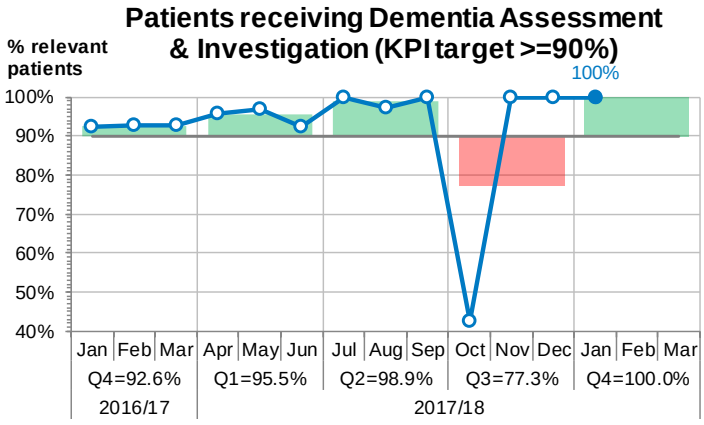


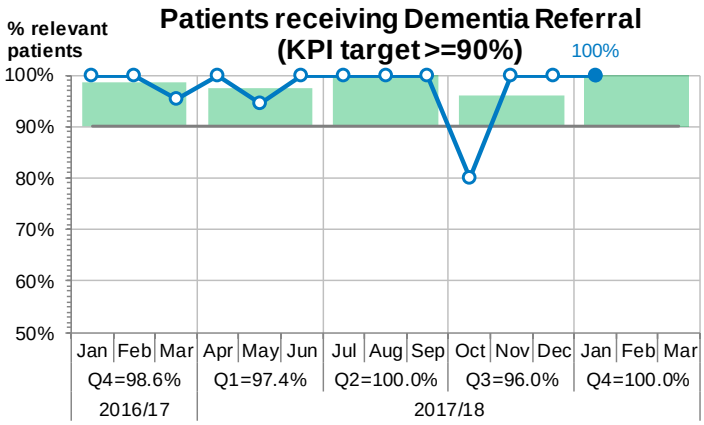
Chart 6



Charts 5 to 7 show performance against the dementia standards.

Compliance against the Dementia Finding question standard has been achieved for January.

Chart 7



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Discharge Summary

Chart 8

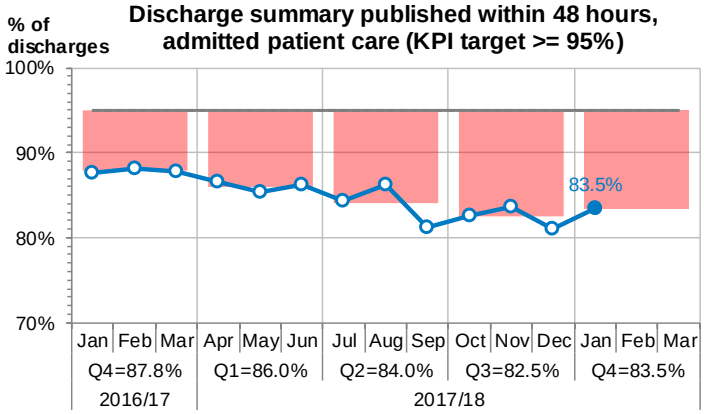

Chart 8 shows compliance with discharge summary completion within 48hrs.

The percentage of discharge summaries published within 48 hours in January was 83.5%, a slight improvement on the December position of 81.0%.

The HCR process and performance rate is discussed on a weekly basis at the Elective Performance meeting, chaired by the Head of Performance. The focus for this meeting is on process issues and how the operational management teams can alleviate them to improve performance against the required standard. The issues identified remain those that have cause sub-optimal performance for a number of months, namely; lack of real time ADT, gaps and lack of consistency in the junior doctor workforce (particularly due to reliance on locum staff) and the number of patients outlying due to ongoing pressures in the Urgent Care flow.

Daily performance reporting is now in place supported by the Performance Team to ensure that all of the operational management teams have a full picture of the work required from their medical teams and each are tasked with ensuring the documents are completed in a timely manner.

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Clinical correspondence (typing backlog)

Chart 9

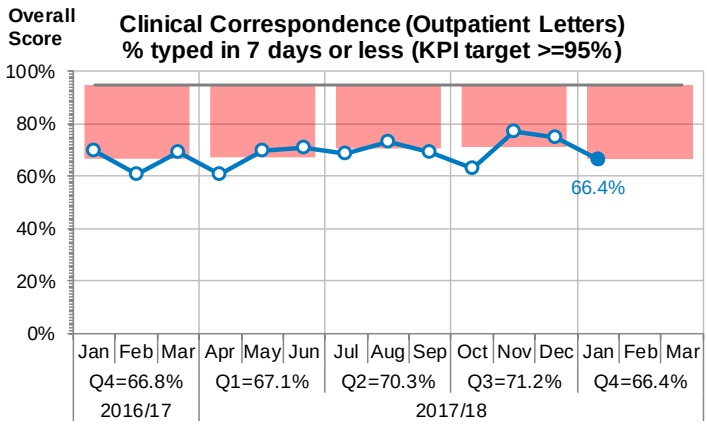

Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 7 days.

While the performance against this metric continues to vary, significant progress has been made with the longest waiting letters by those specialties working as part of the new Correspondence Hub. At the time of writing there are no letters older than 14 days still waiting for the specialty teams in the Hub. This is notable progress and will provide the basis for further improvement as the next phases of development of the Hub are worked through.

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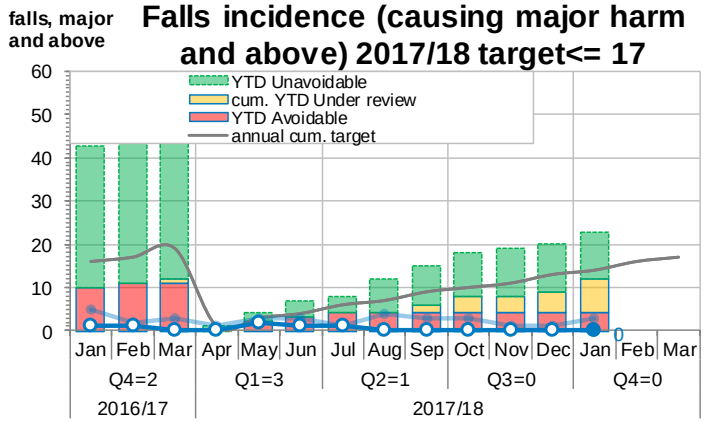
Falls 16

Chart 10



This year's target is 17 or below avoidable falls. In January 3 falls were reported. To date there has been 4 avoidable falls with 8 under review.

In total there have been 23 falls major and above to date.

Work continues to identify patients at risk of falls and ensure the falls bundle is implemented. Further actions identified include:

- A falls collaborative is planned for later this year
- The Sensor mat contract has been extended and continues whilst upgraded equipment is introduced
- Training has been reviewed. Falls training is now included in HCA's Care Certificate and sessions for all staff have restarted.
- The "Steady in Stockport" initiative has been introduced in the community and is taking referrals from the Emergency Department or via in patient therapies
- "Bay tagging" has commenced on A10, M4, D1, B3 and A1. C6 are to follow shortly.

Pressure Ulcers 16

Chart 11

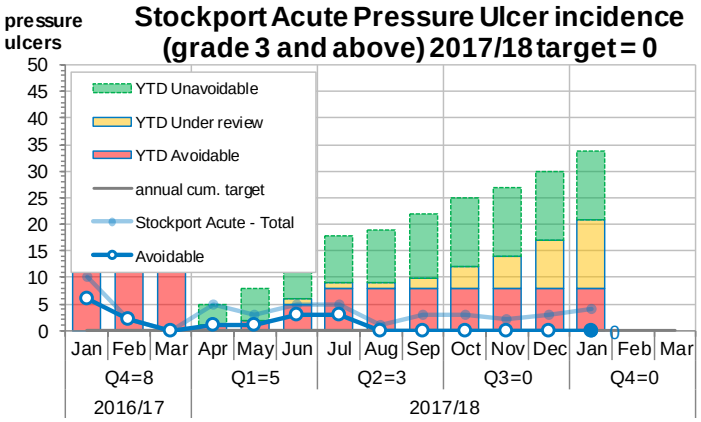
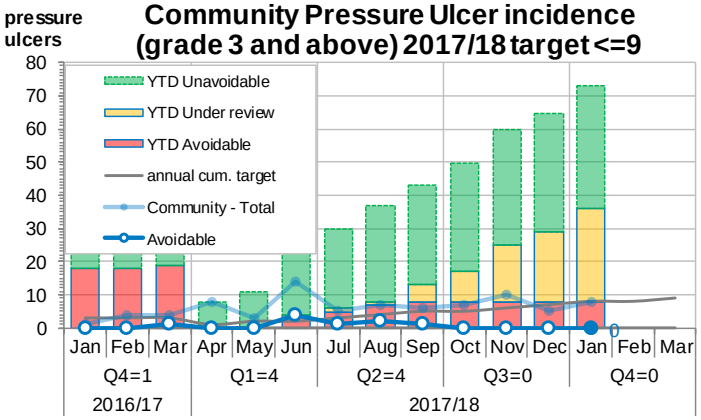


Chart 12



The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017/18. In January, there have been 4, category 3 and above pressure ulcers reported in the hospital, all of these incidents are currently under review, so avoidable/unavoidable status remains to be determined. The total avoidable pressure ulcers, for this financial year is 8, with the outcome of a further 13 yet to be confirmed.

The stretch target for Stockport Community is a 50% reduction in grade 3 and 4 avoidable pressure ulcers by the end of 2017/18. The target is 9 avoidable pressure ulcers for the year. In January there have been 8 new grade 3 or 4 pressure ulcers reported, & of which are still under review. There have been a total of 8 confirmed avoidable pressure ulcers this year in the community setting; however the outcome of 28 incident investigations remain to be confirmed.

A Pressure Ulcer collaboration event has been organized for the 20/3/18. This will involve Key stakeholders from across the whole health economy coming together to identify priorities for pressure ulcer reduction, following a deep dive into the pressure ulcer harms that have been reported as an SI in the last 12 months.

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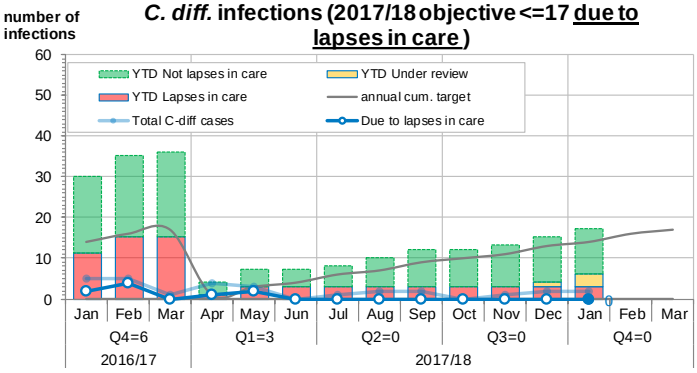
Clostridium difficile (C. diff.) infections

Chart 13



There has been 2 cases of Clostridium difficile in January, the total number YTD is 17. Of these 17 cases 14 have been reviewed with the other 3 cases still under review.

We have been advised by the CCG that 11 cases reviewed by them do not have significant lapses in care and do not reach the threshold for reporting; however 3 cases do have significant lapses in care and do reach the threshold for reporting. Therefore 11 cases would not count towards the trajectory of 17 significant lapses in care but 3 cases will.

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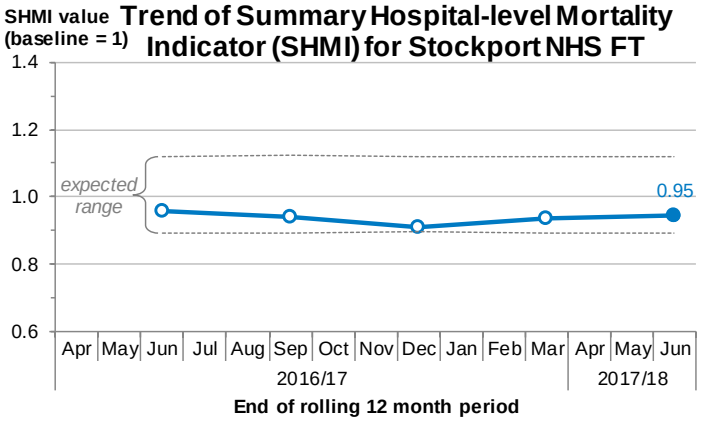
Mortality

Summary Hospital-level Mortality Indicator (SHMI)

This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
Data source: Health and Social Care Information Centre

Chart 14



Mortality analysis now includes 3 measures, SHMI, RAMI, and HSMR (not Dr Foster HSMR but a proxy provided by the CHKS software). Where possible data is shown to represent performance over time, against peers and with weekend/week comparisons.

Whilst overall mortality profile is good and reported as Green, investigation is needed into the varying mortality at the weekend compared to the week. This would be in tandem with the Trust 7 day services action plan

Chart 15

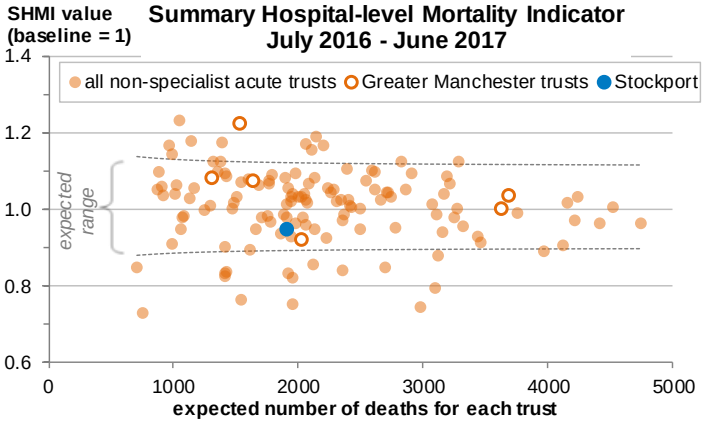
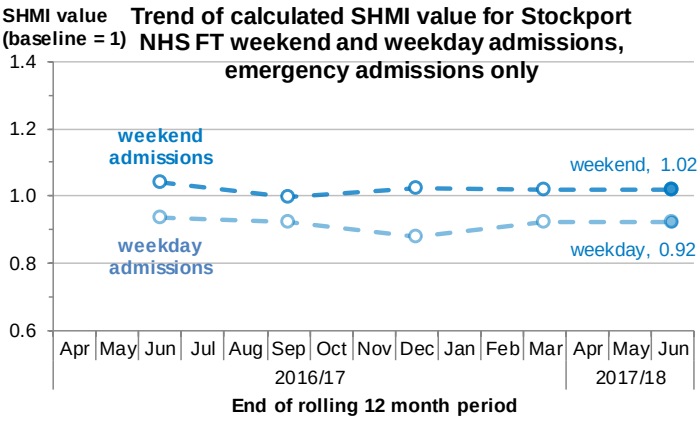


Chart 16



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Risk Adjusted Mortality Index (RAMI)

The main differences in calculation from SHMI are: RAMI only includes in-hospital deaths; it excludes patients admitted as emergencies with a zero length of stay discharged alive, and patients coded with receiving palliative care; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest 2016 benchmarks; RAMI includes data from the whole patient spell rather than just the first two admitting consultant episodes.

Data source: CHKS

Chart 17

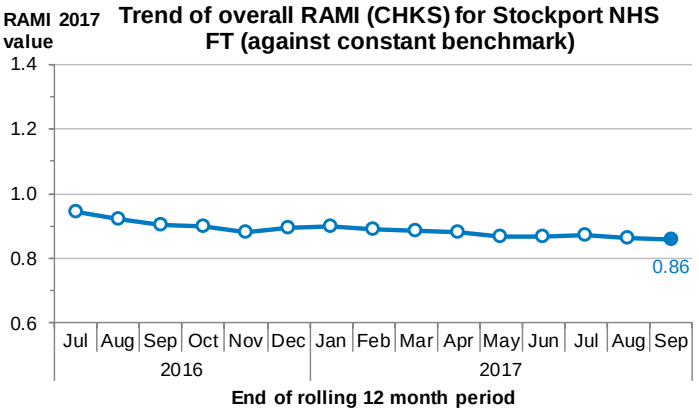


Chart 18

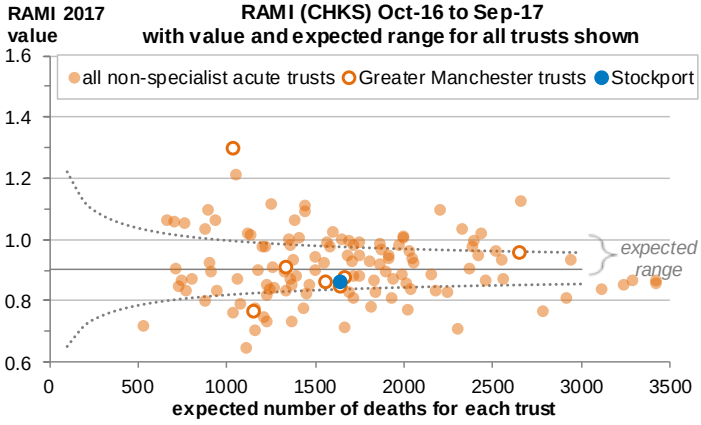
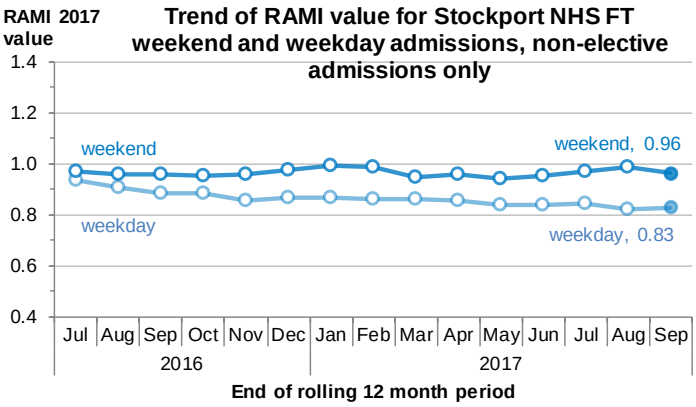


Chart 19



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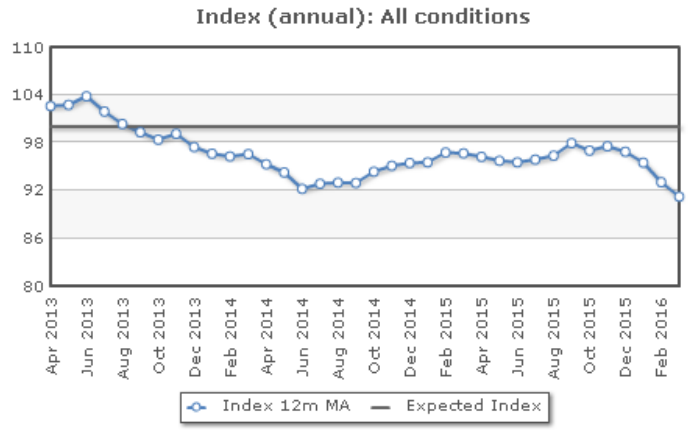
Hospital Standardised Mortality Data (HMSR)

The main differences in calculation from SHMI are: HSMR only includes in-hospital deaths; the factors used in estimating the number of patients that would be expected to die includes whether patients are coded with receiving palliative care, and socio-economic deprivation; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest benchmarks.

Data source: CHKS (using Dr Foster Intelligence methodology)

Chart 20



Referral to Treatment (RTT) waiting times

Chart 21

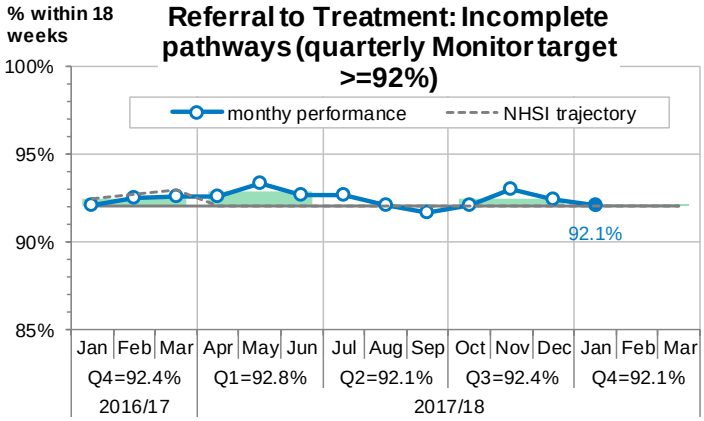
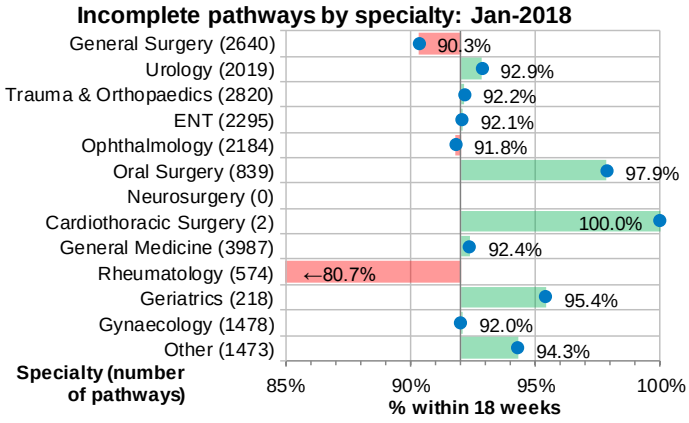


Chart 21 shows performance against the RTT Incomplete standard.

The Trust has achieved the RTT standard in January at 92.1%.

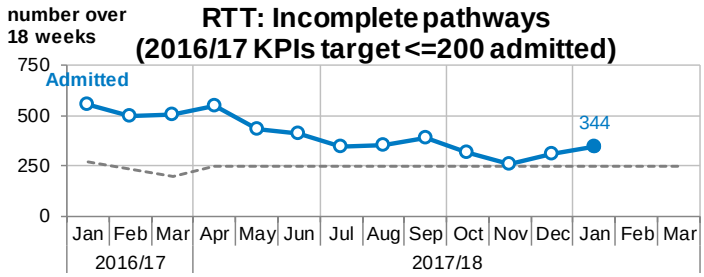
Chart 22



The Board is asked to note the potential future risk to compliance in February and March as a result of the impact of Winter pressures.

Redirection of Clinical resource away from elective activity to support the urgent care pathway has resulted in reduced Outpatient activity in certain specialties. Alongside this, routine elective operations have been cancelled due to bed pressures. Depending on when this activity can be rescheduled, the RTT performance may be adversely affected during the coming weeks.

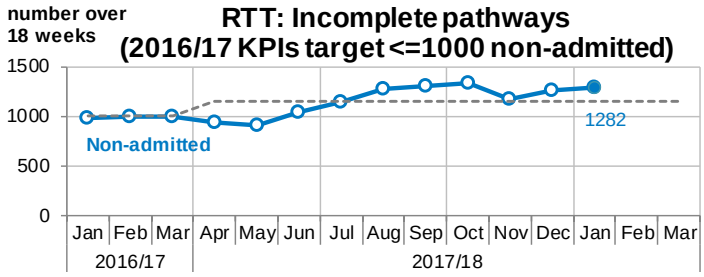
Chart 23



Charts 23 and 24 show the number of patients waiting beyond 18 weeks split by admitted and non-admitted pathways.

The winter pressures continue to impact on the backlog position with increases seen in both the admitted and non-admitted waiting lists.

Chart 24



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Accident & Emergency, Urgent Care & Flow

Chart 25

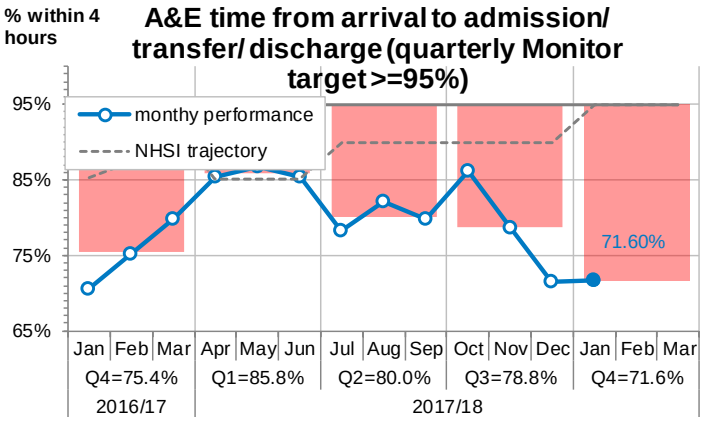


Chart 26

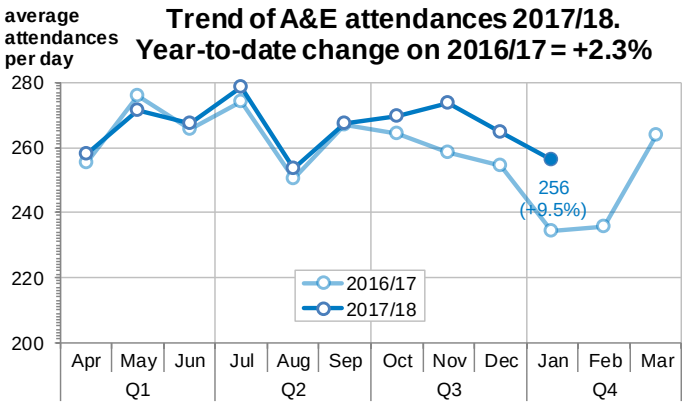
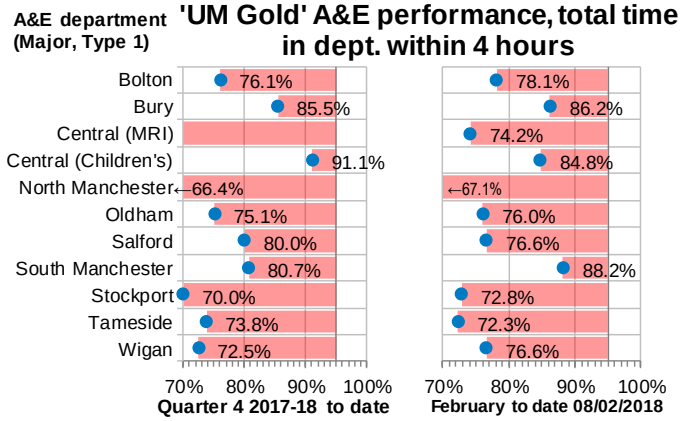


Chart 27



Source: Greater Manchester Academic Health Science Network.

Chart 25 shows compliance against the 4hr A&E standard.

Performance against the 4hr standard was 71.6% in January; however this has begun to improve following the instigation of the Whole System Response work. Chart 27 highlights that every provider in Greater Manchester has been in a similar position for their Type 1 ED performance

Chart 26 highlights the increase in A& E attendances on a monthly basis since October '17, with January 2017 seeing an average of 256 attendances per day, an increase of 9.5% on January 2017

Notwithstanding the evident deterioration in performance, the improvement in performance since the Whole System Response work has begun must be acknowledged. Average daily performance from 01/01/17 to 29/01/17 was 70.6%, since then it has increased to 79.1% - evidently this is still some way short of the expected performance, however this must be considered in the context of the work being done to de-escalate the additional bed capacity that has been opened for Winter, meaning that performance is improving as the bed base is reducing.

It must be noted, that despite the improvement in performance against the 4 hour standard, there have been 52 breaches of the 12 hour standard in January. This is significantly higher than any month in recent years', and coincided with an acute rise in the prevalence of flu cases and demand for side-rooms. Despite this, time to be seen has improved, reflecting faster assessment and decisions to admit which provides earlier plans of care, keeping patients safer. At the time of writing, of the investigations undertaken to date, no patient harm has been identified as a result of a wait beyond 12 hours.

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Chart 28

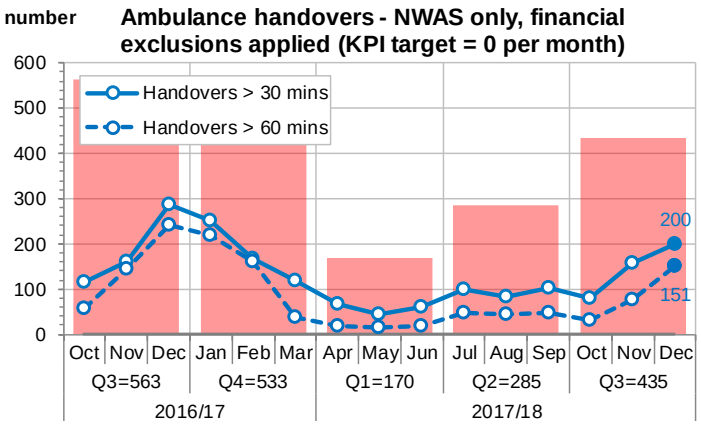


Chart 29

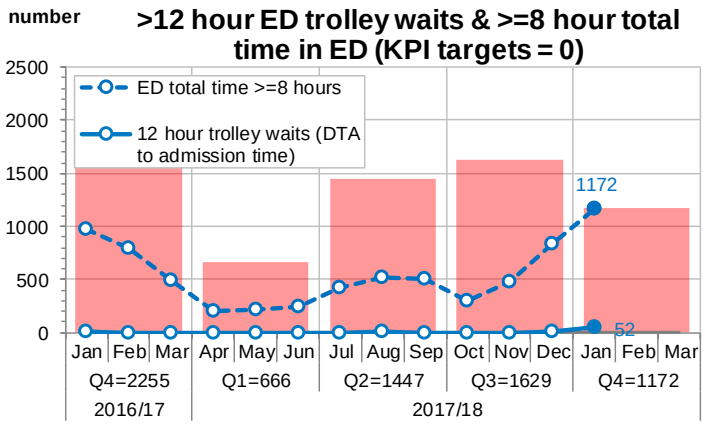


Chart 30

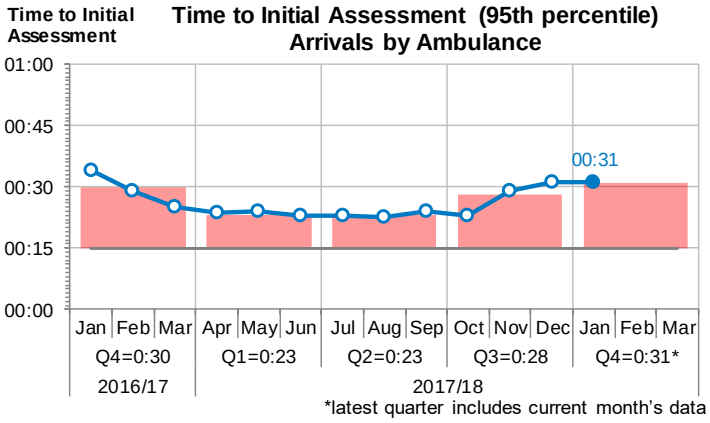


Chart 31

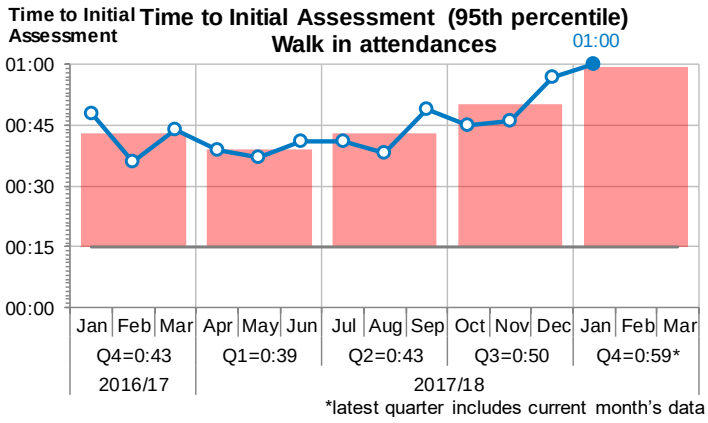


Chart 32

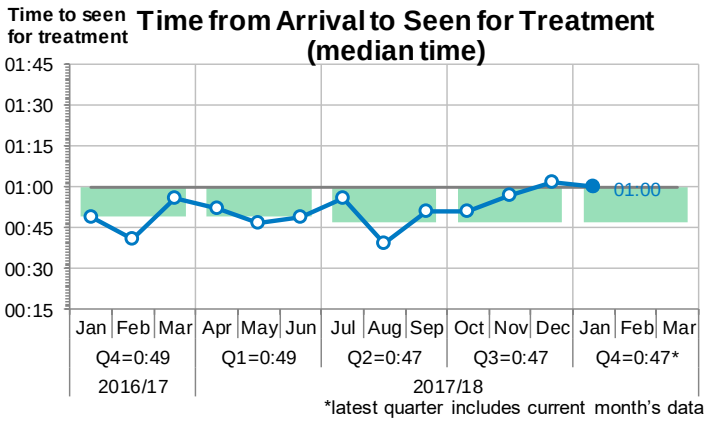


Chart 33

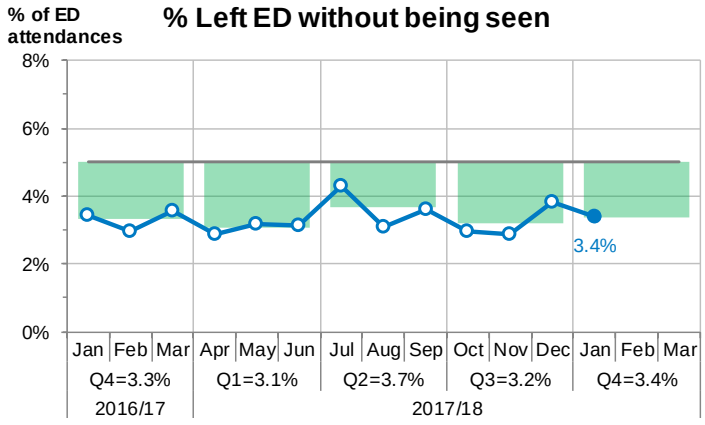


Chart 34

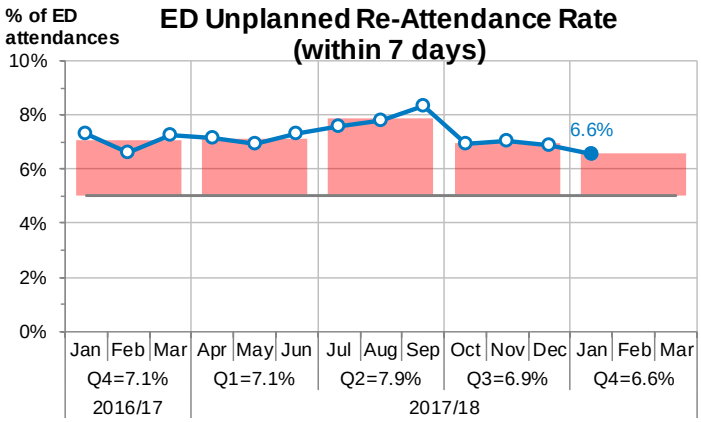
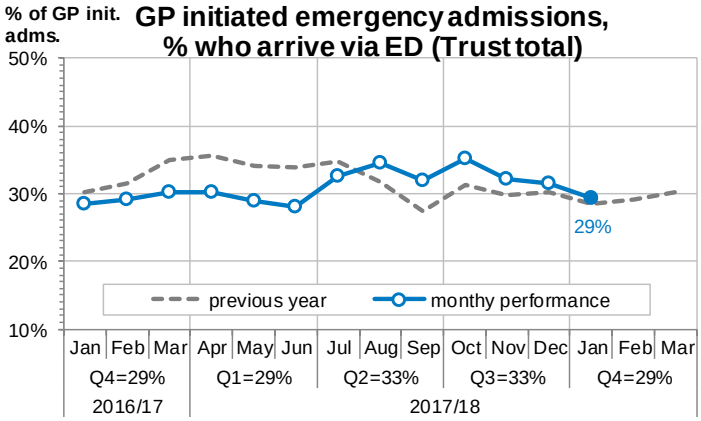


Chart 35



The following charts (35 to 43) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

Chart 36

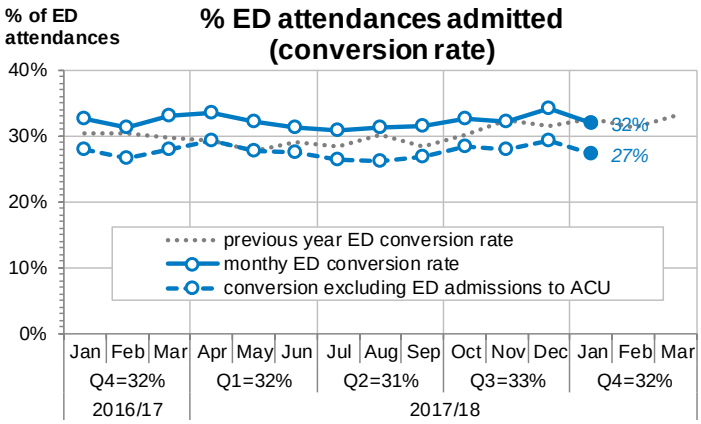


Chart 37

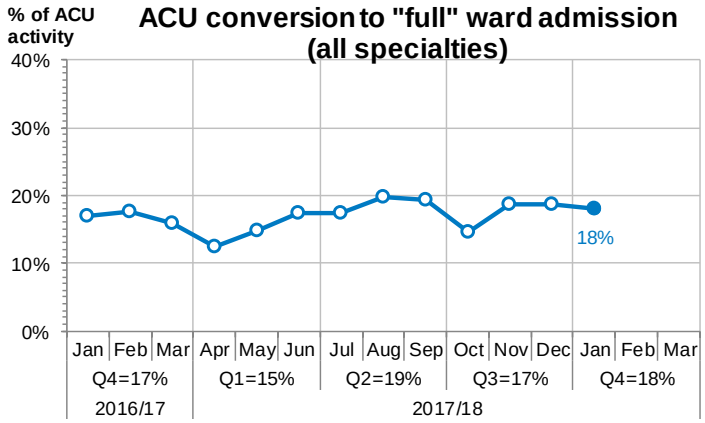


Chart 38

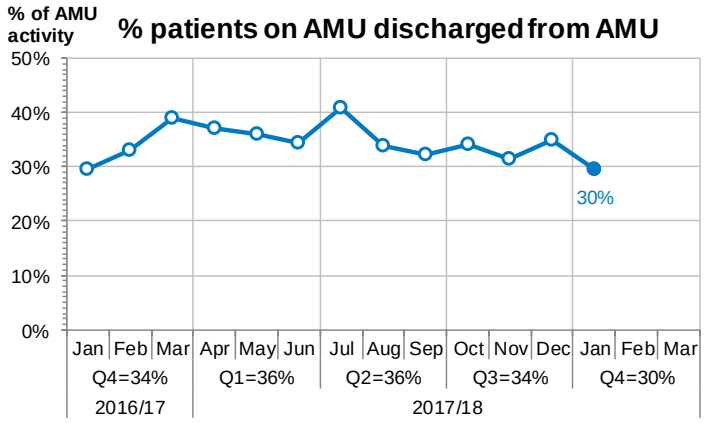


Chart 39

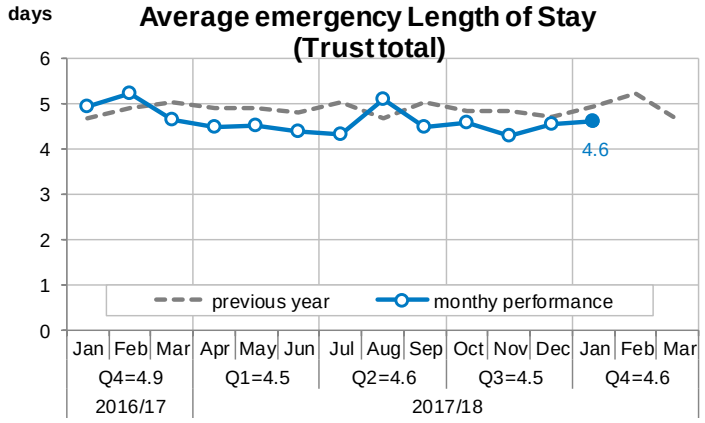


Chart 40

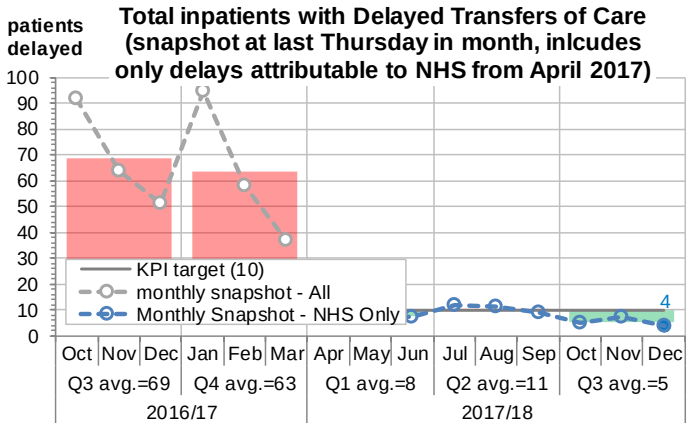


Chart 41

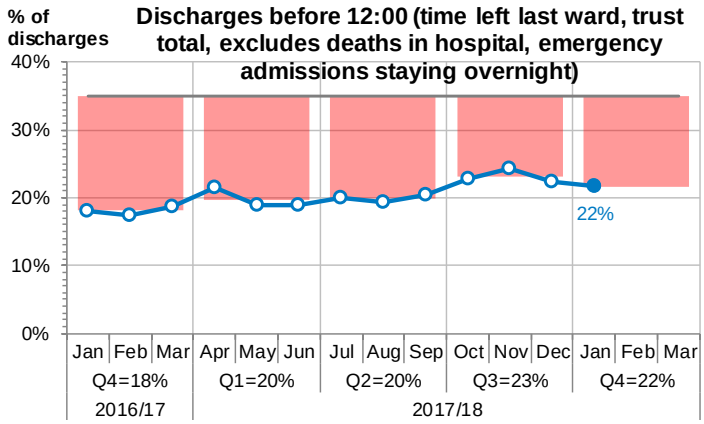


Chart 42

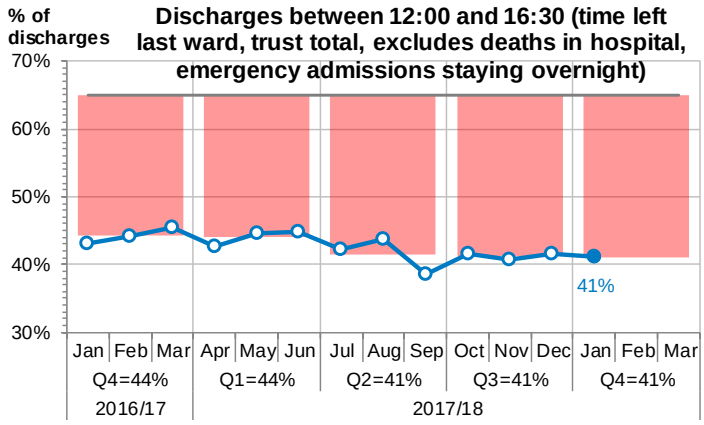


Chart 43

SAFER - is intended to improve the patient journey by ensuring an efficient pathway from admission to discharge by delivering timely appropriate care at the right time in the right place.

Key metrics have been agreed to measure SAFER performance which includes discharges before 12md and 16:30hrs as shown in chart 33 and 34. All wards are invited to attend monthly performance meetings to report compliance against these key metrics and actions plans developed as appropriate.

Identifying patients for discharge at the weekend is just as important as weekday discharges to continue flow and create capacity. An action plan has been developed to strengthen roles and responsibilities' of the on call team at weekend in order to ensure robust plans are in place and adhered to.

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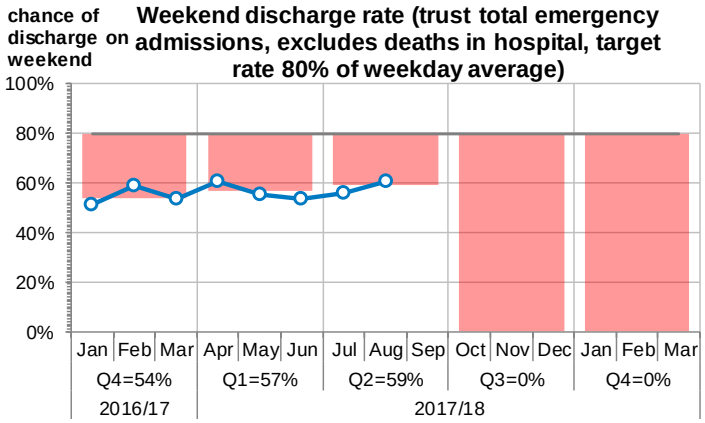

Diagnostic tests (6 week wait) 16

Chart 44

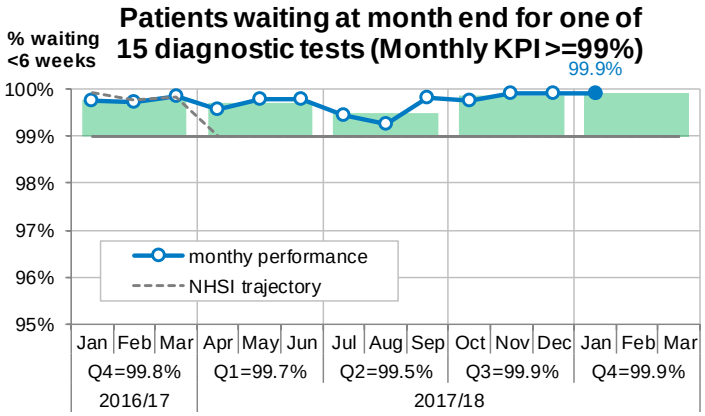

Chart 44 shows performance against the diagnostic standard.

Continued compliance with standard is expected.

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Cancelled Operations 20

Chart 45

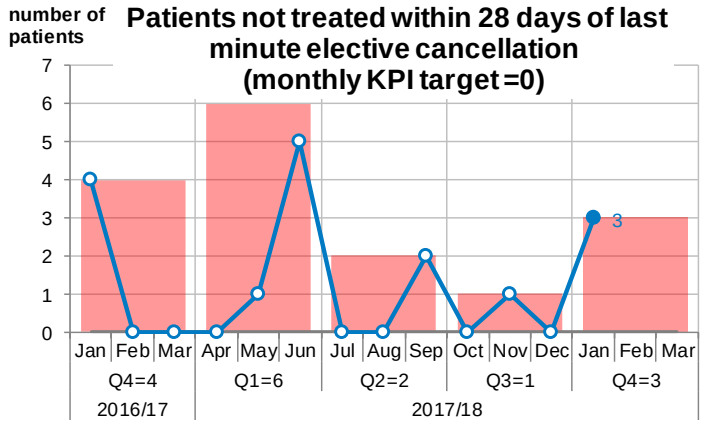

Chart 45 shows that there were 3 breaches of standard in the month of January.

1 was due to Consultant sickness and the other 2 due a lack of beds (winter pressures).

Chart 46

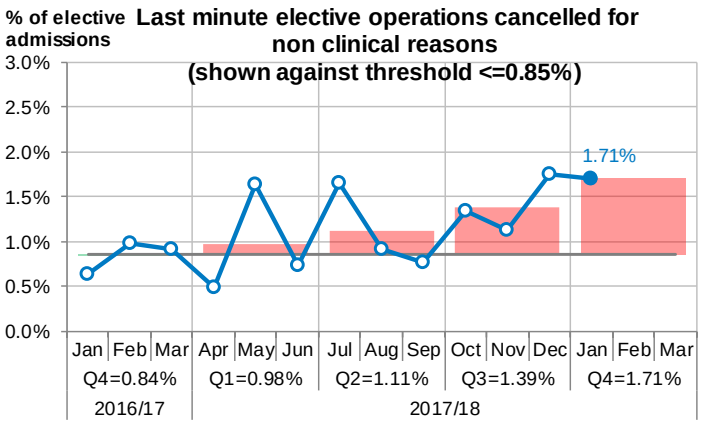

Chart 46 shows performance for last minute elective operations for non-clinical reasons.

In January 55 cancellations were reported on the day for non-clinical reasons.

Overall, the most common reasons for cancellation were no bed availability (25 cases), surgeon availability (7 cases) surgeon sickness on the day (6 cases) and urgent cases taking priority (6 cases).

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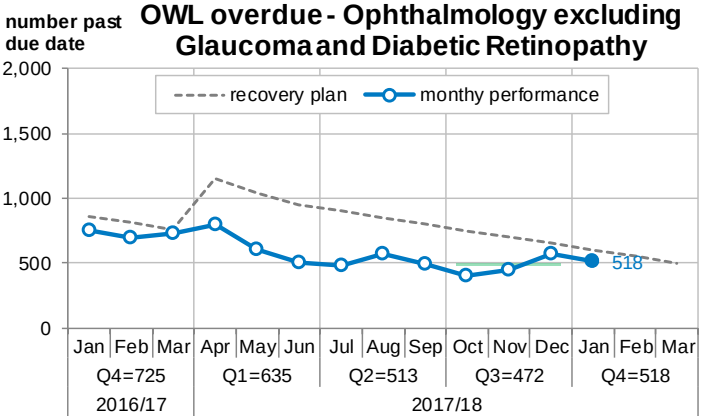
Outpatient Waiting List (OWL)

The Outpatient Waiting List (OWL) is where patients are placed when awaiting a future follow up appointment. When capacity and demand are mismatched, the numbers of patients who are overdue their follow up by a certain date will increase and delay these patients.

There are four specialties within the Trust where this is a current problem. This situation is being monitored by the Quality Assurance Committee (a sub-committee of the Board of Directors). This committee requested that the data should be shared with the Board through the Integrated Performance Report.

As per the contracting agreement, the trajectories for reducing the follow-up OWL were revised based on the service position at the end of Q2. These are reflected in the charts below.

Chart 47 Ophthalmology OWLs past due date

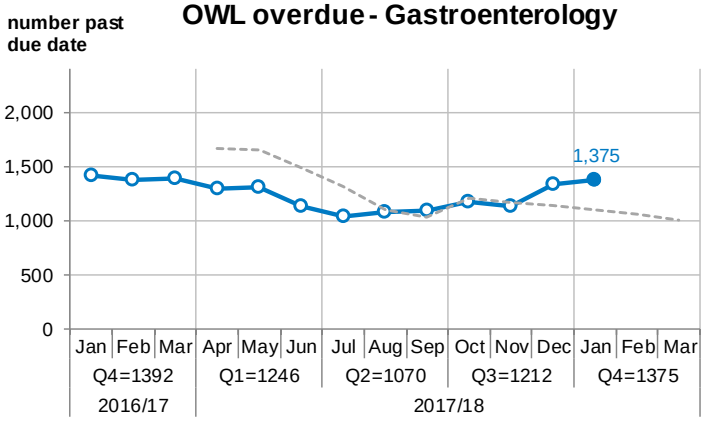


Ophthalmology

Chart 47 shows the number of Ophthalmology patients on the OWL beyond their due date.

Januarys position remains in line with the trajectory plan.

Chart 48 Gastroenterology OWLs past due date

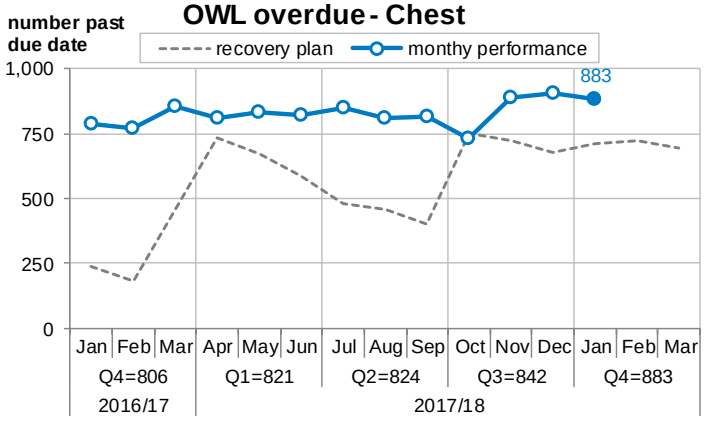


Gastroenterology

Chart 48 shows the number of Gastroenterology patients on the Outpatient waiting list (OWL) beyond their due date.

Gastroenterology have deviated from plan due to the requirement to divert consultant time to provide adequate medical cover to the increased medical bed base during December and January. As these escalation beds have now closed, full clinic capacity can now be resumed.

Chart 49 Respiratory Medicine OWLs past due date

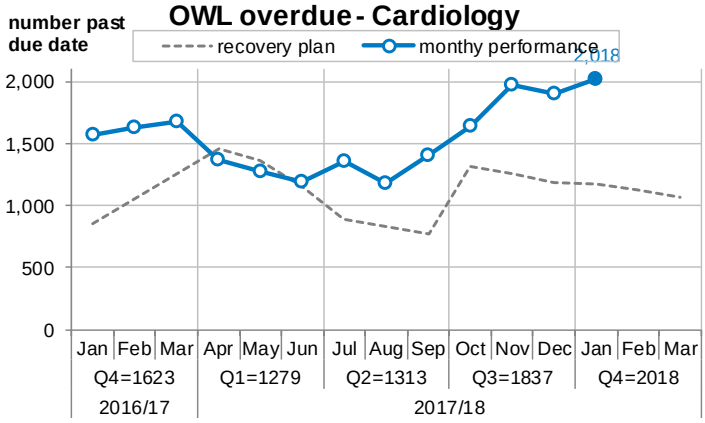


Respiratory Medicine

Chart 49 shows the OWL for Chest patients. A reduction in capacity for lung function tests due to a 50% vacancy factor within the team.

Mitigating actions include trialing virtual review clinics for surveillance cancer patients and a bid for increased MacMillan Nurse support to increase the number of nurse-led clinic sessions.

Chart 50 Cardiology OWLs past due date



Cardiology

Chart 50 shows the continued adverse trend from trajectory.

Significant workforce challenges continue from both a medical and nursing perspective.

Interventions will be considered as part of the Stockport Together Outpatient Programme, and the close partnership working with Primary Care through the Neighbourhood teams.

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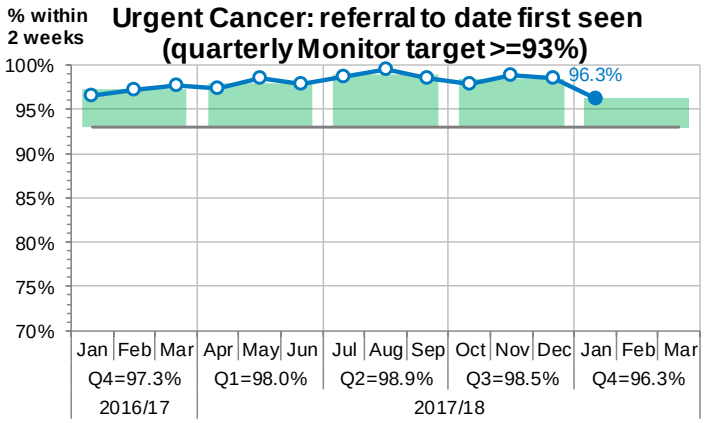
Cancer waiting times M 16

Chart 51



Compliance with the urgent referral standard continues.

Chart 52

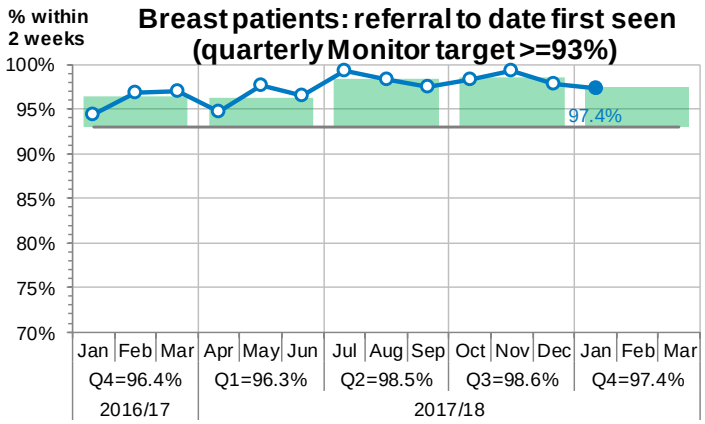


Chart 53

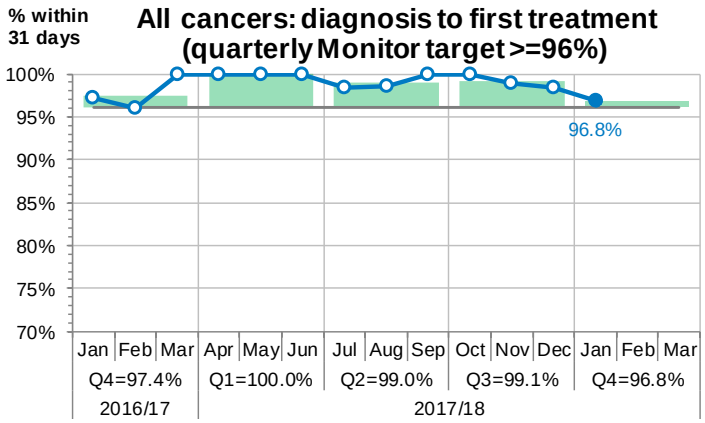
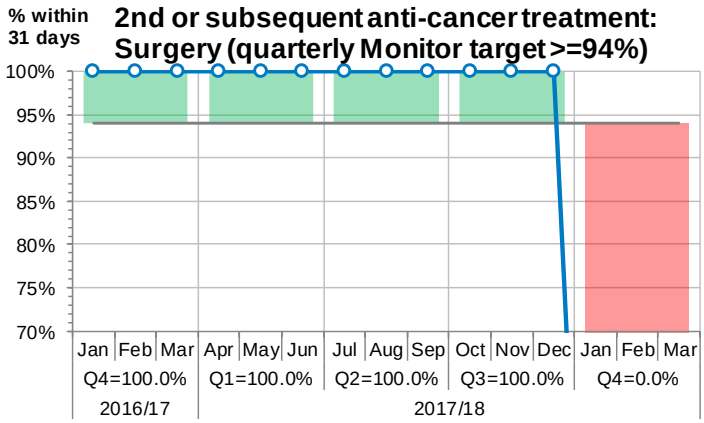


Chart 54



Graph 54 shows non-compliance with this standard in January. However, this related to just one patient episode.

Chart 55

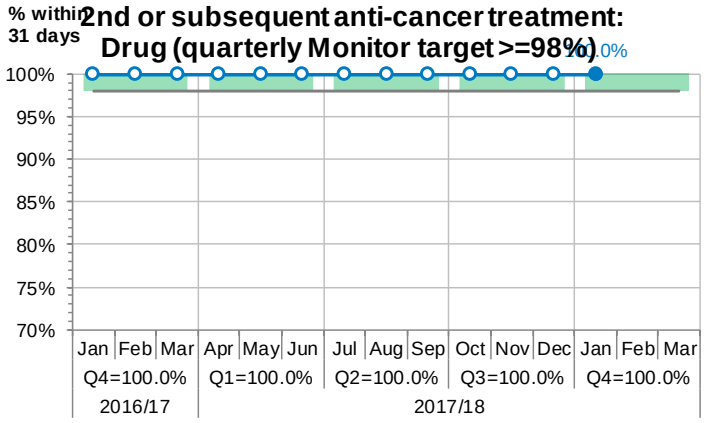


Chart 56

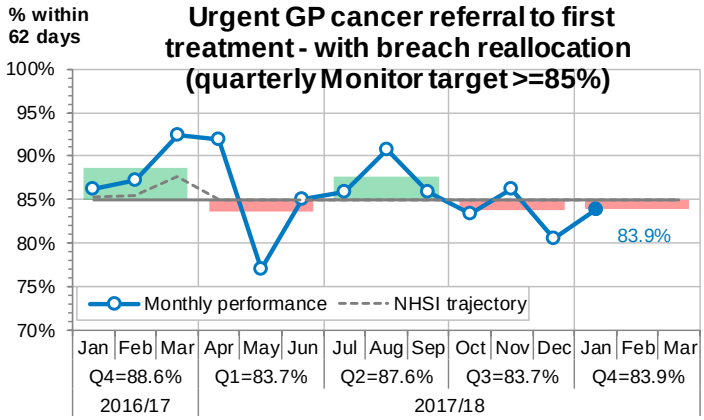


Chart 56 shows performance against the 62 day cancer standard.

December's position closed at 80.5%. The latest position for the month of January is 83.9%.

45 patients were treated on the 62 day pathway in January, which is a slight increase on the December position but remains comparatively low to the year average of 49 and the early autumn months of 60 and 62 treatments respectively.

The 7 patients that were treated beyond day 62 were a mixture of diagnostic delays, complex pathways and patient initiated delays. At the time of writing, no patient has been identified as result of the delay to their treatment.

Improvements in the colorectal pathway are due to come into effect early March as patients will have the ability to book their radiological procedure straight from clinic prior to leaving the hospital. In addition, the straight to test model will commence following successful recruitment. This will reduce the time taken for first diagnostic test.

A cancer strategy is being compiled which will describe the Trusts approach and plans to deliver on the Greater Manchester Cancer review recommendations, the Find Out Faster standard and the revised National Cancer Waiting time data set.

Chart 57 GP referral to first treatment with breach reallocation, by tumour group.

Tumour Group (Jan-18 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Head & Neck	3 / 3.5	14%	
Upper GI	2 / 2.5	20%	
Colorectal	1 / 7.5	87%	
Haematology	1 / 2.5	60%	
Urology	0 / 16	100%	
Breast	0 / 7.5	100%	
Gynaecology	0 / 4	100%	
Lung	0 / 0		

Chart 57 shows performance against the 62 day standard by tumour group.

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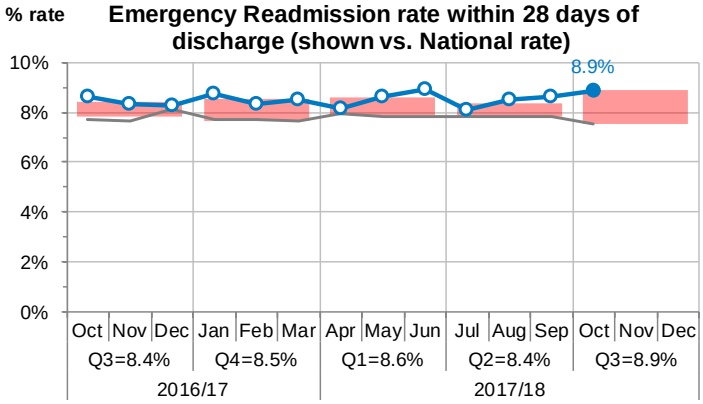
Emergency Readmissions

Chart 58



Data source: CHKS / Health and Social Care Information Centre

Chart 58 shows the Emergency Readmission rate within 28 days of discharge.

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Financial Performance

Chart 59

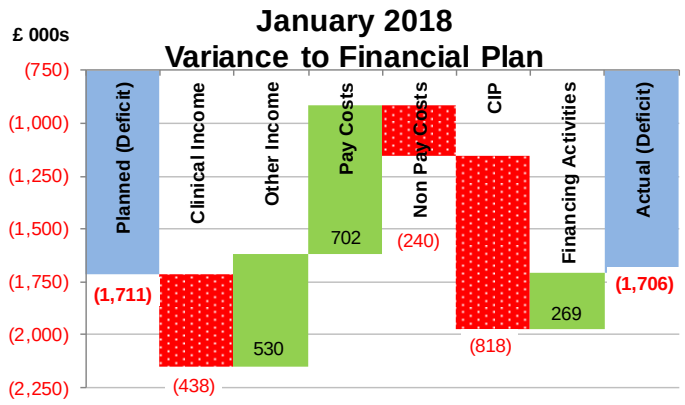


Chart 60

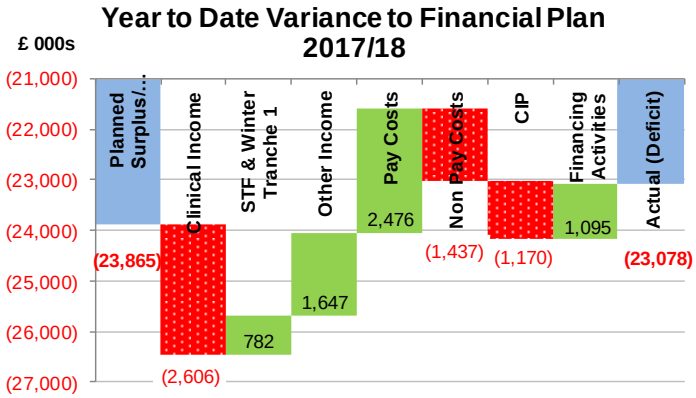
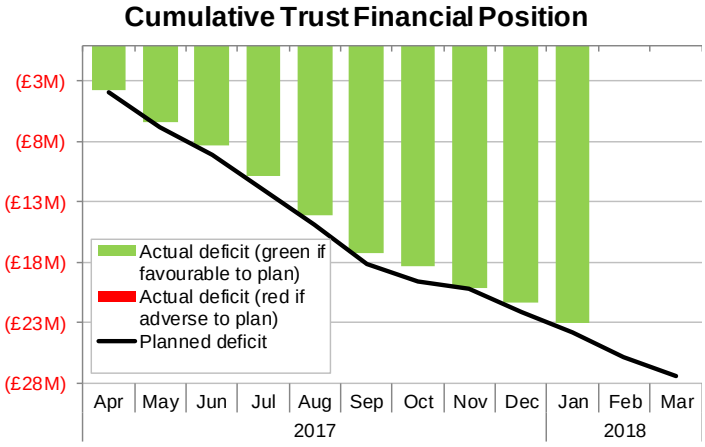


Chart 61



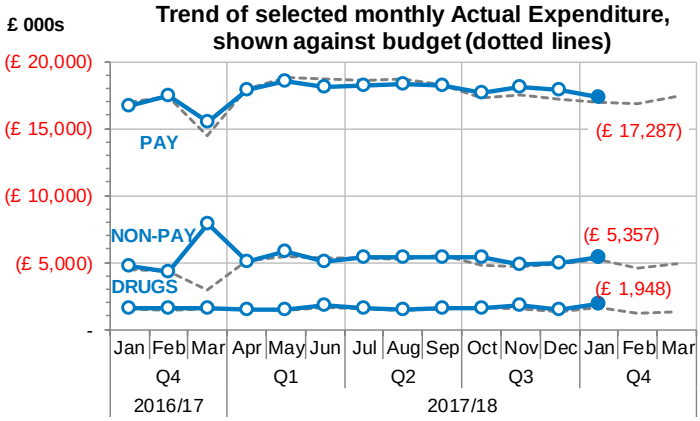
In the ten months to date in this financial year the Trust has lost £23.1m. The planned deficit was £23.9m so this is ahead of plan because of additional external resources. The average loss is £75,000 per day to the end of January.

The Trust has achieved the financial position for the financial year to date as agreed with NHS Improvement (NHSI) at the Enhanced Oversight meetings. There has been no significant overall movement in month (as plans have been profiled to reflect the expected impact of winter pressures), and this is in line with the agreed forecast out-turn position.

The Trust is now able to give an increased level of assurance on having closed the gap in the forecast out-turn in the final quarter and maintain the NHSI submission forecast of a maximum £26.2m loss (excluding the £0.4m STF for 2016/17 and £0.8m Tranche 1 winter funding). This has been possible as the overall business group positions have remained stable despite the under achievement of the recovery plans, which is being offset by updated financing calculations which represent a one-off in-year saving to the Trust.

The Cost Improvement Programme (CIP) is £0.8m adverse to the profiled plan in month, so overall CIP remains £1.2m behind the profiled plan; £10.7m (71%) was expected by this stage in the year when £9.5m (63%) has been transacted. Technical CIP is £0.7m ahead of plan to date, masking greater shortfalls in the transformation programmes. **£6.1m of recurrent CIP (41%) has been delivered, and the £8.9m shortfall places considerable risk on the 2018/19 financial plan.**

Chart 62



Pay budgets are underspent to date excluding CIP by £2.5m, as the Trust level of turnover and vacancies remains high. Agency expenditure to date is £10.3m, but the agency cost is offset by vacancies not covered mainly in the non-clinical areas of the Trust. Bank and agency costs including NHS Professionals, internal locums and waiting list initiative payments total £21.7m and make up 12% of overall pay expenditure.

Non-pay is overspent by £1.4m excluding CIP, which includes £1.3m of out-sourcing costs for surgical specialties and outsourced radiology reporting. Non-pay budgets are over-spending in the business groups linked to the on-going pressure of additional patients in the hospital, which is only partially offset by the additional income received.

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Capital Programme

Chart 63

Description	Plan 2017/18 Year £'000	Month 10 - YTD January 2017/18 Plan £'000	Actual £'000	Variance £'000	Full Year Forecast at end M10 Forecast £'000	Variance £'000
Healthier Together Schemes						
ED Resus Expansion	2,400	2,375	142	2,233	151	2,249
Ward Refurbishments	1,200	850	77	773	85	1,115
Endoscopy Building	250	250	2	248	7	243
Equipment - Critical Care & IT	280	280	28	252	32	248
	4,130	3,755	250	3,505	274	3,856
Internally Funded Schemes						
Equipment						
Endoscopy	250	250	-	250	-	250
Diagnostics	1,139	1,139	699	440	1,495	(356)
Surgery and Critical Care	848	815	560	255	911	(63)
Other Medical Equipment	812	733	218	515	784	28
Estates and Facilities Equipment	610	585	42	543	304	306
	3,659	3,522	1,520	2,002	3,494	165
Information Management & Technology						
Wireless Network	650	650	120	530	120	530
Hardware for Electronic Patient Records (EPR)	380	380	180	200	201	179
Software for EPR - Interfaces & Voice Recognition	590	292	136	156	163	427
Other Hardware	910	832	348	484	979	(69)
Other Software	120	-	91	(91)	112	8
Aspen House Server Room		-	2	(2)	59	(59)
	2,650	2,154	876	1,278	1,634	1,016
Estates						
Backlog Maintenance	335	285	154	131	341	(6)
Non Backlog Maintenance	500	422	697	(275)	1,025	(525)
Other Projects	863	730	98	632	98	765
	1,698	1,437	950	487	1,464	234
Revenue to Capital	-	-	96	(96)	177	(177)
Capital Expenditure Plan (excl. finance leases)	**12,137**	**10,868**	**3,692**	**7,176**	**7,043**	**5,094**
Specific Finance Leases						
Acute EPR - Intersystems - Capital repayments	1,422	1,336	1,437	(101)	1,724	(302)
Community EPR - EMIS- Capital repayments	68	57	57	-	68	-
Pathology - Point of Care Testing				-	15	(15)
	1,490	1,393	1,494	(101)	1,807	(317)
Capital Expenditure Plan (incl. finance leases)	**13,627**	**12,261**	**5,186**	**7,075**	**8,850**	**4,777**
Funded						
Depreciation	9,982	7,474	7,190	284	8,700	1,282
Vanguard Funding - Community			13	(13)	13	(13)
QCNW & Stockport Pharmaceuticals Surpluses			31	(31)	103	(103)
Pharmacy Shop			21	(21)	22	(22)
Disposal proceeds			16	(16)	185	(185)
Externally Funded			15	(15)	35	(35)
Loan Repayment	(1,551)	(1,411)	(1,411)	-	(1,551)	-
Cash Resources	5,196	6,198	(689)	6,887	1,343	3,853
	13,627	**12,261**	**5,186**	**7,075**	**8,850**	**4,777**

Capital costs of £5.2m have been incurred to date against a plan of £12.3m and so is £7.1m behind plan. This is due to a delay in the commencement of schemes linked to Healthier Together of £3.5m, plus a further £2.0m on equipment purchases and £1.3m on IT expenditure.

The full funding of Healthier Together schemes is fundamental to the delivery of the capital programme but is reliant on external parties and their approval processes via the Greater Manchester Devolution Team (GM Devo). This has taken much longer than envisaged as Central Government approvals were delayed, and the projects still do not have an expected start date.

The capital forecast is heavily skewed by the Healthier Together schemes and accounts for the majority of the £4.8m underspend at year end, but this is still reliant on external funding.

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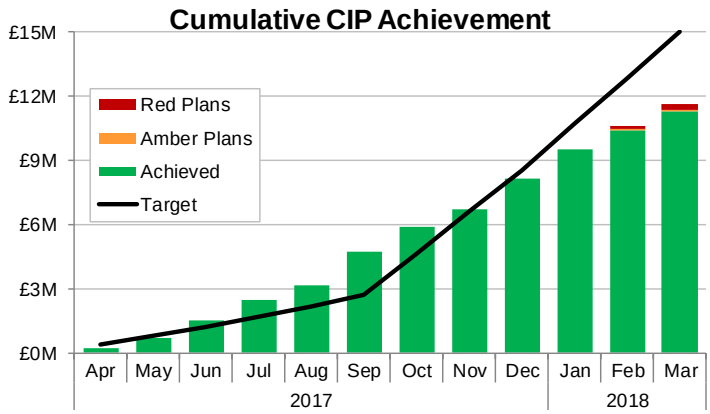
Cost Improvement Programme 20 M

Chart 64



To the end of January £9.5m (63%) of CIP has been actioned towards the year-to-date target of £10.7m (71%), so is £1.2m behind plan. £11.3m (75%) of the £15.0m full year annual CIP has been achieved.

Recurrent CIP remains unchanged from last month at £6.1m (41%), and this £8.9m shortfall places considerable pressure on the 2018/19 financial position and this is another driver of the structural budget deficit.

Chart 64 shows the in year CIP plans still show significant amounts of schemes unidentified or red rated ten months into the financial year. This adds major pressure to the Trust's ability to deliver next year's financial plan. A further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.

Financial Use of Resources Rating

Chart 65

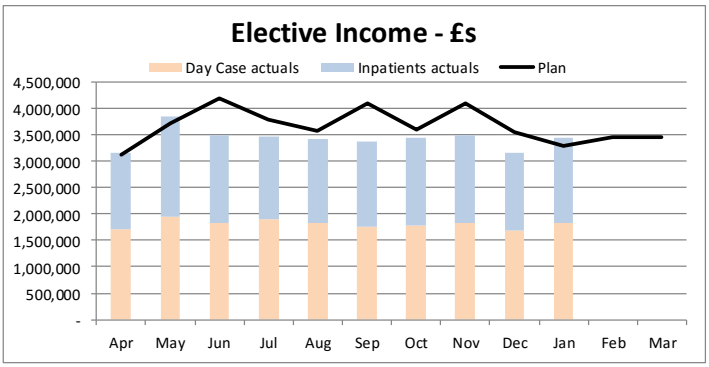
Finance & Use of Resources Metrics		Rating	Trigger Override	Excellent 1	2	3	Poor 4	Weight	Weighted score
Financial sustainability	Capital service cover	4	Yes	2.50	1.75	1.25	< 1.25	20%	0.8
Financial sustainability	Liquidity (days)	4	Yes	0	-7	-14	< -14	20%	0.8
Financial efficiency	I&E margin (%)	4	Yes	1.0%	0.0%	-1.0%	<-1.0%	20%	0.8
Financial controls	Distance from financial plan (%)	1	No	0.0%	-1.0%	-2.0%	<-2.0%	20%	0.2
Financial controls	Agency spend	2	No	< 0%	0%	25%	50%	20%	0.4
Finance Use of Resource Metric (UOR) - Calculated									**3**
OVERRIDE TRIGGERED?			Yes						Yes
Finance Use of Resource Metric (UOR) - Final Reportable									**3**

The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for January 2018 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

Elective Income vs. Plan

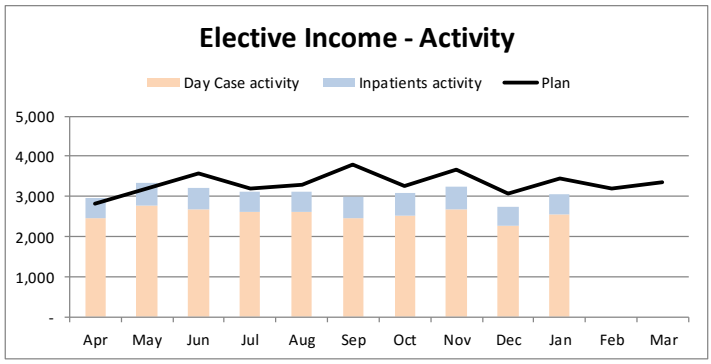
Chart 66



Elective income has shown an improvement again in January as the annual plan had already assumed a higher level of cancellations due to winter pressures than have actually occurred; 77 patient operations were cancelled in January due to lack of bed capacity in the hospital. However this will not continue as a further 90 elective patients have already been cancelled for February, and this was not expected in the plan. Overall elective income is £2.6m behind the annual plan but slightly ahead of the recovery plan.

Inpatient income is behind plan by £1.2m, and day case activity is £1.4m adverse. The Trust has spent £1.9m on waiting list initiatives and £1.3m on out-sourcing in ten months, but this is not solely on elective work and includes out-sourced radiology reporting.

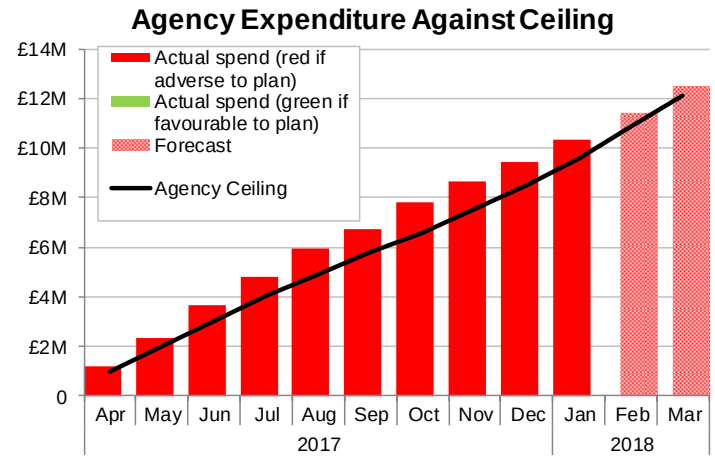
Chart 67



Elective activity continues to the main contributor to this deficit year, with activity 2,472 spells below planned levels. Both day case and inpatient activity is below plan by 1,746 and 726 spells respectively. As a result, the overall elective income is £2.6m adverse to plan. Urology is the main specialty adverse to plan and is 395 spells below its patient target. Endoscopy is 759 cases behind plan, ENT 321, pain 175 and orthopaedic hands 221 behind plan.

Agency Ceiling

Chart 68

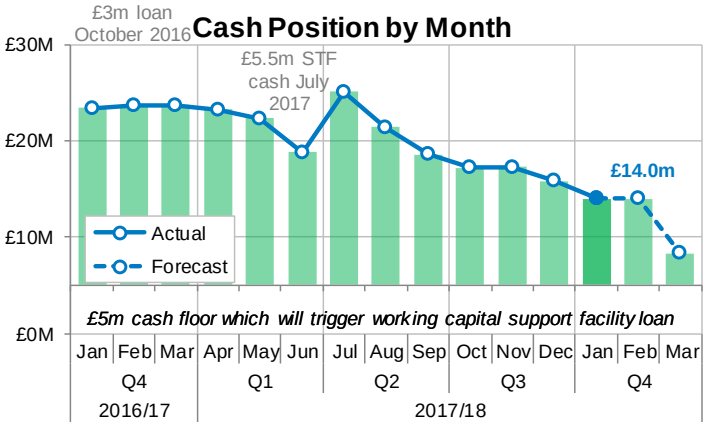


Agency expenditure in January was £0.9m, increasing total agency costs to date to £10.3m, which is 6% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £0.7m.

Bank costs (including NHS Professionals nurses and therapists, and internal locums) are a further £10.0m, plus waiting list initiative (WLI) costs of £1.4m. These temporary staff costs at premium rates total £21.7m and make up 12% of the overall pay expenditure. The Trust has been working to convert agency staff into bank posts and reduce the overall temporary staff cost burden. However whilst agency costs may have reduced, the corresponding increase in bank costs has not created the required financial benefit. The total proportion of pay costs spent on temporary staffing has not fundamentally changed within the current financial year, but has followed the expected seasonal trend.

Cash

Chart 69

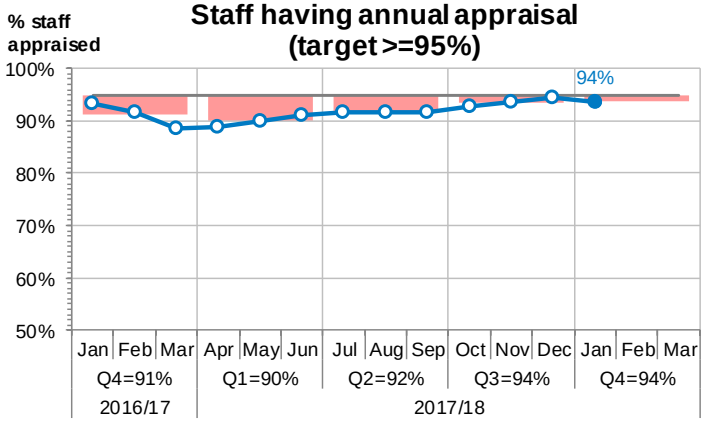


Cash in the bank on 31st January 2018 was £14.0m, which is £1.8m less than last month and £8.8m better than planned. Receipt of £6.2m STF relating to 2016/17, additional winter monies and the capital programme performing significantly below planned levels have preserved cash, along with close monitoring of outstanding debtors.

Cash is carefully managed and the requirement for a working capital support facility loan is now likely to be in May 2018, based on the latest cash flow forecast.

Workforce Appraisals

Chart 70



The Trust's total appraisal compliance for January 2018 is 93.76%. A decrease from December's data which was 94.37%

During January the Learning and Development team have continued their partnership working with the Business Groups to validate appraisals and rectify any anomalies, ensuring accurate data recording. Increased support continues to be focused on areas 90% and below.

Exception reporting and action planning have been an area of focus within Medicine & Clinical Support Business Group, with a plan to achieve target by end March 2018 in development.

Chart 71

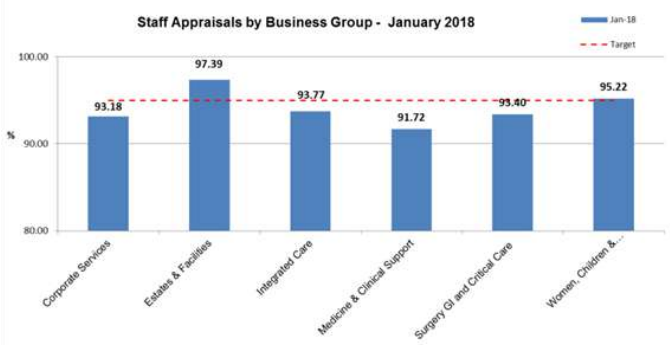


Chart 72

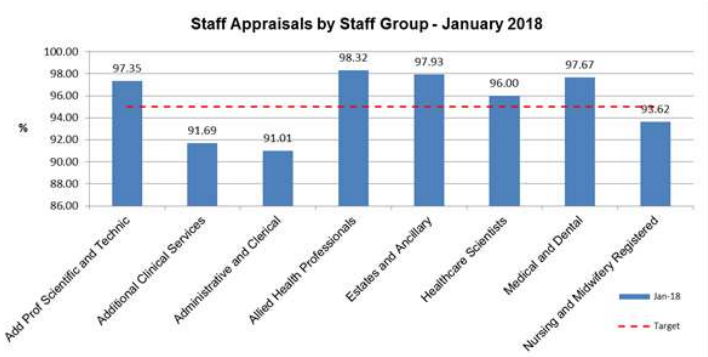
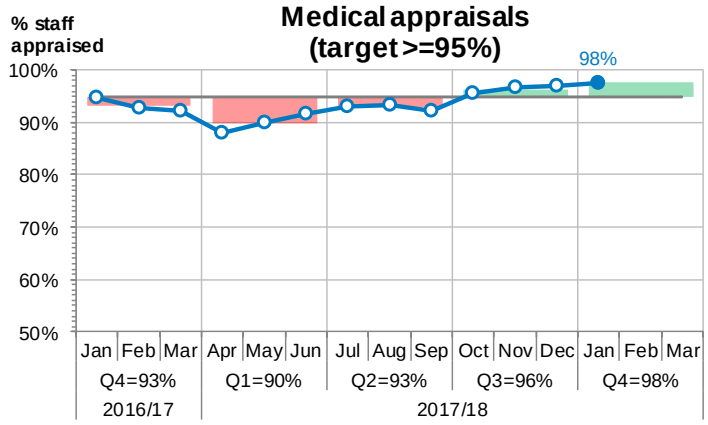


Chart 73



The medical appraisal rate for January 2018 is 97.67%, an increase of 0.61% from December 2017 (97.06%) and above the Trust target of 95%.

Workforce Turnover

Chart 74

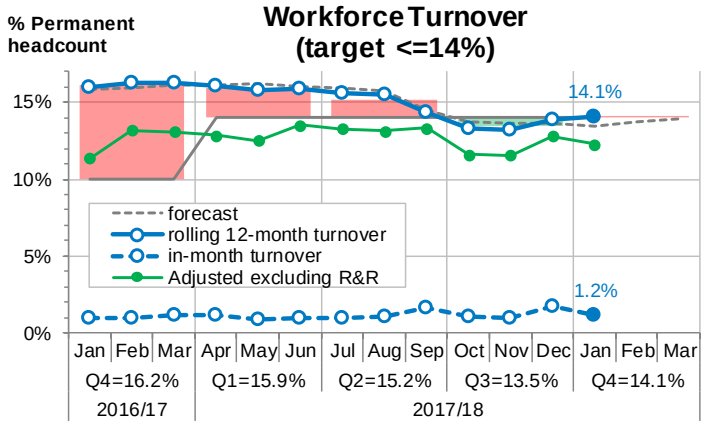


Chart 75

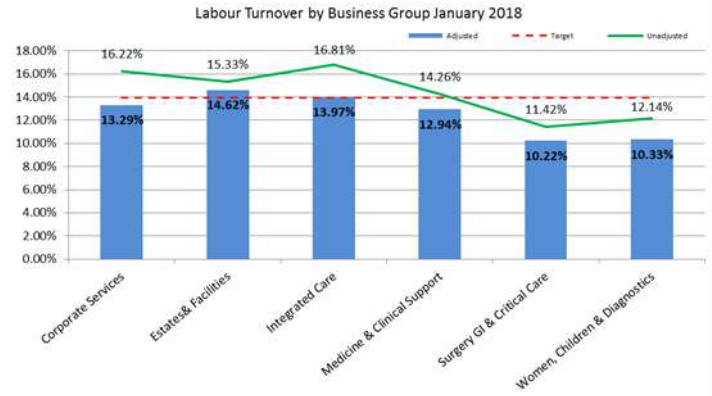
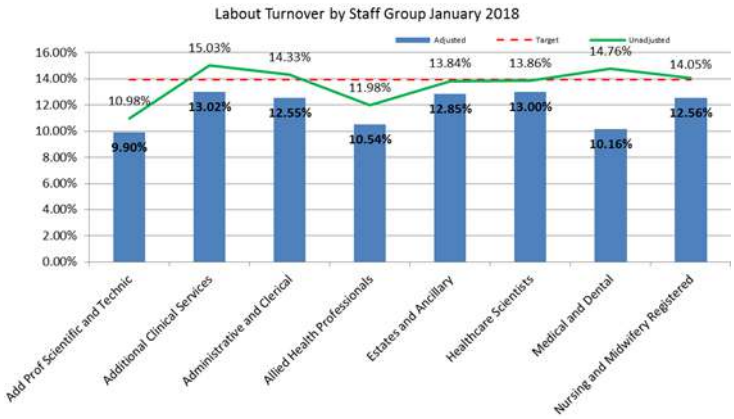


Chart 76



The Trust's turnover figure is reported and compared nationally as an unadjusted figure, meaning that the data includes retire and return employees and TUPE transfers. The Trust target of 13.94% is based on the national average turnover rate for medium size Foundation Trusts in 2016/17.

The rolling 12-month permanent headcount unadjusted turnover figure at the end of January 2018 is 14.08%. The adjusted rolling 12 month permanent headcount turnover figure in the period February 2017 to January 2018 is 12.29%, a decrease on the previous 12-months of 0.5%.

The top leaving reasons are: Relocation 2.52%, Retirement 2.25%, Promotion 1.70% and work life balance 1.68%.

Integrated Care has the highest overall turnover rate at 16.81%, however, when adjusted the figure is 13.97%.

Of the Trust adjusted permanent headcount leavers from February 2017 to January 2018; 39.84% have no further employment, reflective of the retirements and work life balance reasons, and 29.15% have moved to other NHS organisations of which 24% are within Greater Manchester, and a further 4% in the surrounding area.

The Registered Nursing & Midwifery adjusted turnover has seen a decrease 0.98% from the previous month. The top leaving reasons are: relocation; 63, promotion; 33, retirement; 31, work life balance; 29. Of those stating relocation; 32 (51%) have moved to other NHS Trusts, and 14 (22%) have moved abroad; 3 British and 11 European nurses.

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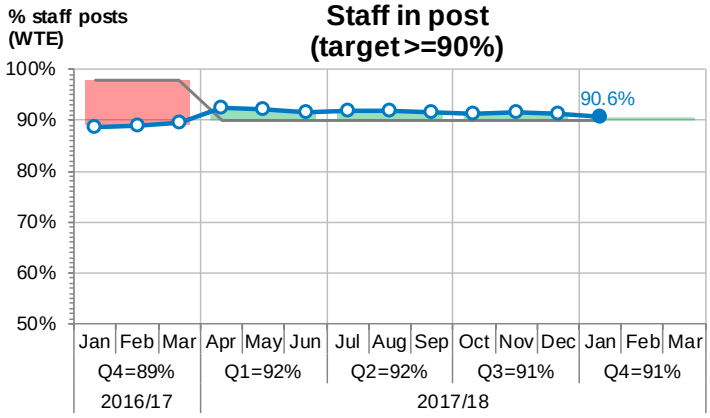
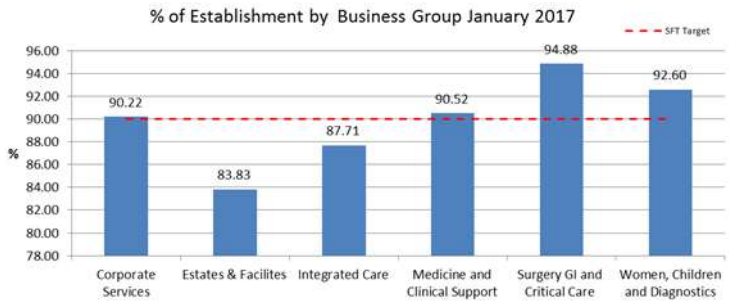
Workforce Efficiency

Chart 77



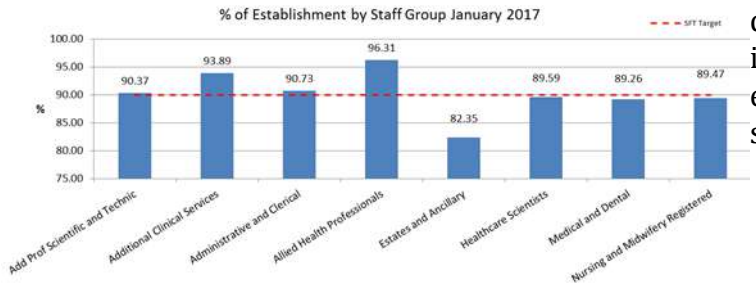
The Trust staff in post figure for January 2018 is 90.6% of the establishment, which is a decrease of 0.55% from 91.15% in December 2017.

Chart 78



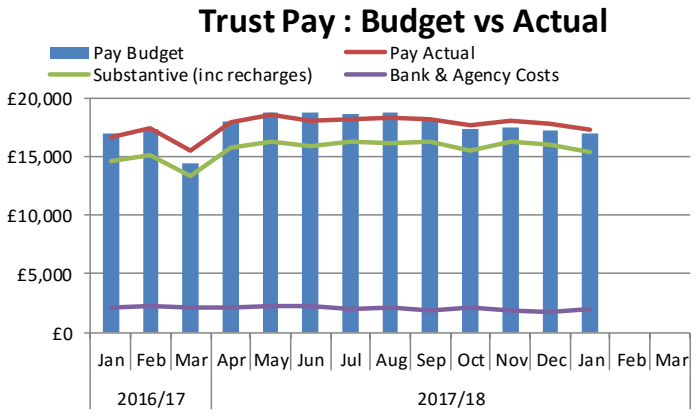
Estates & Facilities have the highest percentage vacancy rate at 17.65% (64.24 FTE vacancies). Of the 50 permanent leavers in the past 12-months in Estates and Facilities; 39 have no further employment. (18 have resigned, 13 have retired, and 7 have been dismissed). A review of establishment is underway, which it is anticipated will be concluded by end March.

Chart 79



Registered Nursing and Midwifery have the highest number of vacancies at 166.90 FTE, (a decrease from 191.18 FTE in December 2017 due in part to the realignment of ODPs establishment), equating to 10.53% of the establishment for that staff group.

Chart 80



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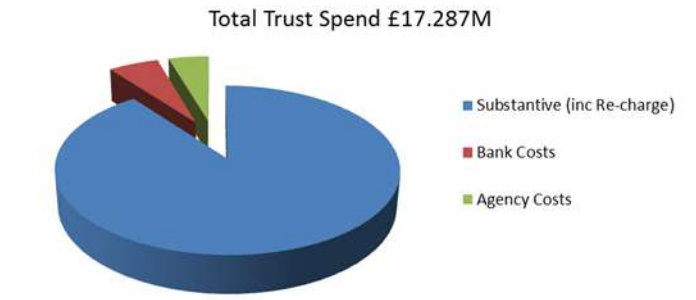

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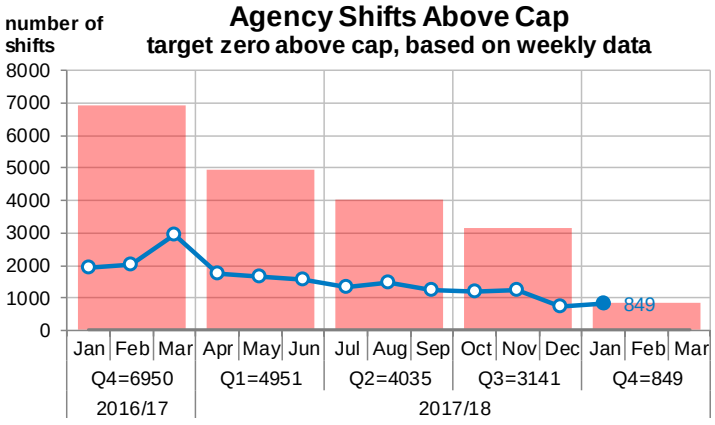

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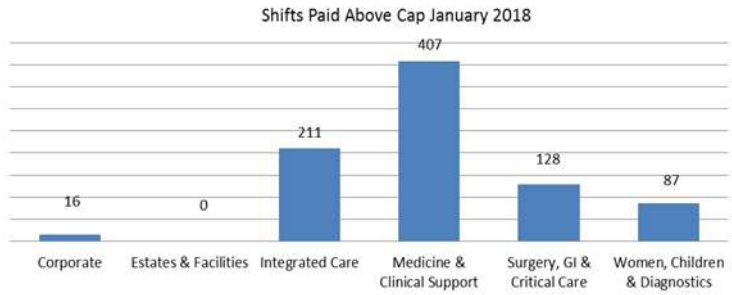


The total pay spend in January 2018 was £15.32M, excluding bank and agency spend. This is a decrease of £743K compared to December 2017.

Total spend, including bank and agency, equates to £17.287M, which is £307K over the total pay budget for the month.

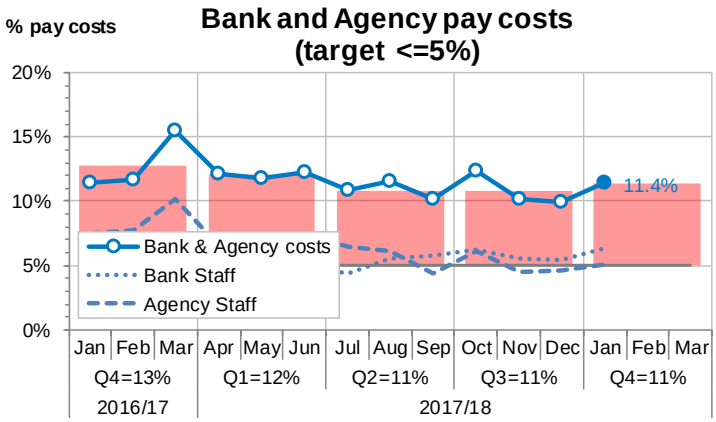
The total spend on bank staff in January 2018 was £1.1M, which is 6.33% of the total pay spend. Agency spend was 5.06% of total pay expenditure, a figure of £0.88M.

There were a total of 849 agency shifts paid above cap in the 4 week period from 1st to 28th January 2018. This equates to an average of 212 shifts per week, an increase of 32 shifts per week compared to the previous month.

There is a rolling advert for bank medical staff for which we are recruiting small numbers of doctors each month. The new cohort of junior medical staff have also been approached at induction to join the bank. This approach will hopefully result in less shifts being worked by agency staff as more internal staff are encouraged to pick up additional shifts.

Discussions are on-going with Trusts within Greater Manchester that are part of the NHSP (Nursing) Agency Partnership program regarding a BankShare agreement. Subject to the resolution of a small number of issues with some Trusts, it is anticipated that the agreement will go line in June, providing a greater pool of bank staff across GM.

Chart 84



Bank and agency costs in month (January 2018) account for 11.4% (£1.97M) of the £17.2984M total pay costs. This is a 1.43% increase from the position reported in December 2017 (£1.78M).

The Medicine & CS Business Group bank and agency spend has increased by £100k from December 2017 to £0.77M in January 2018, and continues to have the highest spend on bank and agency equating to 39.12% of the Trust overall bank and agency spend and 4.46% of the Trust total paybill, predominantly attributable to clinical vacancies.

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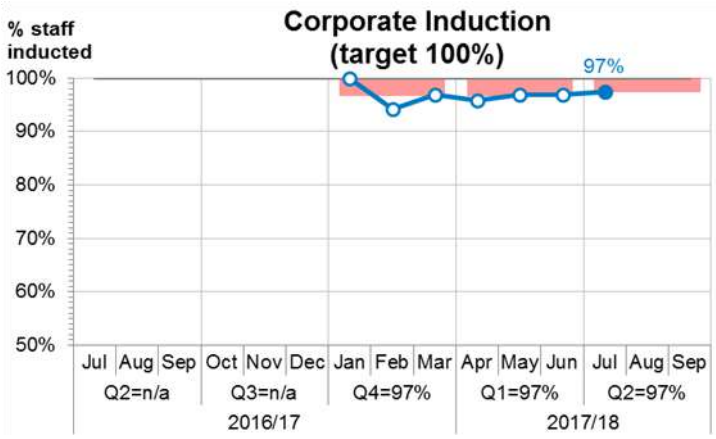
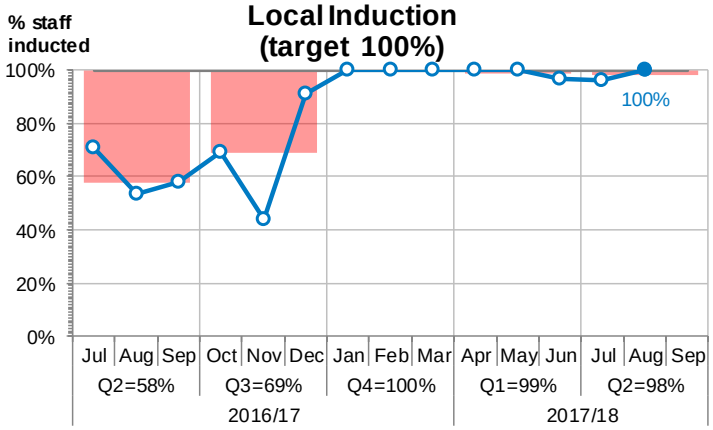
Workforce Induction

Chart 85



Due to technical issues, data for Corporate welcome and local induction is not available for January at the time of writing.

Chart 86



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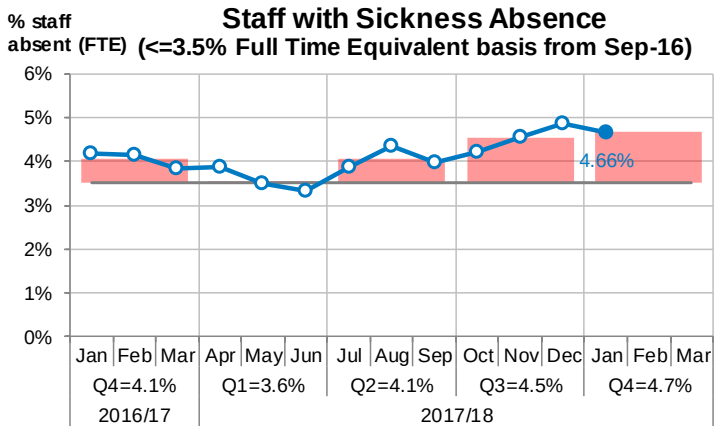
Staff Engagement

To be developed

Sickness Absence

Chart 87



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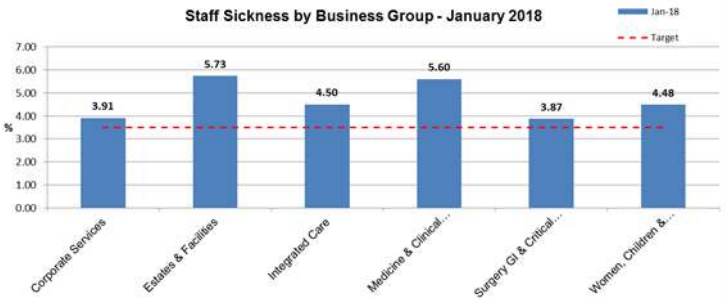
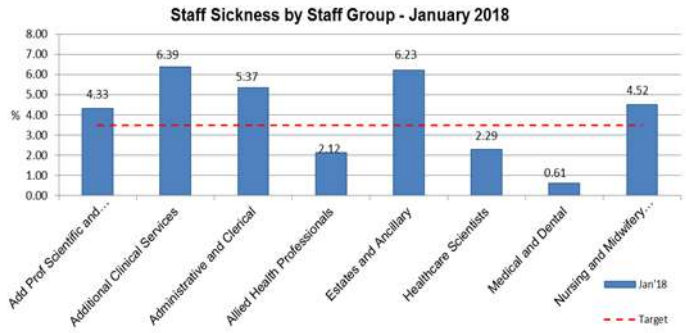


Chart 89



The in-month unadjusted sickness absence figure for January 2018 is 4.66%; a decrease of 0.19% compared to the adjusted December 2017 figure of 4.85%. The sickness rate for comparison in January 2017 was 4.19%. The 12-month rolling sickness percentage for the period February 2017 to January 2018 is 4.10%.

The unadjusted cost of sickness absence in January 2018 is £505,555, a decrease of £9,784 from the adjusted figure of £513,339 in the previous month. This does not include the cost to cover the sickness absence.

The top three reasons for absence in January 2018 are: cough/cold/ influenza/asthma at 25.45% (a large percentage increase of 16.23% from December 2017), back/musculoskeletal problems including injury/fracture at 25.40% (a 0.69% decrease from December 2017). Stress has moved down to third place at 30.18% (8.34% down from December).

Although all Business Groups are above the 3.5% target in January 2018, the majority have seen a decrease. Women, Children & Diagnostics has seen the highest decrease (0.90%) on the previous month followed by Estates & Facilities (0.53%). Corporate Services are the only Business Group to have an increase of 0.89% from 3.02% to 3.91%

The unadjusted short term sickness for February 2017 to January 2018 is 1.22%, a marginal increase (0.04%) on the adjusted short term sickness figure reported last month. The long term sickness for February 2017 (2.88%) remains the same as reported last month.

Estates and Facilities Business Group has the highest sickness rate at 5.73% (2.23% above the 3.5% target) in January 2018. The three highest reasons given are musculoskeletal/back/injury problems at 36.70%, cough/cold/influenza/asthma at 23.20%, and stress at 14.79% of the sickness. Ongoing dedicated HR support is provided to assist managers with the management of attendance in the business group.

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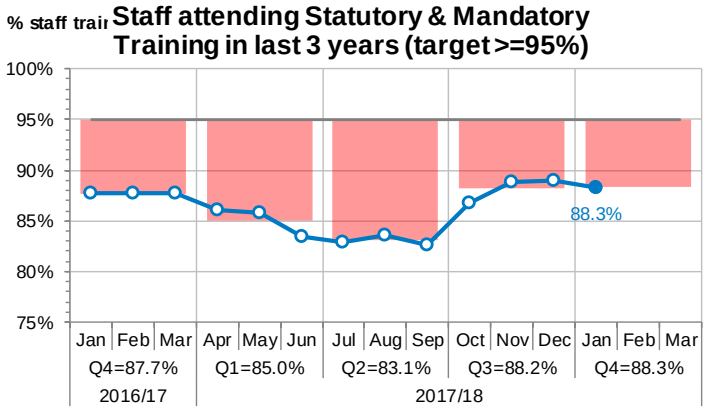
Statutory and Mandatory Training

Chart 90



The statutory and mandatory training compliance is 88.33% for January 2018, a marginal decrease from December's performance.

Following the presentation of the error report an action plan has been produced which is scheduled to be presented at a Quality Summit Committee.

The learning and development team are continuing work in partnership with the Business Groups to ensure system and user error / queries are addressed.

Chart 91

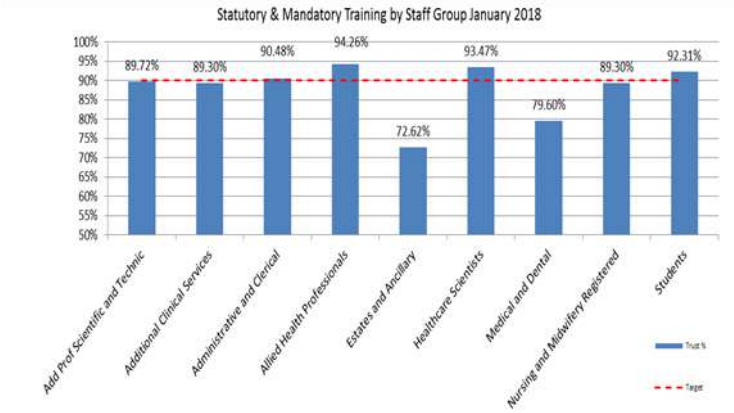
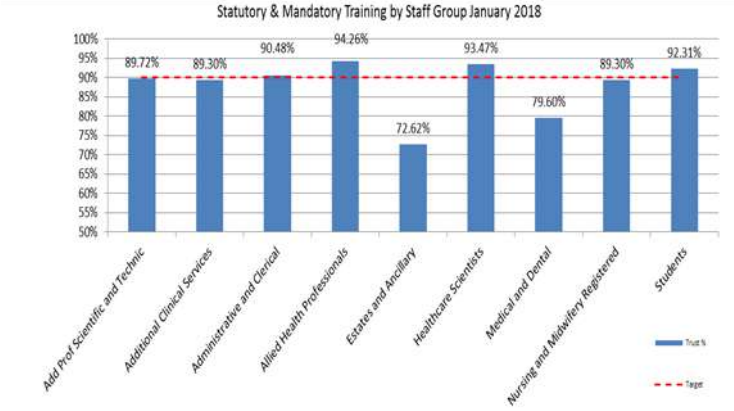


Chart 92



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Flu Campaign

Chart 93

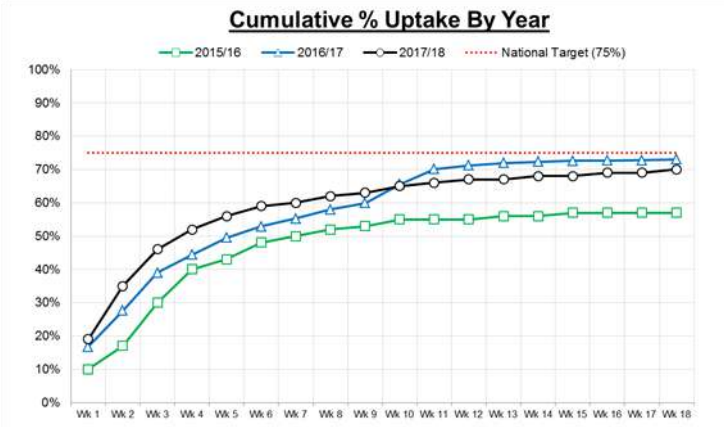


Chart 94

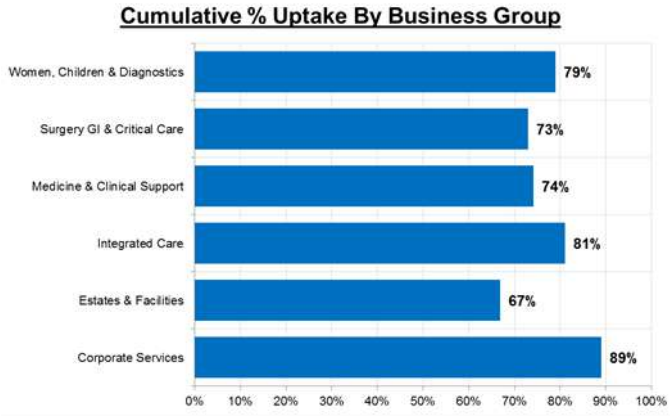
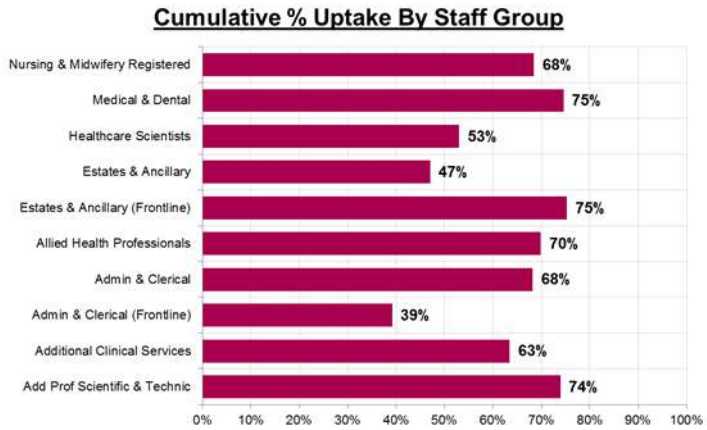


Chart 95



These figures are based on flu forms returned by the link nurses and pharmacy shop vaccinators and entered in the relevant flu week by Occupational Health.

As at week 18 ending 4th February 2018, 70% of all Trust staff, and 71% of front line staff have received the flu vaccine. The latter is 1% above the CQUIN target of 70% to be achieved by the end of February 2018.

Integrated Performance Report
Financial Table

Stockport NHS Foundation Trust

Income and Expenditure Statement	Trust Annual Plan	Year to Date Plan	Year to Date Actual	Variance
	£k	£k	£k	£k
INCOME				
Elective	43,531	36,677	34,074	(2,603)
Non Elective	80,339	66,830	66,733	(97)
Outpatient	31,641	26,430	26,412	(18)
A&E	13,152	11,016	11,052	37
Community Services	29,407	25,480	25,614	134
Non-tariff income	54,422	45,049	45,789	740
Clinical Income from Patient Care Activities	**252,493**	**211,482**	**209,674**	**(1,807)**
Private Patients	52	44	191	148
Other Non-NHS Clinical Income	917	764	599	(165)
Other Clinical Income	**969**	**808**	**791**	**(17)**
Research & Development	485	404	425	21
Education and Training	7,079	5,922	6,275	353
Stockport Pharmaceuticals/RQC	5,462	4,559	4,528	(30)
Other income	14,435	12,162	15,242	3,080
Other Income	**27,461**	**23,047**	**26,471**	**3,424**
TOTAL INCOME	**280,923**	**235,337**	**236,936**	**1,600**
EXPENDITURE				
Pay Costs	(214,310)	(179,979)	(179,955)	24
Drugs	(17,897)	(15,380)	(16,370)	(990)
Clinical Supplies & services	(21,686)	(18,277)	(18,381)	(104)
Other Non Pay Costs	(39,372)	(33,354)	(34,191)	(837)
TOTAL COSTS	**(293,265)**	**(246,989)**	**(248,896)**	**(1,908)**
EBITDA	**(12,342)**	**(11,652)**	**(11,960)**	**(308)**
Depreciation	(9,982)	(8,091)	(7,190)	901
Interest Receivable	63	52	46	(6)
Interest Payable	(1,003)	(798)	(730)	68
Other Non-Operating Expenses	-	-	-	-
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed assets	-	-	1	1
Donations of cash for PPE	-	-	-	-
PDC Dividend	(4,105)	(3,376)	(3,245)	131
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(27,400)**	**(23,865)**	**(23,078)**	**788**

ADJUSTED FINANCIAL PERFORMANCE (CONTROL TOTAL)	Annual Plan	Year-to-date Plan	Year-to-date Actual	Variance
	£k	£k	£k	£k
RETAINED SURPLUS / (DEFICIT)	(27,400)	(23,865)	(23,078)	788
Add back:				
Sustainability & Transformation Fund (STF)	-	-	(390)	(390)
Winter Tranche 1	-	-	(392)	(392)
Depreciation - donated/granted assets	180	150	150	-
ADJUSTED FINANCIAL PERFORMANCE SURPLUS/ (DEFICIT)	(27,220)	(23,715)	(23,709)	6

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Highlight and exception report of Stockport Neighbourhood Care		
Report of:	Caroline Drysdale (Managing Director Stockport Neighbourhood Care	**Prepared by:**	Caroline Drysdale

REPORT FOR APPROVAL

Corporate objective ref:	-----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* Highlight report of :- • System agreements • CQC local system review • Progress with deployment of integrated service solution (maturity assessment) • Implementation highlights • Workforce update • Benefits realisation
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	None

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

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NHS Stockport

STOCKPORT NEIGHBOURHOOD CARE - highlight/ exception report

21 February 2018

1. Purpose

The purpose of this report is to describe progress with the implementation of the Stockport Together Business Cases and to set out the approach to benefits realisation and measurement for 2018/19

2. Summary

- The Summary Economic case commits us to saving £20.1m in 2018/19 based on cost reduction (£26.1m based on national tariff)
- The Stockport Provider Alliance savings requirement component is £14.1m (including £6.5m avoided growth)
- Non Stockport Providers and the SCCG account for the balance of £6m (including £3m avoided growth)
- The savings are underpinned by an agreed risk and gain share (equal thirds) and investment (£19.3m)
- The Integrated Service Solution (ISS) was projected to be fully delivered by the end March 2018. A maturity assessment with a proposed completion date of mid-March 2018.
- There is a described optimisation period of 3 months between full deployment and benefits becoming available. The original timescale for which was end June 2018, which is subject to review pending completion of the maturity assessment.
- The full deployment of the ISS will enable delivery of the agreed 2018/19 financial benefits on the basis that we apply the Stevens test – that sufficient alternative provision is being put in place alongside or ahead of bed closures. Finance executives from Stockport Neighbourhood Care are fully engaged in discussions.
- A set of 'trigger metrics' will be agreed that will enable safe cost reduction underpinned by a contractual risk and gain share agreement
- There remain key risks to the full deployment of the model: 7 Day GP access, GP Clinical triage and Acute Home visiting has been escalated to system CEO's via the Alliance Provider Board**.**

3. Update on System Agreements

1. The Stockport Together Business Cases were approved by Council Cabinet and the CGG Governing body in January 18.

2. Commitment to realising the savings from two main sources remains: avoided future growth (£18.5m) and cost reductions (£20.3m) achieved from deflecting existing activity principally in non-elective care and the transformation of outpatient services (the core assumption that deflected / substituted care can be delivered safely, effectively and more efficiently in alternative care settings).

3. The Stockport Neighbourhood Care senior leadership/ management team was appointed to in October 17 to deliver on the business cases within the remit of Stockport Neighbourhood Care and a refreshed review of management and leadership within Stockport Neighbourhood Care is in draft.

4. CQC Local System Review

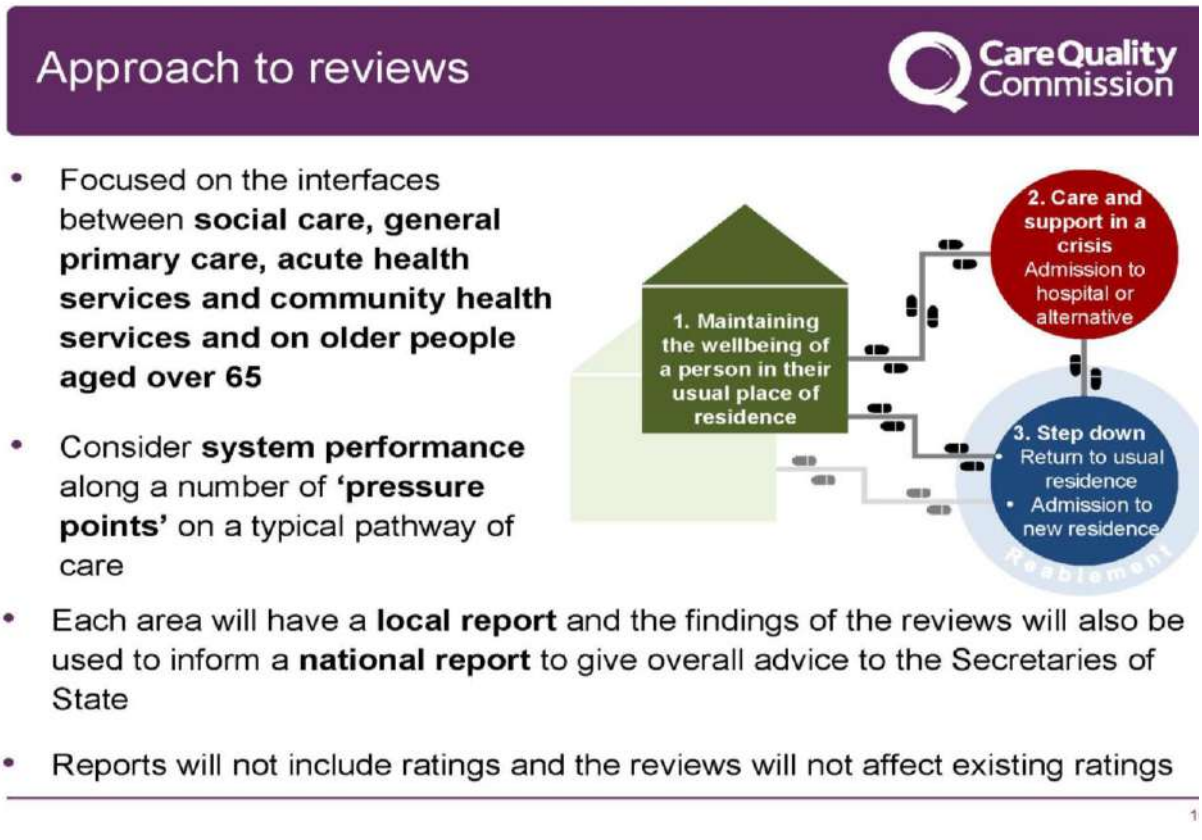
1. Following the Government's 2017 Spring Budget announcement of additional funding for adult social care, the Secretaries of State for Health and for

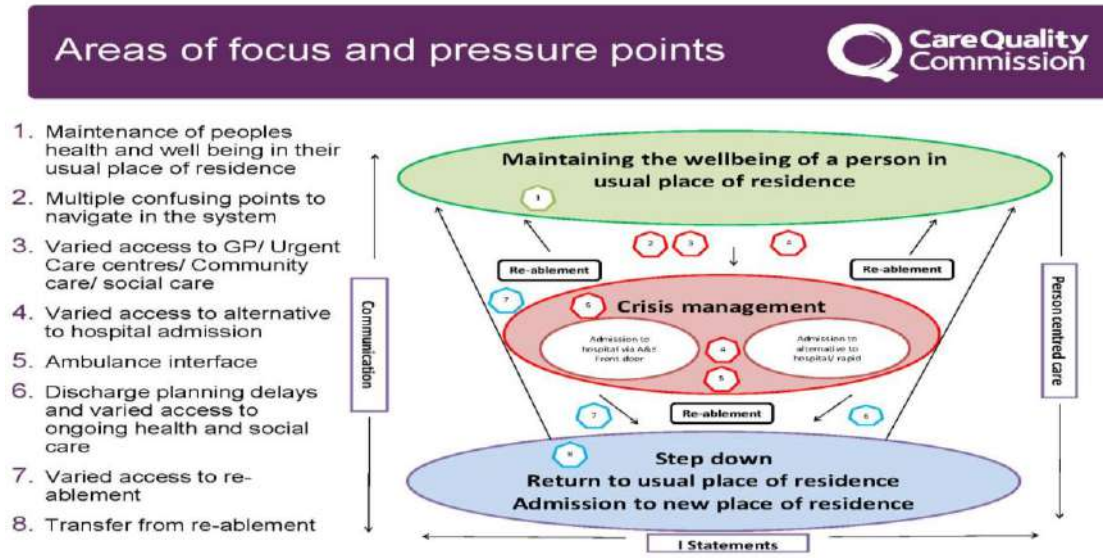
Communities and Local Government asked CQC to carry out a programme of 'system' reviews in a number of local authority areas.

2. The Reviews are designed to find out how services are working together to support and care for people aged 65 and older, using specially developed key lines of enquiry evaluating functioning within and across three key areas: maintaining the wellbeing of a person in their usual place of residence; crisis management; and step-down, return to usual place of residence and/or admission to a new place of residence. For each of these areas the Review will then establish whether services are safe, effective, caring, responsive and well led.

3. Reviews are system wide albeit led by the local authorities. They are not inspections leading to a CQC rating; however the findings are shared at a local summit, are released to the media and are published in a CQC report which is then nationally available.

4. The Review process is scheduled over a 14 week period commencing w/b 12 March. Substantial preparation is required beforehand to ensure that the system is in a state of readiness for the review.





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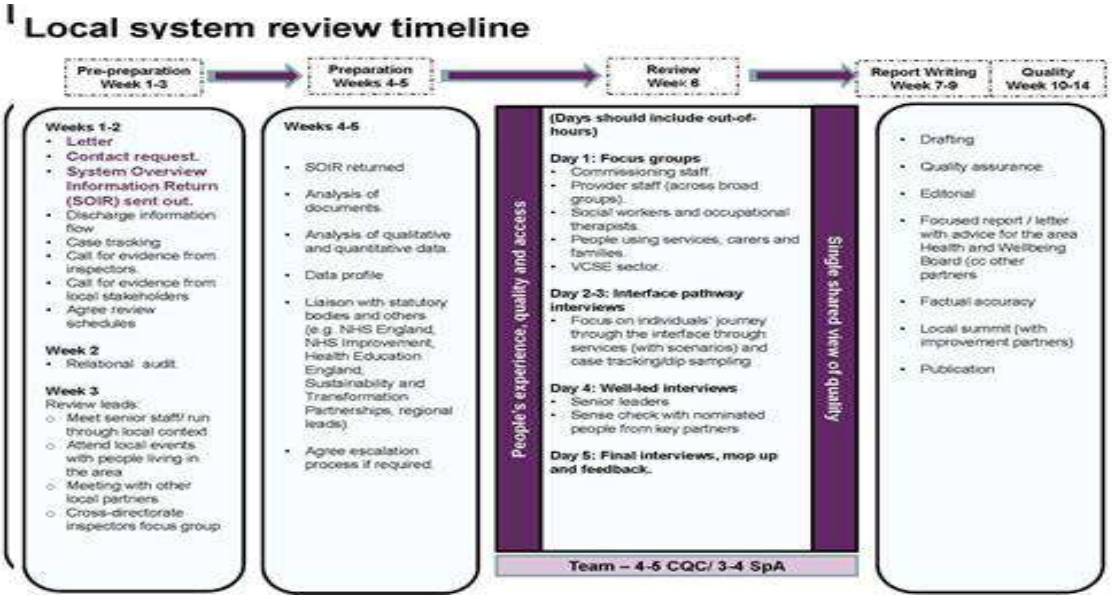


5. Progress with deployment of the Stockport Together Integrated Service Solution (ISS)

1. In order to enable delivery of the whole health economy savings required for 2018/19, the key components of the integrated service solution will need to reach full deployment as described in the business cases (defined as the full mobilisation of the **systems, processes and staffing model**) during Quarter 4 2017/18. The current status of the implementation based on the most recent programme plan is set out in summary in table 1 below:

Fig 1: Deployment Status: Stockport Together (as of 18th Jan 2018)

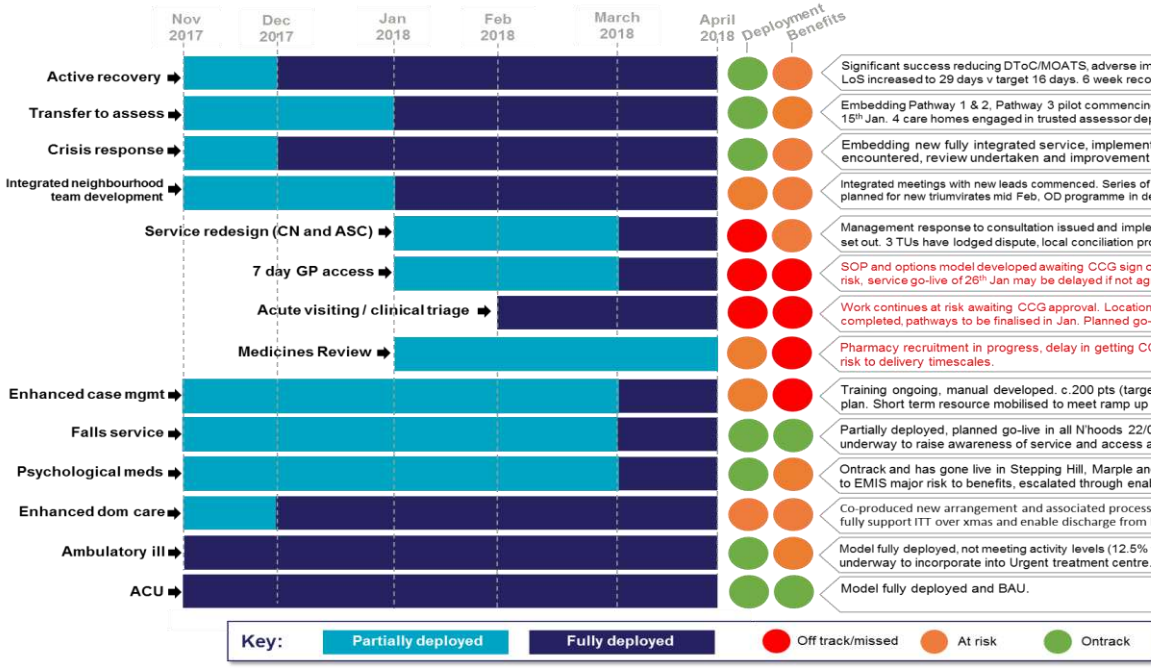
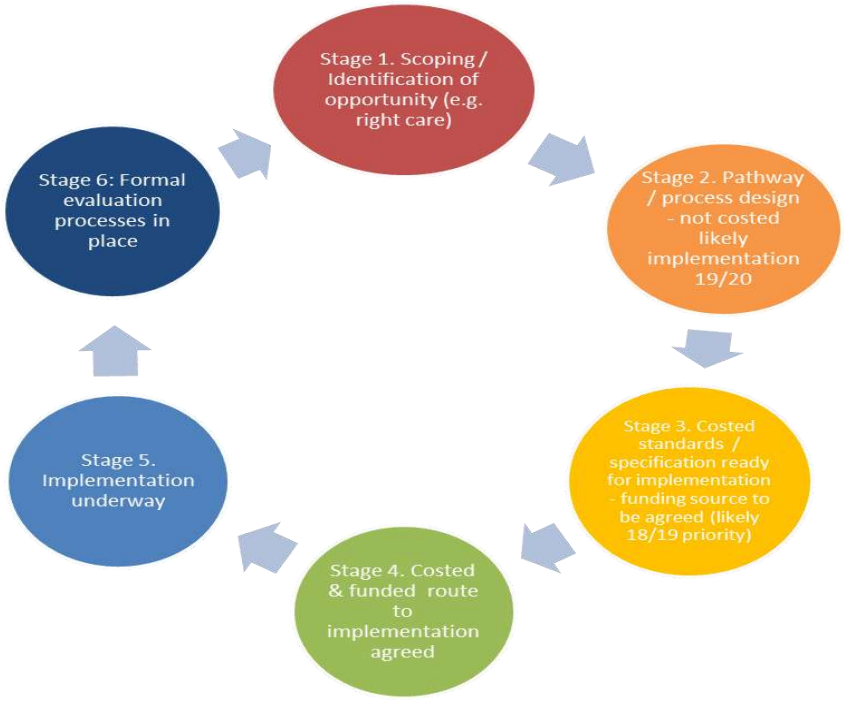


Fig 1, depicts that the ISS (integrated Service Solution) was proposed to be deployed by the beginning of March 2018 based on current plans and assumptions. The key risks to the full deployment of the model currently reside in the progress to date regarding 7 Day GP access, GP Clinical triage and Acute home visiting where Viaduct Care and the CCG are presently engaged in a due diligence and contract negotiation process. Since last reporting a draft contract is in place, with a proposed contract by end Feb 18.

In order to fully understand the associated risks with potential slippage against proposed deployment timescales a maturity assessment is underway (utilising the GM implementation assessment framework (see fig 2) to understand:-

- Scheme deployment as described in the business plan and SNC summary economic business case
- Scheme by scheme slippage timescales
- Scheme by scheme recovery plan to mitigate risk
- Ability to predict full ISS deployment
- Predicted impact upon benefits realisation
- Refresh of enabler support specifications
- Review and potential realignment of transformation investment for 2018/19 against an agreed framework

Fig 2



6. Implementation highlights

Despite some challenges to implementation with some of the work streams there is significant ongoing progress with a number of schemes as described below:-

Core Neighbourhoods:

- **Psychological Support in each of the neighbourhoods –** Stockport is the first economy to have implemented primary care access to psychological support
- **Investment in Allied Health Professional Services:** AHP recruitment commenced
- **Health Champions:** Health Champion's activity continues to grow at Alvanley and Bracondale and Heaton Moor practices. Proposals for further roll-out are in development
- **Social Prescribing and Health Coaching:** Interviews scheduled for February.
- **Find & Prevent:** National Diabetes Prevention Programme is now live in 5 neighbourhoods, ahead of schedule. We now have 59 Healthy Living Pharmacies in Stockport
- **Integrated Transfer team:** The SNC activation centre was launched in December 17 and continued to run throughout January 18 to support winter pressures. Operation is now linked to OPEL escalation processes
- **Frailty Unit** operational under new model of care and referrals increasing
- **Outpatients** implementation board held a planning session on 10th January to assign leads, priorities and develop delivery plans
- **Neighbourhood development** – a detailed plan to deploy the operational plan is in development.

Enablers

- **IM&T: Emis Viewer** – Successfully implemented Emis viewer in the Emergency Department giving full access to GP records at the point of emergency assessment.
- **IM&T: Enhanced Case Management** – the new Goals of Care is now available within Emis Community and CareFirst, and processes are in place to manually upload these into the SHCR to enable sharing.
- **BI**: **Tier 2 Benefits Dashboards –** Completed a draft dashboard showing Tier 2 Benefits. Currently this is reporting on SMBC indicators, and will be widened to include other organisations this month. Data not currently collected for all 25 priority indicators.
- **Estates** - A number of estates changes have been made to accommodate Active recovery, and neighbourhood teams.
- **Workforce: ECM** Training now piloted and rolling out successfully

7. Workforce update

One of the key drivers to deploying the model in full is the recruitment to each of the service lines within the ISS. The status (as at the beginning of February) is described in Fig 3. There has been continued improvement month on month with a 2% increase on last month, with a total fill rate of 6%. Continued focus is given to improve crisis response vacancy position and integrate the team with the primary care acute home visiting service.

Fig 3: Recruitment Mobilisation Fill Rates for Stockport Neighbourhood Care

Service change	18/19. Establishment	Staff in post	Vacancies	Fill rate
Active Recovery	169.7	135.9	32.9	80%
Crisis Response	55.5	35.5	20	64%
ITT	40.8	41.1	-0.3	100%
Neighbourhoods	348.1	291.3	56.8	84%
Total	**613.1**	**503.9**	**109.4**	**82%**

8. Union Dispute

Negotiation with Unison, Unite and The Chartered Society of Physiotherapy continues regarding extension of working hours from 8-8, 7 days per week for neighbourhood team. A collaborative approach between SNC and unions to re-engage with staff is underway. Unions continue to ballot members to strike which is halted until a re convened meeting with Senior SNC leaders and unions in early April 2018. They have specifically requested that a pause to further recruitment takes place until early April, to allow for any agreements made to be taken forward.

9. Benefits Realisation

The CCG continue to lead on the development of a benefits realisation and outcomes framework with a fundamental focus upon

- Financial impact
- Impact upon people
- Impact upon the SNC cohort and at neighbourhood level
- Full programme deployment

The final set will be agreed at the Programme Board in February 2018.

An external evaluation of the Stockport Together Programme has been commissioned and all organisations within SNC have been involved and will continue to contribute to this 18 month process.

10. Recommendation

The Trust Board is asked to note the content of the paper.

Caroline Drysdale
Managing Director
Stockport Neighbourhood Care

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Medical Leadership Development		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR APPROVAL

Corporate objective ref:	C13, 15, 16, 17
Board Assurance Framework ref:	S04, 5, 6
CQC Registration Standards ref:	16,17, 18
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

Following the adverse CQC report of June 2017, concerns were raised that lack of medical engagement and clinical leadership may have contributed to our problems.

In response, we committed to considerable focus upon developing our medical leaders. NHS improvement has provided some financial support.

This paper updates on progress and is presented for information.

Attachments:

Annex A: the new medical leadership structure.
Annex B: Business group objectives.

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 Following the adverse CQC inspection of June 17, feedback from the Greater Mancheser NHSi quality team, was that poor medical engagement and lack of leadership played a considerable part in the decay of our standards.

We agreed that the time was right to re-energise and restructure our medical leadership, with a subsequent focus upon the development and support of our new clinical leaders. NHS improvement provided some funding support.

This paper provides an update on our progress.

2. BACKGROUND

2.1 What is indisputable is that good clinical governance and strong medical leadership go hand in hand. The medicine business group, who bore much of the criticism of the CQC report had grown large, both in patient numbers, ward numbers and staffing numbers. In spite of this growth, the directorate arrangements have shown little change over a number of years. A single Associate Medical Director (AMD) covered the whole of the Emergency Department (ED), acute medicine and specialty medicine. A huge stroke department did not have its own Clincial Director (CD), nor did Gastroenterology or Cardiology, both also big departments. In the surgical directorate, Anaesthetics had grown to 32 consultants, under a single clinical director. In each of these cases, the clinical leaders were doing a heroic job in keeping services running but maintaining tight clinical governance across all clinical areas had proven challenging.

2.2 **Restructure**

Our goal in our medical restructure was to ensure an even distribution of medical leadership resource, such that each directorate would have a breadth and scope that is 'manageable'. Every consultant would have a clinical director to whom they are accountable, and every CD would manage a 'reasonable' number of consultants.

In August 2017, existing Clinical Directors and Associate Medical directors (with the exception of those recently appointed) were served notice that their roles would be re-advertised. They were free to apply for roles within the new structure.

A number of key changes were made (see annex A for the structure);

2.3 **The Associate Medical Director for Stockport Hospital Care** was a new role. The post holder, Dr Krishnamoorthy will not have direct line management of any consultants, nor a business group to manage. He will focus his time on development of key trust agendas, such as the rationalisation of medical workforce, 7 day working and the integration with Stockport Neighbourhood care. This post is the hospital equivalent to the Medical Director of Stockport Neighbourhood care (Dr Metha).

2.4 **A new Associate Medical Director post.** This new AMD post aligned with the division of the (enormous) medicine business group into two. Integrated care is now managed by Dr Bonnici, and Medicine and Clinical Support by Dr Kong.

2.5 **Four new Clinical Directors.** Stroke (Dr Meadipundi), Cardiology (Dr Lewis), Gastroenterology (Dr Jafar) and ICU (Dr Thomas) had all grown considerably without recognition in the leadership structure. The introduction of these CD posts greatly improved the 'spans and layers' (a KPMG term – suggesting staff be managed in chunks of a reasonable size) of our medical leadership structure. The new structure ensures that each Clinical Director manages between 7 and 20 consultants.

2.6 Job descriptions, the HR process and funding was agreed, and the new posts put out to advert in September 2017. Competitive interviews saw appointments to all posts in October and November 2017, with the new appointees in post by January 2018.

Of our new CD's 11/17 are new to the role.

Of our new AMD's 3 / 4 are new to the role.

The new structure, and appointees is represented in annex

3. DEVELOPMENT

3.1 Clinical director development program.

Two full days of development were arranged for our new leaders (31st Jan, 7th Feb), with almost full attendance at both events. The events were extremely well facilitated by Tina Harkin (Head of learning and OD). Key areas covered in the training included;

- Personal resilience
- Holding courageous conversations
- Coaching as a leader
- Leading with compassion
- Case studies and scenario teaching
- Use of policies and procedures
- Pragmatic tool box teaching

Feedback was extremely positive, as was engagement and 'energy' during the training. The mood amongst the new leaders was a mixture of terror and excitement, but the atmosphere was extremely collegiate with real positivity and the collective team spirit was conspicuous.

3.2 CD Forum

We will be building on the development work with monthly half day meetings at the CD forum. These sessions will further build upon the existing development, but will also include cascade and discussion of trust developments.

3.3 Clarity of purpose.

In our appraisal of our existing approach to leadership, we recognised a lack of clarity about

our expectations for our clinical leaders and a history of inadequate feedback about good and bad performance. This environment was ripe for some clinical leaders to drift ever further (unchallenged) from delivery of the role required of them.

We do not want to repeat this mistake, and plan to be clear in our expections, and consistent in the frequency and candour of our (constructive) feedback.

We have developed some explicit directorate objectives which will be the shared responsibility of the directorate (CD's, matrons and business managers), and an equivalent list for the business group leadership (AMD's, AND's and directors). The business group objectives are included in Annex B. These are intended as self assessment check list, and as an aide memoir to facilitate performance review and 1:1 discussions.

3.4 **Feedback.**

The goal of this strategy is to be clear in our expectations and explicit in our appraisal of performance such that our leaders cannot drift unchallenged from the agenda we need them to pursue.

All AMDs will meet with the Medical Director for regular 1:1 meetings.

All AMDs will ensure regular 1:1's with their CD's.

All CD's will ensure at least annual 1:1 meetings with each of their consultants.

3.5 **AQuA focused quality improvement training**

In addition to developing our clinical leaders, it was recognised that we need to improve 'clinical engagement' across the organisation. This will be achieved in part with an improved representation delivered by the leadership structure. We also wish to 'draw in' other senior clinical staff to lead on improvement projects.

The Advancing Quality Alliance offer bespoke training in quality improvement methodology. We aim to use this to deliver three key goals.

- To develop a consistent quality improvement methodology for the organisation
- To engage and develop some key leaders in quality improvement methodology
- To initiate some critical projects.

Key to this program will be three cohorts of project leaders, each receiving three days of focused training directed at their designated projects. Cohort one will have training days in April, May and June. Cohort 2 will run in autumn and cohort three in spring 18.

Cohort 1 will include the following projects.

	Project	Leads			Summary
1	Palliative care	Dave Waterman	Jo Keys		Improved end of life planning across the health economy
2	# NOF optimisation	Alejanro Gomez	Simon Ghalayini	Anjali Prasad	Best practice tariff Reducing length of stay.
3	IV in the	Kathy	Stephanie		Increasing numbers of patients

	community	Herne	Kerfoot		receiving iv in the community.
4	Senior medical staffing in specialty medicine wards	Richard Bell	Janine Cartner		Agreeing what rationalised staffing each ward requires, and how to audit against the standard.
5	Discharge planning	Jane Carpenter	Suman Appukuttan		Optimising our discharge planning process
6	Ward round checklist	Peter Ngoma	Paul Henfrey		Development of minimum standards for ward round documentations
7	Mortality	Anthony McCluskey	Governance rep to be agreed		Development of the trust mortality process
8	Managing the deteriorating patient	Matt Jackson	Sarah Ingleby	Sri Meadipundi	Reviewing our use of EWS and how we monitor and escalate deteriorating patients.

3.6 **AQUA one day introduction sessions**

In addition to the three day focused Quality Improvement training, we aspire to introduce the standardised quality improvement methodology into our wider approach to clinical improvement. Aqua will deliver three one day 'introductory' sessions into their standardised methodology. We plan to recruit as many of our senior clinical leaders, managers, and trust board members to attend this training. Dates will be circulated shortly.

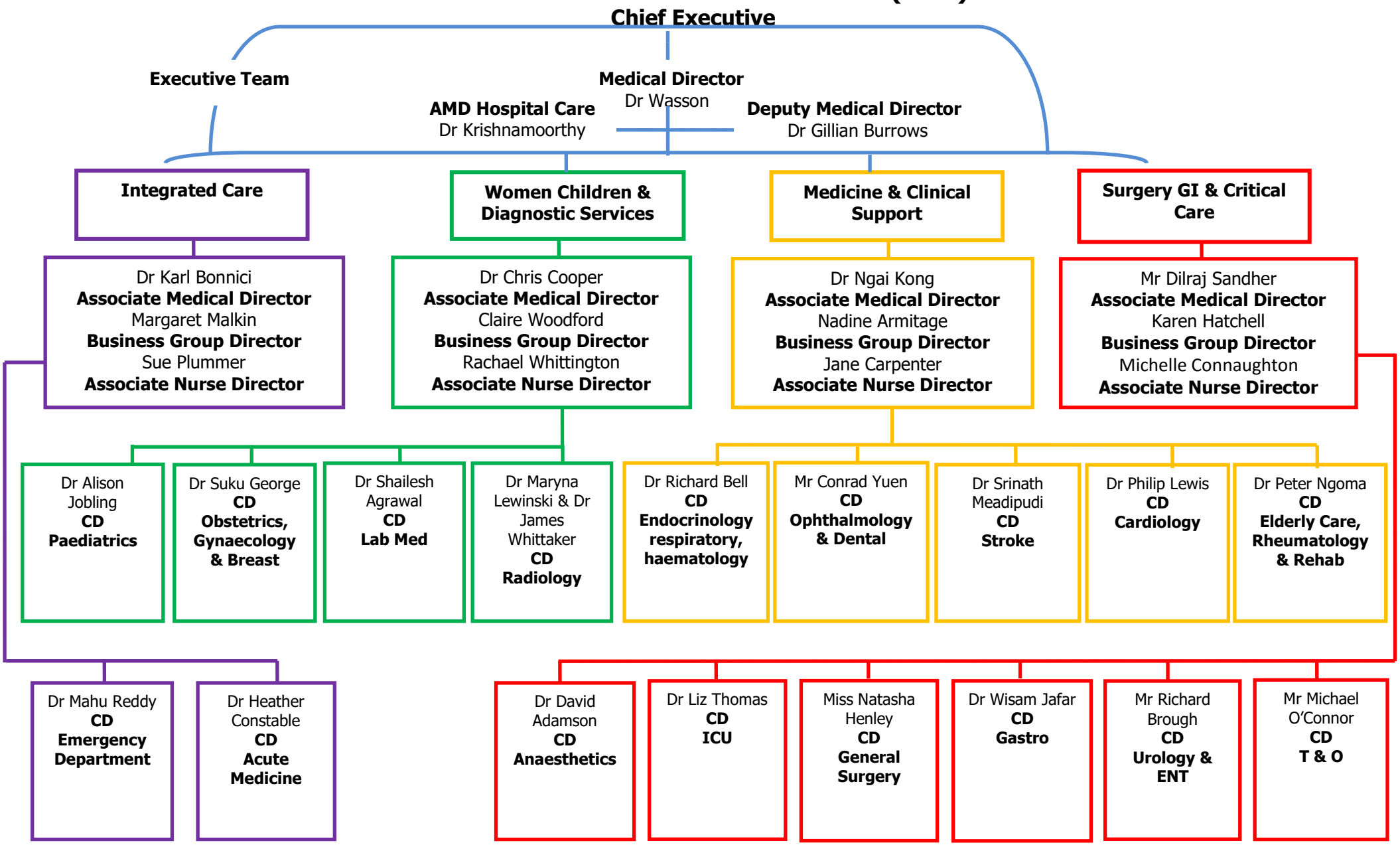
4. CONCLUSION

4.1 In the past six months we have reorganised our medical leadership structure, re-appointed new clinical leaders, and initiated a training program to facilitate their development. Our next phase of training will focus upon the development of a consistent quality improvement methodology, and a launch of some key quality improvement initiatives.

5. RECOMMENDATIONS

5.1 The Board is asked to note the work undertaken, to endorse the appointment and development of our new clinical leaders and the structure within which they are managed, and of the introduction of a consistent quality improvement methodology.

MEDICAL LEADERSHIP STRUCTURE – (New)



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Directorate objectives - 'score card'	
Ward accreditation sign off.	Ward accreditation levels on directorate wards.
Directorate medical meeting, frequency, attendance record and outputs.	AMD allocated RAG rating
Directorate nursing meeting, frequency, attendance record and outputs.	AND allocated RAG rating
Directorate representation at trust meetings	AMD / AND allocated RAG rating
SI investigations not validated within 55 days	Number
Validated SI investigations with unresolved actions 3 months after validation.	Number
Outstanding DATIX reports > 2/52 after reporting.	Number
Complaints not answered within deadline.	Number
Learning cascade from complaints, critical incidents and serious incidents.	AMD / AND allocated RAG rating
Multi-disciplinary morbidity and mortality meetings, documentation and register of attends	AMD/ AND allocated RAG rating
Multi-disciplinary mortality review process and evidence of learning cascade	Trust mortality lead allocated RAG rating.
Effective multidisciplinary use of audit and governance sessions	AMD/ AND allocated RAG rating
Clinical audits without assurance sign off.	Number
Medical appraisals within 12 month deadline.	Number currently breeching 12 months.
Non medical appraisal rate	%
Clinical correspondence published within 7 days	%
HCR within 48 hours	%
Mandatory training rate	% of medical staff 100% compliance.
Job planning	% sign off.
Proportion of consultants over 12 PA's	%
Progress against 7 day working standards	RAG by AMD/AND
Locum, agency and waiting list, and outsourcing expenditure as a percentage of workforce costs	% of medical workforce costs
Unfilled substantive posts	% establishment
GMC trainee questionnaire feedback RAG rating	GMC score against trust and peer mean
Exception reporting response	RAG by Guardian of safe working
Financial position against budget	Surplus / deficit
Financial position against patient level costings	Surplus / deficit.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	The Bawa-Garba case – implications for staff, candour, transparency and reflection.		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR APPROVAL

Corporate objective ref:	C16 C17
Board Assurance Framework ref:	S04
CQC Registration Standards ref:	9,10,12,16,17
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

On 25th January, Hadiza Bawa-Garba, was struck off the UK medical register following judgement by the High Court. The case has been widely reported in the mainstream and medical press.

The death of a child under Dr Bawa-Garbas care in Leicester Royal Infirmary was tragic. Her subsequent prosecution and striking from the medical register have sent ripples of fear through the NHS clinical community.

Of particular concern was the use of personal reflections submitted after the events in the case against her, and the failure to recognise the challenging, understaffed environment as mitigation in a doctor of previously regarded as 'above average'.

The board is asked to consider the case, and how we as a board, might best allay the anxieties of our clinical teams, and maintain a climate conducive to candour, transparency, reflective practice, and continued reporting and learning from errors.

Attachments:

This subject has previously been reported to:

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

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1. INTRODUCTION

1.1 On 25th January, Hadiza Bawa-Garba, was struck off the UK medical register following judgement by the High Court. The case has been widely reported in the mainstream and medical press.

2. BACKGROUND

2.1 Hadiza Bawa-Garba had returned to Leicester Royal Infirmary, after 13 months of maternity leave. On her first day back to work, and without a trust induction, she was asked to cover the Childrens Assessment Unit (CAU), as well as her own ward duties. A Foundation Doctor and Senior House Officer were both working under her, but each had only rotated into paediatrics that month. The consultant covering the ward was teaching elsewhere. The hospitals IT facilities had broken down, and there were nursing staff shortages.

A series of serious clinical misjudgments by Dr Bawa-Garba resulted in the death of a 6 year old boy form sepsis.

In December 2015, Dr Bawa Garba was convicted of manslaughter and given a suspended sentence.

In June 2017, a medical practitioners tribunal suspended Dr Bawa- Garba for 12 months rather than strike her off the register. The basis for the decision was that multiple system failures (outlined in the serious incident investigation) contributed to the death of this child. They felt that 'given the context within which she was working, it would be disproportionate to strike her from the register'.

The GMC contested this decision, taking the case to the high court.

One important piece of evidence widely reported to be included in the court papers was the personal reflections of Dr Bawa-Garba on how she could better have managed the case. On closer inspection, it appears that these reflections were included as attachments to the evidence submitted by one of her consultants, and were not considered by the jury. None the less, the use of personal reflections in the case against her has been widely reported.

In the high court ruling last month, the judge over rules the tribunal decision, describing her failings as

'truly exceptionally bad',

He acknowledged that 'before and after the tragic events (she) was a competent, above average doctor', but that,

'the holes in the patients safety net cannot reduce her personal culpability', 'the behavior was fundamentally incompatible with being a doctor.

Hadiza Bawa-Garba was struck from the medical register.

3. CURRENT SITUATION

3.1 The concerns arising from this case include;

- Staff can and do occasionally find themselves working in sub-optimal circumstances, associated with increased clinical risks. That such conditions will not be considered mitigation should they make an error is making many staff extremely anxious. The implication of the ruling is that they are wholly responsible for the situation that they find themselves in.

- In the face of sub-optimal safety or staffing, staff members cannot leave, but if they stay, they fear being held personally accountable for any adverse outcomes.

- Transparency, candour and reflective practice are critical to our ongoing learning. These may be seen by some, as increasing the personal risk of being held accountable for any errors that they make.

The GMC has issued guidance for doctors working in what they think are unsafe conditions;

- Inform your consultant, and notify your hospital
- Write your concerns down to show you have insight
- Remember that walking out makes int worse for your colleagues, and more unsafe for patients.

Jeremy Hunt has made the following observations

'deeply concerned about possibly unintended implications here for learning and reflective practice in e-journals'

'for patients to be safe, we need doctors to be able to reflect completely openly and freely about what they have done and to learn from mistakes'

Wendy Reid, the Medical Director of Health Education England, said;

'it is vital that trainees feel comfortable discussing and recording their thoughts and reflections on patient care and crucial that they feel they can do this as part of a safe, supportive learning environment.'

NHS England, in a letter to responsible officers recognised that

'reflection as an essential aspect of continuing professional development, and helps to underpin quality and safety of patient care. Indeed a doctors professionalism can potentially be called into question by their facility to demonstrate adequate reflective insight. The overall value of reflection is strongly positive for the doctor, the system, and foremost the patients'.

'Healthcare workers work in challenging roles, often under pressure in difficult situations. We all have a duty to make our care high quality, safe and compassionate. Honest and open

reflection is a key instrument to this end, helping to underpin public confidence in our work.'

Don Berwick, in his mid Staffs report said;

'Fear is toxic to both safety and improvement, and health systems must abandon blame as a tool'.

4. RISK & ASSURANCE

4.1 Dr Wasson, our Medical Director met with all new doctors beginning in February to discuss the Bawa-Garba case, and to endorse the doctors role as a patient advocate. He recognised that clinical errors can and do occur, and strongly endorsed finding the courage to maintain transparency and reflection in the face of any clinical errors that occur. Honesty, candour and putting patients best interests first, are our greatest protection when things go wrong.

There was considerable anxiety evident during the presentation.

5. CONCLUSION

5.1 The difficult clinical context of this case is particularly critical for staff working in our most challenging environments, such as the emergency department and acute medical wards.

The impact of the personal reflections as evidence of poor practice in this case have been overstated, but the damage done by this has been considerable. It may serve as a disincentive to reporting incidents, transparency and reflective practice.

6. RECOMMENDATIONS

6.1 Consideration should be given to communicating a summary position to all our clinical staff. We might hope to reinforce our support for them, recognise the difficult circumstances in which some staff can find themselves, but ultimately reinforce that the greatest protection in the face of errors, is gained from putting the patient's best interests first, from openness, candour and facilitating the learning from mistakes.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Safe Staffing Report		
Report of:	Chief Nurse	**Prepared by:**	Corporate Lead Nurse Workforce

REPORT FOR INFORMATION

Corporate objective ref:	-----	Summary of Report This report provides an overview of Registered Nurse (RN) and Registered Midwife (RM) staffing levels for the month of January 2018. Key points of note are as follows : RN and RM staffing vacancies across the Trust equates to 167 whole time equivalents. Average fill rates for Registered staff, including RN and RM and non-registered care staff remains above 90% for both day and night duty 5 medical wards (A11, B4, A15, C4, E1), 3 surgical / gastroenterology wards (A1, D2, D1), 2 areas in child and family (neo-nates and the Birth Centre) report below 90% registered staff in the month. Temporary staff, both agency and NHS Professionals, have been utilised in the clinical areas to support safe staffing levels. The Board of Directors are asked to note the contents of this report.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	Safe staffing	
Equality Impact Assessment:	☐ Completed ☐ Not required	

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

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1.0 INTRODUCTION

1.1 As part of the ongoing monitoring of staffing levels, this paper presents to the Board of Directors a staffing report of actual staff in place compared to staffing that was planned, for the month of January 2018

The Board of Directors is asked to note the contents of this report.

2.0 BACKGROUND

2.1 NHS England is not currently RAG (Red, Amber and Green) rating fill rates. A review of local organisations shows that fill rates of 90% and over, are adopted with exception reports provided for those areas falling under this level.

January 2018	DAY	NIGHT
RN/RM Average Fill Rate	91.20%	94.20%
Care Staff Average Fill Rate	99.30%	109.3%

3.0 CURRENT SITUATION

3.1 **RN/ RM vacancies (this includes all Registered RN RM staff band 5 upwards)**

Medicine and clinical support reports 73.39 WTE RN vacancies
Integrated Care reports 63.33 WTE RN vacancies
Surgery, Gastro, Critical care reports 07.90 WTE RN vacancies
Women, Children and Diagnostics reports 10.67 WTE RN/RM vacancies
Corporate Services reports 11.61 WTE RN vacancies

3.2 **Temporary Staffing January 2018**

Temporary staffing has been broken down into business groups to enable the board to have clarity as regards percentages utilised. In previous months there has been a focus on the Emergency Department temporary staffing. This month they reported 17% at RN grade and 13% non-registered care staff.

Business Group	RN	CARE STAFF
Medicine and Clinical support	18%	20%
Women Children and Diagnostics	2%	4%
Surgical & Critical Care and Gastro	8%	15%
Integrated Care	16%	15%

3.3 **Recruitment**

Local recruitment campaigns continue with monthly weekend recruitment open days for RNs. Event bright, Facebook, Instagram and twitter campaigns are also ongoing. NHS Jobs open day adverts are placed continuously on a rolling basis. The central recruitment open day in January generated 22 offers which was above average. The Trust attended its first student open day at Keele University which generated significant interest and subsequent attendance from prospective candidates at our open morning event the following week, confirming the strategy to recruit further afield is robust.

3.4 **Retention**

The Trust has joined Cohort 2 of the NHSi (NHS Improvement) retention support program.

The NHSi team visited in January and our formal plan has now been submitted. The four workstreams proposed have been launched. These are the graduate nurse / student nurse programme, review of over 50's opportunities, career crossroads plan (known as Itchy Feet campaign) and a deep dive into the top 10 highest turnover areas.

The focus on retention of future newly qualified nurses that have received a job offer launched in December 2017 continues to be well supported with 25 students attending our January 18 keeping in touch event.

Work has commenced planning a new Graduate Nurse programme to support newly qualified staff that has already joined the Trust through their transition to practice. The first engagement event has taken place with very positive feedback and the first workstream meeting held.

A plan to fund 20 band 5 staff nurses to band 6 to improve retention was approved with interviews planned for the 10th February 2018. All but 2 wards were recruited to at an extremely successful event.

Funding has been secured to recruit a full time E Roster clinical support lead (band 6) to assist with the roll out of safe care and to support ward managers with effective rostering, all with the aim to continue to support the wards to safe staff . The advert will go out in February 18.

4.0 Care hours per patient day (CHPPD)

4:1 January 2018 report also includes information relating to care hours per patient day (CHPPD). This is the staffing metric advised by the Carter review which aims to allow comparison between organisations to a greater extent than previously, whilst noting that location specific services (specialty centres for example) will influence the final measure.

The CHPPD calculates the total amount of Nursing (RN and Care staff) available during a month, and divides this by the number of patients present on the in-patient areas at midnight. This gives an overall average for the daily care hours available per patient (all nursing and midwifery staff). During the Carter pilot stages, 25 trusts were included and their results showed CHPPD range from 6.3 to 15.48 CHPPD and a median of 9.13. For December 2017 our report shows an average CHPPD of 7.2

5.0 RISK & ASSURANCE

5.1 Safe staffing levels have been challenged by the levels of RN and RM vacancies at band 5, however it is noted that overall figures have reduced, and the numbers of vacant band 5 to 167 WTE this month from 187 WTE last month. A reliance on temporary staffing has been required to support wards and departments safe staffing.

5.2 The acuity audit has been completed. 8 areas(A1, D6, Bluebell, E2, E3, A12, B6, A10), report 'red' scores which equates to an overall acuity rating indicating established staffing numbers need to be reviewed. The Chief Nurse and departmental Associate Nurse Directors are reviewing the information in their February staffing one to one meetings with ward managers. Two wards (B4 and C4) are being redone to check the accuracy in relation to level 2 patients. A11 was not undertaken in December and is being redone in February.

5.3 The Chief Nurse and Associate Nurse Directors have implemented ward staffing guidelines along with an escalation in extremis policy with clear guidance as regards safe staffing levels. This will be presented to the People and Performance Committee in February 2018.

Daily safety huddles (Monday – Friday) are robustly attended chaired by the Chief Nurse, to provide assurance as regards staffing levels.

6.0 CONCLUSION

6.1 Staffing levels have been maintained above an overall average of 90% with a number of areas reporting less than 90% staffing levels at RN/ RM, supported by temporary workers

and non-registered care staff.

7.0 RECOMMENDATIONS

7.1 The Board of Directors is asked to note the contents of this report

Appendix A– Unify entry

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RWJ - Stockport NHS Foundation Trust

Period: January_2017-18

Please provide the URL to the page on your trust website where your staffing information is available

www.stockport.nhs.uk/112/safe-staffing

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day		Night		Care Hours Per Patient Per Day (CHPPD)				
Site code	Hospital Site Name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Head of Nursing Comment
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU	300 - GENERAL MEDICINE		4092	3775	3348	3281	3720	3316	3069	3399	88.0%	103.9%	87.1%	112.6%	1680	4.8	4.8	9.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Clinical Decisions Unit	300 - GENERAL MEDICINE	180 - ACCIDENT & EMERGENCY	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	177	5.2	5.2	10.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Olders People's Unit	430 - GERIATRIC MEDICINE		1162.5	1050	790.5	640.5	660	649	682	671	95.3%	96.1%	98.3%	100.0%	476	2.8	2.3	5.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A3	320 - CARDIOLOGY		1423	1288	976.5	939	1023	759	682	682	97.8%	92.9%	92.2%	96.7%	692	3.2	2.2	5.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		2790	2212.5	2046	1954.5	2046	2046	1364	1342	93.6%	112.7%	100.0%	125.0%	816	6.1	5.3	11.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	430 - GERIATRIC MEDICINE		1581	1083	1627.5	1693.5	682	370	682	658	74.1%	123.7%	45.5%	154.5%	822	1.6	3.3	4.9	Sub optimal staffing . Always 2 Registered Nurses on duty . Close review by Matrons to assure safety
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		1906.5	1760	1441.5	1471.5	682	682	682	922	98.8%	100.0%	100.0%	110.9%	790	3.4	3.0	6.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	300 - GENERAL MEDICINE		1209	766.5	604.5	874.5	682	671	682	639.25	67.9%	149.2%	100.0%	100.0%	472	3.3	3.4	6.7	Sub optimal day duty . Always 2 Registered Nurses on Duty. Close review by Matrons to support safe staffing .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		837	628.5	837	652.5	682	638	682	737	98.3%	104.0%	100.0%	105.0%	708	3.5	3.7	7.2	Sub optimal day duty . Always 2 Registered Nurses on Duty. Close review by Matrons to support safe staffing . Ward has been moved to larger ward A15 to support winter escalation beds , staffing results need to take account of this .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	300 - GENERAL MEDICINE		1209	1201.5	1069.5	1075.5	682	682	682	693	100.0%	100.0%	100.0%	100.0%	702	3.0	2.8	5.8	
RWJ09	THE MEADOWS - RWJ88	Bluebell Ward	318- INTERMEDIATE CARE		1209	1209	2077	1897	682	682	682	671	100.0%	81.7%	100.0%	100.0%	763	2.6	3.3	5.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	300 - GENERAL MEDICINE		1209	966	604.5	887	682	704	682	660	84.6%	148.2%	100.0%	98.5%	454	3.7	3.4	7.1	Sub optimal day duty . Always 2 Registered Nurses on Duty. Close review by Matrons to support safe staffing .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Coronary Care Unit	320 - CARDIOLOGY		837	833	465	434.75	682	671	341	352	117.9%	86.0%	135.0%	110.0%	178	11.3	4.6	15.8	
RWJ09	CHERRY TREE HOSPITAL - RWJ03	Devonshire Centre for Neuro-Rehabilitation	314 - REHABILITATION		1069.5	1063.5	1999.5	1837.5	682	660	682	693	98.1%	95.3%	100.0%	150.0%	435	3.2	5.4	8.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		1951.5	1696.5	2309.5	2077	1023	770	1023	1023	90.1%	97.7%	90.0%	100.0%	948	2.8	3.4	6.2	Sub optimal day duty . Always 2 Registered Nurses on Duty. Close review by Matrons to support safe staffing .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2278.5	2199.5	1581	1921	1023	1004	1023	1353	100.0%	124.1%	97.8%	133.3%	1022	3.2	3.3	6.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2278.5	2217	1581	1911	1023	979	1023	1353	98.9%	127.8%	98.9%	168.9%	1056	3.1	3.5	6.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4464	4440	775	763	4123	4056.75	0	0	99.4%	95.2%	99.1%	na	349	26.0	2.3	28.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Surgical Unit	100 - GENERAL SURGERY	101 - UROLOGY	1894.5	1723.5	771	702	891	847	594	594	91.2%	93.1%	98.7%	98.1%	650	4.1	2.1	6.2	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A1	300 - GENERAL MEDICINE		1441.5	1105.5	1209	1177.5	1023	1133	1023	1298	94.6%	96.2%	96.7%	100.0%	980	2.9	2.7	5.7	A1 staffing suboptimal day duty for Registered Nurses , additional beds opened throughout Jan. Assurance given to ensure ward was safe by Matrons undertaking daily staffing reviews and moving staff to support. Unregistered additional staff to cover 1-1 and additional beds
RWJ09	STEPPING HILL HOSPITAL - RWJ09	O6	101 - UROLOGY		837	993	976.5	969.5	682	671	682	902	100.0%	97.5%	100.0%	100.0%	678	3.2	3.4	6.6	Increased Registered Nurses on shift to support escalation beds x 7 open .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1581	1368	1348.5	1363.5	682	693	1023	1067	88.2%	100.8%	100.0%	100.0%	708	3.2	3.6	6.8	Safety assured by Matrons during the week, due to sickness and vacancy, no shift covered with less than 2 Registered Nnurses . Staff moved to support where required.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1143	1003.5	976.5	904.5	682	715	594	561	91.0%	99.6%	100.0%	100.0%	429	3.3	3.0	6.4	Safe staffing assured on ward as a result of ring fenced beds. All shifts had minimum of 2 Registered Nurses on shift
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B3	110 - TRAUMA & ORTHOPAEDICS		837	859	976.5	1071	682	693	495	594	97.8%	103.8%	100.0%	111.6%	481	3.5	3.6	7.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D6	100 - GENERAL SURGERY		1209	1096	1209	1092	682	858	682	891	100.5%	108.2%	103.3%	138.3%	790	2.8	3.2	6.0	Sub optimal staffing during the day affected by increased escalation capacity requiring an additional 1Registered Nurse and 1 Unregistered care worker per shift. All shifts minimum of 2 Registered Nurses , safety assured by Matrons daily review and staff being moved from other wards to support. Nights additional staffing to support 1-1 patients and escalation.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		1567.5	1597.5	1674	1636.5	682	539	1023	1254	83.0%	125.4%	93.3%	148.9%	798	2.7	5.1	7.8	Safety assured by Matrons daily reviews not shifts with less than 2 RNs. M4 have been impacted by 3rd RN being moved to support other wards usually with backfill with an unregistered nurse.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SAU	100 - GENERAL SURGERY	101 - UROLOGY	1813.5	1705.5	976.5	880.5	1023	957	682	660	97.9%	100.0%	98.9%	100.0%	438	6.9	4.1	11.0	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Neonatal Unit	420 - PAEDIATRICS		2325	1905	0	0	1627.5	1333.5	0	0	79.3%	na	79.3%	na	282	8.5	0.0	8.5	Staffing deficit due to long term sickness and 1.92 whole time equivalent clinical vacancies. Staffing is reviewed daily by the Clinical Manager in order to maintain safety.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Tree House	420 - PAEDIATRICS		3255	3075	465	465	2170	1994	0	0	92.4%	100.0%	91.1%	na	585	6.0	0.6	6.6	
RWJ03	STEPPING HILL HOSPITAL - RWJ09	Jasmine Ward	502 - GYNAECOLOGY		930	922.5	465	465	620	620	0	0	100.0%	100.0%	100.0%	na	232	7.7	2.3	9.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Birth Centre	560- MIDWIFE LED CARE	501 - OBSTETRICS	930	765	465	420	620	500	310	300	91.3%	100.0%	87.5%	96.7%	44	54.9	15.1	70.1	Staffing deficit due to 2.6wte long term sickness and Registered Midwife staffing vacancies. Staff recruited and awaiting start date. Staffing reviewed by Inpateint Matron daily and staffing redeployed when necessary to provide safe cover at all times.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Delivery Suite	501 - OBSTETRICS		2790	2662.5	465	435	1860	1730	310	300	98.1%	91.7%	95.6%	70.0%	202	23.0	3.3	26.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Maternity 2	501 - OBSTETRICS	560- MIDWIFE LED CARE	1627.5	1605	930	877.5	620	620	310	230	98.6%	100.0%	100.0%	100.0%	414	4.4	2.4	6.8	
		Total			56060.5	51148	37413	37142.25	35666.5	33584.25	22732	24840.25	91.2%	99.3%	94.2%	109.3%	20251	4.2	3.1	7.2	

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	New Strategic and Corporate Objectives 1 April 2018 to 31 March 2019		
Report of:	Interim Chief Executive	**Prepared by:**	Andrea Gaukroger, Director of Strategy and Planning

REPORT FOR APPROVAL

Corporate objective ref:	Master
Board Assurance Framework ref:	New
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

The attached document details the new strategic and corporate objectives for the next financial year. These objectives will be underpinned by operational objectives to be developed at a 'local' business group and corporate department level.

Further refinement, additions or edits may be required throughout the year ahead dependent on strategic developments. Measures of success and deadlines will be added once the objectives have been agreed.

Progress against the strategic and corporate objectives will be reported on a quarterly to the Board of Directors. The Chief Executive will be the sponsor of the item.

Board members are recommended to;

- Approve the new strategic and corporate objectives 1 April 2018 to 31 March 2019

Attachments:	New strategic and corporate objectives 1 April 2018 to 31 March 2019

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

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1. INTRODUCTION

1.1 The purpose of this report is to consider and approve the new strategic and corporate objectives for 1 April 2018 to 31 March 2019.

2. BACKGROUND

2.1 The strategic and corporate objectives have been developed in conjunction with Executive Directors and were discussed at the Executive Management Group 20 February 2018.

2.2 The Interim Chief Executive is the sponsor of the item.

3. CURRENT SITUATION

3.1 The attached document details the new strategic and corporate objectives for the next financial year. These objectives will be underpinned by operational objectives to be developed at a 'local' business group and corporate department level. These in turn are expected to enable the individual objective setting cycle.

3.2 The new strategic and corporate objectives will be included in the strategy outline document which is currently under development.

3.3 Further refinement, additions or edits may be required throughout the year ahead dependent on strategic developments. Measures of success and deadlines will be added once the objectives have been agreed.

3.4 Progress against the strategic and corporate objectives will be reported on a quarterly basis.

4. RISK & ASSURANCE

4.1 The Board Assurance Framework will be revised in due course to take into account the new strategic and corporate objectives.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the new strategic and corporate objectives 1 April 2018 to 31 March 2019

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Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

Your Health. Our Priority.
Vision statement: currently under review
Trust Priorities: currently under review

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**
Strategic Objective 1	**To achieve full implementation and delivery of the Trust's Refreshed Strategy 2018/22**	**Chief Executive**	
Corporate Objective 1a	To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy	Director of Support Services	Finance and Performance Committee
Corporate Objective 1b	To lead the annual operational planning cycle in line with NHSI guidance	Director of Support Services	Finance and Performance Committee
Strategic Objective 2	**To deliver outstanding clinical quality and patient experience**	**Chief Executive**	
Corporate Objective 2a	To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee
Corporate Objective 2b	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

Your Health. Our Priority.
Vision statement: currently under review
Trust Priorities: currently under review

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	Executive Director accountable	Assurance obtained from subcommittee:
Strategic Objective 3	**To strive to achieve financial sustainability**	**Chief Executive**	
Corporate Objective 3a	To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee
Corporate Objective 3b	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee
Corporate Objective 3c	To review and monitor a revised performance management framework	Director of Support Services	Finance and Performance Committee
Strategic Objective 4	**To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including;** **a. Stockport Together/ Stockport Neighbourhood Care/ Integrated Service Solution** **b. Healthier Together** **c. Theme 3 & 4 Programmes (GM Health & Social Care Partnership)**	**Chief Executive**	
Corporate Objective 4a	i. To implement the new integrated service solution model of care working with our key partners ii. To realise the financial and non-financial benefits of the Stockport together business cases iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate	Director of Stockport Neighbourhood Care	Provider Board

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

Your Health. Our Priority.
Vision statement: currently under review
Trust Priorities: currently under review

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**
Corporate Objective 4b	To progress with planning for the realisation of the Healthier Together decision in line with GM defined timescales and investment	Director of Support Services	Finance and Performance Committee
Corporate Objective 4c	To progress work streams relating to a)Theme 3 and b) Theme 4 in line with the GM Transformation Strategy	Director of Support Services/ Chief Operating Officer	Finance and Performance Committee
Strategic Objective 5	**To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements (non-financial)**	**Chief Executive**	
Corporate Objective 5a	The Trust will complete an independently assessed Well Led Review by 30 September 2018	Director of Corporate Affairs	Audit Committee
Corporate Objective 5b	The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018	Chief Operating Officer	Finance and Performance Committee
Corporate Objective 5c	The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan	Chief Operating Officer	Finance and Performance Committee

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

Your Health. Our Priority.
Vision statement: currently under review
Trust Priorities: currently under review

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**
Corporate Objective 5d	The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week	Medical Director	Quality Committee
Strategic Objective 6	**To develop and maintain an engaged workforce with the right skills, motivation and leadership**	**Chief Executive**	
Corporate Objective 6a	To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum	Medical Director	Quality Committee
Corporate Objective 6b	To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement	Director of Workforce & Organisational Development	People Performance Committee
Corporate Objective 6c	To develop programmes of work to ensure the Health and Wellbeing Strategy is embedded across the trust and supports all staff in improving their health and wellbeing, delivering an environment where staff wellbeing is integrated into day-to-day practices	Director of Workforce & Organisational Development	People Performance Committee
Corporate Objective 6d	To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage	Director of Workforce & Organisational Development	People Performance Committee

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

Your Health. Our Priority.
Vision statement: currently under review
Trust Priorities: currently under review

	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**
Strategic Objective 7	**To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality**	**Chief Executive**	
Corporate Objective 7a	To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience	Director of Support Services	Finance and Performance Committee
Corporate Objective 7b	To refresh the Estates Strategy based on the six facet survey and master planning information	Director of Support Services	Finance and Performance Committee
Corporate Objective 7c	To manage investment relating to the Trust's capital programme relating to; i. Medical equipment ii. IT iii. Estates	Director of Support Services/ Director of Finance	Finance and Performance Committee

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report** **The data for this report was collated on the 1st February 2018.** This paper provides the Board of Directors with an overview of the current risk register. It is to be noted that there are still some issues with the transfer of risks from the old system to the new system. This report includes all current risks of 15 and above for Board members to review. There are currently 319 live risks recorded on the Risk Register systems. There have been no new risks added of 15 or above Across the 42 risks rated 15 or higher; ➢ 13 risks are associated with staffing issues causing a risk to patient safety, experience or timely care ➢ 8 risks are associated with lack of capacity causing a risk to patient safety, experience or timely care ➢ 8 risks are associated to a risk of services not being able to be delivered due to ageing machinery or inadequate equipment ➢ 4 risks, including one that is scored at 25, describe a risk of not meeting financial targets
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment: ☑ Not required	

Attachments:		
This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ F&P Committee	☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council x Other – Risk Management Committee / Quality Governance Committee

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1. Trust Wide Risk & Severity Distribution

1.1 There are currently 238 live risks recorded on the new Trust Risk Register system.

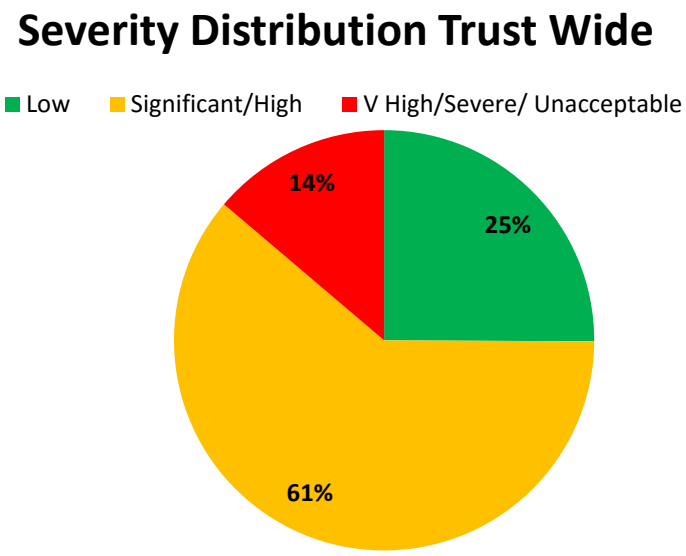
1.2 There are 81 live risks on the old risk register.

1.3 There has been no movement on closing / transferring risks from the old register to the new system in month.

1.4 The Business Groups and corporate teams need to close the risks on the old system once they have been transferred by the 28 February 2018.

1.5 Trust wide distribution of risk is shown below:-

	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Old System	0	3	11	19	1	10	8	8	2	17	1	1	0	0
New System	2	4	10	31	1	27	26	32	6	57	8	21	12	1



2. Trust Risk (approved) distribution across Business Groups

Very High		Severe	Unacceptable	
15	**16**	**20**	**25**	**Total**
Medicine and Clinical Support				
1	2	2		**5**
Women Children and Diagnostics				
	4			**4**
Integrated Care				
	3	2		**5**
Surgery GI and Critical Care				
	3	1		**4**
Estate and Facilities				
Corporate Risk (Nursing, Finance, I.T. Executive Team, HR)				
4	4	4	1	**13**

2.1 New Risks Identified

There have been no new risks identified as scoring 15 or above to be placed on the Trust Risk Register this month

2.2 Existing Risks

There are 42 risks rated 15 or above on the Trust Risk Register.

This is a reduction of 5 compared to last month. This is due to the ongoing work in refining the Trust Risk Register as the new system is embedded.

- Two risks have been reduced to below a risk of 14 (295 and 236) both in the Women, Children's and Diagnostics Business Group.
- Risk 164 regarding reputational risk due to the CQC report has been included into risk 164 and therefore closed
- Six risks have been removed as they are awaiting Business Group Approval
- Risk 240 is a duplicate risk of 109
- Five risks have been added as they have been given Business Group approval at a level over 15
- In total there are ten risks that have Business Group approval only

2.3 Trends

The most significant risk is that of failure to deliver the financial plan and currently scores a maximum value of 25

Across the 42 risks rated 15 or higher;

- 13 risks are associated with staffing issues causing a risk to patient safety, experience or timely care
- 8 risks are associated with lack of capacity causing a risk to patient safety, experience or timely care
- 8 risks are associated to a risk of services not being able to be delivered due to ageing machinery or inadequate equipment
- 4 risks, including one that is scored at 25, describe a risk of not meeting financial targets

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (Initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Strategic Risk	74	Rigby, Susan	Patel, Feroz	Finance	There is a risk that the Trust will not deliver its financial plan due to competing pressures and a failure to deliver transformational change, meaning that recurrent CIP is not delivered.	In order to improve decision making and financial control within the Trust, the Trust agreed a new framework for delivery of its Transformation and CIP through the FIP in May 2016. Due to the change in Executive responsibilities, an independent review of the CIP governance and process was commissioning and for the new financial year the Trust has agreed to some amendments and further steps to ensure control and accountability, these included: • Weekly key issues report to the Executive Management Team on the development of ideas and opportunities into CIP projects at pace to deliver the overall target; • The merging of Financial Improvement Group (FIG) A and FIG B, which will now be chaired by the CEO, to ensure Accountable Officers (Executive Directors) and Senior Responsible Officers (Business Group Directors) are held to account for their delivery/change programmes. This new approach will support communications across the Trust	20	5	5	25	10	Weekly Paper to Execs	31/03/2018
Corporate Risk	78	Carpenter, Jane	Lynch, Alison	and Clinical	There is a risk that the quality of care to patients and of poor documentation, due to high numbers of registered nurse	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers,	20	4	5	20	8	Continue with existing controls	29/09/2017

					vacancies compounded by long term sick and maternity leave. There is a risk that wards cannot reach their safe staffing standard of RNs on a ward shift by shift, causing higher use of agency resulting in overspend of nursing budgets.	significant gaps to be escalated to Matrons Daily staffing safety Huddle with Surgery Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment Quarterly organisational one stop recruitment events Management of sickness in line with Trust policy Effective and efficient duty rostering, completed 6 weeks in advance and as per rostering policy Effective and efficient duty rostering in line with agreed levels for annual leave Matrons scrutinise ward rosters to ensure they are fit for purpose and approved appropriately Planned week day Matron rounds each morning Monthly monitoring of turnover and sickness						Reference to the Minimum safe staffing escalation policy	29/09/2017
													Trial of ward based band 5 pharmacy technicians	29/09/2017
													Additional Health care assistants	29/09/2017
													Trial of paramedics in ED – completed.	29/09/2017
													Continue with existing controls	31/03/2018
													Recruitment of Trial of ward based band 5 pharmacy technicians	15/01/2018
													Review against the Minimum safe staffing escalation policy daily	31/03/2018
													Additional Health care assistants - over establish numbers on wards with excessive vacancies	31/12/2017
Strategic Risk	101	Rigby, Susan	Patel, Feroz	Finance	There is a risk that the Trust will not have sufficient cash reserves to operate	" Daily cash reconciliation " Cash flow forecast on a 13 week basis with a 15 month look ahead " Cash Action Group meets on a monthly basis " Cash reporting to Finance and Performance Committee " Cash reporting to Board of Directors as part of IPR " Liquidity days reported to NHSI as part of the Trust's Use of Resources finance score " Updated Finance and Performance Committee on the process to draw down a revolving working capital facility.	20	5	4	20	5	Stress testing of the 13 week cash flow by the Cash Action Group on a monthly basis	31/03/2018
													As part of Finance and Performance meetings highlight the Trust cash position and the inter-dependencies on a monthly basis	31/03/2018
													Implementation of No PO No Pay policy	30/03/2018
Strategic Risk	159	Birch, Sylvia	Wasson, Corporate Nursing		There is a risk that staff will be unable to comply to Coroners' requests in a timely manner due to the increase in the number of	Clear process for the: 1 triage of inquests 2 management of statement requests 3 pre inquest support	20	4	5	20	8	Summarise increase and pressures	04/10/2017

					inquests and therefore an increase in time required to complete the requests								
Corporate Risk	231	Glynn, Marie	Lynch, Alison	Corporate Nursing	There is a risk that the IP service is unable to meet all its obligations due to a lack of medical and nursing staff resulting in only mandatory work being undertaken.	•2 Consultant Microbiology posts have been advertised with one including the IP doctor role •Pathology have provided the IP service team a member of staff for an hour per week to input the information on to the MESS data collection system •Monthly meetings have taken place between the DIPC and the IP strategic lead nurse •Business case was produced in May 2017 and taken to SMG twice	20	4	5	20	8	review long term option for IV service	23/02/2018
												review IP accommodation	30/03/2018
												review BG for wider IP team	30/03/2018
												review links with sepsis agenda	30/03/2018
												Options following Business case review at SMG	22/02/2018
												Current work load undertaken by the IP service team	15/02/2018
												To produce a gap analysis against the Health & Social Care Act	30/03/2018
												present compliance data against the H&SC act	20/04/2018
Corporate Risk	75	Waterman, David	Toal, Sue	Integrated Care Business Group	There is a risk that; patients may not receive timely and appropriate palliative care, reputational issues with commissioners and financial penalties may be incurred due to a single Consultant in Palliative Medicine for the Organisation. This may result in a failure to provide consultant cover over weekends and during the doctors absences to specialist palliative care patients	• During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. • Clinical Nurse Specialists attend some cancer MDT's if they have capacity .	20	4	5	20	8	All actions have been completed	29/09/17
Strategic Risk	134	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk that Subject Access requests are not responded too in a timely manner, breaching the data protection act, due to vacancies and long term sickness within the team	Workload is discussed weekly between band 3 and Risk and Customer Services Manager. All mail is checked on arrival and priority is given to court orders, emails are checked and the same principle applies	20	4	5	20	8	Weekly updates from Team	31/03/2018
												weekly monitoring of situation for 3 months	31/03/2018

Corporate Risk	130	Plummer, Susan	Toal, Sue	Integrated Care Business Group	There is a risk of poor patient experience, patient safety breaches, reputational issues with commissioners and financial penalties, due to the failure to deliver high quality care to patients in a timely manner and breaching the 4 hour target	Existing internal escalation processes	20	4	5	20	10	Q3 ED Recovery Plan	28/02/2018
Strategic Risk	135	Lehnert, Mrs Jean	Lynch, Alison	Information and IT	Subject Access Provision	1. Medico Legal Team adhere closely to guidance (see earlier risk re pressures) 2. There is a clear process (doesn't include all areas) 3. Health Records follow process	20	4	5	20	8	Determination of requirements to meet legislation post review	13/12/2017
Risk Assessment	261	Nuttall, Lynn	Toal, Sue	Surgery GI and Critical Care	There is a risk to patients of delays and cancelations to the endoscopy list due to an aging JetAer automated scope reprocesser. This could lead to the failure to meet Caner waiting targets	Silver service maintenance contract with 'Cantel' medical for quarterly service, Quarterly HTM and annual validation. Scopes are processed in Endoscopy in event of breakdowns.	12	4	5	20	4	Business case required for transfer of decontamination of flexible cystoscopes to be centralised in endoscopy	07/02/2018
Business Group Risk	126	Harrop, Jen	Toal, Sue	Integrated Care Business Group	There is a risk that when there is a surge in demand in the Emergency Department, Patients are cared for on trollies in the corridor , leading to poor patient experience, patient safety breaches, reputational issues, failure to meet national standards and a CQC requirements	Use of Trust escalation policy - this focuses on assessing demand in ED, assessing capacity in the Acute Medical units (AMU 1 and 2)) and hospital wards. There are RAG rated trigger thresholds that correspond with actions for senior manager, directors and executives	20	4	4	16	8	Implementation of the Stockport Together programme at work aimed at Admission Avoidance. Includes Crisis Response Team (CRT) and neighbourhood models of care including maintenance at home an intermediate care	03/03/2018
Corporate Risk	3134 (Old system)	Lenhert, Jean	Mullen, Hugh	IT	IT Network Assessment/Audit Outcome	The IT Department manages the network on a day-to-day basis, with external assistance as appropriate.	16	4	4	16	8	Health Check undertaken by 3rd party to identify any issues and make recommendations Address any immediate minor configuration issues highlighted in the assessment report, making any necessary	31/03/2017 31/03/2017

													changes	
													Develop business case for Capital Board of options and cost to replace/upgrade the network equipment, as per recommendation from the Network Assessment	30/06/2017
													Review contract for maintenance/support of the network, which is due for renewal in August. Issue invitation to tender	30/06/2017
													Select and commence new network maintenance/support contract	31/08/2017
													Purchase required hardware as per agreed option	30/09/2017
													Implementation of new core network hardware	31/12/2017
													Proactively monitor network for potential hardware issues using automated monitoring tools	31/12/2017
Business Group Risk	125	MR1	Sue Toal	Integrated Care Business Group	Inability to recruit the number of medical staff needed to fulfil the rota for ED cover due to a tight labour market, resulting in an increased reliance on locum medical staff and internal staff covering extra shifts Consequence of uncertain delivery of key objectives / service due to lack of substantive staff and loss of key	Dependant on internal cover and locum bookings	20	4	4	16	8	New Consultant rota to be negotiated	30/03/2018
												Implementation of the Stockport Together programme	31/03/2018

					staff due to low staff morale							Implementation of the Stockport Together programme of work aimed at discharge to assess, trusted assessor and Intermediate bed base away from the acute site to expedite flow through the hospital and thus reduce overcrowding	31/03/2018
Corporate Risk	87	Lehnert, Mrs Jean	Mullen, Hugh	Information and IT	Exchange Email Server Failure	The IT Department manage the Network on a day-to-day basis, with external assistance as appropriate.	16	4	4	16	4	Introduction into the Mail system and removal of failed and redundant servers	31/01/2018
Corporate Risk	109	Jones, Mr David	Toal, Sue	Children and Diagnostics Business	Failure of Ultrasound equipment Siemens Antares 006-US00024420 (Ultrasound Room 3) and Siemens Antares 006-US00024421(Ultrasoun	Limitation of the workload on this equipment. Additional lists outside the usual working week to maintain the service	16	4	4	16	4	Purchase replacement scanner	28/02/2018
Business Group Risk	240	Jones, Mr David		Children and Diagnostics	Failure of Ultrasound equipment Siemens Antares 006-US00024420 (Ultrasound Room 3) and Siemens Antares 006-US00024421(Ultrasoun	Limitation of the workload on this equipment. Additional lists outside the usual working week to maintain the service	16	4	4	16	1	Purchase replacement scanner	28/02/2018 Duplicate risk

Strategic Risk	183	Hodgson, Mrs Karen	Toal, Sue	Executive teams	Failure to meet the 62 day Cancer target standards	Monthly Cancer Board chaired by Trust Lead Cancer Clinician There is an established team of experienced Cancer Trackers and Cancer MDT Coordinators who are tracking all cancer patients to ensure they are treated within 31 and 62 days. Cancer Services Manager monitors performance on a daily basis using the 'Predictor tool' Cancer Access Manager undertakes weekly Tumour specific PTL meetings with Business Manager and Cancer Pathway Tracker. Weekly Trust-wide PTL chaired by the Director of Operations An escalation policy is in place to alert business groups of any issues causing delay to patient pathways	12	4	4	16	8	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	31/03/2018
													Action plan being created with input from Business Groups to ensure sustained performance	31/03/2018
													Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	31/03/2018
Corporate Risk	108	Jones, Mr David	Toal, Sue	Women Children and Diagnostics Business Group	19% staff vacancy , coupled with maternity leave x 3 has caused a reduced service capacity, leading to delayed diagnosis/treatment/discharge and failure to meet cancer/RTT targets.	Service currently supported by extra sessions which is provided on a voluntary basis " Part time staff working additional hours " 2 x Locum Radiographers contracted until 26/08/16 " Review of processes to optimise efficiency " Rolling advert on NHS Jobs for Band 5 Radiographer posts	16	4	4	16	8	All actions completed	22/01/2018
Business Group Risk	145	Hatchell, Karen	Patel, Feroz	Surgery GI and Critical Care	Due to lack of funds causing a Reduction in income against expenditure, increased CIP for financial year and the use of bank / agency / locum staff Puts the Trust at risk of not meeting its financial targets and the potential that the Trusts		16	4	4	16	8	Business Group Financial Recover Plan	15/10/2017
													Winter planning arrangements	30/11/2017

					Financial Sustainability Risk rating will reduce to 2 or below.							Recovery plan to sustain M6 position	31/10/2017
Business Group Risk	127	Snelson, Karen	Shaw, Jayne	Medicine and Clinical Support	Medicine & Clinical Support Business Group Agency Workforce 2017/18 High numbers of vacancies due to inability to recruit / attract & retain substantive staff. High use of expensive agency locums. Higher use of agency resulting in overspend across numerous budget lines.	Monthly reporting of finance and performance; including review of Clinical Income (including activity), Expenditure budgets and CIP. Documentation highlighting financial position shared to Business Group senior management team and cascaded as appropriate. Weekly local meeting with Business Accountant to review requirement for medical locums and position against national agency cap. Twice weekly local meeting with Medical Staffing and Business Accountant to review locum rates and contractual arrangements.	16	4	4	16	12	Introduction of medical e-rostering	31/01/2018
												Growing Internal Bank & GM Collaboration	31/12/2017
												International recruitment	31/12/2017
												Domestic recruitment	31/12/2017
Corporate Risk	53	Curtis, Mrs Kelly	Wasson, Colin	Women Children and Diagnostics Business Group	Due to the number of vacancies in middle grade doctors, there are gaps in the middle grade doctors rota leading to delays in treatment and diagnosis	Existing controls: Agency locum staff are employed to cover shifts, or where possible existing staff are moved to other duties to provide cover. This takes considerable time to manage. At times locum staff have changed plans at last minute resulting in consultants having to cover SPR shifts hence causing cancellations to clinics and increased cost. Consultant providing twilight shifts & `winter pressure` middle grade weekend cover (locum SPR). On-going day - to day management of middle grade rota to mitigate effects of gaps.	16	4	4	16	12	All action completed	31/07/17
Corporate Risk	76	Bryson, George	Mullen, Hugh	Integrated Care Business Group	Due to the Wheelchair service decommissioned by Tameside and Oldham CCGs, resulting in a lack of a suitable venue within Stockport from which to deliver comprehensive clinical wheelchair assessments due to hoisting and storage requirements, potentially leading to long-term incapacity or disability of patients	Business as usual whilst the Service prepares for 'worst case' scenario and develops a contingency plan, quality impact assessment and an action log which identifies potential issues and the mitigating actions	16	4	4	16	12	Continue to press NHSPS to commence sourcing viable alternative accommodation	31/01/2018
												Clarify timescales for remedial building work	31/01/2018

Corporate Risk	137	Conway, Joanne	Lynch, Alison	Corporate Nursing	There is a risk that patients will get avoidable pressure ulcers due to the lack of timely care	Integrated Tissue viability Service advises/disseminates evidence based guidelines trust wide on pressure ulcer prevention and management strategies to support staff in clinical practice Equipment contract to supply pressure relieving mattresses, cushions and bedframes (Hillrom/Nightingale contract in acute and Ross care contract in the community) Static mattress audit within acute hospital Monthly nursing Indicator audits which includes pressure area care Monthly data collection for safety thermometer survey across hospital and community sites Safety cross completed on all wards for grade 2 and above hospital acquired pressure sores (incidence) which is reported externally each month via open and honest reporting All organisationally acquired category 2 and above ulcers are reported locally as a clinical incident All organisational acquired pressure ulcers have a pressure ulcer Proforma completed to identify any lapses in care RCA and investigation of all avoidable organisational pressure ulcers meeting the criteria of an SI TV link nurses with signed R&R on all wards /community teams Quarterly Risk reports indicating prevalence and numbers of pressure ulcers developing in hospital and on community caseloads. Feedback to contracts monitoring ,Community/hospital Nursing Managers, and to the Board Pressure ulcer prevention and management training is mandatory for all clinical staff including, nursing, medical and AHP staff Training database maintained of all staff who have attended PU prevention and equipment training who are employed by SFT	16	4	4	16	9	No actions recorded	No dates recorded

Business Group Risk	96	Rogers, Stuart	Toal, Sue	Medicine and Clinical Support	Due to Insufficient capacity to match the demand of the Opthalmology outpatient service causing delays in patients receiving appointments, resulting in delay in treatment and diagnosis	Waiting list sessions are undertaken by Consultants, middle grade doctors to backfill current lists and clinics where possible. Constant validation is also taking place and urgent cases and short term follow ups are being prioritised	16	4	4	16	8	Virtual clinics	30/09/2017
												Business Case (2nd review)	30/09/2017
												Nurse Staffing Review	30/08/2017

Business Group Risk	167	Daly-Brown, Gail	Mullen, Hugh	Surgery GI and Critical Care	Due to Lack of secure storage facilities on wards / units causing insecure patient records leading to failure of CQC / ICO standards in relation to confidentiality of patient information	Patient records are stored notes trollies, most of which are placed in non-patient areas. The notes are accessed by multiple members of the clinical teams - medical, nursing, midwifery and therapy.	16	4	4	16	8	Secure records in non-compliant areas	29/12/2017
Corporate Risk	46	Smethurst, Mr Richard	Mullen, Hugh	Women Children and Diagnostics Business Group	Telepath Server Failure Due to Obsolete 'live' and 'shadow' Telepath servers, causing potential loss of IT links between Lab Medicine and GPs / Wards and electronic access to results, leading to delayed treatment/diagnosis/discharge.	Telepath has 24/7 365 day support (hardware 7 years old). This system also has a failover server (also 7 years old). " Mirrored Hard Disks " Daily data tape backup, with monthly operating system backups " Manual processes to book requests directly into analysers for emergency requests. " Send routine work to other laboratories This emergency service would mean manual transcription of lab results, and greatly increases risks of serious errors. This service could only be maintained for a relatively short period of time (up to 48 hrs) and has a significant impact on departmental staffing requiring additional hours, and all managerial staff aiding in keeping the emergency service functioning.	16	4	4	16	4	To make sure all necessary control measures are in place	30/03/2018
Strategic Risk	170	Wheelton, Fiona	Shaw, Jayne	and Critical	Upper GI Bleed Service Provision Due to lack of 7 day on call rota for GI bleeds causing Lack of skilled endoscopy staff and endoscopists who	out of hours our surgical team support the care of these patients. The skill set of our surgical endocscopists does not include the management of some conditions. Such	20	4	4	16	8	Expand gastroenterology team	30/04/2017

					are familiar with the treatment of acute upper GI bleeds leading to none compliance with NICE Clinical Guidance 141 (Acute Upper Gastrointestinal bleeding management) out of hours.	patients can be left at risk if presenting out of hours. The challenge of providing this care 7/7 relatively common in district general hospitals.						Development of bleeding rota	01/02/2018
Corporate Risk	3123 (Old System)	Rigby, Susan	Patel, Feroz	Finance	Inability of the Trust to Deliver the Required Savings Through Transformational Projects as Part of Stockport Together	The Stockport Together Finance Directors Leaders Group to meet on a regular basis to review progress with the business cases. PWC have been appointed for a 3 year period to maintain a finance model which is agreed across all 3 organisations. An economic case supporting the Stockport Together Business Case has been prepared and agreed by all Directors of Finance and this will be presented to all party Boards in June 2017. As part of the economic case and the arrangements for working as part of an Alliance Contract the Directors of Finance have agreed a risk and gain share.	15	5	3	15	5	Board approval of full economic case- to be presented on 26.06.17 Operational plan to be developed	20/07/2017 31/10/2017
Strategic Risk	162	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, quality experience and Trust reputation	NHSI improvement Board Patient Quality Summit weekly Safe, High Quality care action plan Quality Governance Framework Regular contact with the CQC	20	5	3	15	5	Deliver Safe, High Quality care action plan	31/03/2018
Risk Assessment	177	Farnell, Hellen	Lynch, Alison	Medicine and Clinical Support	High numbers of RN vacancies, sickness and maternity leave causing other wards to be short staffed means that staff from the E wards are being moved compromising quality of care and documentation	Ward often staffed to 2RNs+1AP+4 HCAs (or 2RNs + 5HCAs)on E1 to reduce the likelihood of an RN being taken and to support patient care and safety, however E2 and E3 do not have AP in their establishment and are often depleted of a 3rd RN. Regular review of Business Group wide	15	3	5	15	6	Daily Rationalisation of staffing across business group to maintain patient safety. Proactive monitoring of staff moves	31/12/2017 31/12/2017

						staffing to consider organising additional HCA for E1 if it in known an RN will have to be moved. Twice a year acuity audits.						E Ward Managers to monitor RN moves	31/12/2017
Strategic Risk	160	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk that staff may not use Policies and procedures if they are not Workable, intelligible, correct and in routine use	Nursing care indicators quarterly SI report monthly governance report	16	3	5	15	9	Review Si data on a 6 monthly	31/03/18
												Review policy on Policies and ensure all policies are up to date	30/09/18
Corporate Risk	288	Glynn, Marie	Lynch, Alison	Corporate Nursing	There is a risk that the Trust will not be able to provide a safe service for the insertion, care and management of central vascular access devices, due to the resignation of the specialist nurse causing lack of specialist skills in the Trust.	a) Consultant anaesthetists have a weekly Tuesday session in theatre b) IP service nurses review all newly inserted lines 24-48hours after insertion c) IP service nurses review all patients with CVAD's on a weekly basis until removed d) IP service lead is reviewing evidence regarding positioning of lines and risks of incorrect positioning	15	3	5	15	12	Options paper	02/02/2018
												Develop IP service nursing team knowledge & skills	31/01/2018
												Develop a training package in care and management of CVAD's	16/02/2018
Business Group Risk	91	Gidley, Chris	Toal, Sue	Operations	Utilisation of side rooms across the Trust	Bed management team maintaining side room database SOP for isolation of patients Ongoing training around usage of side rooms	15	3	5	15	9	Monthly audit of compliance of completion and accuracy of the side room database	30/09/2017
												Attendance at Medicine Sisters' Governance meeting to discuss process for utilisation of side rooms	31/08/2017

Business Group Approved Risks

Business Group Risk	285	Malkin, Margaret	Malkin, Margaret	Integrated Care Business Group	Risk in not attaining Financial Cost Improvement Target 2017/18 Reconfiguration of the Business Groups in September 2017 has resulted in the realigned budgets showing a shortfall in the first year end forecasts leading to the indicated forecast variance of £2.7m adverse represents 0.99% loss of Trust annual budget of £277m	• Monthly reporting of finance and performance at business group Quality Board and Operational meeting; including review of Clinical Income, Expenditure budgets and CIP. Discussion and challenge encouraged. Documentation highlighting financial position shared to Business Group senior management team and cascaded as appropriate. • Monthly budget meetings with budgets holders to review individual cost centre level performance. • Weekly review of workforce spend requests such as bank/agency and change to posts requests scrutinised via senior management core team meeting. • Monthly Medical Staffing budget specific meetings with Clinical Directors, Medical Staffing and Business Accountant to review vacancies, locum rates and contractual arrangements.	20	4	5	20	16	Financial Recovery Plan	30/03/2018
Corporate Risk	335	Plummer, Sue	Malikin, Margaret	Integrated Care Business Group	There is a risk that the Trust will not be able to deliver same sex accommodation in CDU due to decreased bed capacity	Explain the reasons for mixing with the patient and / or their relatives, carers or loved ones and apologise.	20	4	5	20	10	Patient assessment Resolution of mixed sex accommodation	03/01/2018 03/01/2018
Business Group Risk	193	O'Neill, Mrs Melanie	Woodford, Claire	Women Children and Diagnostics Business Group	Due to a lack of Breast service admin causing a backlog of work leading to a risk to deliver high quality patient care	All current staff are maintaining their roles in the short term until new arrangements can be made. This will not continue in the longer term.	20	4	5	20	8	Develop job description for band 4 support Secure funding for band 4 support post Recruit to band 4 support post	29/09/2017 27/10/2017 29/12/2017

Corporate Risk	86	Reason, Mr Dan	Mullen, Hugh	Estates and Facilities	Aged Telephone Technology/Infrastructure, resulting in telephone system outages causing disruption/delays in patient care/service delivery.	The Facilities Department manage the Telephony system on a day-to-day basis, with external assistance from suppliers as required.	16	4	4	16	4	Telephony Task & Finish Group	30/07/2017
												SMG approval to develop Full business Case for provision of Unified Communications	31/08/2017
												Approval of full Business Case by ET	30/09/2017
												Procurement of new Unified Communications system via a framework & mini competition	31/01/2018
												Implementation of new solution	31/03/2018
Business Group Risk	64	Jones, Mr David	Woodford, Claire	Women Children and Diagnostics Business Group	Inability to Provide Timely Radiology Report for Plain Film Imaging	• All imaging, excluding GP referrals, is reviewed by the referring clinician/team and findings/actions documented in the patient record. • Use of external reporting service (Medica/Atlas) for batch reporting waiting over 10 weeks • Chest reporter training now moved to September 2017 by course provider. • Radiologist appointed to commence August 2017. • SpR reporting under WLI	20	4	4	16	8	• Continue to monitor the plain film backlog and outsourcing to Medica/Atlas	25/06/2017
												Commence training of in-house Radiographer to report chest x-rays (18 month course)	31/08/2017
												Remove backlog plain film reporting with a combination of outsourcing and additional voluntary reporting lists by in-house Radiologists	25/10/2017
												Enter into an agreement with outsourcing companies to receive plain films twice weekly to to maintain timely reports and prevent backlog.	25/10/2017

Business Group Risk	199	Clayton, Gill	Hatchel, Karen	Surgery GI and Critical Care	Aged diathermy machines		12	4	4	16		Purchase machines	04/04/2018
Business Group Risk	207	Dent, Charlotte	Hatchel, Karen	Surgery GI and Critical Care	Use of Recovery as level 2 / level 3 area	Only utilised when there has been an agreement between the Critical Care Consultant and the Theatre Consultant Overall responsibility for the longer term anaesthetic/intensivist care of the patient has to be agreed Considered in conjunction with emergency CEPOD workload Daily staffing level assessment at Safety huddles to ensure safe staffing which take place twice a day	16	4	4	16	12	Review capacity within ICU/HDU	03/04/2017
												HDU Capacity paper drafted	01/03/2017
												Audit to be undertaken to quantify frequency of recovery use	05/07/2017
												Share learning around the care of level 2 / 3 patients	07/06/2017
Business Group Risk	205	Dent, Charlotte	Hatchel, Karen	and Critical Care	Patient Bed side Monitoring System – Critical Care Unit.	EBME periodic maintenance and repair and manufacturers maintenance requirements. Manufacturers review software revision and sub contract, non-standard repairs.	9	4	4	16	3	Report faults	03/01/2018
												Purchase monitors	03/01/2018

Risk Assessment	346	Capener, Jackie	Armitage, Nadine	Medicine and Clinical Support	Due to lack of bed capacity across the Trust and within Medicine in particular the Business group have been asked to close B5 (14 beds) and open A15 (26 beds) resulting in an additional 12 beds.	All appropriate stakeholders are aware of the move Opening of a ward SOP was followed. B5 Nursing staff transferred to A15 Nurse staffing establishment agreed and rosters to be prepared as per E roster policy working towards a 6 week advacne planning for staffing. Early identification of gaps for shifts to put out onto NHSP Ward situation discussed at every Trust staffing meeting 11:30 each day which includes a review of all shifts up to and including the following morning. Staffing equalised across the Business Group and the Trust to ensure safety across all wards. A review of non ward based Nurses is being undertaken and availability scoped support the wards High intensive visits, support and monitoring by Matron for safety and acuity. Discussions held around selectiveness of appropriate patients with AMU -4 - 5 day LOS Medical cover being reviewed on a daily basis with Associate Medical Director.	15	3	5	15	6	Daily intensive review and evaluation of the ward status	28/02/2018
Risk Assessment	263	Wilson, Sara	Armitage, Nadine	and Clinical	Lack of retention and recruitment leading to high vacancy factor causes a risk to the ability to locate, retrieve and provide case notes in time for	• Vacant hours in various stages of recruitment process • Raised at BG Quality Assurance Team meeting	15	3	5	15	6	Recruit to Section Manager post (band 4)	30/11/2017

					patient care, leading to a Failure to provide medical staff with potentially critical information. Increased stress levels in staff resulting in high turnover/sickness levels.	• Raised at BG Management Team meeting • Staff stress risk assessment being considered • Continual reassignment of staff to cover priority tasks • Use of bank staff • Decline requests from other areas for the Health Records dept. to undertake work that is not for direct patient care (eg. Clinics / admissions) or complaints. • Temporary contracts made permanent to provide stability • Details of vacant posts circulated to existing staff to encourage internal applications from bank staff • Mat leave cover organised • More staff trained to cover outpatient receptions • Vacant hours spreadsheet completed weekly by section managers to ensure maximum use of vacant hours, whilst not overspending.							
												Recruit to Supervisor post (band 3)	30/11/2017
												Recruit to 8 x clinic prep / reception / Evolve posts (band 2)	29/12/2017
												Test	01/11/2017

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

LEVEL	DESCRIPTER	DESCRIPTION
5	Almost certain	Likely to occur on many occasions, a persistent issue - 1 in 10
4	Likely	Will probably occur but is not a persistent issue - 1 in 100
3	Possible	May occur/recur occasionally - 1 in 1000
2	Unlikely	Do not expect it to happen but it is possible - 1 in 10,000
1	Rare	Can't believe that this will ever happen - 1 in 100,000

The risk factor = severity x likelihood

By using the equation, a risk factor can be determined ranging from 1 (low severity and unlikely to happen) to 25 (just waiting to happen with disastrous and widespread consequences). This risk factor can now form a quantitative basis upon which to determine the urgency of any actions.

	CONSEQUENCE				
LIKELIHOOD	**1**	**2**	**3**	**4**	**5**
	Low	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 - Almost Certain	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*	RED *(unacceptable)*
4 - Likely	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*
3 - Possible	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	AMBER *(high)*	RED *(very high)*
2 - Unlikely	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*	AMBER *(significant)*	AMBER *(high)*
1 - Rare	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*

QUALATIVE MEASURE OF CONSEQUENCE

Impact Score	1	2	3	4	5
Domains / Description	**NEGLIGIBLE / LOW**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <7 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 7-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Fatality Multiple permanent injuries/irreversible health effects	An event which impacts on a large number of patients Multiple Fatalities
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Inquest / ombudsman negative finding	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice Register concern	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Local Press >1 Potential for public concern	Local media coverage >1 Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. Full Public Inquiry MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims / cost	Small loss Risk of claim remote < £2k	Loss of 0.1–0.25 per cent of Trust budget Claim / cost less than £2- 20k	Loss of 0.25–0.5 per cent of Trust budget Claim(s) / cost between £20k -£1M	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of Trust budget Claim(s) / cost between £1m and £5m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >5 per cent of Trust budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£5 million
Service / business interruption Environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment in more than one critical area	Permanent loss of service or facility Catastrophic impact on environment
Project related	Insignificant impact on planned benefits	Variance on planned benefits <5% and <£50k	Variance on planned benefits >5% or >£50k	Variance on planned benefits >10% or >£500k	Variance on planned benefits >25% or >£1m

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	National Joint Registry Annual Report		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR ASSURANCE

Corporate objective ref:		**Summary of Report** The annual audit of outcomes from joint replacements undertaken across the country was published this month. Participation in the National Joint Registry is mandated, and it is robust summary of performance data. Put simply our results are exemplar, with one of the best outcomes in the country. In the winter months, much of our attention turns to pressures of flow and performance of the emergency department, such results serve as reminder (as we saw with stroke recently) of just what high quality care is consistently delivered in our hospital across the year. Greater Manchester theme three is currently debating the future of of orthopaedics across the city. We are likely to see consolidation of specialist orthopaedics into two or three sites. We are the second largest unit (close behind Wrightington), and with the results to match. Our Professor Turner will be president of the British Orthopaedic Association next year, reinforcing our position. It is an important time to recognise the strength and quality of our orthopaedic services, and this report offers us this positive assurance.
Board Assurance Framework ref:		
CQC Registration Standards ref:		
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☒ Quality Governance Committee.

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1. INTRODUCTION

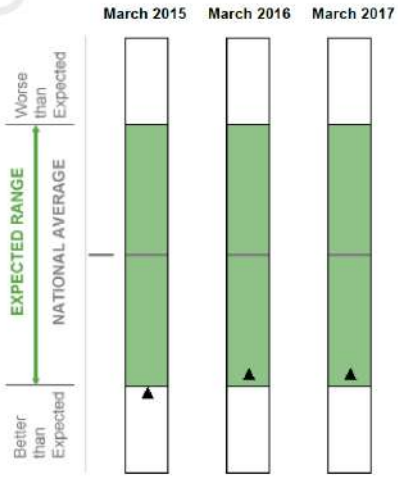
1.1 The National Joint Registry is mandated for all hospitals undertaking joint replacement surgery. It serves as a benchmark for performance.

2. BACKGROUND

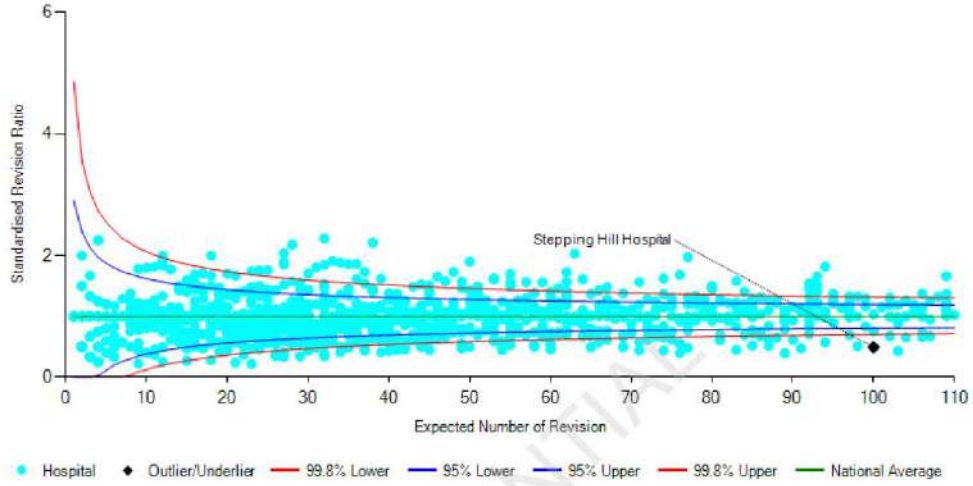
2.1 The report is extremely comprehensive, but the only the headline outcome data is summarised here. The full report contains confidential information (noted in the watermark on the attached graphs), so is not suitable for sharing in a public forum, however the headline metrics included here tell much of the story.

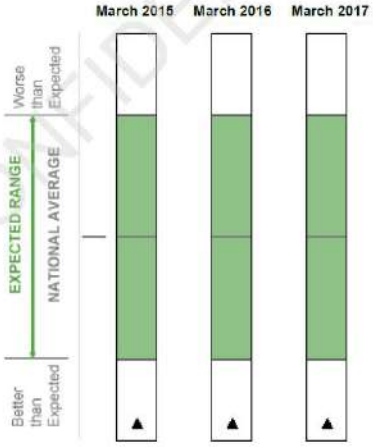
2.2 The funnel plots represent the size of each orthopedic unit (X axis) and the outcomes / frequency of joints needing to be revised (y axis). The further to the right your position, the larger the unit (and so the less statistical variation seen, thus the shape of the funnel). The lower the point, the better the outcomes with the red lines representing the 99.8 % confidence interval that this outcome is not due to chance.

Hip surgery



(iv) Hospital SRR - All Knees





3.0 DISCUSSION

Putting these results in context, for hips, and averagely performing unit of our size would have had 92 revisions, but have only had 60. For knee replacements, and average unit of our size would expect to revise around 100 but have only had 50.

A conservative estimate of the overall cost of revising a major joint revision to the health care economy is around £30,000. These outcomes represent a saving of approximately £2.5 million.

Additionally, our 90 day mortality ration for hip replacement surgery is 1.0, and for knee replacement surgery is 0.67, again reinforcing the quality of the service delivered.

4. CONCLUSION

4.1 The results confirm our position as one of the country's leading orthopaedic hospitals. We are the second largest unit in Greater Manchester, and these excellent results are testament to the high quality care provided.

4.2 It is also worthy of note, that our Professor Turner will be the British Orthopaedic Association president in 2018. Professor Turner is leading the GM theme three review of the future provision of orthopaedic services across GM.

4.3 Theme three is likely to see far greater collaboration across the city, with consolidation of some specialist orthopaedic surgery into leading providers. Stockport is well placed to play a significant role in this reconfiguration.

5. RECOMMENDATIONS

5.1

The trust board are recommended to take considerable positive assurance from these results, and to recognise the role we may have to play in orthopaedic provision across Greater Manchester in the future.

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NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date:**	28 February 2018
Subject:	Diabetes Care		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR ASSURANCE

Corporate objective ref:	S3, C8, C9. C10
Board Assurance Framework ref:	S04
CQC Registration Standards ref:	13
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

Following our June 2017 inspection, the CQC raised significant concerns regarding our management of diabetes.

This paper reviews the concerns raised and the commitments made in response to these concerns.

We have now received the external review of our diabetes management undertaken by Professor Heller. His suggestions are triangulated against the CQC actions.

Outstanding issues are summarised, and a plan for implementation confirmed.

The board are asked to take positive assurance of the progress made, and the residual actions in hand by of the diabetes task and finish group.

Attachments: Annex A: External Review Report

This subject has previously been reported to:

☒ Board of Directors	☐ People Performance Committee
☒ Council of Governors	☐ Charitable Funds Committee
☐ Audit Committee	☐ Nominations Committee
☒ Executive Team	☐ Remuneration Committee
☒ Quality Assurance Committee	☐ Joint Negotiating Council
☐ Finance & Performance Committee	☒ Quality governance committee.

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1. INTRODUCTION

1.1 The CQC visit of 22nd / 23rd June 2017 identified a number of concerns regarding our treatment of diabetes. Of all the issues of concern raised, it is our care of diabetes that appeared to gain greatest publicity. The CQC concluded that;

> **'The trust must ensure that patients with diabetes receive safe and effective care'**

While progress has been made, we are likely to see little tolerance of failure to address these concerns. This paper reviews the concerns, the pledges we took in response, and progress against these pledges.

2 BACKGROUND

2.1 The CQC comments were as follows;

> 'We found that incidents were not being reported in line with the trust's own reporting policy and procedures. An example of this was that 21 incidences of hypoglycaemia of less than 3.5 mmols were found in the seven days prior to the inspection and zero of these 21 events had been reported in line with the trust's practice, protocol and alert. Staff on the ward had a mixed understanding of when to report incidences of hypoglycaemia and what actions to take.
>
> Staff on one ward told us that health care support workers would stop and amend the rate of intravenous insulin pumps when they recorded patients' blood sugars. This was not in line with the trust's policy on managing medicines.
>
> We observed an incident where a health care support worker called a nurse after taking a patient's blood sugar reading and advised the nurse to stop the pump and told her what rate to change the insulin infusion to. We observed that the nurse followed this instruction.
>
> The trust's policy on medication management states that all intravenous medication and insulin should be double checked. Insulin infusion pumps were not being double checked when the rate was changed.
>
> We reviewed all diabetic patient monitoring charts (16 patients) on ward xxx. We found that seven patients had experienced at least one hypoglycaemic (low blood
> sugar) event in the seven days prior to the inspection. In total there were 21 incidences of hypoglycaemia of less than 3.5 mmols in this time period. In nine out of 21 cases there was no documented action taken in response to the hypoglycaemic event. In a further eight cases the action taken did not match the action required by the hypoglycaemia protocol. In all 21 cases the repeat blood glucose test required by the hypoglycaemia protocol was not undertaken within the specified 10-15 minutes time frame.
>
> Three out of 16 patients had experienced at least one episode of hyperglycaemia (high blood sugar). The total number of hyperglycaemic events was 11 in the seven
> days prior to the inspection. In ten out 11 cases the hyperglycaemia protocol had not been followed and ketones had not been recorded.'

2.2 In response to these comments by the CQC, the following commitments were made;

2.3 **Transactional changes** – completed following the report, no residual commitment**;**

1	The Trust has commissioned an external review of diabetes .
2	A case note review of all patient deaths with diabetes coded as their primary condition
3	Diabetes and safe management to be the subject of medical staff Grand Round,
4	A Trust Risk Management Alert was hand delivered
5	The Director of Nursing and Midwifery has written to all Registered Nurses and Midwives.
6	A triangulation of incidence of hypo-glycaemia readings against historical data will take place.
7	A triangulation of incidence of hypo-glycaemia readings against national comparative data using the National Diabetes inpatient Audit 2010-2016 will take place
8	A triangulation of incidence of hypo-glycaemia readings against a neighbouring trust of similar size that uses
9	Commission CHKS to undertake a review of mortality data
10	Diabetes team to provide immediate support, practical advice and training
11	Diabetes Specialist Nurses have now moved to work on A11 to offer support to nursing staff
12	Diabetes specialist nursing Team to undertake a full competency assessment for eligible nursing staff on A11.
13	Diabetes Specialist Nursing Team delivering systematic refresher training to all eligible nursing staff in medical wards.
14	Diabetes Specialist Nursing Team delivering systematic refresher training to all eligible nursing
15	All Consultants will be contacted by the Medical Director every week until they are compliant with diabetes e learning. No study leave or pay progression will be approved until compliant.
16	The Medical Director has written to all doctors to reinforce the importance of meticulous diabetes management and monitoring
17	Posters to be designed around management of diabetic emergencies to support staff in compliance. These will be placed in highly visible areas i
18	Diabetes team to develop a 7 minute briefing on lessons learnt
19	A review of hypo-glycaemic incidents over the last 3 months based upon point of care testing results and Datix reporting in partnership with the CCG. Clear
20	Salford Royal asked to arrange for the ward manager of the diabetes ward to act as a mentor
21	Salford Royal asked to arrange for the Matron of the diabetes ward to act as a mentor
22	The Medical Director will include in his Trust Induction the Importance of safe and evidence based diabetes management.

Transformational changes – implied rolling commitment to maintain

2.4

Overview of diabetes.

1	A comprehensive Review to be undertaken of current procedures around management of Diabetes for inpatients and in the community.
2	All Datix reported low BM recordings require that a doctor is asked to review. Performance management regarding non-adherence will take place.

2.5

Ward spot checks

3	The trust has instigated assurance spot checks on all Medical wards to monitor adherence to the diabetes patient chart and diabetes SOP.
4	Board of Director Members will commence regular ward visits
5	The surgical ward Matrons will commence random ward checks
6	The trust has instigated assurance spot checks on all Medical wards to monitor adherence to the diabetes patient chart and diabetes SOP.
7	Board of Director Members will commence regular ward visits
8	The surgical ward Matrons will commence random ward checks

2.6

Trust oversight and assurance

9	Head of Nursing receives immediate notification of an incident reported regarding a low blood glucose recording to ensure sighted on frequency.
10	The Head of Risk and Customer Services has established a weekly report on Low Blood sugars
11	The process for the monitoring of hypo-glycaemic episodes to ensure clear learning and monitoring of trends to reduce potential harm to patients will be the subject of continuous quality monitoring

2.7

Mandatory training

11	All Trust compliance with E learning to achieve 95% of eligible staff

3 CURRENT SITUATION

3.1 The draft external review from Professor Heller concludes as follows;

		Comment
1	The background of insulin poisoning by a male nurse in 2011 appears to have influenced some of the guidance for the management of hypoglycaemia. Some of this guidance is inappropriate for the management of patients with diabetes and should be reviewed. Identification of hypoglycaemia by point of care testing either routinely or in a symptomatic patient should be followed by appropriate oral treatment and a repeat test within 10-15 min. This should be followed by more substantial long acting carbohydrate, considering the likely cause and importantly by a review of treatment regimen. If appropriate this should lead to adjustment of therapy, with a dose change or different medication. The episode should be recorded in the hospital records to ensure that medical staff responsible for the everyday care of that patient are alerted to the event	To be incorportated into a new hypoglycaemia policy Policy submitted for approval at February Quality governance committee. Roll out from March 1st.
2	There should be a system in place which is robust and ensures	

	that all serious hypoglycaemia (glucose levels <3mmol/l) is reported to the diabetes nursing inpatient team who should visit the ward and provide the appropriate advice. Where necessary the specialist medical team should be informed.	
3	There should be stickers in the note and in advance of the electronic record, consideration needs to be given as to how serious hypoglycaemia should be identified and the relevant actions undertaken.	Stickers now on order
4	Hypoglycaemia Boxes should be present on each ward, clearly marked and containing the appropriate treatment for hypoglycaemia. Stickers should be included and placed in the medical notes after a hypoglycaemic episode. The boxes should be regularly restocked.	Complete
5	Standard dual function glucose meters should be available in all ward areas. Point of care testing for plasma ketones is now standard to people with diabetes who are issued with dual function meters and arguably it should be easier to check for ketones in ward areas where patients with diabetes are managed less often. Similar devices which are used across the hospital would improve safety and simplify staff training.	Risk assessment completed. Diabetes team costing for short form business case
6	Junior medical staff education on diabetes should be practical and delivered at each induction, consisting of brief insulin management, treatment of hypoglycaemia and high glucose values.	Irfan Baig leading – in place.
7	Now that staff have been re-trained, it is difficult to be sure how much they have learnt and whether they are putting their learning into practice. Spot checks on key wards, particularly in regards to insulin management should be implemented.	Some in place by DSN team. Formalisation required.
8	Repeat audits of diabetes care should be instituted which concentrate on management of severe/serious hypoglycaemia and adherence to standards.	Richard Bell leading – in place.
9	Competent patients with diabetes should keep their insulin, without the need for 1 let alone 2 nurses to check the dose, the delays in finding 2 nurses at busy times (ie before meals) means it is likely that the insulin timing is variable and will worsen glycaemic control.	Self administration of insulin policy to be re-introduced – Richard Bell to lead.
10	The nursing team on A11/12 has the potential to provide backup for an over stretched inpatient team and provide diabetes expert resource for the rest of the hospital. This will require additional training, perhaps secondment to the in-hospital diabetes team	For discussion.

4. RISK & ASSURANCE

4.1 **Risk 178 – Diabetes Safe Management** (taken from current risk register)

The CQC have raised a concern with regard to Diabetes management within the trust specifically in relation to:-

- Safe Management of Diabetic Patients on A11
- Failure to adhere to management of hypo glycaemia according to trust guidance
- Failure to adhere to management of hyper glycaemia according to Trust guidance
- The clinical management of diabetes patients across the whole trust

Agreed actions:-

- E Learning for all clinical staff
- Key trainers on all wards
- Clear guidance available on the microsite related to hypo and hyper management
- Previous launch of the "think glucose" campaign

5. CONCLUSION

5.1 Given the magnitude of the concerns relating to diabetes care, we need to ensure thorough rationalisation of outstanding commitments from the CQC response, and delivery of the suggestions made by our external review.

The following action plan and timescales are suggested;

1	Rewrite of hypoglycaemia policy, with cascade and retraining	Feb Quality Governance Committee. Introduction March 2018
2	Introduction of hypoglycaemia stickers	
3	Means of highlighting severe hypoglycaemia to diabetes specialist nursing team to be agreed.	
3	Business case for dual function ketone / BSL meters to be submitted.	By April 18
4	Rationalisation and agreement of ongoing spot checks and ward oversight	To be agreed
5	Regular audit of hypoglycaemia	Annual audit, twice this year.
6	Self administration of insulin policy to be agreed and introduced	By April 18
7	A12 to offer advice and guidance to other wards	To be agreed

6. RECOMMENDATIONS

6.1 The actions summarised here should be agreed, with plans for rationalisation of diabetes ward care spot checks, and for development of A12 as a source of advice and guidance.

Review of Diabetes Care at Stepping Hill Hospital

Simon Heller, Professor of Clinical Diabetes, University of Sheffield and Hon Consultant, Sheffield Teaching Hospitals Foundation Trust.

Background

At the end of June 2017, I was approached by Dr Vince McCauley and subsequently agreed to conduct a review of inpatient care, with specific attention to be given to the management of hypoglycaemia at Stepping Hill Hospital, Stockport.
This followed a visit to the hospital from the Care Quality Commission (CQC) who had undertaken an unannounced inspection at Stockport NHSFT earlier in the month. They visited three wards, one of which was the specialist ward for patients with diabetes. The CQC inspectors identified a number of concerns about management of diabetes as follows:
After reviewing diabetic patient monitoring charts (16 patients) on the diabetes ward they had found 21 incidences of hypoglycaemia for these patients in the seven days prior to the inspection. None of these events had been reported in line with the trust's practice, protocol and alert.
In nine out of these 21 incidences there was no documented action taken in response to the hypoglycaemic event and in a further eight cases the action taken did not match the action required by the trusts hypoglycaemia protocol.
In all 21 incidences, the repeat blood glucose test required by the hypoglycaemia protocol was not undertaken within the specified time frame.
Three of the 16 patients had experienced at least one episode of hyperglycaemia. The total number of hyperglycaemic events was 11 in the seven days prior to the inspection. In ten out 11 cases the hyperglycaemia protocol had not been followed and ketones had not been recorded.

The report concluded that the CQC wished to 'receive robust assurance that sets out how Stockport NHS Foundation Trust was ensuring that patients living with diabetes were cared for safely and appropriately.'

In response, the Trust initiated the following action plan:

CQC action and assurance plan
Case note review of all deaths coded as diabetes as primary diagnosis
A 'task and finish group' to review evidence and protocols relating to diabetes care.
A medical staff grand round on diabetes
Immediate introduction of all hypoglycaemic episodes being reported as a critical incident
Spot checks of diabetes management introduced on all wards, with central collation of audit data.
Board of directors contributing to ward inspections.
Director of nursing writing to all nurses outlining key standards
Medical director writing to all doctors outlining key standards
All hypoglycaemic incidents copied to Medical and Nursing directors.

Triangulation of hypoglycaemic data against historical data, national data, and a comparable local trust.
CHKS to complete a review of diabetes related data.
Additional training to ward staff from specialist diabetes nurses.
Focus on driving 'safe use of insulin' compliance beyond 95%.
Completion of a case note review of a sample of hypoglycaemic episodes
Key issues in diabetes care included in the trust induction.

I agreed to conduct an external review which consisted of the following:

ToR review of Diabetes management

Stockport NHS FT committed to commissioning an external expert review of our medical management of adult patients with diabetes.

- Does not include peri-operative care
- Does not include obstetric care.
- Does not include paediatric care.
- Does not include community care, but does include discharge information.

The goal of the external review was to inform the work of the newly set up 'Diabetes Task and Finish group' in refining current diabetes management, process and policies.

The review to include consideration of three key sources of data;

1. **An overview of external and internal audit data to seek key themes that should influence future practice.**

National diabetes in-patient audit
National diabetes foot care report audit
Historical trend analysis of hypoglycaemia incidents
Comparative hypoglycaemia results against comparative peer results (University Hospital South Manchester)
CHKS review 2017 of data relating to diabetes admissions

2. **An overview of existing diabetes policies, consider how these align with national practice.**

Standard operating procedure (SOP) on Insulin administration
Hyperglycaemia and hypoglycaemia flow charts.
Ambulatory care unit hyperglycaemia management kit. (SOP)
Sliding scale management (SOP)
End of life care in diabetes (SOP)
DKA pathway, blood monitoring chart, fluid balance chart and prescription charts.
Inpatient hyperglycaemia pathway and management guidelines. (SOP)

Insulin administration by healthcare professionals. (SOP)

3. A site visit and discussion with key diabetes staff.

- Diabetes consultants.
- Specialist diabetes nurses.
- Diabetes ward manager.
- Diabetes ward staff and ward visit.
- Medical and Nursing Executive Directors.

Site Visit on November 15th 2017

The week before my visit I was supplied with a folder containing the following documentation:
Inpatient guidelines including management of DKA, hyperglycaemia, management of CSII
Treatment of hypoglycaemia
Intravenous insulin infusion, prescription chart and staff training
Adult glucose monitoring chart
Foot inpatient care guideline
Think glucose referral criteria
Medication chart
Surgical Care of diabetic inpatients
End of life diabetes care training slides

Patient information leaflets
Audit and internal view reports

Staff training lists
Diabetes and pregnancy guidelines

On 15th November I met initially with the Medical Director, Dr Colin Wasson and then on the ward spent two hours with the diabetes lead consultant Dr Ngai Kong and Diabetes Nurse Manager, Ms Kay Bottrell. I also met the two inpatient diabetes nurses and later in the morning, I was shown round the lead diabetes ward. I then met the other diabetes consultants Dr Richard Bell and Dr Irfan Baig who showed me round the acute admissions unit.
I spoke on the phone to the Ward Manager, Ms Polly Begum on 12th December as she had been away from the hospital on 15th November.

Review and comment on existing diabetes policies.

DKA guidelines seem appropriate and similar to my own hospital guidelines

Hyperglycaemia/Ketone pathway, are also appropriate and similar to my own hospital guidelines

Management of hypoglycaemia
This is not dated, but apparently based on "Think glucose" programme based on JBDS 2010 and 2013 guidelines

Mild hypo <4mmol/l,
Treatment - administer 15-20g fast acting glucose 4-5 glucotabs or 1x60 ml glucojuice
Or 2 tubes oral glucose gel

Recheck, if below 4 after 15 min repeat,

Fast bleep doctor if:
1) less than 4 after 45 min or 3 cycles
2) severe hypo or patient is unconscious (*is a severe hypo!)*_
3) if blood glucose is less than 2.5mmol/l.

If unconscious or unable to take oral treatment,
administer IM glucagon, or 150ml 10% glucose IV over 10 min

Always follow up with slowly digested food.

Comment
These guidelines are based on think glucose guidelines but differ slightly from our own guidelines which are based on the same guidance
There are some clinically relevant differences as follows:
1) Glucagon is no longer first choice; if IV access is available. Use 10 or 20% glucose.
2) check blood glucose 5-10 min later
3) use glucagon only once
4) ask diabetes team to review if severe or if glucose less than 3mM
5) place hypo sticker in the notes so regular team can review
6) current Stepping Hill guidelines don't appear to recommend review of treatment

Guidelines on management of CSII,
These are appropriate and practical in as much as they permit the patient to keep their own insulin delivery and assess competence to self-manage as well as requiring the specialist diabetes team to review

Variable rate intravenous insulin infusion guidelines
Apparently are currently awaiting approval – appear generally appropriate although there are some discrepancies from those at our own hospital. We would use 10% glucose rather than 5% and run it in at 50ml/h, we also add potassium 20mmol in 500ml bag when potassium levels are less than 5mmol/l in ready made bags.

National inpatient audit 2016
shows that the Trust was generally average for most of the findings. The items worthy of note are as follows:
Foot assessment well above average but see below

Use of insulin infusion was low (3%) compared to average of around 8%
Those admitted with active foot disease, only 22% seen by specialist team compared to average of 55%.

Management of hypoglycaemia audit, dated 22 May 2017, presumably pre-dating CQC visit.
This is an important document but I am afraid I found it very confusing, both in understanding the standards and interpreting the results.
The two chosen audit criteria were:
1) number of patients with blood glucose <4 who had blood glucose rechecked within a satisfactory time
2) Readings should have ID attached.

The audit appears to have been conducted following an audit in 2010 which highlighted poor compliance. A 7 year gap does seem a large and unacceptable interval between audits. I understand from the clinical team that although a re-audit was planned, this drifted due to other priorities. The hypoglycaemia management protocol based on the JBDS 2010 guidelines were launched in March 2011. I am told that in May 2011, hypoglycaemia reduction was made a corporative objective as part of Think Glucose, with point of care testing using established connectivity meters to generate charts of hypoglycaemia rates. In 2012 a new glucose monitoring form was launched and hypo boxes placed on all ward and clinical areas. This new protocol was updated in 2017, which was the version I was sent.

The 'hypo box' contained glucose treatments with stickers which were designed to record events and be placed in notes to improve documentation and ensure that the regular medical team acted upon the event.

After reading and re-reading the audit standard, I cannot understand why the standard is so complicated. In our own trust, we would expect a blood glucose to be rechecked within 10 min of treatment. I fail to understand why a wait of 30 min might be acceptable. The important issue to address is to ensure that blood glucose is not falling further.

The audit showed that of 539 hypos across medical wards, in 34% was blood glucose checked between 15-30 min with some wards less than 25%. It is of major concern that so few readings in the hypoglycaemia range had blood glucose rechecked. Indeed, a comment on the findings was that staff might be confused by the current guideline. I would agree and note that the suggested action was to simplify the ward guidance

A re-audit was apparently repeated in September 2017 but only 55 of 113 episodes have been audited. An audit which only captures under 50% is inadequate. I also note that many episodes were not followed by a glucose measurement repeated within 30 min if I understand the report correctly. It also appears that there was only 33% of severe episodes that were responded to with a fast bleep which is a hospital standard.

I had wondered whether this was due to problems with the information system but I have been informed this was a consequence of time constraints following the CQC visit and other competing demands. This meant that only a partial audit was undertaken, accessing data

that could be readily accessed. I understand that the intention is both to complete this and also examine causes of hypoglycaemic episodes in the cases identified.

In summary, the in-hospital audit shows that the Trust is failing to meet its own quality standards and thus reflects the CQC findings. My conclusion is that the Trust should adopt clearer guidelines for the management of hypoglycaemia which relate to the important clinical issues concerning people with insulin treated diabetes, concentrating on episodes which are of clinical relevance and ensuring these are managed appropriately.

CHKS review,
I didn't find any results worthy of note.

Action briefing- No 1 in relation to hypoglycaemia dated June 2017 in the case of an unexpected hypoglycaemia event

It wasn't clear to me whether these instructions applied to someone with or without diabetes or both since hypoglycaemia, even a value equal to below 2.5mmol/l is not unexpected in a known insulin treated patient. I assume this was in relation to the previous poisoning events with insulin of non-diabetic individuals. It is unclear whether this also applies to those with diabetes. If it does, can I assume that there is an standard operating procedure regarding responsibilities of health care assistants, as I assume they may be undertaking the Point of Care testing.

The information required to be completed on the incident form is inappropriate for managing a case of severe hypoglycaemia in someone with diabetes. There is no guidance for individuals without experience in managing diabetes (for example adjusting therapy), and there is no requirement for a member of the diabetes team (either medical or one of the nursing diabetes team) to visit. This needs addressing.

Meeting with medical/nursing staff.

Dr Wasson explained that diabetes guidelines, particularly those pertaining to hypoglycaemia had been drafted following the conviction of a ward nurse for the murder of non-diabetic individuals on the medical wards using insulin in 2011. He pointed out that it has become hospital policy to record all low glucose values using the hospital Datix systaem which recorded point of care results. These were then provided to governance staff within the directorates and also to the medical director. He provided a list of the actions implaemented following the CQC visit.

I was informed that the diabetes ward (A11/12) was essenWTEtially a medical ward and while there was some specific diabetes knowledge and diabetes patients were frequently placed on the ward, the trained staff were not diabetes specialists and did not always have the experience to guide changes in therapy etc. This was confirmed when I talked to Polly Begum. She felt that the trained ward staff would be enthusiastic about developing their diabetes skills and would be capable of providing additional diabetes expertise when the inpatient diabetes team were unavailable, such as weekends, during the evening and overnight. However, there would need to be adequate staffing and training.

Kay Bottrell explained that as senior diabetes nurse manager she was responsible for both the community team who supported patients in out-patients and the in-hospital nursing team, consisting of two WTE nurses. One nurse, recently appointed was relatively inexperienced but both supported ward staff throughout the hospital. Following the CQC visit they had embarked on an extensive and detailed training exercise across all ward areas although as far as I could tell they had initiated this on the medical wards. Medical staff had been required to complete e-learning on the Trust intranet, a directive which had generally been followed. There did not appear to any current plan to undertake spot checks of diabetes management and knowledge on the medical wards. However while desirable, this might require considerable additional resource.

New F1 medicalstaff received some training in diabetes although this appeared to have been undertaken annually and not always when the F1 staff rotated.

The nursing staff and Dr Kong confirmed that the Datix hypoglycaemia data were circulated widely. The current Datix system operated whereby all glucose values below 2.5 were apparently sent to the Medical Director and at some stage to an administrator responsible for clinical governance. The staff were charged with investigating these low values, although in practice these activities were rarely addressed.

The team confirmed the existence of the Hypo Box, although in discussion It appeared that the medical staff were not always briefed as to its existence or exactly what it contained. They also explained that although at some point there had been a CQUIN policy of placing stickers into the medical notes following a significant hypoglycaemia episode, these were not always available in the HypoBox, apparently due to budgetary restraints. This meant that the current time, stickers were rarely placed in the medical notes.

The diabetes team described that following the case of murder in 2011, guidelines had focussed on collecting forensic evidence in response to a severe hypoglycaemia event. However, since almost all hypoglycaemic episodes occurred in people with diabetes and were not unexpected, this guidance was frequently ignored.

I was impressed by the staff on the acute admissions ward who appeared to be familiar with the management of diabetic ketoacidosis and competent to manage it. There was a clear understanding of the criteria which mandated a patient be transferred to the ITU. The diabetes consultants made themselves available to provide advice to medical colleagues dealing with diabetic patients even when not formally on call

As described above, there is detailed written guidance for patients using insulin pumps and once assessed as competent they are permitted to remain in charge of their own-self management, during their stay. However, it appears that patients taking insulin by injection are rarely permitted to either keep their own insulin supply or self-administer their insulin doses. Indeed, current hospital regulations, apparently require that doses of insulin, both background and bolus, be checked by two members of the trained staff. Unsurprisingly, this made it difficult to time pre-meal insulin, particularly when trained staff were

undertaking other activities. This was not conducive to keeping blood glucose within tight targets while patients were in hospital.

Currently, glucose meters with the capacity to measure plasma ketones are not available in all ward areas. The senior diabetes clinical team confirmed that in those areas which lack this equipment, staff are instructed to send a lab sample or measure urinary ketones.

Impression

My overall impression of diabetes care provided at Stepping Hill Hospital is that the multi-disciplinary diabetes team is of high quality and committed to providing a quality service. This includes the diabetes nurse manager, the inpatient nurses and the consultant diabetes team. I did not meet diabetes dietitians or podiatrists so cannot comment on these members of the multi-disciplinary team. I was told that some pharmacists contribute to diabetes care but the extent to which this occurs was unclear to me and I didn't talk to hospital pharmacists.

The diabetes ward manager is also keen to provide a high quality diabetes service although the ward's responsibilities in delivering care in general internal medicine in addition to diabetes may contribute to the relative lack of diabetes expertise on the ward. As far as I can judge (I spoke in detail only to Polly Begum) the trained staff have not received specialist diabetes training above that available to any staff on the adult medical wards. Subsequently I have been informed that some of the trained ward team did receive additional diabetes training but due to staff turnover, the numbers with this additional training are relatively few. Furthermore, since many of their patients have diabetes and are transferred to the ward from other areas such as the acute admissions ward, the ward staff have acquired general competence in diabetes care.

The written protocols for the management of hyperglycaemia and diabetic ketoacidosis are detailed and appropriate. They are comparable to the documents used in my own hospital with only minor differences.

Written guidance in the management of hypoglycaemia is lacking in some aspects. Advice concerning the timing of repeat measurements following identification of a low glucose is confusing. Additional guidance regarding practical steps to ensure that the episode is identified, recorded in the medical notes and that action is taken if necessary to prevent a further event, is not clearly specified. I believe this contributes to the worrying audit findings and the apparent lack of response to hypoglycaemia on the ward.

I am unpersuaded by the value of recording hypoglycaemia by Datix and providing these data to the directorate governance staff and the medical director. Such a system might be valuable in conducting an audit but I fail to understand how it helps ward staff identify and treat a hypoglycaemic episode appropriately. It may be that the system was implemented following the tragic criminal episode but I couldn't see how currently, it helps to ensure that episodes of hypoglycaemia are identified and treated promptly.

There appears to be a reluctance to allow adults who are competent, to self–manage their diabetes while in hospital, and in particular remain in charge of their own insulin treatment. The need to have doses checked by two trained staff is an important case in point and likely contributes to worsening of glucose control in hospital and an increased risk of both high and low glucose values. It is not clear to me why patients using insulin pumps are apparently deemed sufficiently competent to continue to manage their therapy yet those on multiple injections are not.

The diabetes inpatient nursing team have worked extremely hard to provide education for what appears to be virtually all the staff on adult wards in the hospital. The senior medical staff have also undertaken e-learning to improve their knowledge of diabetes. This is most impressive. Yet, there is a need for the diabetes in-patient team to be able to provide ongoing support for patients with diabetes who are scattered around the hospital. I am concerned that the presence of only two specialist nurses providing advice on the management of diabetes may be inadequate in a hospital of this size. This is particularly the case outside of daylight hours and at weekends. There is potential in providing additional training for the trained staff on the diabetes ward who could then act as an additional resource providing diabetes advice when the inpatient team are off-duty. However, such activity would need to be ongoing to address the issue of turnover of staff.

Management of high glucose levels has a different policy in different parts of the hospital. Currently, glucose meters with the capacity to measure plasma ketones are not available in all ward areas and on wards which lack this equipment, staff are instructed to send a lab sample or measure urinary ketones.

Recommendations

1) The background of insulin poisoning by a male nurse in 2011 appears to have influenced some of the guidance for the management of hypoglycaemia. Some of this guidance is inappropriate for the management of patients with diabetes and should be reviewed.

2) Identification of hypoglycaemia by point of care testing (either routinely or in a symptomatic patient) should prompt appropriate oral treatment and a repeat test within 10-15 min. This should be followed by oral long acting carbohydrate, considering the likely cause and importantly by a review of treatment regimen. If appropriate this should lead to adjustment of therapy, with a dose change or different medication. The episode should be recorded in the hospital records to ensure that medical staff responsible for the everyday care of that patient are alerted to the event.

3) There should be a system in place which is robust and ensures that all serious hypoglycaemia (glucose levels <3mmol/l) is reported to the diabetes nursing inpatient team who should visit the ward and provide the appropriate advice. Where necessary the specialist diabetes team should be informed.
Hypoglycaemia stickers should be placed the medical notes in advance of the introduction of an electronic record to alert the responsible medical tea.
Thus the focus needs to be on to how to identify serious hypoglycaemia ensure that the relevant actions are completed.

4) Hypoglycaemia Boxes should be present on each ward, clearly marked and containing the appropriate treatment for hypoglycaemia. Stickers should be included and placed in the medical notes after a hypoglycaemic episode. The boxes should be regularly restocked and be immediately available or use during a hypoglycaemic episode.

5) Standard dual function glucose meters should be available in all ward areas. Point of care testing for plasma ketones is now standard to people with diabetes who are issued with dual function meters and ward staff need to be able to check plasma ketone levels promptly in ward areas wherever patients with diabetes are managed. Similar devices which are used across the hospital would improve safety and simplify staff training.

6) Junior medical staff education on diabetes should be practical and delivered at each induction, consisting of brief insulin management, treatment of hypoglycaemia and high glucose values.

7) Now that staff have been re-educated, it is difficult to be sure how much they have learnt and whether they are putting their learning into practice. Spot checks on key wards, particularly in regards to insulin management should be implemented.

8) Repeat audits of diabetes care should be instituted which concentrate on management of severe/serious hypoglycaemia and adherence to standards.

9) Competent patients with diabetes should keep their insulin and treat themselves, without the need for 1 let alone 2 nurses to check the dose. The delays in finding 2 nurses at busy times (ie before meals) means it is likely that the insulin timing is variable and will worsen glycaemic control.

10) The nursing team on A11/12 has the potential to provide backup for an overstretched inpatient team and provide diabetes expert resource for the rest of the hospital. This will require additional training and perhaps secondment to the in-hospital diabetes team.

Simon Heller, 06 February 2018