NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

MEETING HELD IN PUBLIC

1 DECEMBER 2022

Making a difference every day.

NHS Stockport NHS Foundation Trust

Board of Directors Public Meeting
Thursday, 1 December 2022
Held at 09.30am at Pinewood House Education Centre
(This meeting is recorded on Webex)

AGENDA

Time			Enc	Presenting
09.30	**1.**	Apologies for absence		
	2.	Declaration of Interests		**All**
	3.	Patient Story		**Research & Development Team**
	4.	Minutes of Previous Meeting – held on 6 October 2022	✓	**T Warne**
	5.	Action Log	✓	**T Warne**
09.40	**6.**	Chair's Report	✓	**T Warne**
09.50	**7.**	Chief Executive's Report	✓	**K James**
	8.	**Performance**		
10.00	8.1	Integrated Performance Report • Quality • Operational Performance • Workforce • Finance	✓	**K James / Executive Directors**
	9.	**Quality**		
10.20	9.1	Safe Care including: - Annual Nursing & Midwifery Strategic Staffing Report - Safe Care Quarterly Report	✓	**N Firth** **A Loughney**
10.30	9.2	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services	✓	**N Firth**
10.40	9.3	Maternity and neonatal services in East Kent: 'Reading the signals' Report Briefing	*Verbal*	**N Firth**
10.45	9.4	Introduction to Patient Safety Incident Response Framework	✓	**N Firth**
	10.	**People**		
10.55	10.1	People Plan Progress Report	✓	**A Bromley**
11.05	10.2	Freedom to Speak Up - Freedom to Speak Up Progress Report - Self-Assessment against Planning Toolkit	✓	**C Parnell / P Elms**
11.20	10.3	Guardian of Safe Working Report	✓	**A Loughney / T Finnigan**

11.30	10.4	Wellbeing Guardian Report	✓	**M Logan-Ward**
Comfort Break				
	11.	**Strategy**		
11.40	11.1	Annual Corporate Objectives – Mid Year Review	✓	**K James**
11.50	11.2	Transformation Programmes – Mid Year Review	✓	**K James / A Brierley**
	12.	**Governance**		
12.05	12.1	Board Assurance Framework 2022/23 – Q2	✓	**K James**
12.10	12.2	Scheme of Reservation and Delegation: Approval	✓	**J Graham**
12.15	12.3	Annual EPRR Report – Core Standards & Statement of Compliance	✓	**J Graham**
	13.	**Standing Committee Reports**		
12.25	13.1	Board Committees – Key Issues & Assurance Reports: • Finance & Performance Committee • People Performance Committee • Quality Committee • Audit Committee	✓	**Committee Chairs**
	14.	**Closing Matters**		
	14.1	Any Other Business		
	15.	**Date, Time & Venue of Next Meeting**		
	15.1	Thursday, 2 February 2023, 9.30am, Pinewood House Education Centre		
	15.2	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*		
12.45		**Close**		

STOCKPORT NHS FOUNDATION TRUST

Minutes of the meeting of the Board of Directors held in public on Thursday, 6 October 2022 9.30am in Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Prof T Warne	Chair
Dr S Anane	Non-Executive Director
Mrs C Anderson	Non-Executive Director
Mr A Bell	Non-Executive Director
Mrs A Bromley	Director of People & OD
Mrs N Firth	Chief Nurse
Mr J Graham	Chief Finance Officer / Deputy Chief Executive
Mrs K James OBE	Chief Executive
Dr M Logan-Ward	Non-Executive Director / Deputy Chair
Dr A Loughney	Medical Director
Mrs J McShane	Director of Operations
Mrs M Moore	Non-Executive Director
Mr J O'Brien	Director of Strategy & Partnerships
Mrs C Parnell	Director of Communications & Corporate Affairs *
Dr L Sell	Non-Executive Director

** indicates a non-voting member*

In attendance:

Dr J Black	Consultant Clinical Psychologist
Mrs S Curtis	Deputy Company Secretary
Mrs R McCarthy	Trust Secretary
Dr P Nutall	Director of Informatics

Observing:

Mrs S Alting	Lead Governor
Ms O Perfect	Business Development Executive, Xyla Elective Care

147/22 Apologies for Absence

An apology for absence was received from Mr Hopewell, Non-Executive Director. The Chair welcomed Board members and observers to the meeting.

148/22 Declaration of Interests

There were no declarations of interest.

149/22 Staff Story

The Board of Directors welcomed Dr Jo Black, Consultant Clinical Psychologist and Clinical Lead for the Staff Psychology & Wellbeing Service (SPAWS) to the meeting. The

Consultant Clinical Psychologist delivered a presentation regarding SPAWS, which covered the following subject headings:

- SPAWS – Jan 2022 – July 2023
  - NHS Charities Together Stage 3 Covid Recovery Grant
  - Recent additional funding by Stockport NHS Charity
- Individual psychological input
  - Assessment, brief support/intervention, onwards referral/signposting
- Benefits of being an 'embedded' specialist psychology service
- Service Satisfaction
- Broader Activity
- Looking to the future – Opportunities and Risks

The Board heard that the response to SPAWS had demonstrated the need for the service and the Consultant Clinical Psychologist highlighted the need to secure increased funding going forward, after the NHS Charities Together grant ended in July 2023, with a view to moving from a charity funded service to the service being a core business of the Trust.

There followed a comprehensive discussion with Board members supporting the need for a continued and sustainable SPAWS service as a core function of the Trust. Board members suggested quantifying the success and associated savings made. In response to a question from the Director of Strategy & Planning about help available to staff requiring longer term access to SPAWS or critical incident stress management, the Consultant Clinical Psychologist briefed the Board on the prioritisation process and noted the current lack of capacity to provide extensive support.

A Non-Executive Director / Wellbeing Guardian commented that health and wellbeing was a priority for the Board and queried the staff perception. The Consultant Clinical Psychologist commented that the SPAWS service had been well supported by the Board but that due to the persistent organisational pressures, staff wellbeing was still a concern.

The Chief Finance Officer highlighted the need for a business case to provide clarity of the funding required and Board members agreed to support the SPAWS team in this area. The Chief Nurse commented that it was important for the SPAWS team to also have access to help from a resilience perspective and she agreed to put the team in touch with the Deputy Director of Quality Governance regarding post-incident support.

The Board of Directors:

- **Received and noted the staff story**
- **Supported the need for a continued and sustainable SPAWS service as a core function of the Trust, and offered support in the business case development**

The Consultant Clinical Psychologist left the meeting

150/22 Minutes of the previous meeting

The minutes of the previous meeting of the Board of Directors held on 4 August 2022 were agreed as a true and accurate record of proceedings.

151/22 Action Log

The action log was reviewed and it was noted that all actions were closed.

152/22 Chair's Report

The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. He noted the new team in place at the Department of Health and Social Care, highlighting the need to develop relationships, and the expected renewed interest in performance management from NHS England and the Department.

The Board of Directors:

- **Received and noted the report**

153/22 Chief Executive's Report

The Chief Executive presented a report providing an update on local and national strategic and operational developments.

She briefed the Board on the content of the report and highlighted the following areas:

- "Our Plan for Patients"
- Greater Manchester (GM) Provider Federation Board
- Autumn booster programme
- Emergency and Urgent Care Campus
- National joint registry
- Clinical leadership appointments
- Research awards
- Improved maternity care
- Making a Difference awards
- Trust's charity

A Non-Executive Director congratulated the Chief Executive on her appointment as Chair of the GM Provider Federation Board.

The Chief Nurse referred to the autumn booster programme and encouraged Board members to get their flu and Covid booster vaccinations.

The Chair referred to a BBC Panorama programme which had aired the previous week and highlighted work in response to the programme regarding the quality and safety of mental health, learning disabilities and autism inpatient services that would be reported to the Board of Directors in due course. A Non-Executive Director highlighted the importance of ensuring that all staff, as well as other public services, involved with the Trust were well educated in this area.

The Board of Directors:

- **Received and noted the report**

154/22 Integrated Performance Report

The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note.

QUALITY

The Medical Director and Chief Nurse presented the quality section of the IPR and highlighted performance and mitigating actions regarding mortality, antibiotic administration, infection prevention and control, pressure ulcers and complaints due to under-achievement in month. It was noted that all these topics had been discussed in depth at Quality Committee meetings.

OPERATIONAL

The Director of Operations presented the operational performance section of the IPR and highlighted the continued operational pressures and consequent adverse impact on the A&E, 6-week diagnostic, Cancer, Referral to Treatment (RTT), No Criteria to Reside (NCTR), elective activity including outpatients and theatre efficiency metrics due to under-achievement in month. She briefed the Board on mitigating actions, including significant work with locality colleagues around winter planning and transformational work regarding flow and discharges, and highlighted the importance of resilience support to teams.

The Board heard that, despite the continuing pressures within urgent care, the Trust's performance against the A&E 4-hour standard remained the best in GM for Type 1 Emergency Department attendances in month and year to date. The Director of Operations was reported that 104+ week waits had been eliminated in line with national expectations, and any patients still on the list had delayed their treatment due to personal choice.

In response to a question from a Non-Executive Director regarding the impact of the cost of living on delayed discharges, e.g. people not wanting to be discharged to their residence due to heating costs, the Director of Operations advised that Age UK offered support to people in this area, but acknowledged the associated risk. The Chief Executive highlighted ongoing work at neighbourhood level to address the consequences of the cost of living challenges.

In response to a question from a Non-Executive Director about patient initiated follow ups and impact of policy on health inequality outcomes, the Director of Operations confirmed that it was not an enforced offer and that careful consideration took place between clinicians and their patients, with the option of face to face appointments still available. She also confirmed that the policy included an equality impact analysis.

In response to a question from a Non-Executive Director who queried the opportunity of blended roles to address the issues around timely discharges, the Chief Executive briefed the Board on GM discussions to develop career structures, noting that the associated impact would take some time to develop.

The Chief Finance Officer highlighted the need for the Board to consider the impact the various challenges and developments had on the population, noting the link to GM and place based partnership work. The Chair endorsed the comment, noting the

recently published national Strategy for Women's Health as an area where the Board should consider its response.

PEOPLE

The Director of People & OD presented the workforce section of the IPR and highlighted performance and mitigating actions around sickness absence, appraisal rates, turnover, statutory and mandatory training, and bank and agency costs due to under-performance in month. She advised that successful recruitment continued, which was positively maintaining the Trust's substantive workforce figures. The Chair encouraged Board members to read the health & wellbeing newsletter.

FINANCE

The Chief Finance Officer presented the finance section of the IPR and advised that the Trust's position at month 5 was £1.1m adverse to plan – a deficit of £10.6m. He reported that the primary drivers of the movement from plan were escalation beds remaining open beyond the planned winter period, continued growth in ED attendances, and additional inflationary pressures.

The Chief Finance Officer advised that the Cost Improvement Plan (CIP) for 2022/23 was £18.1m (£12.1m recurrent) and highlighted that the CIP plan for month 5 had been delivered, however the majority on a non-recurrent basis. He confirmed that the Trust had maintained sufficient cash to operate during August, and that the capital plan for 2022/23 was £43m. He advised that at month 5 capital expenditure was behind plan by £1.284m, however this spend would be reprofiled into future months.

In response to a question from a Non-Executive Director about the ability to improve the bank and agency costs position, the Chief Finance Officer highlighted the ongoing substantive recruitment but noted that given the staffing challenges, including workforce availability, an improvement in the short term was unlikely. The Chief Nurse noted that the Trust had robust processes in place in this area but highlighted the financial impact of staffing the escalation wards. She advised that a review was being undertaken to establish whether these wards should be substantially recruited to.

A Non-Executive Director highlighted the significant additional challenges the Trust had faced since the financial plan had been signed off, including around ED attendances, Covid and inflation. The Chief Finance Officer acknowledged the comment and the significant adverse impact on financial and operational performance.

In response to a question from a Non-Executive Director about the quality impact around the use of bank and agency staff, it was noted that the triangulation and granularity was through the StARS assessments and divisional performance reviews, and that daily risk assessments took place to ensure safety on all wards. The Director of Operations added that the same high standards were expected from all wards, including escalation wards.

The Chief Finance Officer commented that the Board's risk appetite was the driving factor informing the decision making and to ensure quality and safety remained priority. The Director of Strategy & Partnerships highlighted the ongoing and future challenges from a finance, workforce and planning perspective, noting that

maintaining quality whilst trying to obtain best value for money would be a key challenge and focus for the Board.

In response to a question from a Non-Executive Director, the Director of People & OD briefed the Board on ongoing work around recruitment and retention, and specifically wellbeing and pastoral support offered to international recruits.

The Board of Directors:

- **Received and noted the Integrated Performance Report**

155/22 Learning from Deaths Report

The Medical Director presented the Learning from Deaths Report for Quarter 1 2022/23, providing information regarding the Learning from Deaths process in the Trust and a summary of the learning that has been gained in the last quarter. He advised that the high level information about the actions that have been taken in response would be reported through the Quality Committee meeting in October 2022.

The Chair welcomed the clear process and evidence provided in the report, and that the Trust remained on track regarding the Learning from Deaths reviews. The Director of People & OD was pleased to report that the Trust had obtained further support in this area.

The Board of Directors:

- **Received and noted the report and the processes that the Trust has in place that allow it to learn from deaths**

156/22 Safer Care Report

The Chief Nurse and Medical Director presented the Safer Care Report, detailing key care staffing assurances, risks and mitigating actions associated with safe nurse, midwifery and medical staffing, and the measures being implemented to enable employees to safely remain in work by supporting their health and wellbeing. It was noted that the report had been discussed in detail at the People Performance Committee and triangulated with the issues highlighted in the Integrated Performance Report.

The Chief Nurse briefed the Board on the decision to recruit to turnover and positive work around international recruitment and retention, and student nurses. The Medical Director referred to consultant vacancies, highlighting care of older people as a key area of challenge, and briefed the Board on the roll out of medical staff rostering.

The Chair noted that the report once again highlighted the challenges associated with staffing the open escalation wards.

In response to a question from a Non-Executive Director regarding Healthroster, the Chief Nurse noted that the Mersey Internal Audit Agency (MIAA) review had reported substantial assurance regarding the process, and that sustaining the improvements would be the focus going forward.

The Board of Directors:

- **Received and noted the report and confirmed action being taken to maintain safe care**

157/22 National Inpatient Survey 2021

The Chief Nurse presented a report summarising the results for the National Inpatient Survey 2021, as carried out by IQVIA. She advised that the survey included nine sections designed to mirror the service user journey, with high level analysis summarising:

- Comparison to Stockport's 2020 survey
- Comparison to other trusts surveyed by Quality Health
- Noise at Night response
- Next steps

She briefed the Board on the survey findings and highlighted the improvements made since the survey had been undertaken, as well as ongoing mitigating actions.

A Non-Executive Director commented that the Chief Nurse's verbal update triangulated with a recent walk round she had undertaken, during which she had received positive feedback from international nurses regarding their induction, and patients regarding communications from their consultants and clarity about discharge dates.

The Board of Directors:

- **Reviewed the outcome of the National Inpatient Survey 2022 and confirmed the next steps.**

158/22 Medical Appraisal and Revalidation Annual Report

The Medical Director presented a report providing positive assurance on the Trust's process of medical appraisal and revalidation. The Board heard that the Trust's rates of medical appraisal were very good, which in part resulted from a long-standing positive culture around medical appraisals.

The Board of Directors:

- **Received and noted the report**
- **Recommended the annual return for sign off by the Chief Executive**

The Director of Informatics joined the meeting

159/22 Annual Digital Strategy Progress Report

The Director of Informatics presented a report providing an update on the delivery of the Trust's Digital Strategy 2021-2026, focusing on the following digital ambitions:

- Digitise patient care delivery
- Empower our patients
- Support our staff
- Invest in our infrastructure
- Engage clinical leaders to improve quality
- Enhance performance and operational service delivery
- Collaborate with our partners

A Non-Executive Director welcomed the progress made with the Trust's digital ambitions and queried if there were any areas of concern. The Director of Informatics highlighted some delays around WiFi work and challenges regarding recruiting and retaining IT and clinical coding staff but noted that the issues were not critical at this stage.

In response to a question from a Non-Executive Director regarding the previous digital maturity assessment, the Director of Informatics confirmed that the Trust's position would not improve in this area until the single Electronic Patient Record was in place.

In response to questions from a Non-Executive Director, the Director of Informatics provided further clarity about the "bring/use your own devices" workstream and confirmed that the Stockport CCG Digital Team referred to in the report now sat within the Integrated Care System.

The Chair acknowledged the progress made and invited the Director of Informatics to include any risks to the delivery of the strategy in future progress reports.

The Board of Directors:

- **Received and noted the Annual Digital Strategy Progress Report**

The Director of Informatics left the meeting

160/22 Communications and Engagement Strategy

The Director of Communications & Corporate Affairs presented a Communications and Engagement Strategy 2023-26, setting out the Trust's proposed approach in this area and supporting the Trust's long term strategy to be an outstanding and well led organisation delivering high quality care for local people. She briefed the Board on the content of the strategy, including a plan on a page and the process for evaluating the delivery of the strategy.

The Director of Communications & Corporate Affairs thanked Board members for their previous comments regarding the strategy, which were reflected in the final draft.

Board members welcomed the strategy and provided general feedback on its content. Comments were made about the need to include staff in non-uniform in communications material to ensure all staff groups felt included and that some of the background colours used in the strategy made it difficult to read the print.

In response to a comment from a Non-Executive Director about the frequency of Board updates, it was proposed that update reports on the strategy's effectiveness

would be presented annually, with twice yearly progress updates provided regarding its delivery.

The Chair highlighted the importance of engagement in transformation work and the Director of Communications & Corporate Affairs acknowledged the comment and briefed the Board on work with place based colleagues in this area, including mapping work on using existing networks for engagement.

The Board of Directors:

- **Received and approved the Communications and Engagement Strategy 2023-26**
- **Agreed to receive annual update reports on the strategy's effectiveness, with twice yearly progress updates provided regarding its delivery**

161/22 Board Committees – Key Issues & Assurance Reports

FINANCE & PERFORMANCE COMMITTEE

The Chair of Finance & Performance Committee (Non-Executive Director) presented a key issues and assurance report from the Finance & Performance Committee meeting held on 15 September 2022. He briefed the Board on the content of the report and highlighted key operational and financial issues considered, noting triangulation with the Integrated Performance Report. He made particular reference to issues around CIP and longer waits, and good progress made regarding the Estates Strategy and Green Plan. He also referred to the Emergency & Urgent Care Campus scheme, noting that an associated report would be considered in the Private Board meeting.

The Board of Directors:

- **Reviewed and confirmed the Finance & Performance Committee Key Issues & Assurance Reports, including actions taken**

PEOPLE PERFORMANCE COMMITTEE

The Acting Chair of People Performance Committee (Non-Executive Director) presented a key issues and assurance report from the People Performance Committee meeting held on 8 September 2022. She briefed the Board on the content of the report, which triangulated with the Integrated Performance Report. She highlighted discussions around the Freedom to Speak Up function, GMC national training survey, and work to further refine relevant reports to highlight sources of assurance to Committee meetings.

The Board of Directors:

- **Reviewed and confirmed the People Performance Committee Key Issues & Assurance Report, including actions taken**

QUALITY COMMITTEE

The Chair of Quality Committee (Non-Executive Director) presented a key issues and assurance report from the Quality Committee meeting held on 27 September 2022.

She briefed the Board on the content of the report, noting triangulation with the Integrated Performance Report. She highlighted a mental health related patient story, and discussions around serious incidents, CQC insights report, incident reporting, smoking cessation, and violence and aggression training.

A Non-Executive Director commented that she had attended a recent Integrated Safeguarding Board meeting, which had been well attended with good content and assurance that complemented the assurance received at the Quality Committee.

The Board of Directors:

- **Reviewed and confirmed the Quality Committee Key Issues & Assurance Report, including actions taken**

AUDIT COMMITTEE

The Acting Chair of Audit Committee (Non-Executive Director) presented a key issues and assurance report from the Audit Committee meeting held on 22 September 2022. He briefed the Committee on the content of the report and highlighted the outcome of the Internal Audit reviews, particularly the substantial assurance provided by the StARS review, and consideration of the Board Assurance Framework and arrangements by which staff can raise concerns.

The Board of Directors:

- **Reviewed and confirmed the Audit Committee Key Issues & Assurance Report, including actions taken**

162/22 Any Other Business

There was no other business.

163/22 Date, time and venue of next meeting

The next meeting of the Board of Directors held in public would be held on Thursday, 1 December 2022, commencing at 9.30am in the Lecture Theatres, Pinewood House.

164/22 Resolution

The Board resolved that:

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

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Meeting	Minute reference	Subject	Action	Bring Forward	RO
1 Jun 2022	79/22	Integrated Performance Report	Summary Dashboard - Consider inclusion of improvement trajectories. **Update August 2022** – To be considered via Executive Team in Aug 2022. **Update October 2022** – Discussion via Executive Team. Forecasting trajectories for operational performance measures are included in Finance & Performance Committee – Operational Performance Report. IPR continue to include summary dashboard, supported by historical performance, SPC trend analysis, and one-month forecast.	Closed	Chief executive
4 Aug 2022	133/22	Board Committees – Key Issues & Assurance Reports	Quality Committee: Confirm level of reporting for Mental Health Plan. **Update October 2022** – Discussion with Chair, Executive Leads and Chair of Quality Committee – Confirmed quarterly report to Quality Committee with escalation to Board is required.	Closed	Chair
4 Aug 2022	131/22	Risk Management Strategy	'Risk Escalation & Approval' Table – Clarify description of approval and oversight via respective committee. **Update October 2022** – Risk Management Strategy updated and live on intranet.	Closed	Chief Nurse
6 Oct 2022	160/22	Communications & Engagement Strategy	Twice yearly progress report to be scheduled. Update December 2022 – Scheduled in Board Work Plan. Next progress report to be reviewed in April 2023	Closed	Director of Communications & Corporate Affairs

Meeting	Minute reference	Subject	Action	Bring Forward	RO
On agenda					
Not due					
Overdue					
Closed					

Stockport NHS Foundation Trust

Meeting date	1st December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chair's Report					
Lead Director	Trust Chair		Author	Professor Tony Warne		

Recommendations made / Decisions requested

The Board of Directors is asked to note the content of the report.

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
X	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	**X**	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	X	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low

			morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

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

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of the Chair's reflections on his recent activities.

2. EXTERNAL PARTNERSHIPS

As I write this report the invasion and war in Ukraine has been ongoing for 273 days. Since we last met, many of us will have attended a Remembrance Service, at which we remembered and reflected on the sacrifice made by all those who lost their lives in the two World Wars. It was also to remember those who today continue to be involved in conflict around the world. It remains important that we continue to keep all those caught up in the Ukraine/Russia war and in all other conflicts, in our thoughts and prayers.

You will be aware that since our last Board meeting in public, we have yet another Prime Minister and new Secretary of State (SoS) for Health and Social Care, Steve Barclay. He was, for a brief period a former SoS for Health and Social Care and has a working knowledge about the issues facing the NHS. Both Steve Barclay and the Shadow SoS for Health and Social Care, Wes Streeting, presented at this year's NHS Providers Conference. Perhaps due to the upcoming Autumn statement, neither presentation had much in the way of substance.

As we have seen, the NHS was singled out as the public service that would be protected. Whilst there have been additional funding and more promised in the future, the challenges facing the NHS remain. Of these, Emergency and Urgent care is the number one national priority. As we have seen in our own ED, the demand for services continues to be very high. Despite this, the four-hour target is back, and we will be scrutinised against this measure alongside others such as ambulance turnaround times and bed occupancy. The focus on our elective recovery is beginning to yield results, but more needs to be done to maintain this improvement.

One of the issues complicating our efforts is the continuing problem of patients who don't need to be in an acute bed but cannot be discharged due the appropriate level of support not being available. The first tranche of the promised £500 million to help further develop social care is being made available this month, the second tranche early in the new year. Alongside this funding an additional £1 billion is being made available nationally through Local Authority Better Care Funding. Both these funding streams will make a difference. The good relationships we have with Stockport MBC means that much more can be done to ensure we increase the flow of patients through the hospital and into appropriate social care and domiciliary services. Two examples of how this is currently being developed are highlighted in our Chief Executive, Karen James's Board Report.

There was also a very interesting discussion around improving access to primary care. Paula Cowan, who is practicing GP and also the North West Medical Director of Primary Care led the discussion. Despite what might be said in the media, the number of people seen in primary care has increased to 113% of the pre-pandemic levels of activity. Primary care colleagues are using a range of different approaches, including virtual appointments, telephone appointments as well as face to face appointments. These won't all be with a GP, and primary care is one area where a growth in other professions can be seen to be having a real impact on access. Two targets have been set, (1) gaining an appointment within 2 weeks, and an emergency appointment within 24 hours, and (2) smoothing out the 08.00 scramble for appointments.

Jane McCall, Chair at Tameside & Glossop Integrated Care NHS Foundation Trust, and I together facilitated our third Board to Board meeting between our two Trusts. The meeting was a further step on our journey to working more collaboratively with each other. We were able to explore the benefits, challenges, and possible next steps of our working more closely together. The benefits have been both tangible, in the shape of several joint executive director posts being developed across the two organisations, and the closer working between some clinical services, and perhaps less tangibly, gaining a stronger more powerful voice withing the Greater Manchester system.

Our growing approach to working in this way has enabled us to learn from best practice in each organisation, as well as harness all the skills and experience available in both organisations for the benefit of the neighbouring communities we serve. Following the retirement of Pete Weller as Director of Nursing and Integrated Governance at Tameside, both Boards agreed to the appointment of Nic Firth, currently Chief Nurse at Stockport, to take on this role across both Trusts. Her appointment will help ensure a closer alignment of the leadership of nursing and governance responsibilities across both organisations and work has begun on carefully considering what arrangements will be needed in both trusts to ensure that our front-line clinical colleagues in our hospital and community services have equal access to senior nursing and governance advice and support.

I attended the second Stockport Health and Wellbeing Board of the year. A number of issues were discussed, including a report of the Independent Chair of the Safeguarding Children and the Safeguarding Adults Partnerships was presented and discussed. Many interesting and innovative approaches were noted, including the use of Ring doorbells being used to help keep young care leavers safe.

A Pharmaceutical Needs Assessment (PNA) report was presented to the Board. This examined the current provision of pharmaceutical services across Stockport's Health and Wellbeing Board (HWB) area. There are 63 community pharmacies, and 68 when including other providers such as the one we have at Stepping Hill hospital.

The report was positive in terms of both the number of pharmacies across Stockport and the scope of work being undertaken by many of them.

Finally, there was a further positive report on the outcomes of the recent SEND revisit undertaken jointly by OFSTED and CQC to assess whether the Stockport had made sufficient progress on the five areas of weakness identified in the 2018 SEND inspection. Despite the challenges of the pandemic, four of the five areas were now found to be good, and work was progressing on the final area.

I participated in two NHE England North West Regional Leaders meetings. These tend to focus very much on the performance of the three ICS within the North West Region but there is also the opportunity to focus on specific areas of concern or learning across the patch. At the last meeting we were able to explore the lessons learned from the terrorist attack a years ago at the Liverpool Women's Hospital. Colleagues working at the time presented their account of events and shared the challenges they faced and what they had learnt from dealing with the incident. Whilst the attack was horrific, it could have been much worse. The Police and North West Counter Terrorism Unit declared the incident as a '*near miss*'. The discussion reminded all NHS organisations to remain vigilant and practice their major incident response plans on a regular basis. Since the arena attack, there have been several of these Great Manchester wide rehearsals.

I participated in the second Greater Manchester Chairs and NEDs meeting which updated colleagues on the progress being made across the GM Integrated Care System.

As well as the NHS Provider Annual Conference, I was able to participate in the North West Regional meeting of the NHS Providers. This meeting focussed on the challenges facing acute, community and mental health services across the North West.

Finally, I was able to meet with the interim Chief Executive of East Cheshire NHS Trust, Andrew Smith. The process of recruiting a new chair is underway. Andrew and I agreed we would convene a Board to Board meeting in the New Year.

3. TRUST ACTIVITIES

I have continued to meet with our Council of Governors both formally and informally. During this past period, the Nominations Committee were able to successfully undertake a recruitment process for the appointment of a new NED. Subject to formal Council of Governors approval, the successful candidate would commence in January 2023.

I have chaired three appointment panels for consultants in Stroke, Respiratory and Trauma and Orthopaedic services. We were able to appoint to all these posts, and this is something I think reflects our growing reputation for being an excellent place to work.

I have been able to participate as a non-participant observer at all the recent round of Board Assurance committee meetings. The high quality of many of our assurance reports, with well-defined metrics, presented at these meetings was encouraging and reassuring. My participation was part of my own exploration of whether our governance processes are delivering the right level of assurance, and the outcomes from my reflections will feed into a wider governance review in early January 2023.

As a Trust, we were able to hold our first colleague award celebration event since the start of the pandemic. Karen James and I hosted the evening and were joined by the well-known BBC health correspondent, Dominic Hughes, who presented the awards. Some 300 colleagues enjoyed an evening of good food, fun and music while celebrating the wonderful achievements of so many. Many thanks to all those involved in organising the event and to our sponsors for supporting the evening.

Karen and I were also able to celebrate the contribution made by a number of our long serving colleagues. 70 of our colleagues working in all areas of our Trust were able to attend the event. It was a fantastic opportunity to hear the citations, written by their manager, of the work that indviduals had done and their approach to their work. Each person received a badge, certificate and retail vouchers. There are some 250 colleagues working across the Trust who between them have contributed 5,000 years' service to the NHS.

Finally, one of the most interesting sessions at the NHS Providers conference was one that focused upon equality, diversity, and inclusion. The session looked the creation of both '*safe*' and '*brave*' spaces for people to speak out about their experience, ideas, concerns and so on. The concept comes from the work of Edgar Schein, (Humble Leadership, Humble Inquiry, and Humble Consulting), and is something I would like to see us explore as we take our EDI and kindness and civility strategies forward.

One of the ways we are doing this is through the relaunch of our staff networks. Some of these had been running for some time. I would like to recognise two colleagues who have co-chaired the Race Equality Network (formerly known as the BAME Network) and acknowledge the sustained and major contribution they have made over the last 14 years to our equality, diversity and inclusion ambitions. They are Gerol Williams (Senior Charge Nurse) and Richard Lewis (Digital Systems Training Manager). Many thanks from our Board to you both for all that you have done in taking this work forward.

4. STRENGTHENING BOARD OVERSIGHT

Our Board development journey continues. We had one Board Development session since we last met. This focused on possible future collaborative governance models. The session was framed around a scoping exercise that looked at different models in use across England. Whilst the various models all had their benefits and challenges, as a Board we decided that we would continue to work as we do at present and continue to look at opportunities to work more closely with both East Cheshire NHS Trust and Tameside & Glossop Integrated Care Trust.

Finally, our NEDs and Governors took part in a ‘holding to account’ development session. The all day event has evaluated well and will feature as part of our ongoing Governor training programme.

5. RECOMMENDATIONS

The Board of Directors is asked to note the content of the report.

Meeting date	1 December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chief Executive's Report					
Lead Director	Chief Executive		Author	Director of Communications & Corporate Affairs		

Recommendations made / Decisions requested

The Board of Directors is asked to note the content of the report.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	**X**	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	X	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	X	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	X	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of

			priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

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

- NHS Operating Framework
- NHS Providers' New Chief Executive
- Strike action
- New CEO for Manchester University NHS Foundation Trust
- Operational pressures
- Winter planning
- NHS Chefs of the Year

- Deputy Finance Director of the Year
- Recognition for joint delirium project

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of strategic and operational developments.

2. NATIONAL NEWS

2.1 NHS Operating Framework

NHS England (NHSE) has published its new operating framework, which sets out how the NHS will operate in the new statutory framework created by the Health and Care Act 2022.

It sets out the accountabilities and responsibilities of provider organisations, Integrated Care Boards (ICBs) and NHS England. Under the new framework providers will:

- retain their statutory responsibilities for the delivery of safe, effective, efficient, high quality services;
- continue to comply with the provider licences, Care Quality Commission standards and NHS planning guidance requirements;
- contribute to effective system working via ICS strategies and plans,
- remain accountable to people, communities, service users, Boards of Governors and ICS partners;
- be accountable to ICBs for business as usual delivery of services and performance, and for their agreed contribution to system strategies and plans;
- be accountable to NHSE as their regulator by escalation/exceptions or agreement with ICBs;
- deliver some of these accountabilities and responsibilities with the support of provider collaborative.

ICBs will be required to:

- provide effective system leadership and oversee delivery of system strategies, plans and Long Term Plan priorities;
- commission and manage contracts, delegation and partnership agreements;
- ensure delivery of the ICB core statutory functions;
- oversee the budget for NHS services in their system;
- be accountable to NHSE, via regional directors and to NHSE as a regulator, directly;
- be accountable to CQC for leadership, quality, safety and integration of services, as part of ICS (not as individual organisations);
- provide first line oversight of health providers across the ICS to oversee performance and contribution to overarching plans; coordinate/help tailor any support for providers.

NHS England will:

- agree the mandate for the NHS with government and secure required resources;
- contribute to effective system working and delivery on a national and regional level,
- foster relationship and alignment with government and be “stewards of the NHS”,
- shape and set national policy, strategy and priorities, and support systems and providers to achieve these, including via statutory intervention;
- remain accountable to Parliament, via the Secretary of State;
- oversee ICBs’ delivery of plans and performance;
- directly oversee providers’ delivery by exception and “generally in agreement” with ICBs’
- lead on support for organisations in SOF segmentation three and four,
- work jointly with other regulators including the CQC.

2.2 NHS Providers’ new Chief Executive

Julian Hartley, the current Chief Executive of The Leeds Teaching Hospitals NHS Trust, is to be the new Chief Executive of NHS Providers from February 2023.

He will take over the position from Saffron Cordery, who has been interim Chief Executive of the membership body that represents every NHS hospital, mental health, community and ambulance service in England.

2.3 Industrial Action

Following the announcement of the two NHS Pay Review Body recommendations, and the subsequent acceptance of the review body’s recommendations by the Government, a number of trade unions have been consulting their members around the pay deal and whether members would be prepared to take industrial action in relation to the deal.

Six trade unions have announced their intention to ballot for industrial action with the Royal College of Nursing being the first to conclude their ballot on 2 November 2022.

We have established a weekly emergency preparedness/industrial action meeting to oversee the planning and response to any industrial action.

Following a letter from NHS England detailing the expectations for preparedness for industrial action in the NHS, our industrial action preparedness group and key leads have begun completing the self-assessment checklist. This will be further updated

and refined as part of our planning process and through oversight at the task and finish group.

While members of the RCN have voted to take strike action over fair pay and safe staffing, the outcome of the ballot at in the Trust did not meet the threshold for strike action and therefore our staff who are RCN members are not eligible to strike. We are currently awaiting the outcomes of the other five other trade union ballots.

3. REGIONAL NEWS

3.1 New CEO for Manchester University NHS Foundation Trust

Mark Cubbon, Chief Delivery Officer at NHSE, is to be the new Chief Executive of Manchester University NHS Foundation Trust. He will take over leadership of one of the largest trusts in the country in Spring 2023, following the retirement of Sir Mike Deegan.

4. TRUST NEWS

4.1 Operational pressures

Since our last Board meeting, our services have continued to be under pressure as a result of increased demand for care coupled with on-going difficulties in being able to promptly discharge patients from hospital.

As a result we had one day in October when we declared OPEL 4 under NHS' Operations Pressure Escalation Levels (OPEL) system. OPEL is used to measure the demand and pressure a locality is under, and OPEL 4 is classed as a high escalation level that is instigated when all usual operational actions have not resulted in a steady flow of patients through a hospital.

Declaring OPEL 4 prompted a number of actions across our hospital and community services, as well as by our partners across the Stockport locality and wider GM health and care system. We were not the only NHS organisation in GMunder significant pressure at the time, but our partnership approach to tackling the issues meant that we were able to de-escalate the situation very quickly, moving from OPEL 4 to 2 within 24 hours.

Our social care partners really stepped up to help rapidly discharge patients who no longer needed acute hospital care, and as a result we saw a big reduction in the number of patients in this position. The improvement was a testament to what our local health and care system can achieve when everyone works together.

We have held a de-brief to reflect on the actions that we took both internally and as a system, and we had good assurance about the effectiveness of actions and lessons

we have learnt to inform our response should similar circumstances occur in the future.

In recent weeks we have also seen the start of two transformation projects we hope will help us to continue to improve the flow of patients through our hospital services. We have set up a virtual ward as part of a joint scheme with Tameside and Glossop Integrated Care NHS Foundation Trust, which is providing the digital element of support to people in their homes.

We have also opened the Thistle Discharge Unit on ward A1 as a test for change project. The 24 bedded unit is led by GP and therapy staff supported by a multi-disciplinary team including nursing and therapy teams, support workers, social care and Age UK colleagues. They are all focused on fast tracking discharge for patients, who are medically fit to leave hospital, with an emphasis on home first if at all possible.

4.2 Winter planning

Each summer we hold de-briefing sessions locally and with GM colleagues to reflect on our response to the previous winter pressures, and to learn lessons for the coming winter.

As a result of that learning and with the Trust as active partners, the Stockport system agreed a number of priority schemes for additional winter funding. This included an additional 16 discharge to assess beds which opened at Cherry Tree Nursing Home in Romilly at the end of October and additional support for local social care services to enhance discharge arrangements.

4.3 NHS Chefs of the Year

Two of our assistant head chefs – Erica Bell and Shelley Pearson-Smith were named as NHS Chefs of the Year in a competition run by NHSE to celebrate the best in health service catering.

The duo competed against teams from across the country in a number of menu challenges in the contest held at a catering academy in Somerset. Teams were eliminated stage by stage, Masterchef style until just three teams competed in the final.

Erica and Shelley secured the title with their winning recipes for watercress soup with a poached egg; braised ox cheek, celeriac fondant and greens, and chocolate fondant with a chantilly cream, which will be on our menu for patients at Stepping Hill Hospital.

The teams were judged on a number of factors including flavour, innovation, nutritional value, affordability, and reducing the carbon footprint of ingredients, and

the duo's success has attracted congratulations from across the country, including Great British Bake Off's Prue Leith.

Our catering team has received a number of accolades for the excellent quality of their food over the last year, including winning trophies at the national Public Sector Catering Awards, and the regional awards of the North West branch of the Hospital Catering Association last year. They are one of 14 'exemplar sites' as part of an NHS scheme improve hospital food standards across the country.

4.4 Deputy Finance Director of the Year

Kay Wiss, our Finance Director, has been shortlisted for a national award by the Healthcare Financial Management Association (HFMA).

She is one of three people in line for the Deputy Finance Director of the Year award, for the work she has done in fostering a positive culture in our finance department.

Kay, who recently took on the role of Finance Director, has worked for the Trust for 17 years, and has been instrumental in making it one of a small group in the North West to retain the highest level of accreditation from the Finance Leadership Council and NHS Skills Development Network.

She has played a key role in furthering partnerships with other NHS finance departments across Greater Manchester, including helping to set up a GM Deputy Director of Finance Group, and has won praise for how she has championed staff development including mentoring colleagues within the Trust and across the region.

The winner of the national awards will be announced in London at the HFMA annual conference in December.

4.5 Recognition for joint delirium pathway

A project to improve the care and support for patients with delirium has been recognised with local and national awards.

The Person Centred Community Delirium Pathway, which our community services set up in partnership with Pennine Care NHS Foundation Trust, was shortlisted in the Deteriorating Patients & Rapid Response Initiative category of the Health Service Journal Patient Safety Awards 2022.

The crisis response team, which introduced the new pathway, also won the Improvement and Innovation award at our own Making A Difference Every Day awards last month.

The pathway was introduced with the close involvement of Dementia United' Greater Manchester's integrated care's programme for dementia that works alongside clinicians, charities, professionals and those living with dementia and their families and carers.

Following a successful pilot in 2020, the pathway has now been introduced to community teams across the Stockport area. It has helped to reduce hospital admission and readmission rates, as well as the need for long-term care. It has also minimised patients' distress, leading to a better patient experience.

5. RECOMMENDATION

The Board of Directors is asked to note the content of the report.

Meeting date	1ST December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Integrated Performance Report					
Lead Director	Chief Executive		Author	Head of Performance		

Recommendations made / Decisions requested

Performance against the associated metrics for the last available month (October 2022 for the majority of indicators) is reported. Exception reports have been provided for areas of most significant note.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
x	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	x	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	x	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
	x	**PR3.1**	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of

			priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
	x	**PR3.2**	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	x	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
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	x	**PR6.2**	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
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	x	**PR7.2**	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Board is asked to note and discuss:

- Performance against the reported metrics;
- The described issues that are affecting performance;
- The actions described to mitigate and improve performance in the exception reports.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting Period October 2022

Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Trust Highlight Report

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

Operational Highlights
Exception reports included this month relate to performance against **A&E , 6 Week Diagnostic, Cancer, RTT, NCTR, Elective activity** and **OP** and **Theatre Efficiency** metrics due to under-achievement in month.

It should be noted that despite the continuing pressures within urgent care, the Trust's performance against the **A&E 4hr** standard remains the 3rd best in Greater Manchester year to date for all attendance types, and 2nd best for type 1 attends.

Quality Highlights
Exception reports included this month relate to performance against **Mortality**, **Sepsis, Falls with Harm, Hospital Acquired Covid, Category 2 Pressure Ulcers and Infection Prevention** metrics due to under-achievement in month.

The **Medication Incident Rate** is 5.18, which is above the local benchmark of 4. No concerns have been identified.

The **Written Complaints Rate** is 9.1 in month which is a rise on previous months. The Patient and Customer Services continue to focus on resolving concerns informally, where appropriate.

6 **Steis reportable** incidents were declared in month. Duty of candour has been completed and investigations are underway.

Workforce Highlights
Exception reports included this month relate to **Sickness Absence, Appraisal Rates, Turnover, Mandatory Training and Bank & Agency Costs** due to under-performance in month.

Substantive staff in post remains above target levels.

Financial Highlights
The Trust has submitted a revised plan with an expected deficit of £23m for the financial year 22-23. This was following agreement to increase the CIP target by £4m to £18.1m and increased contract income of £5m to reduce the deficit.

At month 7 the Trust position is £1.7m adverse to plan – a deficit of £13.2m

The drivers of the movement from plan are escalation beds remaining open beyond the planned winter period, continued growth in ED attendances and additional inflationary pressures. The impact of this is the increase in premium rate costs for nursing, medical and therapists.

The CIP plan for 22-23 is £18.1m (£12.1m recurrent). The CIP plan for month 7 (based on the revised CIP plan) has been delivered however, at this point the majority is non-recurrent.

The Trust has maintained sufficient cash to operate during October.

The Capital plan for 22-23 is £43m. At month 7 expenditure is behind plan by £4.334m, however this spend will be reprofiled into future months.

Risks
CIP continues to be a challenge in 2022/23 with the recurrent target of £12.1m and a non-recurrent target of £6m; total £18.1m.

Cost of inflation remains a high risk for the Trust and whilst the plans included some increase to address the pressure, costs continue to escalate for materials, food, and energy.

Cashflow – Based on the opening cash balance of £50m, a planned deficit of £23m and £13m of capital creditors, the need for cash support is being closely monitored and likely required from Q4.

The increased emergency demand and the related impact on the financial position including the elective recovery targets will continue to be monitored. There continues to be a risk that income will be reduced from any underperformance and that the costs of emergency demand will be higher than planned. The Trust is also overperforming on high cost drugs and the income for this is on a block basis.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Summary Dashboard

Performance

Blue indicates that the measure has met the target.

Orange indicates that the measure has fallen short of the target.

Target assurance

Grey indicates that variation is inconsistently passing and falling short of the target

Blue indicates that variation is consistently passing the target

Orange indicates that variation is consistently falling short of the target

Forecast position

Blue indicates that the measure is forecast to achieve the target next month

Orange indicates that the measure is forecast to fall short of the target next month

N=National / L=Local

Quality Metrics	Performance		Target assurance		Forecast
Mortality: HSMR (rolling 12-mth)	Aug-22	113	N	<= 100	
Mortality: SHMI (rolling 12-mth)	Jul-22	100	N	<= 100	
Sepsis: Timely recognition (rolling 12-mth)	Oct-22	95.8%	L	>= 95%	
Sepsis: Antibiotic administration (rolling 12-mth)	Oct-22	81.9%	L	>= 95%	
Hospital Onset Covid (HOC) Rate	Oct-22	54.7%	L	<= 51.65%	
Infection Rate - C. diff (rolling 12-mth)	Oct-22	59.44	L	<= 20.37	
Infection Rate - MRSA (rolling 12-mth)	Oct-22	2.27	L	<= 0	
Infection Rate - MSSA (rolling 12-mth)	Oct-22	22.23	L	<= 8.94	
Infection Rate - E. coli (rolling 12-mth)	Oct-22	106.62	L	<= 24.34	
Medication Incidents: Rate	Oct-22	5.18	L	<= 3.76	
Never Event: Incidence	Oct-22	0	N	<= 0	
Serious Incidents: STEIS Reportable	Oct-22	6	L	<= 5	
Stroke: Overall SSNAP Level	Jun-22	A	N	>= C	
Falls: Rate of Moderate Harm and Above	Oct-22	0.21	L	<= 0.13	
Pressure Ulcers: Hospital, Category 2	Oct-22	52	L	<= 48	
Pressure Ulcers: Hospital, Category 3 and 4	Oct-22	5	L	<= 4	
Written Complaints Rate	Oct-22	9.15	L	<= 5.93	
Complaints: Timely response	Oct-22	95.7%	L	>= 95%	

Operational Metrics	Latest Performance		Target		Forecast
ED: 4hr Standard	Oct-22	56.4%	N	>= 95%	
ED: 12hr Trolley Wait	Oct-22	266	N	<= 0	
Diagnostics: 6 Week Standard	Oct-22	19.1%	N	<= 1%	
Cancer: 62-day standard	Oct-22	68%	N	>= 85%	
Cancer: 28-day standard (FDS)	Oct-22	65.7%	N	>= 75%	
Cancer: 14-day standard (2WW)	Oct-22	98.7%	N	>= 93%	
Referral to Treatment: Incomplete Pathways	Oct-22	49.9%	N	>= 92%	
Referral to Treatment: 52 Week Breaches	Oct-22	3937	N	<= 0	
No Criteria To Reside (NCTR)	Oct-22	123	L	<= 73	
Activity vs. Plan: Elective Inpatient and Daycase	Oct-22	-14.3%	L	>= 0%	
Activity vs. Plan: Outpatient	Oct-22	-14.8%	L	>= 0%	
Activity vs. Plan: ED Attendances	Oct-22	8%	L	<= 0%	
Outpatient DNA rate	Oct-22	8.5%	L	<= 5.8%	
Outpatient Clinic Utilisation	Oct-22	84.6%	L	>= 85%	
Patient Initiated Follow Up (PIFU)	Oct-22	4.6%	L	>= 3.33%	
Theatres: Capped Utilisation	Oct-22	79.9%	L	>= 90%	

Workforce Metrics	Latest Performance		Target		Forecast
Substantive Staff-in-Post	Oct-22	90.5%	N	>= 90%	
Sickness Absence: Monthly Rate	Oct-22	6.6%	N	<= 4%	
Workforce Turnover	Oct-22	14.7%	L	<= 11%	
Appraisal Rate: Overall	Oct-22	86.9%	N	>= 95%	
Statutory & Mandatory Training	Oct-22	91.1%	N	>= 95%	
Bank & Agency Costs	Oct-22	16.4%	L	<= 5%	

Finance Metrics	Latest Performance		Target		Forecast
Financial Controls: I&E Position	Oct-22	12.3%	L	<= 0%	
Cash Balance	Oct-22	23.2			
CIP Cumulative Achievement	Oct-22	0.2%	L	>= 0%	
Capital Expenditure	Oct-22	-8.3%	L	<= 10%	

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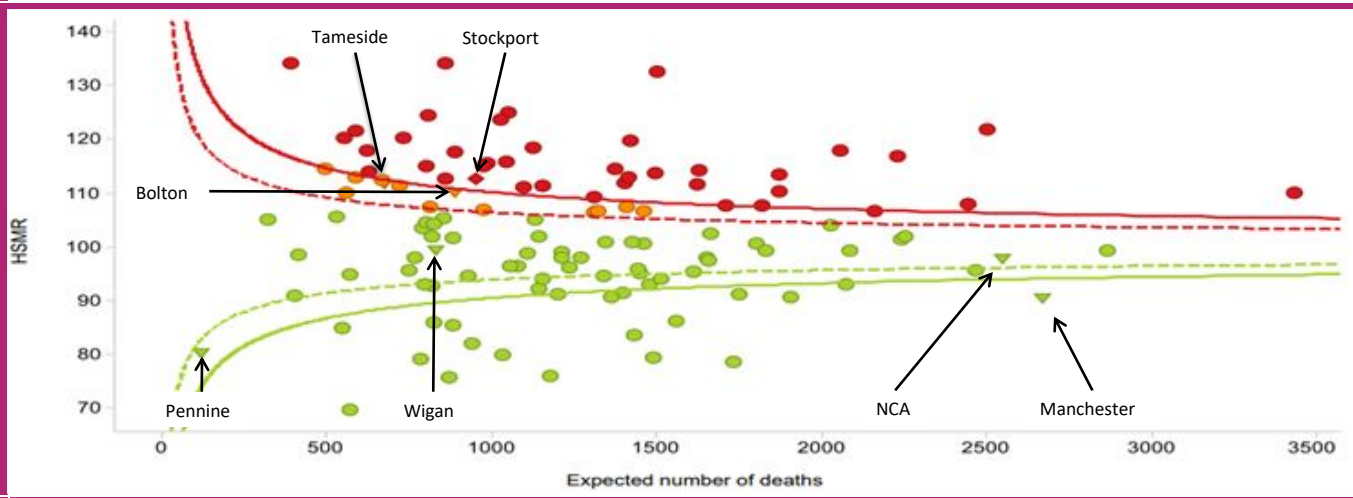
NHS Stockport NHS Foundation Trust

Measure	**Mortality: HSMR (includes narrative for SHMI)** The Hospital Standardised Mortality Ratio (HSMR) shows the ratio of the observed to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell, multiplied by 100. Data sourced from the Healthcare Evaluation Data (HED) system.
Performance of this measure over time	
What the chart tells us	Stockport is now the only GM Trust currently ranked as "very high" with mortality rates outside the statistical control limits in the red zone. Bolton and Tameside continue to report high in the amber zone, but are within expected mortality levels. All other Trusts across GM are classed as "within range", and Manchester is reporting as lower than expected.

Latest Performance	Next Month Forecast
	

Variance

Latest Month	Actual
Aug-22	113

Assurance

Target: <= 100

Narrative	Issues:	Actions & Mitigations:
	The SHMI index is currently 99.72 for the period August 2021 to July 2022. This is currently 8 points better than the GM peer median average, and 4 points better than the national median. HSMR is 112.74 for the period September 2021 to August 2022. This is currently 15 points above the GM peer median average, and 10 points above the national median. It should be noted that the HSMR is categorised as 'very high' (i.e. 112.74 is outside statistical control limits).	The 'primary diagnosis' of UTI is one of the main factors driving the HSMR upwards. Figures for the year 2021-2022 show that UTI was the primary diagnosis for 74 people who died, but was the cause of death in just 12 of these. We are currently auditing the standard of care in these cases. Dr Foster is currently consulting on a proposal to remove the effect of palliative- care coding from HSMR. This change is likely to significantly affect the current HSMR positions of numerous hospital trusts.

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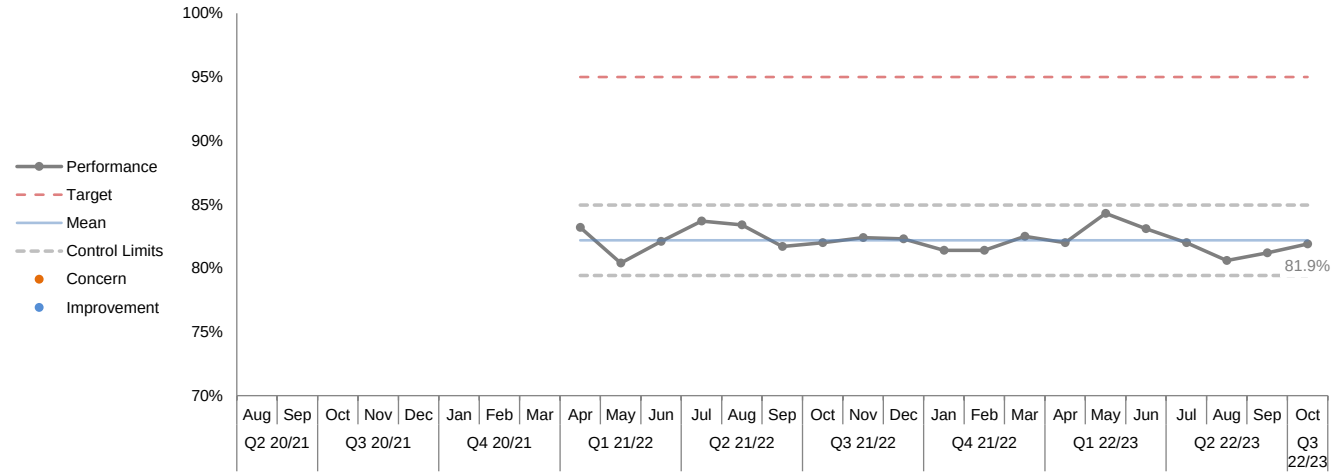
Measure	**Sepsis: Antibiotic administration (rolling 12-mth)** The number of patients who received IV antibiotics within agreed standards for sepsis patients, as a percentage of those eligible patients audited and found to have sepsis. Performance is based on a rolling 12-month. Data for the current month is based on part-validated data, and a fully validated position is updated one month in arrears.
Performance of this measure over time	
What the chart tells us	Performance for this metric is expressed as a rolling 12- month average. The chart shows that over the last 12 months performance has been maintained around the average of 82%. There have been no significant changes in performance across the period.

Latest Performance	Next Month Forecast
	

Variance

Latest Month	Actual
Oct-22	81.9%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

>= 95%

Performance consistently exceeds the target value

Narrative	Issues:	Actions & Mitigations:
	76% compliance for antibiotics in October. There were 6 red flag fails and 1 amber flag fail. There were 3 fails across Surgery and 1 within Medicine. 3 of the breaches occurred out of hours. The average delay in receiving antibiotics is at 4hrs 56mins. Nurse delays were a factor across all fails, but delayed prescribing accounted for a significant cause in 4 of the 7 fails.	Provisional Go Live date for Revised Sepsis Screening Assessment tool 24th November. Although there are a number of plans to support successful implementation, there could be an impact on future performance until embedding of the tool is achieved. There are plans to engage doctors and nurses. The new tool will mean that medical and nurse assessments are recorded within patient-track. It enables greater scrutiny of performance for delivering sepsis six, and is an opportunity to improve communication between medics/ nurses caring for patients with suspected sepsis. Training will focus on the time critical nature of delivery of sepsis six. In time this tool should embed timely administration of antibiotics

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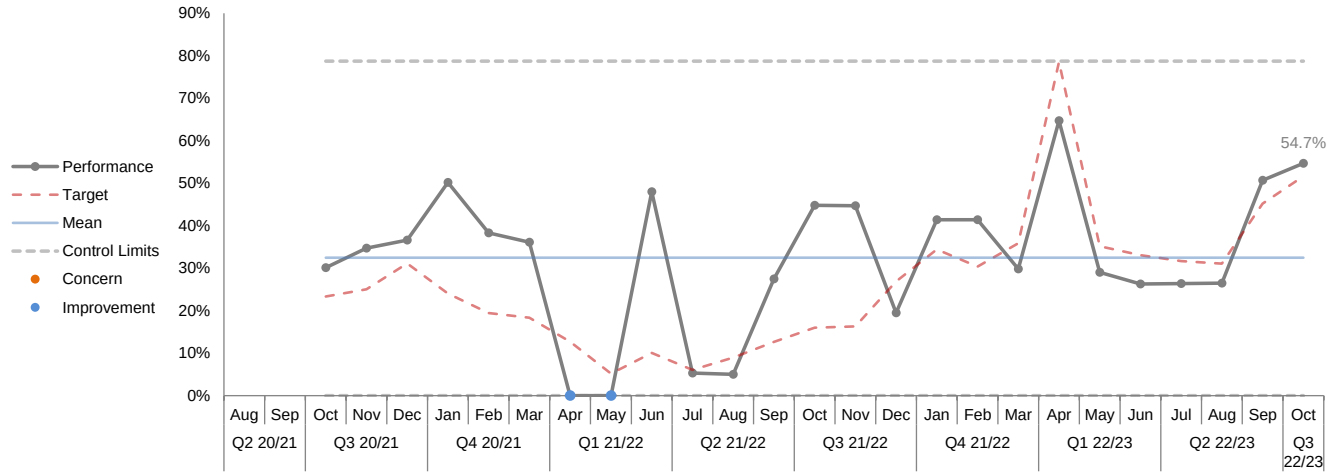
Measure	**Hospital Onset Covid (HOC) Rate** The number of patients diagnosed with probable and definite hospital onset covid-19, as a percentage of all patients diagnosed with covid-19. Patients diagnosed 8-14 days following admission are classed as probable HOC, and patients diagnosed 15+ days following admission are classed as definite HOC. The target for this indicator represents the regional average at the time of reporting.
Performance of this measure over time	
What the chart tells us	The charts shows that performance of this metric has been variable for the whole reporting period. Stockport's performance has tracked below the GM average for the last several months, but September and October data has shown that Stockport is now reporting above the GM average.

Latest Performance	Next Month Forecast

Variance

Latest Month	Actual
Oct-22	54.7%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 51.65%

Performance against the target has not been consistent in the last 6 month period

Narrative

Issues:	Actions & Mitigations:
The Trust has reported 64 covid positive cases in October with 35 of these being nosocomial which is a decrease on the previous month. The Trust currently has a rate of 55% against the Northwest rate of 52%. This is an increase in the Northwest over the last months reported rate.	National team have agreed that RCA investigations are no-longer required for nosocomial cases unless they meet the serious incident criteria or patient is poorly with Covid-19. As the COVID positive numbers fluctuate, escalation and de-escalation of COVID areas will be actioned accordingly.

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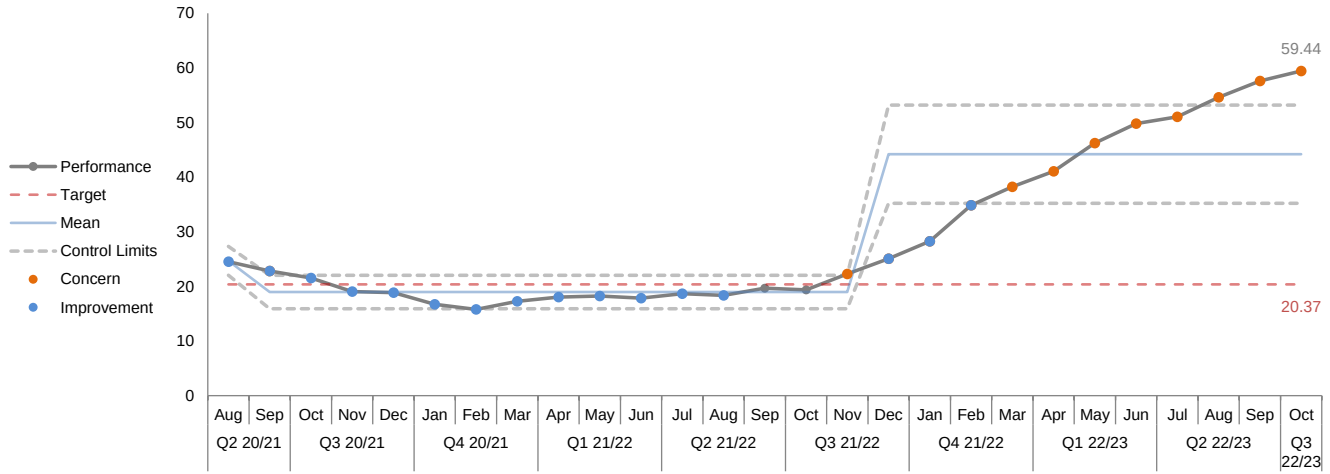
Measure	Infection Rate - C. diff (includes narrative for E. coli infections) This indicator shows the count of hospital-onset Clostridioides difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older. The value shown is calculated from data across a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month		Actual
Oct-22		59.44

The data shows special cause variation, indicated by an increasing trend over the last 8 months.

Assurance

Target

<= 20.37

Performance consistently exceeds the target value

What the chart tells us

Despite low rates for much of the early reporting period, the chart shows a significant rise in the infection rate from November 2021 onwards. This increasing trend has continued for the last 12 months.

Narrative

Issues:

For C.Diff, there were 6 cases in October; 2 of these cases have been presented at HCAI panel, 1 deemed unavoidable, 1 deemed Avoidable and 4 cases await panel review.

The Trust is over the proposed threshold of 23.9 for October with a YTD of 42. Thirty-eight cases have been presented at the HCAI panel; 33 cases deemed unavoidable, and 5 cases deemed avoidable. 4 cases await panel review.

Whilst SFT have now exceeded our Trajectory of 41 cases, our Greater Manchester peer group also show a month-on-month spike in their Cdiff rates. Nationally there has also been an increase in cases.

Actions & Mitigations:

For C.Diff, 4 cases remain outstanding and are due to be heard at the HCAI panel in November.

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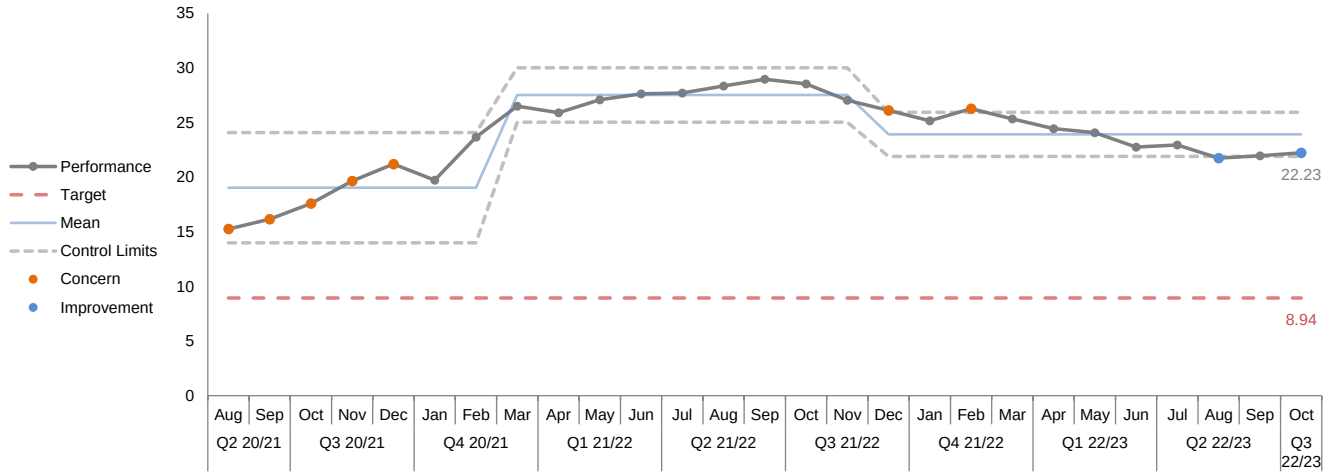
Measure	Infection Rate - MSSA (includes narrative for MRSA infections) This indicator shows the count of hospital-onset meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia infections per 100,000 bed days. The value shown is calculated from data across a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Oct-22		22.23

The data shows special cause variation, indicated by a value near to the lower control limits.

Assurance

Target

<= 8.94

Performance consistently exceeds the target value

What the chart tells us

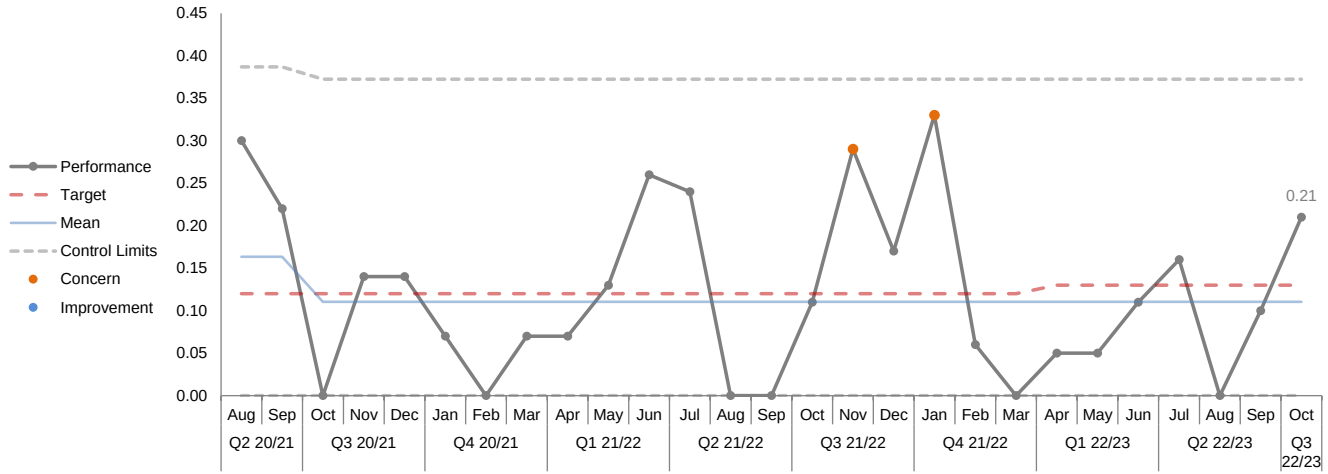
The chart shows that the MSSA infection rate has continued to rise throughout the reporting period, with significant increased seen throughout 2020/21 and again through Apr21 to Nov21. The latest data shows a significant improvement, with the MSSA rate reported below the average for the last five months.

Narrative

Issues:	Actions & Mitigations:
2022-23 internal threshold for MSSA is 16 cases, this equates to a 15% reduction on 2021-22 figures. This is based not only on Trust apportioned cases but also Community Onset, Hospital Associated (COHA) cases. There were 2 Trust apportioned HOHA cases in October. YTD total is 19 which is over the proposed threshold of 10.5 for the end of October.	To develop a simplified RCA tool that can be used for divisions to investigate cases

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Falls: Rate of Moderate Harm and Above** The number of falls causing moderate harm and above, calculated as a rate per 1000 bed days. Excludes any patient falls in the emergency department.	**Latest Performance**	**Next Month Forecast**
Performance of this measure over time		**Variance** **Latest Month** Oct-22 **Actual** 0.21 Data shows common cause variation, suggesting no significant changes in performance **Assurance** **Target** <= 0.13 Performance against the target has not been consistent in the last 6 month period	
What the chart tells us	The chart shows that throughout the reporting period the rate of moderate harm falls has not changed significantly. The rate has been remained below the target/benchmark for much of the year so far, but the latest figures show that falls rates causing moderate harm have increased.		

Narrative	**Issues:**	**Actions & Mitigations:**
	The Trust Quality Improvement target for 2022/2023 is a 10% reduction in both the overall number of falls, and those causing moderate and above harm. No issues to report.	Nursing and Therapy teams are working collaboratively to support work around falls prevention. Falls Prevention Improvement work includes: - Expansion of the Quality Team and Patient Experience and Quality Improvement Matron who is the overall lead for falls reduction. - Royal College of Physicians guidance of L+S BP has been incorporated into the falls risk assessment. Overarching Falls Action Plan for each Directorate will be monitored at the Quality & Safety Improvement Strategy Group. - Introduction of 'at a glance' ward moves/transfers during current patient admission episode supporting decision making around patient transfers. - Falls Sensors' programme – at present at Bluebell, M4, E1. - Bay Nursing has been launched with ongoing training and Bay coordinator role commenced - ED documentation is being reviewed, along with the post-fall doctor checklist. - Falls Awareness week took place with full MDT approach - A slipper socks, fall champions, bimonthly newsletters, certificates for 0 falls month areas, Safety cross boards, weekly falls review panel in place and ' think yellow' pilot with Pharmacist pilot is awaiting to commence alongside reviewing e-learning package. Staff knowledge and understanding is monitored via the ward StARS Accreditation programme.

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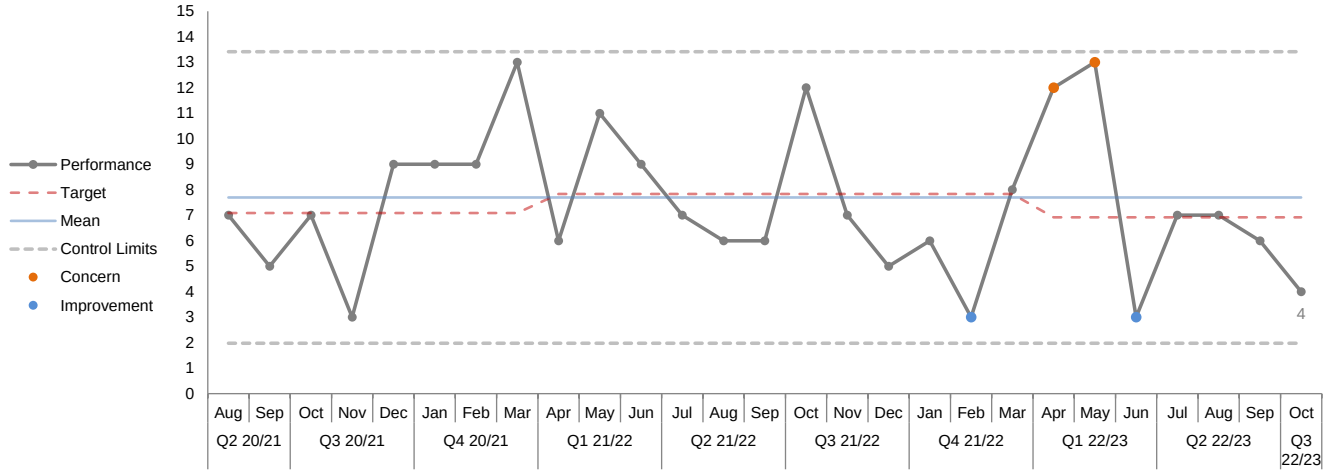
Measure	Pressure Ulcers: Hospital, Category 2 (includes narrative for category 3 & 4) Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	52

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 48

Performance against the target has not been consistent in the last 6 month period

What the chart tells us

For much of the reporting period, the number of category 2 pressure ulcers reported has been variable between 3 and 13 and there have been no significant changes. The number of pressure ulcers reported in April and May were double the expected number, and although pressures ulcers reported June onwards have been in line with expectations (7 per month) the cumulative total for the Trust remains above expected levels.

Narrative

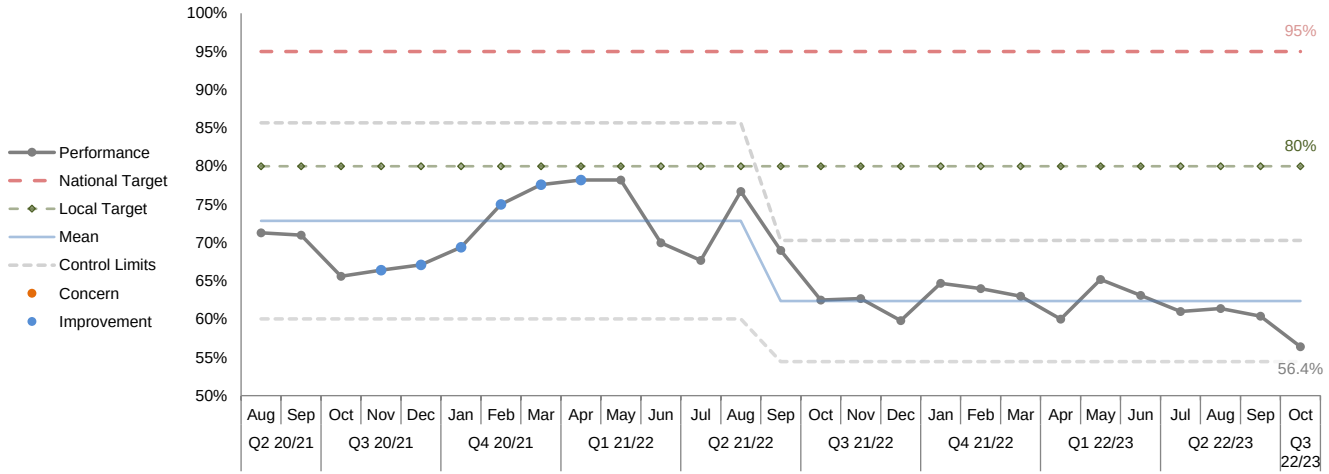
Issues:	Actions & Mitigations:
The Trust has set a target to reduce the overall number of hospital acquired pressure ulcers by 10% for year April 2022- April 23. This month (October data) we have had 4 category 2 pressure ulcers reported. This includes 2 pressure ulcers as a result of medical device. This month we have seen a decrease in the number of pressure ulcers reported. The Trust remains approximately 8% over trajectory to meet the reduction target however the reduction target is still achievable with sustained improvement. There have been no Category 3 or 4 pressure ulcer incidents this month.	Divisional leads are conducting regular pressure ulcer review panels to discuss all incidents reported in their divisions. The pressure ulcer verification masterclass continues to be delivered to senior nurses as required. A pathway for the management of fractures and the devices used to manage them has been launched which includes the risk assessment and consideration of reducing pressure ulcers caused by these devices. Additional training sessions have been arranged focusing on the management of fracture devices such as air cast boots. The Pressure Ulcer Prevention training programme continues with monthly sessions; the TV team are working closely with the divisional practice facilitators and the learning and development team to ensure all relevant staff attend the training sessions. In response to a number of incidents occurring in relation to oxygen tubing, a review of foam protection devices available is taking place.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	ED: 4hr Standard (includes narrative for 12hr trolley waits) The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	56.4%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target >= 95%

Performance consistently falls short of the target value

What the chart tells us

Since September 2021, ED performance against the 4hr standard took a dip from the 73% average to 63%. Since then, performance has been consistently between 60% and 65%, but the latest months performance dips below 60% for the first time since December 2021.

Narrative

Issues:

Stockport were the 2nd best performing Trust within GM for type 1 ED attendances in October,

-Average attendances remain high at 307 per day, with ED attends trending higher than the 2019/20 baseline year.
- Overall performance benchmarks well but is significantly deteriorated vs last year.
- Significant driver of the 4hour standard remains the challenged position to good flow.
- Bed occupancy continually exceeds 98%, which is beyond the recognised safe limits for effective flow.

- Timely access to domicile care and community beds is significantly challenging.
- Overall levels of patients with no reason to reside are significantly more than optimised position of 40-50 per day and double the position in the same period last year.
- The number of out of area patients with no reason to reside is excessive, with other localities failing to meet demand. This relates to North Derbyshire and East Cheshire.

Actions & Mitigations:

-The internal "Programme of Flow" work continues which features twice weekly ward MDT reviews and "Let's talk about flow" sessions led by the Director of Operations and with input from the Medical Director and Chief Nurse.
- Director of the Day rota has been established to support flow and challenge the discharge position.
- 7 day support is in place including adult social care
- Long LOS reviews and measure to support weekend discharges commenced in month.
- Excess bed charging to out of borough patients to commence in November-22
- A transformational flow programme has commenced whereby the trust has opened a community D2A unit within a ward on the hospital site. This opened 31.10.22 and has 24 beds under the care of a GP.

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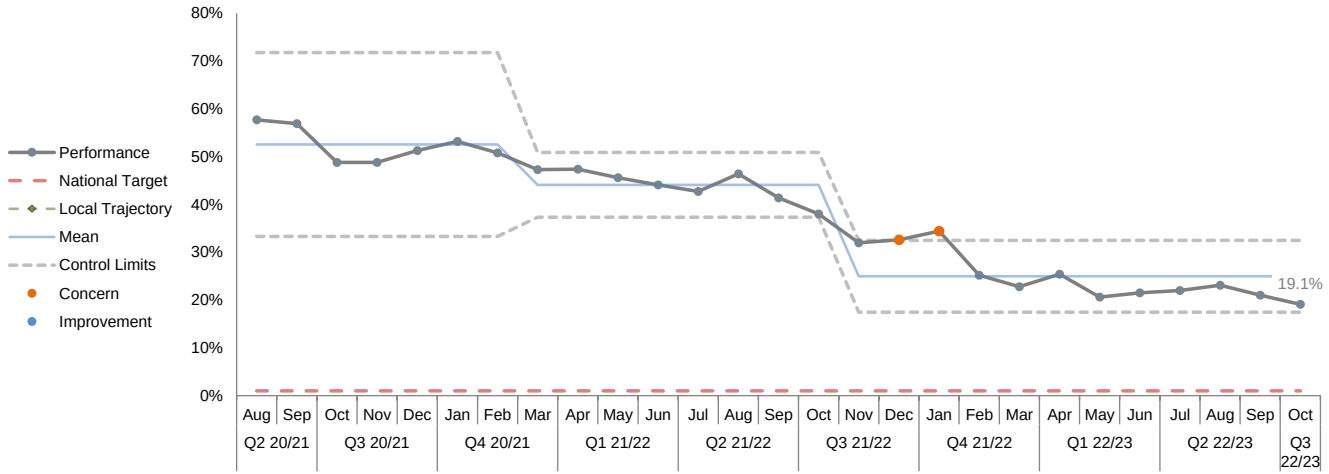
NHS Stockport NHS Foundation Trust

Measure	Diagnostics: 6 Week Standard The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	19.1%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 1%

Performance consistently exceeds the target value

What the chart tells us

Performance has been improving steadily since May 2020. Significant improvements in performance can be seen with a change in March 2021, and then again in November 2021 with a new average performance of 26%. For the last several months, performance has been below this average.

Narrative

Issues:	Actions & Mitigations:
Forecast position for end of October is 19.5 % waiting 6+ weeks, slightly improved from September. Benchmarking against peers is also improving. Pressure on Endoscopy remains, as a result of increased colorectal suspected cancer referrals. The endoscopy estates scheme to deliver a 4th room is delayed until February 2023. Further outsourcing options are being secured. Biggest area of challenge, and highest backlog is Echocardiology. Estates work being considered to create a 6th room. Latest position does show a continued reduction in both the waiting list size and 6+ week waits.	All the imaging modalities continue to be compliant with the national 6 week wait standard and the Trust is on trajectory to achieve the diagnostic waiting time standard by the end of the financial year with the mitigations in place. Echocardiology - efficiency & productivity is being maximised so avenues for increase capacity is being explored. Estates work are being considered to create a 6th room. Latest position does shows a continued reduction in both the waiting list size and 6+ week waits. Pressure on Endoscopy remains, as a result of increased colorectal suspected cancer referrals. The endoscopy estates scheme to deliver a 4th room is delayed until February 2023. Further outsourcing options are being secured and financial implication will be considered in December. Focus on productivity & efficiency remains on going.

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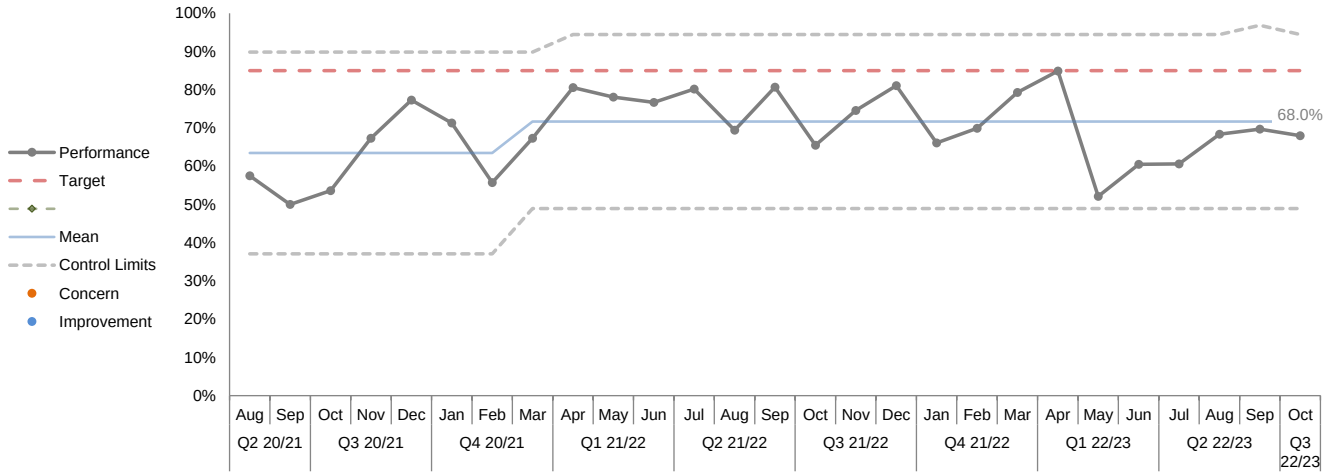
Measure	Cancer: 62-day standard (includes narrative for 28-day FDS and 14-day) The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral. Screening referrals are not reported as not statistically viable due to low number received

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	68%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
>= 85%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that in the last 12 months performance has been variable but around the average of 74%. In April 2022 we achieved the national target of 85% for the first time across the whole reporting period, although performance since May 2022 has dropped back below the average.

Narrative

Issues:	Actions & Mitigations:
The final position for September shows performance at 69.7%. The current position for October is 68%.	The wider cancer transformation programme continues which includes improvement plans across Radiology and the operational divisions to enable the Best Timed Pathways to be achieved.
Sustained increase in suspected referrals continues to impact on access times. At Trust level a 25.6% increase is seen to month 7, compared to the same time period last year.	One stop neck lump and improved processes for step downs in endoscopy are being implemented.
Colorectal has seen a 31% increase in referrals, Urology 32% and Gynae 35% year to date.	Trust elective performance meetings continue to focus on progressing patient pathways and eliminating all 104 day waist for cancer treatment.
Access & reporting times for some imaging and diagnostic tests are being impacted by the high level of referrals, along with the continuing non-elective pressures and staff sickness absence levels.	Key recruitments now in post in Colorectal which will positively impact on the referral to diagnosis part of the pathway.
The Trust continues to show strong performance against the '14 day referral to first seen' standard.	The Trust continues to utilise capacity at the Christie for Urology and General Surgical cases.
28 day Faster Diagnosis Standard also shows an improvement in month.	

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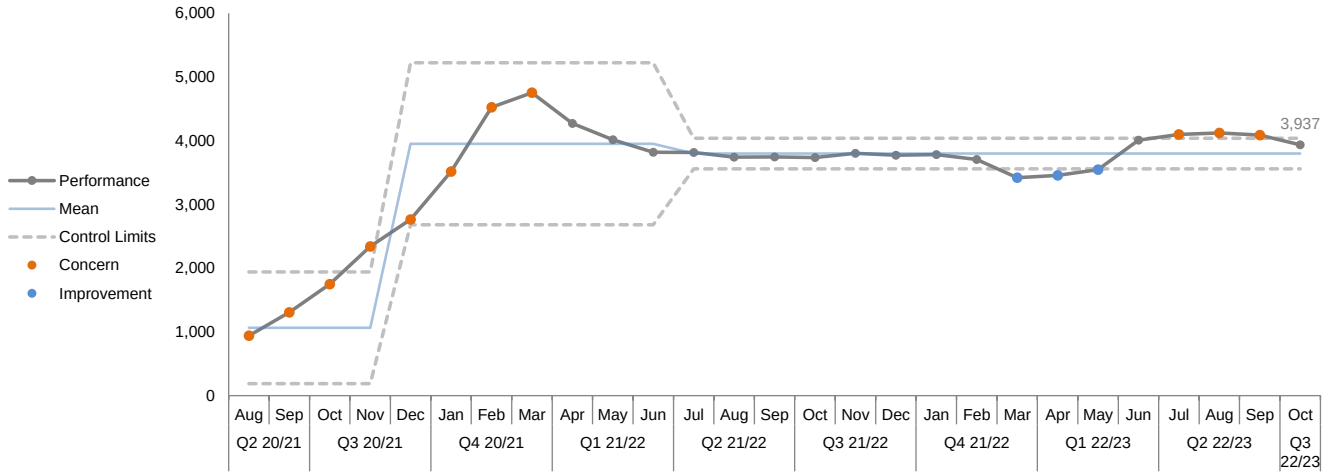
Measure	Referral to Treatment: 52 Week Breaches (includes narrative for incomplete pathways) The total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Oct-22		3937

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target <= 0

Performance consistently exceeds the target value

What the chart tells us

The number of breaches has remained fairly consistent between July 2021 and February 2022. A significant improvement is seen between March 2022 and May 2022, but then a significant increase is seen from July 2022 to September 2022.

Narrative

Issues:	Actions & Mitigations:
A good reduction in the number of patients waiting 52+ weeks to commence treatment was seen in month. The Trust continues to reduce the number of patients waiting 104+ weeks, reporting just 19 at month end. None of these extended waits were due to lack of capacity, namely patient choice to defer or clinically complex cases. A good reduction in 78+ waits was also seen. The levels of urgent and suspected cancer referrals remain high, resulting in extended waits for routine referrals in some services. Staffing challenges within theatres also continues to impact full recovery of elective activity.	Further validation on patients awaiting 1st appointment to assess for mutual aid is underway as per NHSE directive. New national patient choice instructions have been issued and the impact of this on patients choosing to wait is being reviewed before being enacted. Validation exercise via the digital communications system is being mobilised which will communicate with long waiters via text messaging to confirm ongoing treatment choices. Mutual aid for cancer capacity due to anaesthetic staffing issues continues for colorectal and urology. Circa 900 patients transferred / treated in month under the GM independent sector contract. Trust elective performance meetings continue to focus on progressing patient pathways and eliminating long waits.

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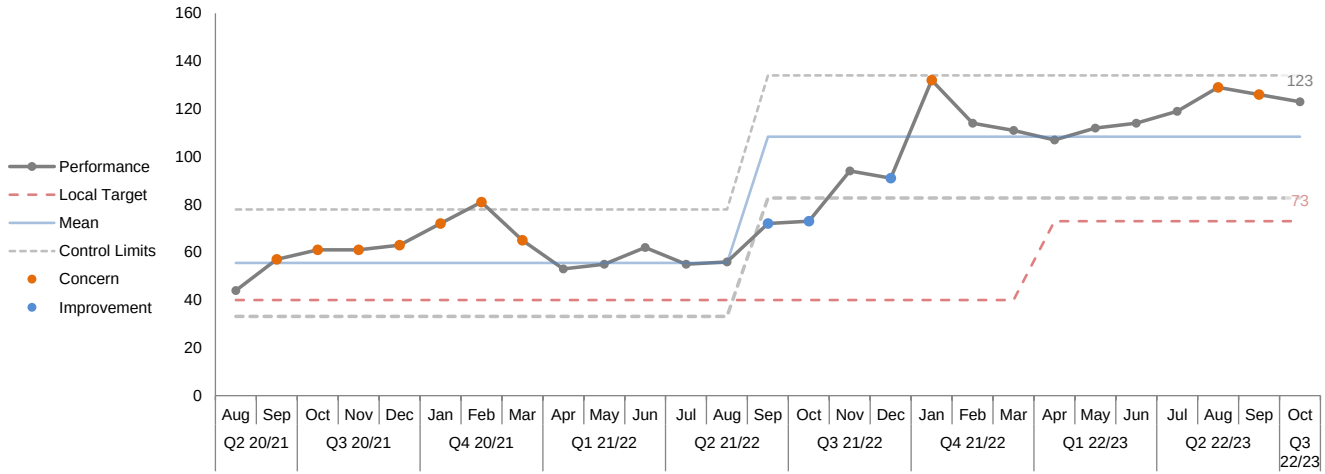
Measure	**No Criteria To Reside (NCTR)** Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	123

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 73

Performance consistently exceeds the target value

What the chart tells us

September 2021 shows a significant increase in the number of patients with no criteria to reside, moving from an average of 56 to an average of 109 patients per day. Since January 2022 performance has been above this average each month, apart from in April where it dips just below.

Narrative

Issues:

The number of patients with no criteria to reside (NCtR) in month remains higher than the target level and has been on an upward trajectory. Access to timely care home beds and community packages of home care is challenging and adversely impacting on patient flow through the hospital and also on flow through the community D2A beds and the community D2A Hub.

A reduction in a 71 bedded private D2A care facility to 50 beds from 1.7.22 exacerbated the issue and this will further reduce in March 23 EMI residential care beds have been commissioned till the end of the financial year to replace the planned withdraw of the general nursing care beds by the private provider.

The number of Out of Area (OOA) NCtR patients is high with other localities struggling to access community capacity within their areas which is impacting on the ability of SFT to discharge / transfer patients to their local area. We have seen some improvement however North Derbyshire and East Cheshire continue to have the highest number of Out of Area NCtR

Actions & Mitigations:

- Continued working system partners supporting discharge of Stockport patients on pathways 1&2.- System tactical meetings held 3 x a week as we continue to escalate.
- Review of all patients on the NCtR list daily to ensure patients are on the correct pathway.
- Additional community care has been commissioned to support flow via Pathway 1 from Routes and the operational management of this contract has moved over to SFT.
- GM winter funding secured for the Trust to commission an additional 20 community D2A beds with a private provider and transfers has commenced into these beds
- Internal Flow project. A number of projects in place to support flow, which includes MDTs taking place daily across the trust to provide support to all wards
- Work with OOA partners continues with daily operational meetings in place with North Derbyshire in particular and East Cheshire colleagues to support mitigating actions preventing flow.

A transformational flow programme has commenced whereby the trust has opened a community D2A unit within a ward on the hospital site. This opened 31.10.22 and has 24 beds under the care of a GP.

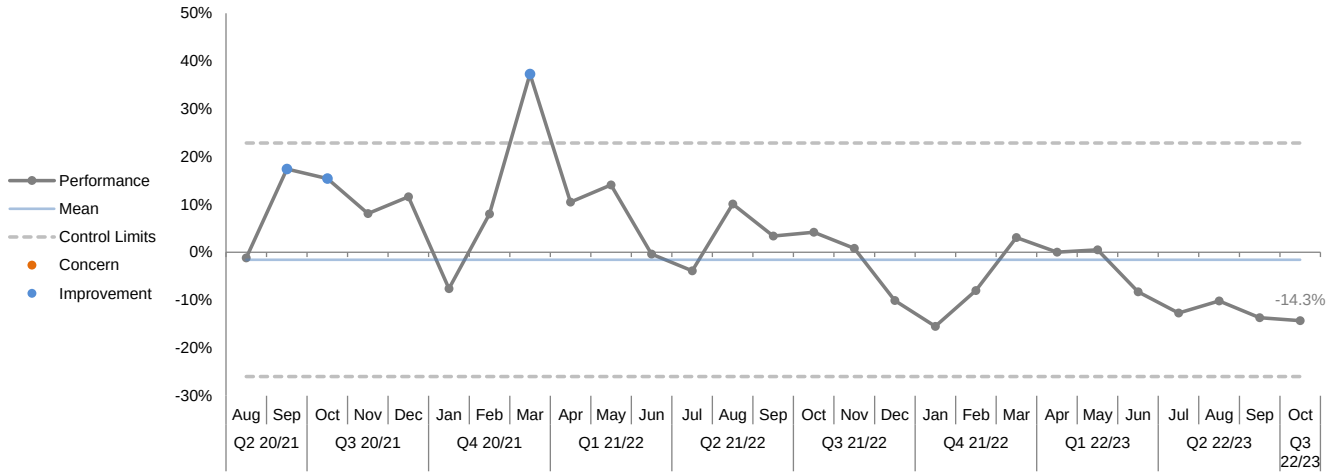
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Activity vs. Plan: Elective Inpatient and Daycase (includes narrative for Outpatients and ED attendances)** The percentage variance between the total elective activity (Elective-Inpatient and Daycase) and the total planned elective activity submitted for 2022/23. Excludes Breast Surgery and Swanbourne House activity. Based on the flex/freeze position, not the SUS position. A value above 0% indicates that activity is above planned levels.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	-14.3%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target: >= 0%

Performance consistently falls short of the target value

What the chart tells us	The chart show that elective and daycase performance against the plan has been variable across the reporting period. Data shows that activity delivered has been consistently below the operational plan since June 2022.

Narrative

Issues:	Actions & Mitigations:
Elective activity was 14.3% adverse to plan in month , driven by elective in-patient underperformance, delays to electie ward capacity opening, the additonal bank holiday and urgent care demand. Anaesthetic staffing issues remain, affecting the ability to fully restore theatre capacity to pre-covid levels. There was also a short term cessation of elective operating within Orthopaedics in month due to extremely high non-elective demand. ED attendances were 8% above plan levels. Outpatient activity was 14.8 % below plan. Key drivers of the position being middle grade gaps in Ophthalmology, combined with sickness across several services in month. Clinic activity has also had to be cancelled to allow additional Consultant support to patient flow in response to the urgent care demand.	Ophthalmology have recruited to vacant post, start dates awaited. A Working Intelligently data group has been established to deep dive available data sets relating to efficiency and corporate areas.

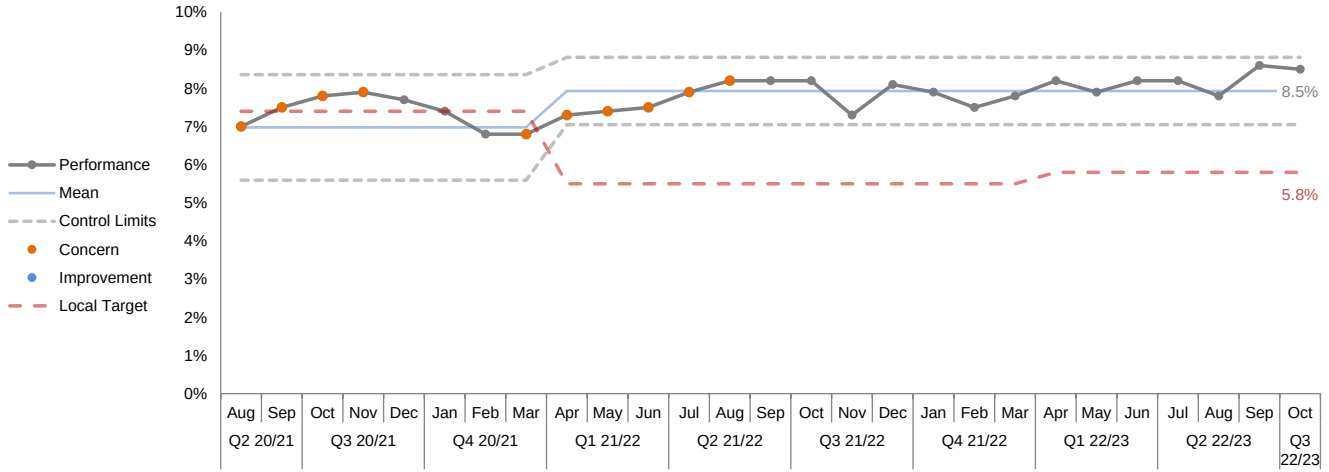
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Outpatient DNA rate (includes narrative for clinic utilisation and patient-initiated follow-up (PIFU))** The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types. The latest target for this metric is based on the peer median performance for April 2021 in NHSEI Model Hospital.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Performance

Latest Month		Actual
Oct-22		8.5%

Assurance

Target

<= 5.8%

Performance consistently exceeds the target value

What the chart tells us	The data shows that since Apr21 there was a significant change in the DNA rate rising from 7% to 7.9%. DNA rates have been variable, but consistent with this average since then and there have been no significant changes.

Narrative

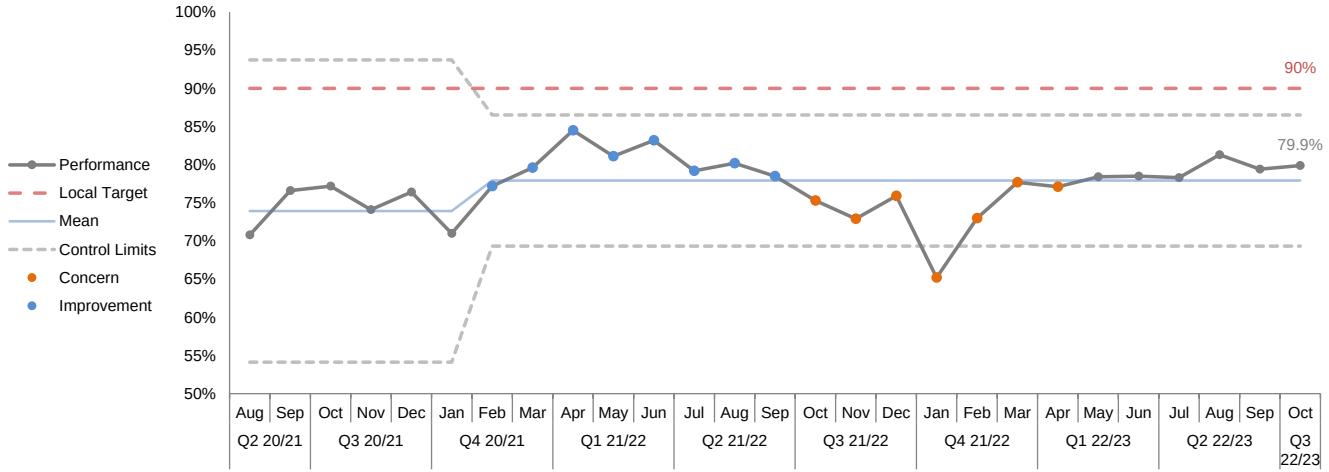
Issues:	Actions & Mitigations:
The DNA rate has increased slightly over the last 2 months. and is at 8.5%. Increase in DNA rate for October, can be linked to COVID infection rates. The Trust continues to benchmark well compared to GM peers . Outpatient clinic utilisation dropped just under target levels in month. Patient initiated follow up rate is 4.6%, the positive step change is driven by the recent implementation within Physiotherapy & OT. Stockport continues to be the best Performing Trust in GM for PIFU rates and meeting the year end target of 5% is looking positive.	The nudge texting trial was launched in DMOP. Benefit analysis will be undertaken and a meeting has been arranged for late November to consider effectiveness. The booking window for all specialties within the Division of Medicine was reduced to 4 weeks in August following a data intelligence review to help support a reduction in the DNA rate. A further deep dive around booking patterns is underway. The Outpatient Transformation project has been refreshed and new workstreams created to support delivery of the efficiency and effectiveness agenda.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Theatres: Capped Utilisation The actual session times as a percentage of the planned session time. Based on the time from the start of the session to the end of the session unless it lasts longer than the planned session minutes in which case it is capped at 100%. Downtime between operations in a session is included in these utilised minutes. Includes elective and paediatric sessions only, and excludes maternity and endoscopy theatre locations.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Performance

Latest Month	Actual
Oct-22	79.9%

Assurance

Target >= 90%

Performance consistently falls short of the target value

What the chart tells us

The data shows that between October 2021 and April 2022 there was a period where performance was significantly worse than normal. Since then performance returns to above average, with the latest performance just under 80%.

Narrative

Issues:

Overall capped utilisation for elective theatres has stabilised in recent months. Most surgical specialties are performing around the nationally recommended 85% mark with the exception of Ophthalmology and Oral Surgery.

Anaesthetic workforce challenges remain a pressure and are impacting on cancellation of lists at short notice.

October was adversely impacted by the suspension of elective T&O inpatient surgery for 4 days in response to opel 4 escalation. However, the number of elective sessions running has increased by approximately 15% in October compared with the previous month.

Actions & Mitigations:

2 new service improvement projects have been launched focusing on:
- improving pre-op assessment processes and elective patient flow on the day of surgery.
- centralisation of elective booking and scheduling processes.

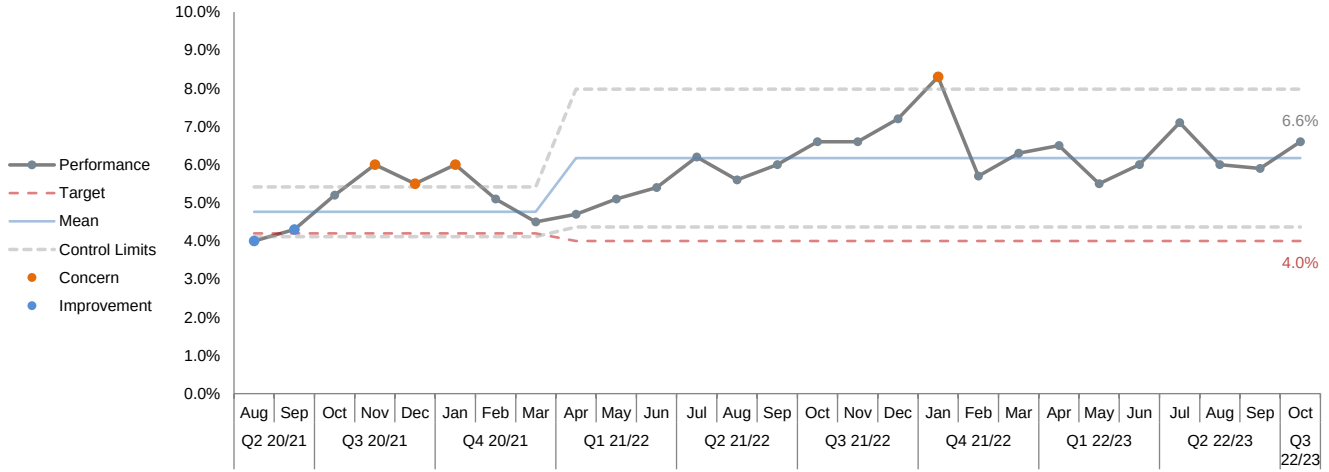
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Sickness Absence: Monthly Rate** The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	6.6%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 4%

Performance consistently exceeds the target value

What the chart tells us

A significant increase in sickness rates can be seen from April 2021 onwards as the average sickness rates increase from 4.7% to 6.2%. Apart from a spike in sickness levels in January 2022, with a rate of 8.4%, there have been no significant changes in the sickness levels.

Narrative

Issues:

The Trust rate has increased from 5.91% in September to 6.61% in October. All Divisions have seen an increase in absence rates compared to September, except Estates & Facilities, which has seen a slight decrease.

Actions & Mitigations:

The top 3 reasons for absence remain as stress/anxiety/depression, infectious disease & MSK, it is of note that the increase in the levels of MSK absence have predominantly been driven by our additional clinical services staff and in response to this have increased the moving and handling training capacity to better support compliance. Promotion of access to fast-track self-referral physiotherapy is underway.

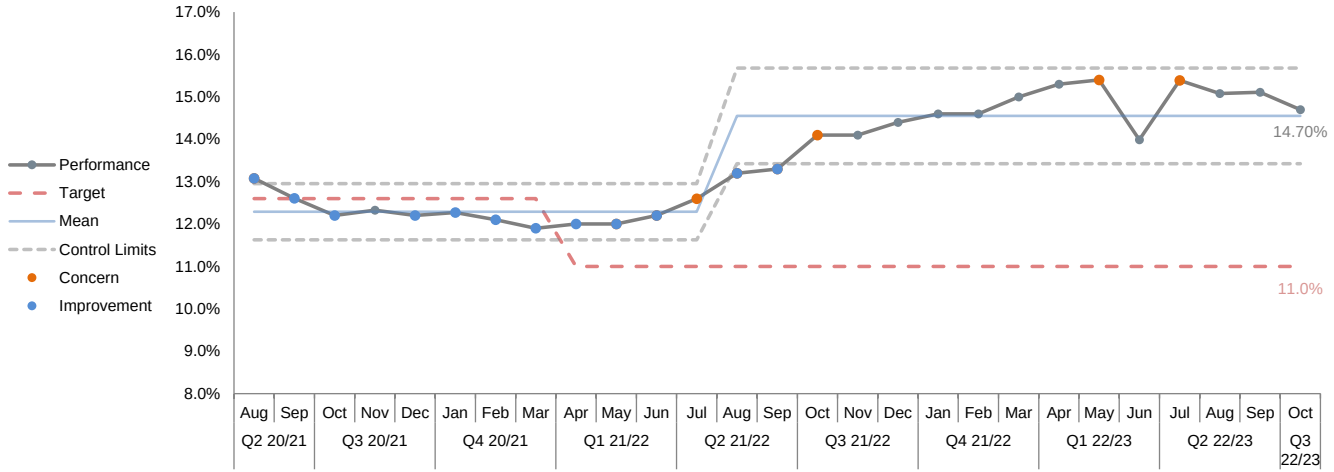
Other factors impacting on our sickness absence levels relate to staff wellbeing and the increasing challenging times at home with the cost-of-living crisis. We are widely promoting the Food Bank vouchers and health and wellbeing offers that provides a broad range of initiatives, and support for staff.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Workforce Turnover** The percentage of employees leaving the Trust and being replaced by new employees.	**Latest Performance**	**Next Month Forecast**
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	14.7%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 11%

Performance consistently exceeds the target value

What the chart tells us

In August 2021 a significant increase can be seen with a rise from 12.3% average to 14.3%. Between October 2021 and May 2022 turnover has continued to rise, with significant increased flagged in May and then again in July.

Narrative

Issues:

The Trust 12 month turnover rate up to October 22 was 14.70%, a decrease of 0.41% from September 22. The decrease is reflected across all Divisions, except Corporate, which has seen a slight increase.

The top known leaving reason is Voluntary Resignation:
– Voluntary Resignation (Promotion) (27%)
– Retirement (including flexi-retirement) (17%)
– Voluntary resignation (Work life balance) (15%).

Actions & Mitigations:

The Attract, Develop & Retain group continue their work to make improvements to flexible working opportunities, career progression opportunities and supporting staff at different stages of their careers in order to address the reasons why people say they are leaving the organisation.

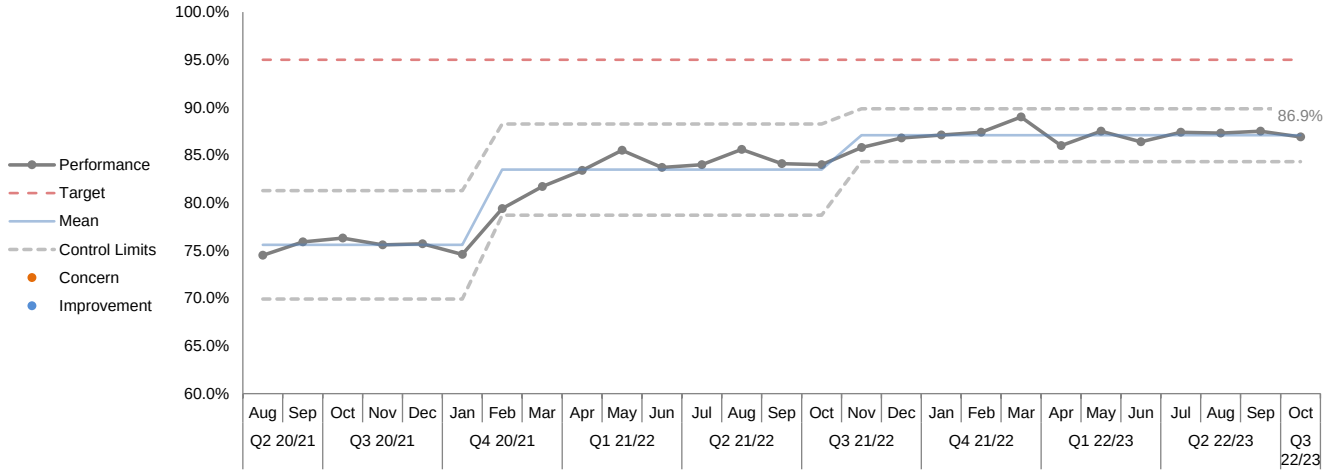
Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Appraisal Rate: Overall The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	86.9%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

>= 95%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that February 2021 and then again in November 2021, significant improvements in performance can be seen as average appraisal rates increase. Since the change in November to the 87% average, there have been no significant changes in performance.

Narrative

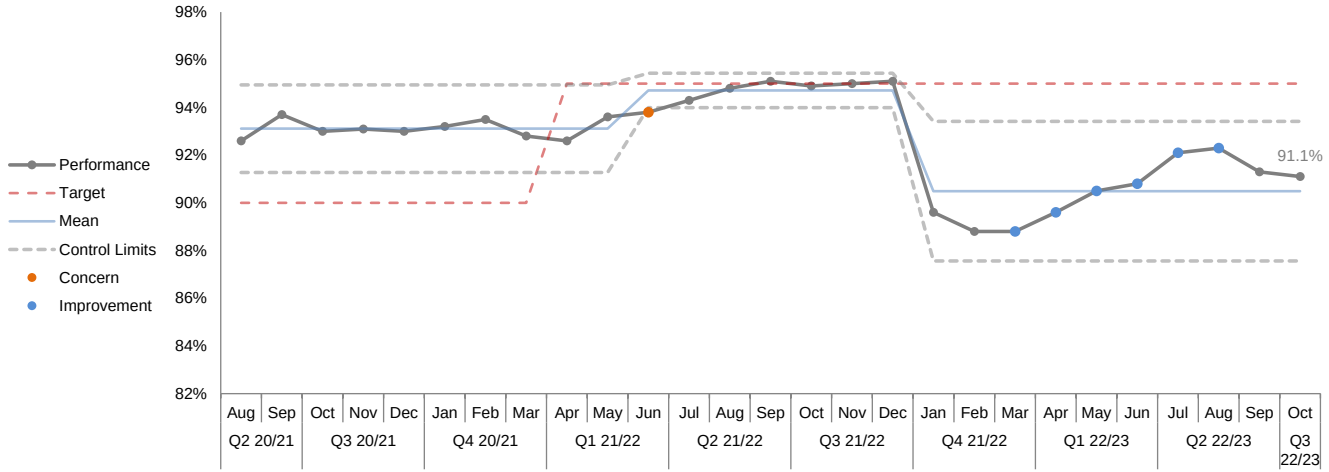
Issues:	Actions & Mitigations:
Appraisal compliance has seen a slight (0.60%) decrease in month and currently stands at 86.64%. All divisions remain below the 95% target. Women and Children's is the only division in the Trust to be above 90% and is reporting a compliance rate of 94.21% The medical appraisal rate decreased between September and October from 91.08% to 90.67% and remains below the Trust target of 95%.	Targeted support is offered to divisions to increase compliance rates for appraisals. Learning & Education and HRBMs continue to meet regularly to discuss divisional performance, hot spots and trajectories.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Statutory & Mandatory Training The percentage of statutory & mandatory training modules showing as compliant.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	91.1%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

>= 95%

Performance consistently falls short of the target value

What the chart tells us

New competencies added in December 2021 have led to a sudden drop in reported performance. From February 2022 there is an improving trend in performance, which is flagged as a significant improvement, but this trend ends with performance in September and October 2022 dropping to 91%.

Narrative

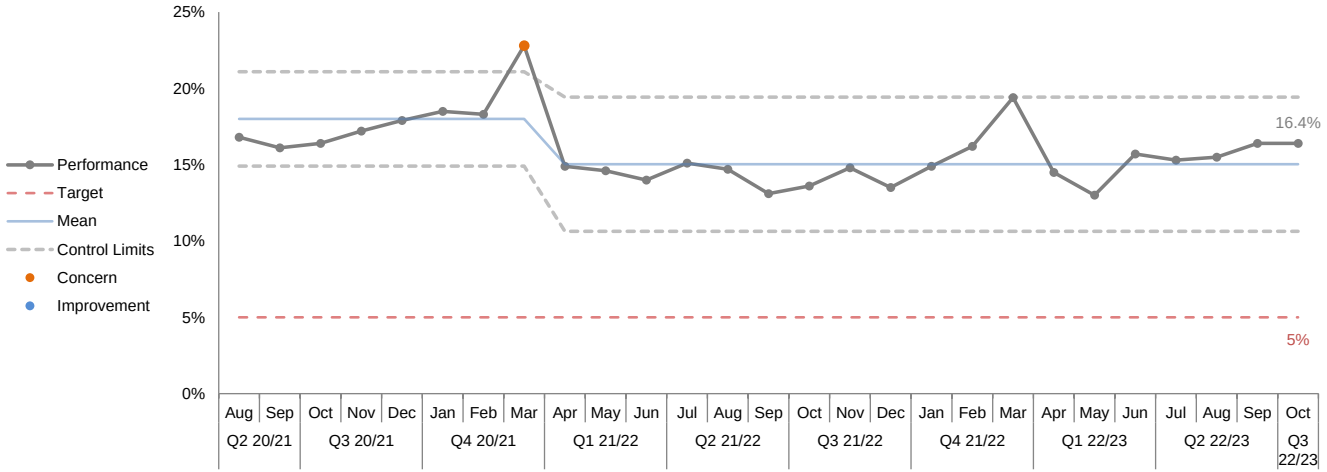
Issues:	Actions & Mitigations:
Statutory & Mandatory training currently stands at 91.1% for the Trust. This is a small decline of 0.02% from October. There are no obvious trends.	Learning & Education continue to work with key colleagues in the organisation (HRBMs/Educators) to support divisions to increase their statutory and mandatory training. Work is ongoing with various divisions to put plans in place to increase compliance rates.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Bank & Agency Costs The total bank & agency cost as percentage of the total pay costs	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Oct-22	16.4%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 5%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that in April 2021 there was a significant drop in the average bank and agency costs to 14.9%. There have been no significant changes in bank and agency costs since that time.

Narrative

Issues:

The total bank and agency spend in October 22 was £4.24M, which represents 16.41% of the total pay bill within the month and is £290K lower than in September 22. The Division with the highest bank & agency spend in October 22 was Medicine (£1.38M), followed by Surgery with £936K.

Actions & Mitigations:

A successful medical recruitment fair took place with 20 JCF offers made in the Division of Medicine.

85 international nurses have joined to date from our recruitment programme with a further 30 in the pipeline.

BMA rate card discussions have impacted on bank fill rate amongst medical staff.

The impact of potential industrial action on temporary staff useage is under consideration as the ballot outcomes emerge.

Meeting date	1 December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Safe Care Quarterly Report					
Lead Director	Chief Nurse / Medical Director		Author	Deputy Chief Nurse		

Recommendations made / Decisions requested

The Board of Directors is asked to receive the report and confirm action being taken to maintain safe care.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
	3	To work with partners to co-design and provide integrated service models within the locality and across acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure that is fit for purpose and meets service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health

		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	X	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This report provides the Board of Directors with an update on the following:

- The latest position in relation to key care staffing assurances
- Current challenges regarding maintaining safe staffing levels & the actions being taken to mitigate risks identified
- The measures being implemented to enable employees to safely remain in work by supporting their health and wellbeing.

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

NHS
Stockport
NHS Foundation Trust

Safe Staffing Report – November 2022 (September 2022 data)

Report of: **Nicola Firth**
Chief Nurse

Making a difference every day

Contents

Stockport NHS Foundation Trust

1. Introduction

Stockport NHS Foundation Trust

The following report provides the Board of Directors with an update on the following:

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

2. Vacancies

Stockport NHS Foundation Trust

Registered Staff	WTE Actual	Number of WTE Vacancies	Post Recruited in TRAC WTE
Clinical Support Services	59.17	-2.45	1
Corporate Services	75.61	2.95	50
Emergency Department	116.03	-22.62	15
Integrated Care	375.02	-38.08	41
Medicine	328.99	-40.18	17
Surgery & Urgent Care	427.39	1.96	38
Women & Children's	389.73	-32.28	51
Grand Total	1771.94	-130.70	213

Healthcare Support Workers	WTE Actual	Number of WTE Vacancies	Post Recruited in TRAC WTE
Clinical Support Services	31.31	-5.73	0
Corporate Services	11.77	4.74	114
Emergency Department	39.81	-3.37	4
Integrated Care	196.64	-2.41	11
Medicine & Urgent Care	208.18	-40.05	7
Surgery & GI	222.51	29.09	9
Women & Children's	85.30	-2.27	2
Grand Total	795.52	-20.00	147

Issues:

- High number of vacancies, pro-longed sickness, short-notice sickness & unfilled NHSP shifts

Key Actions:

- The Workforce Matron & Finance reviewing staffing establishment & utilising the patient acuity tool on the Safecare Live system
- Continue to facilitate regular recruitment events

** Information provided by Workforce – August 2022 data*

3. Recruitment

Issues:

- Delay in start dates due to the high number of new starters required to complete the Care Certificate
- In May 2023 we anticipate a high number of newly qualified nurses joining the Trust following successfully completing their nursing degree and obtaining their PIN
- Ward management engagement to ensure retention
- Delay in ward managers approval of references & occupational health pre-employment checks

Key Actions:

- Allocation of new staff members to be introduced & integrated into their new ward teams
- Interviewing CSWDs for NHSP ongoing
- Interviewing international nurses on the 14th November 2022
- HR to monitor that exit interviews are meaningful to triangulate the reasons for staff leaving
- All 800 attendees of the Nursing Times Careers Fair emailed & invited to future recruitment event on the 4th November
- Just-R, social media company, to visit Trust on the 1st December to take photographs for next recruitment campaign
- Trust to attend University of Salford's Careers Fair on the 15th November 2022 to meet students & discuss opportunities at the Trust

4. Turnover & Sickness

NHS Stockport NHS Foundation Trust

Labour Turnover Rate		
	Staff Group	**WTR FTE %**
Clinical Support Services	HCAs	19.0891%
	AHPs	23.0745%
	Nursing & Midwifery Registered	8.4939%
Corporate Services	HCAs	16.4480%
	AHPs	0.0000%
	Nursing & Midwifery Registered	11.9430%
ED	HCAs	14.9454%
	AHPs	0.0000%
	Nursing & Midwifery Registered	16.8771%
Integrated Care	HCAs	19.6026%
	AHPs	22.6329%
	Nursing & Midwifery Registered	14.9167%
Medicine	HCAs	15.8408%
	AHPs	0.0000%
	Nursing & Midwifery Registered	10.3696%
Surgery	HCAs	13.9245%
	AHPs	10.0830%
	Nursing & Midwifery Registered	14.2582%
Women & Children's	HCAs	13.9634%
	AHPs	8.7320%
	Nursing & Midwifery Registered	12.4851%

Key Actions:

- Introduction of GROW (Grow & Retain Our Workforce) – see Slide 5
- Continue to review line manager's management of sickness on a monthly basis to ensure they are following trust policy
- Workforce Matron attending the Professional Nurse Advocate (PNA) committee where sickness prevention methods are discussed between organisations to support for the workforce in the Covid-19 recovery plan

Issues :

- Exit interviews not being completed consistently

** Information provided by Workforce*

5. Retention, Staff Health & Well-being

NHS Stockport NHS Foundation Trust

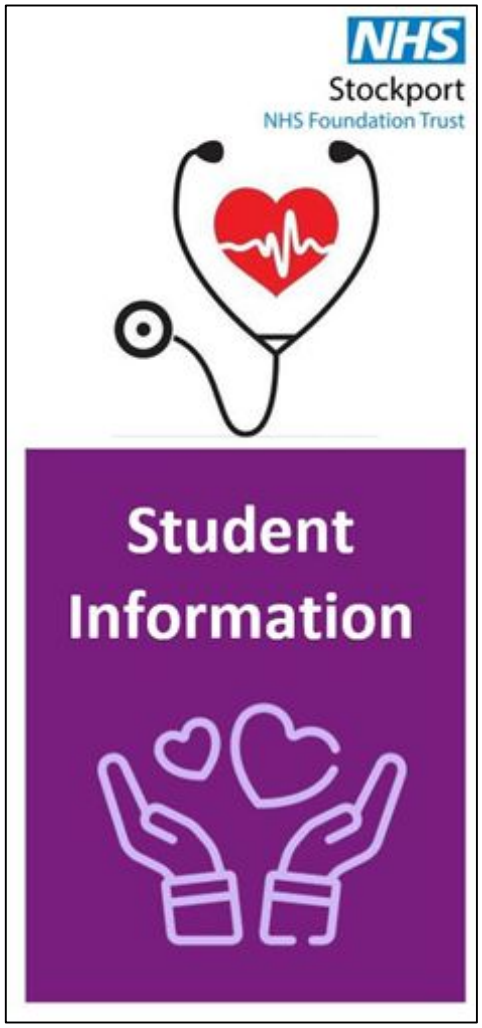
Key Actions :

- Staff well-being is on the PNA agenda & supported throughout the PNA training programme
- PNAs have formed a monthly working group meeting every second month for trainee PNAs to attend for support and advice
- Finalisation of GROW (Grow & Retain our Workforce) process.
- Promote Flexible Working & Retire & Return policies to support health, well-being & work life balance
- The Trust has supported the clinical psychology teams to provide support to teams
- Executive Walkabout Wednesday & Senior Nurse Walk Round Friday continues to have a positive impact on staff ensures the senior team are visible & approachable
- Trust are working with colleagues from the mental health Trust to promote support for all staff
- Information about the role of a PNA to be circulated in October by Comms

Issues :

- Continued awareness of the immense pressure staff are under and how their usual support mechanisms may be impacting upon their health and wellbeing remains a priority

6. Student Recruitment



Key Actions :

- A QR code has been created for students to register their interest in working at the Trust on a permanent basis. The information is forwarded to the relevant business group, Matrons contact the students.
- Third year students are invited & have been attending recruitment events
- Attending 'Keeping In Touch' sessions, co-ordinated by the PEF Team, to ensure that there is a robust communication network maintained between the student, their future manager and colleagues
- Literature produced providing information about the Rotational and Preceptorship Programmes
- All students have been sent a 'Welcome' email and asked where they would like to work so they can be sign posted to the correct matron and division
- Attending the University of Salford Careers Fair on 15th November to meet students & provide information about career opportunities at the Trust

7. International Recruitment

NHS Stockport NHS Foundation Trust

Issues :

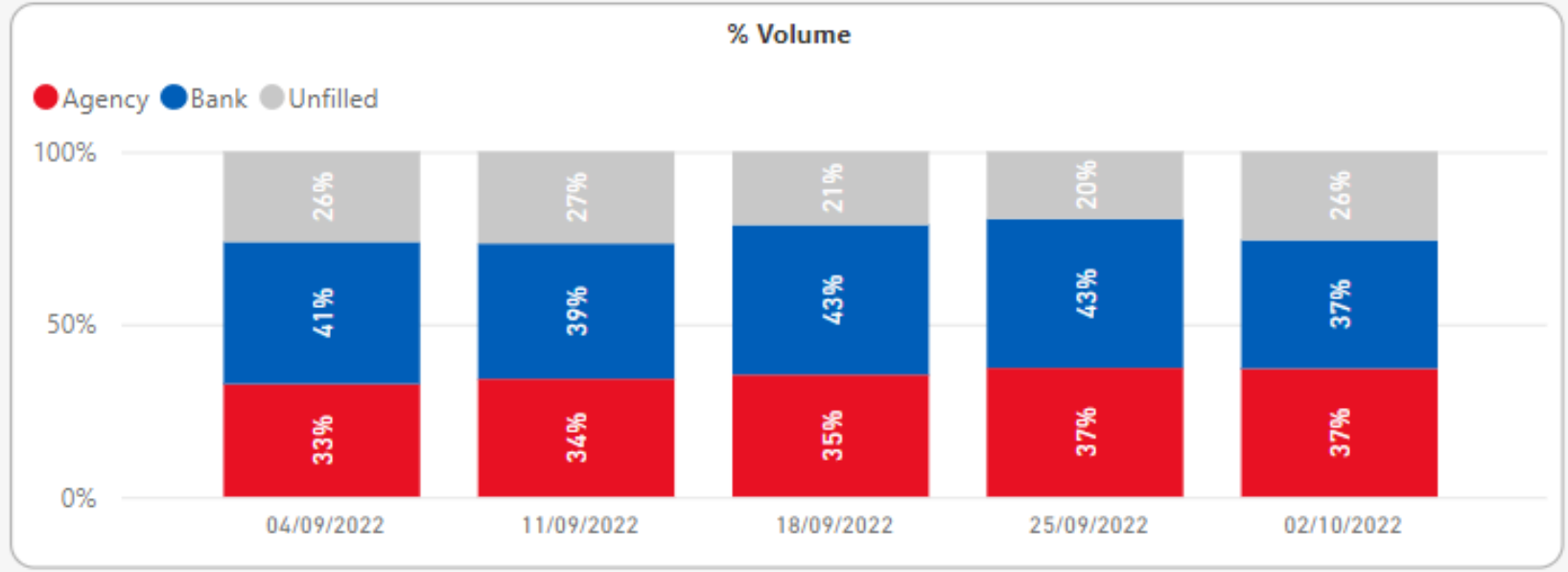
- Limited availability of onsite accommodation
- Continued issue regarding the limited number of spaces available for OSCE examinations resulting in nurses taking the OSCE over the proposed 3 month period
- Across all trusts there has been an increase in the number of nurses failing their OSCE. This issue has been raised at the regular regional IR meetings & is being addressed
- Unexpected additional costs due to paying for OSCE resit examinations, travel & accommodation. Therefore it has now been enforced that the Trust will only pay for the initial examination, any resits will be paid for by the nurse

Key Actions :

- Cohorts continue to join the Trust on a monthly basis.
- District Nursing exploring the recruitment of international nurses
- Trust continues to have great success and interest from nurses who wish to join the Trust as a direct recommendation by a friend or family member already working at the hospital; therefore building a stronger workforce, ensuring retention & creating a supportive community
- Approval from NHSE to recruit an additional 30 international nurses from January – March 2023

8. Temporary Staffing (NHS Professionals)

NHS Stockport NHS Foundation Trust



Issues:

- Safe staffing remains an operational challenge on a day to day basis due to a high level of substantive vacancies and increased levels of sickness.
- ED has high acuity activity with minimal patient flow.
- The number of temporary workers engaged during this period remains significantly higher than would be pre-Covid.
- A number of blocked booked agency nursing staff have been utilised to ensure safe continuity of care as a preferred option to the use of last minute higher cost agencies.

Key Actions:

- Twice daily meetings between NHSP, divisional matrons and Workforce Matron
- Workforce Matron to continue rolling review of agency costs with NHS Professionals
- Recruitment to Bay Nursing
- Continuing of CSWD programme, support by the Trust

** Information provided by NHS Professionals*

9. Healthroster

NHS Stockport NHS Foundation Trust

Roster period - 10 October – 6 November 2022								Total	Roster period – 12 September – 9 October 2022	
Business Group	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Unused Hours (4 week period)	Over contracted Hours (4 week period)	Total Hours balance		Additional Duties in hours (Total Hours)	Safecare % compliance across 3 Census periods (average)
ED	12.0	40	19.9	45	671.4	403.6	267.8		583.46	n/a
Integrated Care	12.5	41.31	20.7	29	1982.5	556.2	1426.3		3596.16	71.12%
Medicine	14.1	47.72	23.4	34.7	2377.0	958.4	1418.6		2886.33	73.44%
Surgery & CC	12.4	63.85	25.6	37.3	4038.8	963.2	3075.6		2155.02	59.16%
Women & Children's	14.6	61.14	31.2	30	2353.6	538.2	1815.4		767	68.64%
									9987.97	68.09%

Issues:

- Monthly roster challenge meetings in place to ensure rosters are approved 12 weeks in advance now show significant improvements

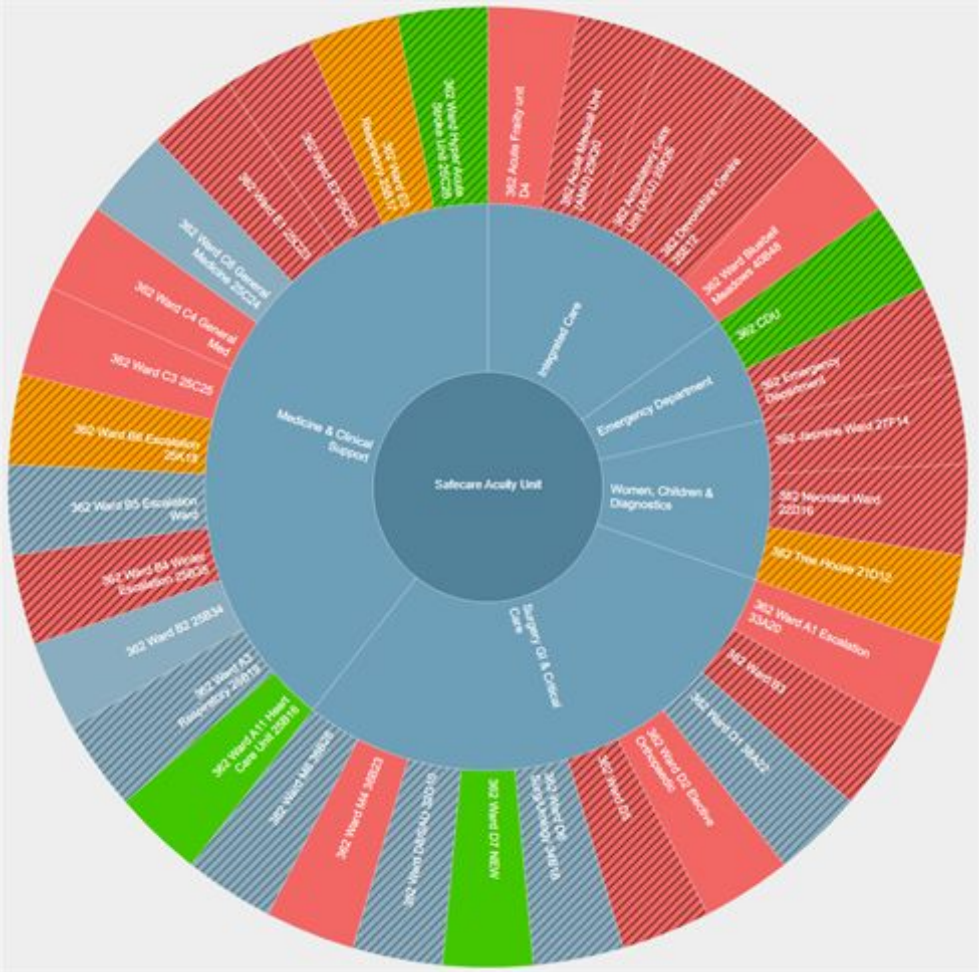
Key Actions:

- Programme of training new & existing users ongoing
- Rostering indicators developed & in use highlight teams where practice falls short of expected standards
- Roster management to be transferred to nursing teams
- Deputy Chief Nurse, DNDs & Workforce Matron meet weekly to review safe staffing
- Twice daily overview of the staffing position using the SafeCare live system at the staffing meeting
- In collaboration the Healthroster Team and Workforce Matron will have close oversight of the roster building, requests for annual leave, sickness recording and actions

** Information provided by Healthroster*

10. Safecare Live

NHS Stockport NHS Foundation Trust



Issues :

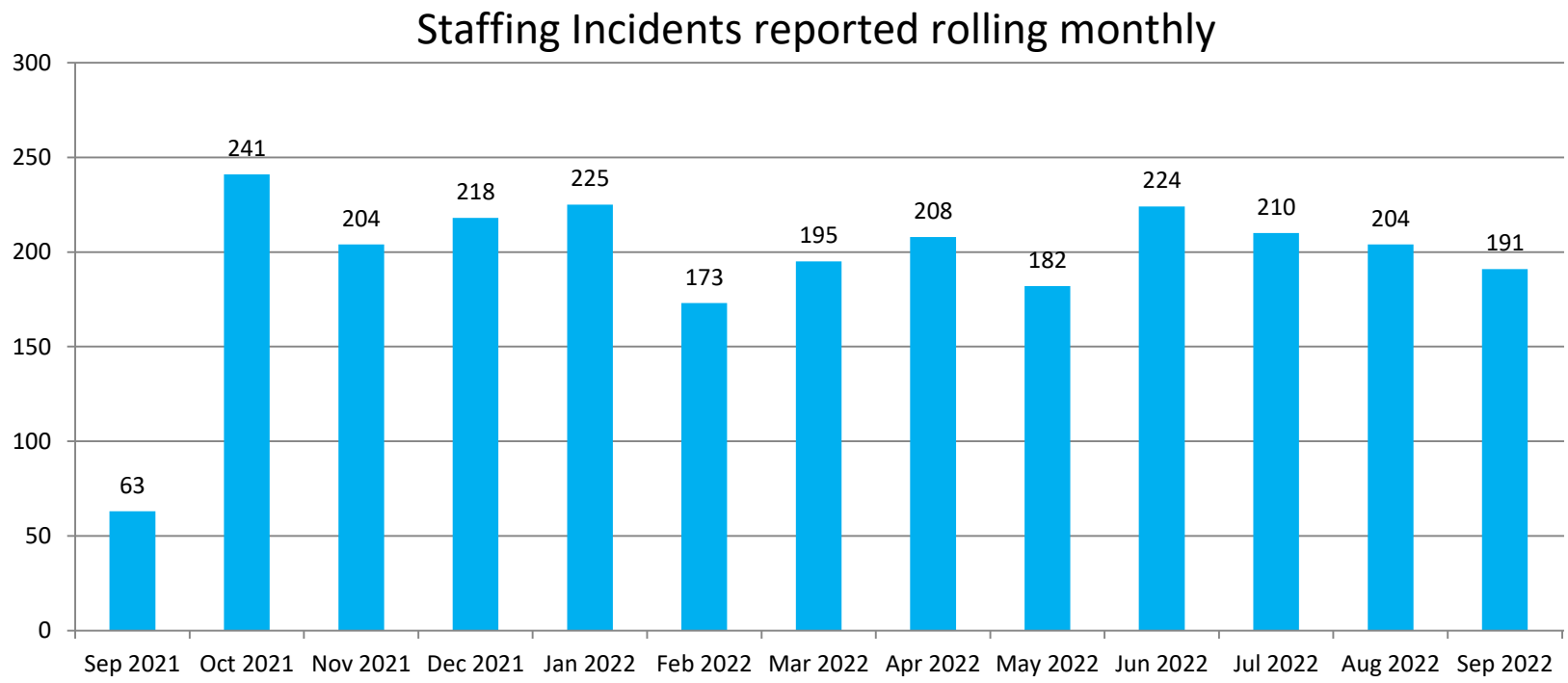
- Ensure updated in real time to ensure fair and equitable nursing
- Staff are on the correct roster due to multiple staff and ward moves

Key Actions :

- The 3rd census data collection continues to be monitored by the Safecare Lead to ensure completion
- Safecare Lead facilitating 1:1 training sessions, to ensure staff are familiar and competence
- Safecare Lead completes daily ward rounds to provide on-hand and visible support
- Attending daily staffing meetings
- Divisional matron overview of particular areas of concern to ensure accuracy in recording staffing numbers and acuity of patients

11. Risk & Assurance

NHS Stockport NHS Foundation Trust



Issues

- 191 incidents registered in September 2022
- Staffing shortfalls are not all being red flagged on Safecare

Key Actions

- All staffing incidences reviewed with the DNDs at weekly incident review meeting
- Continue to raise awareness of the staffing escalation processes SOP
- Continued focus on the scrutiny of all types of incidents, complaints and patient feedback to triangulate & provide support where needed
- Promoting transparency by incident reporting across the site

** Information provided by Datix*

12. Maternity Update

NHS Stockport NHS Foundation Trust

- **Current Establishment;**

	WTE Actual	Number of WTE Vacancies	Post Recruited in TRAC WTE
Registered Midwives	163.89	-5.12	2

	WTE Actual	Number of WTE Vacancies	Post Recruited in TRAC WTE
Unregistered	37.78	-0.34	0

- **Recruitment**;
  - B8a – 1 WTE Inpatient Matron - Pending
  - B7 - 0.8 WTE Diabetes specialist Midwife –Pending

- **New starters**;
  - B7 Antenatal Triage/ANDU Manager to commence in January
  - B6 Smoking in pregnancy midwife to commence in February
  - 7 x B5 preceptee midwives commenced in October
  - B5 + B6 commenced November

- Full birth rate plus midwifery staffing review commenced in August 2022, final report due in December 2022 (date to be confirmed)
- Recruitment and Retention Midwife in post to support newly qualified midwives and return to practice midwives
- Funding allocated from the national team to recruit to a MSW recruitment and retention post
- Engaged with the Midwifery international recruitment and have confirmed 2 IR midwives will be starting in wave 1. One is due to arrive in December and we are waiting on a confirmation date for the second IR midwife to arrive
- The Trust has applied for go further funding and requested a further 3 IR midwives are appointed to Stockport NHS Foundation Trust
- Professional Midwifery Advocate (PMA) relaunched in October 2022

12. Maternity Update

NHS Stockport NHS Foundation Trust

Action Plan Overview

Safety Metric	Owner	Update November
Ockenden – 15 IEA	DepHOM	Further review of GAP analysis to be undertaken and to be updated to reflect service updates and LMNS recommendations
CNST YR 4	DepHOM	**Challenges:** **Action 1** - PMRT – Not compliant with 100% submission of factual accuracy before 2 months – Mitigation letter to be submitted with declaration **Action 5** - SBLCB – Element 1 SATOB/SATOD current compliance <95% for SATOD action plan required **Action 8** - MDT training compliance – Obstetricians/Anaesthetist remain <90% review of reporting period following publication of new guidance
MDT Training Compliance	DepHOM	As above action 8
SBLCB V2	DepHOM	Compliant with all 5 elements GAP analysis on going as part of CNST
Continuity of Carer	DepHOM	Letter released 21/09/21 (CNO/CMO) National targets for MCOC suspended. Intention to roll out full continuity in: CORA 1 and CORA 2. CORA 2 will be determined by increase in midwifery establishment within the community.

12. Maternity Update

Stockport NHS Foundation Trust

- **Midwifery Continuity of Carer (MCoC)**
  - A letter from the national team in September 2022 advised providers that there are no longer target dates for maternity services to deliver full MCoC, local services will instead be supported to develop local plans that work for their service.
  - The top priority for maternity and neonatal services is to continue to be ensure the right workforce is in place to serve women and babies across England;
    - Focus on retention and growth of the workforce
    - Develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths
  - Stockport will continue to follow recommendation 2 as below:
    - **Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.**
  - The service will continue to roll out the first team to provide MCoC to enhanced and vulnerable groups with a view to roll out a further enhanced team in March 2023 following a review of midwifery workforce.
  - Additional funding has been applied for through the LMNS for a band 4 maternity support worker to support these teams.

12. Maternity Update

NHS Stockport NHS Foundation Trust

- **Providing Continuity of Carer at Stockport by default means:**
  - Offering MCoC to all vulnerable women as early as possible and within an enhanced team
  - Offering MCoC to all women as early as possible in pregnancy
  - Putting in place clinical capacity to provide MCoC to all those eligible to receive antenatal, intrapartum and postnatal care from Stockport Midwives

- Calculations form the MCoC workforce modelling tool show that we require 21.02 wte Midwives over 6 waves (2022 – 2026) to achieve full scale MCoC of 3050 eligible women (based on in area births)
  - Plan to recruit in waves to the 21.02 wte deficit, subject to funding.
  - Wave 1 2022 –recruit to current vacancy 3 wte
  - Wave 2 22/23 – 4wte
  - Wave 3 23/24 -4wte
  - Wave 4 24/25 – 7wte
  - Wave 5 25/26 – 6wte

Medical Staffing

NHS Stockport NHS Foundation Trust

The tables below show an overview of the directly employed Medical Workforce position within the Trust.

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	244.49	220.8896	-23.6004
Tier 1 & 2	225.042	205.56615	-19.47585
Grand Total	469.532	426.45575	-43.07625

Medical Staffing

Stockport NHS Foundation Trust

Tier 3: Expert clinical decision makers. These are clinicians who have overall responsibility for patient care. In the medical workforce these are our consultants.

Tier 2: Senior clinical decision makers. These are clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment. For the medical grades this is largely specialty doctors and senior clinical fellows.

Tier 1: Competent clinical decision makers. These are clinicians who are capable of making an initial assessment of a patient. For the medical grades this is largely foundation doctors and junior clinical fellows.

N.B. The Trust is also a host employer on behalf of the Lead Employer, St Helens and Knowsley NHS Trust, for specialty, core and general practice trainees and we host a further 166 trainee doctors working at the Trust across our specialties.

The teams are currently developing a medical version of the Safecare functionality which will clearly demonstrate the minimum medical staffing requirement per area, alongside the actual staff available each day. This will better aid the movement of doctors between areas to ensure that safe staffing is maintained.

13. Next Steps

Stockport NHS Foundation Trust

- Continue engagement with Just-R visiting the Trust on the 1st December to photograph staff from community and urgent care
- Support Theatres with recruitment event for Scrub Nurses
- Chinchu Joy is providing pastoral care to the international nurses
- Attending University of Salford's Careers Fair to meet student and talk about career opportunities at the Trust
- Recruitment event for Registered Nurses, Student Nurses and Registered Nursing Associates to taken place November
- Interviews for international nurses scheduled during November
- Working collaboratively with the Learning and Education Department to facilitate the 'Keeping in Touch' session in November for students nurses

14. Conclusion

Stockport NHS Foundation Trust

Maintaining safe staffing levels to meet the current demands of services remains a challenge

Significant recruitment of registered nursing staff and health care assistants, including international nurses

There is a continued focus on scrutiny of all types of incidents, complaints and patient feedback to triangulate & provide support where needed.

Implementation of Safecare live giving oversight for all areas of acuity and safe staffing levels

There is ongoing work, in partnership with NHS Professionals, to oversee temporary staffing pay rates, develop initiatives to increase fill rates and review processes to cascade unfilled shifts to agencies with a significant reduction in agency staff.

Significant reduction in the use of off-frame work agency staff with none being utilised during this reporting period.

Continuous oversight of our position is appraised in collaboration with regional colleagues and National Directors of Nursing regarding skill mix, ratio and guidance. The GM Chief Nurses group review this for consistency.

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Annual Nurse & Midwifery Strategic Staffing Report					
Lead Director	Nicola Firth Chief Nurse		Author	Helen Howard Deputy Chief Nurse		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm that the investment in nursing and midwifery staffing has provided the organisation with safe staffing establishments across the organisation.

The Board of Directors is asked to receive the paper in conjunction with the quarterly staffing paper for detailed current analysis.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
x	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	**X**	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	X	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	X	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-

			quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	X	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This paper provides the assurances and risks associated with safer nursing and midwifery staffing and the actions in progress to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks.

The NHS Long Term Plan responds to changes in society and health needs. Nursing, midwifery and care staff have a pivotal role to play in its delivery. Strengthening and supporting leadership at all levels is a key area of focus set out in the Long Term Plan to support staff to do their jobs effectively.

Nursing, midwifery and health care leadership provides a strong vehicle to ensure that staff can create

and deliver the changes that are needed on the ground

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

NQB's guidance states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- must use an approach that reflects current legislation and guidance where it is available.

The underlying nurse staffing position has remained consistent with a reduction in nursing and midwifery vacancies and a levelling out in turnover. Systems are in progress to provide assurance that safer nursing and midwifery staffing across the organisation is a priority, in order to maintain patient quality and safety. With the role out of Safecare utilising the safer nurse care tool (SNCT) in November 2021 has triangulated patient acuity, the number of patients and the nursing staffing levels.

1. BACKGROUND

The purpose of paper is to present the findings from the annual acuity and dependency safe nurse staffing study which ensures we:

- have the right staff, with the right skills in the right place
- have patient driven staffing levels
- improve the safety and care on our wards
- improve key quality performance indicators

The report provides a review of the nursing, midwifery and healthcare staffing situation, and the latest position in relation to key staffing assurances and acuity and dependency using the safer nursing care tool.

It highlights the current challenges regarding maintaining safe staffing levels & the actions being taken to mitigate risks identified. It also outlines the measures being implemented to enable employees to safely remain in work by supporting their health and wellbeing.

2. CURRENT SITUATION

It is acknowledged that no one tool can give assurance in relation to safe staffing as this fluctuates over time and can be influenced by seasonal change. At Stockport NHS Foundation Trust three tools are used to determine safe nurse staffing levels; The Safer Nursing Care Tool (SNCT) was used in conjunction with Professional Judgement (PJ) and review of Safecare Live system to triangulate the patient needs to determine safe staffing. These tools were introduced within a stringent quality control framework to ensure a robust approach was maintained for data collection and consistency.

Maintaining safe staffing levels to meet the current demands of services remains a challenge. This was evidenced by the investment of £5.1 million in the nursing and midwifery workforce following a full establishment review in April 2021. All of these nursing and midwifery increases have been established within the divisions.

There are staffing meetings three times a day at which nurse staffing are discussed, with good divisional representation. A weekly staffing meeting chaired by the Deputy Chief Nurse and attended by the Healthroster team, NHSP and HR colleagues. Additionally there is a monthly staffing meeting that provides the assurance to the People and Performance Committee.

With continued focus on recruitment, events are promoted via social media co-ordinated by Just-R. Just-R are scheduled to visit the Trust in preparation for future events.

The Trust works closely with the local colleges and universities to ensure we participate in national initiatives where appropriate – for example – the Nurse Associate programme, apprenticeship schemes, international nursing offers etc.

2.1 Nursing, midwifery and healthcare support worker vacancy data by division and all bands

The Trust has agreed to recruit to turnover for registered and non-registered staffing to ensure the workforce is able to meet the demands of the service at all times.

Registered Staff	FTE Actual	Number of FTE Vacancies	Post Recruited to in TRAC FTE
Clinical Support Services	60.71	-0.01	**0**
Corporate Services	71.61	-1.05	27
Emergency Department	114.47	-24.18	20
Integrated Care	371.21	-40.91	55
Medicine & Clinical Support	335.07	-19.37	18
Surgery GI & Critical Care	417.57	-4.24	38
Women, Children & Diagnostics	390.10	-33.72	46
Grand Total	**1760.74**	**-123.48**	**204**

Healthcare Support Workers	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE
Clinical Support Services	31.29	-5.75	**0**
Corporate Services	13.31	6.63	73
Emergency Department	36.64	-6.54	2
Integrated Care	185.31	-13.74	5
Medicine & Clinical Support	181.79	-67.20	9
Surgery GI & Critical Care	187.62	-3.15	4
Women, Children & Diagnostics	84.90	-2.67	2
Grand Total	**720.86**	**-92.42**	**95**

** Information provided by Workforce*

The Workforce Matron and Finance teams meet monthly and review staffing establishments by utilising the patient acuity tool on the Safecare Live system.

Since the new programme for recruiting international nurses commenced in March 2022, 30 nurses have passed their Objective Structured Clinical Examination and have received their unique registration code and are working on the wards as registered nurses. The Trust currently has 51 international nurses in the recruitment pipeline.

The Trust is exploring international nurse recruitment opportunities for district nursing.

3.1 Medicine & Emergency Department

The division of medicine and the emergency department have funded establishments that have been assessed and confirmed as correct. The emergency department establishments currently meet RCN national guidance.

There are currently several unfilled vacancies within the division. Recruitment for registered staff is on-going with planned recruitment events scheduled. Turnover has increased slightly. Going forward the Workforce Matron will be involved in capturing the exit interview data to support the retention agenda.

Workforce training is being rolled out by the workforce team for the Senior nursing teams. The Workforce Matron will support in identifying staff who may be looking to leave the organisation. This will provide a proactive rather than reactive approach to ensure retention.

There has been excellent engagement from the Matrons relating to the Grow and Retain Our Workforce (GROW). The logo/brand has been finalised and the formal process is currently being finalised with HR.

3.2 Surgery & Critical Care

All areas were included in the establishment review and improvements to the overall establishments approved in April 2021 which met national standards.
Due to the multiple ward moves during the pandemic and the ever changing function of some of the ward activity, the wards are dynamically risk assessed and any perceived staffing establishments are addressed as required with oversight from the Chief Nurse.

3.3 Integrated Care & Community Nursing

The Division of Integrated Care has identified there has been an increased number of patients transferred to all wards who are assessed as requiring enhanced supervision. In particular Bluebell, where all patients are accommodated in single bedrooms, and therefore enhanced nursing care needs are under review.

There is a robust process for the review of community nursing and although previously there have not been national standards available there is now a national programme of discussion and benchmarking which Stockport is participating in. The community services use rostering and technology well to enable the movement of staff to support patient need.

3.4 Women & Children's Division

Midwifery, using the birth rate plus tool, staffing establishments have been determined to be correct. The midwifery continuity of care model is currently being reviewed nationally in light of the multiple national reports regarding safety in maternity services.

Paediatric staffing

Paediatric staffing meets with RCN guidance.

Gynaecology staffing

The Gynaecology Service nurse staffing establishment is currently under an establishment review with the oversight of the Chief Nurse.

4 SUMMARY

In summary the investment of £5.1M in the adult inpatient areas in nurse staffing has seen an improvement in the establishments across the organisation. In addition all areas are reviewed at least annually although in reality are under constant review in reflection of the fluidity of operational pressures and circumstance.

5 RECOMMENDATIONS

The Board of Directors is asked to:

- Receive assurance that the investment in nursing and midwifery staffing has provided the organisation with safe staffing establishments across the organisation.
- Receive assurance that news ways of working and new models of nursing care are under continual appraisal and review.

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Response to NHS England Letter: Quality & Safety of Mental Health, Learning Disability & Autism Inpatient Services.					
Lead Director	Chief Nurse		Author	Deputy Chief Nurse, Deputy Director of Quality Governance, Head of Safeguarding		

Recommendations made / Decisions requested

The Board of Directors are asked to note the content of the report and consider any additional assurances required.

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
X	3	To work with partners to co-design and provide integrated service models within the locality and across acute providers
X	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
X	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure that is fit for purpose and meets service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
	x	**PR1.2**	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered

	x	**PR2.1**	There is a risk that the Trust fails to support and engage its workforce
	x	**PR2.2**	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes
	x	**PR5.1**	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
		PR5.2	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
		PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
		PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards
		PR7.2	There is a risk that the Trust does not materially improve environmental sustainability
		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

Executive Summary

This paper provides an overview of the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services provided at Stockport NHS Foundation Trust following the BBC Panorama program which showed patients being abused while in the care of an NHS Trust in September 2022, and the BBC Panorama programme "Will the NHS Care for Me?" whereby Stockport NHS FT featured in this programme in October 2022.

In addition to providing assurances based on these two programs the paper will also provide updates around Learning Disability and Autism based on the recent CQC report published in November 2022 "Who I am Matters".

The paper reviews the key findings of the programmes and recent published documents to provide assurance of processes in place, and any additional action required on top of current activity.

1. Purpose

1.1 This paper provides assurances regarding recent communications from NHS England regarding the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services following the BBC Panorama programme which showed patients being abused while in the care of an NHS Trust in September 2022.

1.2 This paper also provides updates and assurances regarding the BBC Panorama "Will the NHS Care for Me" in October 2022, whereby families raised concerns about the care and treatment of two patients who attended Stockport NHS Foundation Trust in 2018 and whom had a learning disability.

1.3 Moreover, the paper will provide an update on the recent CQC published reports "Who I am Matters" and provide assurance on the work being undertaken to learn from this national review.

2. Background

2.1 According to data from the 2020/21 national census the population of Stockport is recorded as 294,197. The data shows that in Stockport there was 1673 children and young people with a diagnosis of a learning disability and 5682 adults, this data does not include Autistic people.

- The table highlights the comparing statistics across Greater Manchester

ONS AREA	POPULATION	CYP – LD	ADULTS-LD	Total – LD
BURY	190708	1131	3636	4767
OLDHAM	237628	1564	4377	5941
ROCHDALE	223659	1409	4182	5591
STOCKPORT	***294197***	***1673***	***5682***	***7355***
TAMESIDE	227117	1335	4343	5678
GLOSSOP	92663	462	1855	2317
	1265972	7574	24075	31,649

2.2 Following the first BBC Panorama programme a letter was received by the Trust from the National Mental Health Director, Dr Claire Murdoch, on 30th September 2022 in the immediate aftermath of the programme with a proposal that there is a need to proceed on the basis that this could be happening elsewhere. The Trust was asked to urgently consider what more can be done nationally, with regulators, with our inpatient quality programme about to be launched and with issues such as workforce supply.

2.3 It stipulated that abuse is grown and prevented locally by registered staff taking accountability for theirs and other's actions, by teams who regularly review the quality of care they provide, by local leaders who support, challenge and role model, by senior clinicians and managers, who train colleagues and have an open door and by boards who have line of sight to data, complaints, other intelligence, who walk the patch and who create a safe environment for people to speak up about poor care.

3. Matters under consideration

3.1 The programme identified a number of findings and requested the Trust to consider a number of elements.

3.2 In order to provide assurance against the issues raised within the Panorama programme, the key recommendations are included below, with a narrative provided regarding Stockport's current position and any additional action required.

3.3 **BBC Panorama - Undercover Hospital: Patients at Risk**

Recommendations	Stockport position	Action Required	Assurance Monitoring
1. Board to review the safeguarding of care in your organisation and identify any immediate issues requiring action now; including but not limited to: a. freedom to speak up arrangements, b. advocacy provision, c. complaints, d. CETRs and ICETRs, e. other feedback on services	All safeguarding incidents are reported on a weekly basis to Incident Review Group (chaired by the Deputy Director of Quality Governance) where appropriate action is agreed related to incidents from the following week. Where required escalation to Serious Incident Review Group (attended by Chief Nurse and Medical Director) is agreed. Processes also in place for immediate identification of potential serious incidents and allegations requiring rapid review and presentation to SIRG which takes place three times per week. Processes in place in relation to receipt, investigation and approval of informal and formal complaints received. Monthly complaints report to Patient Experience Group giving oversight of complaints received and any themes, trends identified. The Trust has a Freedom to Speak Up guardian who completes ward and department walk rounds, he has a visible presence in the Trust and regularly updates the Trust Board on his work - FTSU guardian has direct access to Chief Executive Officer and Director of People and OD - FTSU Ambassadors - Freedom to speak to mandatory training The Trusts Adult Safeguarding team, work in collaboration with Stockport Advocacy to assist patients with all aspects of advocacy support	Review of the safeguarding risk register by Head of Safeguarding and Deputy Director of Quality Governance. Adult Safeguarding team to review advocacy referrals from Trust and present data in	Quarterly Patient Safety Report to Patient Safety Group (PSG), Quality Committee (QC) Monthly Notification of SI Report to PSG, QC Divisional Quality Groups – with monthly governance reporting in place. Monthly Complaints Update reported to Patient Experience Group (PEG) Trust Integrated Safeguarding Group receive bimonthly dashboard

		Adult Safeguarding Dashboard	
2. Board to consider: - Could this happen here? And how would we know? - How robust is the assessment of services and the culture of services? - Are we visible enough? - Do we hear enough from patients, their families and all staff on a ward e.g. the porter, cleaner, HCAs?	The Trust has a safeguarding service that supports the fundamental right to protect people from harm and abuse. Safeguarding professionals regularly seek assurances regarding peoples right to live in safety and be protected from harm and abuse. The Trust currently has both operational and strategic meetings, reports, training, and assurances processes which supports the identification of abuse and or neglect: - Trust Integrated Safeguarding Group chaired by Chief Nurse - Safeguarding operational groups - Safeguarding data and activity reports - Safeguarding reviews for all patient safety incidents - Reviews all safeguarding concerns submitted by the Trust and against the Trust - Annual ICB commissioning standards - Training and Education packages - Annual safeguarding report - Membership and regular attendance and participation in safeguarding partnership boards - Safeguarding supervision across the Trust - Deputy Director HR membership at TISG - HR process for managing allegations - Mental health partnership board and partnership group with reciprocal working, training, and learning from incidents The Trust has a raising concern – (speaking up policy) The Trust has a senior nurse walk round fortnightly led by the Chief Nurse, invitations are extended to all senior nurses and attendance at this is always well represented, the senior nurse walk round looks at quality and safety themes, wellbeing safeguarding, patient, and staff experience.	Deputy Director of OD to develop OD delivery plan across both Trusts to support - multi professional leadership - clinical development - Civility Saves Lives - Staff survey action plans	The Trust reviews dashboards, key issues report, activity and performance data and reports this through to Quality Committee and Trust Board.

	- Chief Nurse positively encourages staff engagement forums - The Trust has walk about Wednesday with Non-Executive Directors / Executive Directors - Values into action sessions – in place with executive directors, all executives attend areas and seek direct feedback from staff at all levels - Divisional engagement events and Quality Boards The Trust participates in national staff and patient surveys, results from these support divisional and Trust actions plans twice a year The Trust has a quality improvement program called StARS Stockport Accreditation Recognition System is designed to measure the quality of care provided by individuals and teams throughout the Trust. It incorporates key clinical indicators and supports the standards in providing evidence for the Care Quality Commission's Fundamental Standards. The framework considers 14 standards with each standard subdivided into the following 3 categories Environment, Care and Leadership. The Trust have a variety of staff forums to support staff and engage with others across the Trust. Each staff network has a board sponsor – - LGBTQI+ - Disability and wellness network - Race equality - Carers network	Presentation of staff stories at PPC	Joint Negotiating & Consultation Committee / People Performance Committee Quality Safety and Improvement Group, Divisional Quality, Safety and Governance Boards, Quality Committee, Trust Board People Performance Committee are updated on these networks and any areas of support
3. In the programme, patients told those around them of the unsafe and abusive care they were subjected to. In your own organisations you must ask how you are not only hearing	The Trust maintains is relationships with Pennine care NHS FT through partnership meetings and Boards which has service user representation on. - Patient stories are used in all meetings - Learning from complaints / incidents are used to support action planning with patients and carers at the centre	Continued engagement in the AqUA collaborative relating to the Introduction of Patient Safety Partners at Stockport NHS FT – led by the Deputy Director of Quality Governance	Mental Health Partnership Board / Quality Committee

the patient voice, but how you are acting on it?	Weekly safeguarding and security meetings Bodycam footage Patient stories presented to Trust Board, Trust Integrated Safeguarding Group and Quality Committee		Trust Board / Trust Integrated Safeguarding Group
4. We also saw the role inappropriate use of restrictive interventions played in the unsafe treatment of patients, including Long Term Segregation and Seclusion. You will want to double down on the efforts in your organisation to tackle and reduce the use of restrictive interventions. What is the plan to support them out of these restrictive settings?	The Trust actively reviews its position of reducing and removing restrictive interventions - Violence and aggression task and finish group, review of national standards and action plan review - Violence reduction strategy in place - Safe hold training - Hate crime training for staff partnership with Hate UK - Protected characteristics training, learning from complaints on use of pronouns, access to facilities, single sex accommodation - Any incidents we take action to learn from this and improve - Conflict resolution training - Partnership work with system partners to support best practice on reducing restrictive interventions - Paediatric Enhanced Supervision, Restrictive Intervention and Clinical Holding Policy and training plan - Adult Therapeutic interventions and enhanced supervision training, which focuses on preventative interventions - All security staff are compliant with standard 219 for the Restraint Reduction Network	Violence and aggression task and finish group to review policies, procedures, and strategy	Health and Safety Group

3.3 **BBC Panorama – Will the NHS Care for Me?**

The program highlighted why people with a learning disability are more than twice as likely to die from avoidable causes than the rest of the population. The reporter heard from relatives who have lost loved ones prematurely. Stockport NHS FT were named in this program and the episode highlighted two patients who had sadly died back in 2018 who had accessed Trust services.

The episode described elements of care that were not to the standard that is required and that there were lapses in procedures which the Trust apologized for. The Trust has worked

hard to review learning and identify actions to improve the care that patients with Learning Disability and Autistic people have experienced.

In line with planned improvement work and in response to the program the Trust reviewed its Learning Disability and Autism action plan and updated this, this can be found in Appendix 1 of this report.

3.4 **CQC report "Who I am matters"**

The Care Quality Commission published a report in November 2022 titled "Who I am matters" This report looks at what people with a learning disability and autistic people experience when they need physical health care and treatment in hospital.

The report provides another stark reminder that people with Learning Disabilities and Autistic people face inequalities when accessing and receiving health-based services. The report highlights that parity for people with a learning disability and autistic people is now a critical patient safety issue. The CQC carried out a review looking at the impact and experience of people with Learning Disabilities and Autistic people when they needed physical health care and treatment in hospital. The report looks at five specific domains:

- Access to care
- Communication
- Care and treatment in hospital
- Other equality characteristics and quality of care
- Workforce skills and development

The recommendations and associated actions from this report will be incorporated into the Trust's Learning Disability and Autism action plan for monitoring and will provide a springboard to improvement for the Trust. This will be reviewed by the Trust's Integrated Safeguarding Group chaired by the Chief Nurse. The action plan will be updated and reflective of the CQC recommendations and this will be presented at the January 2023 Trust Integrated Safeguarding Group, however the recommendations are already being operationalized to support this area of work.

4. Areas of Risk

4.1 There is a continued risk that there is no dedicated Learning Disability and/or Autism professional in the Trust. The adult safeguarding team currently supports this group of patients from a specialist perspective and work with system partners.

4.2 The newly announced mandatory training for Learning Disability and/or Autism will require support from dedicated specialist staff to deliver this training and ensuring outcomes are met and staff have the right level of training.

Stockport NHS FT – Learning Disability and Autism Action Plan V.1.1
Date Issued: 10/10/2022
Date Reviewed: 11/11/22

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

Action Plan author – Tom Parker-Evans (Head of Safeguarding)

Action Plan Executive Lead – Nic Firth (Chief Nurse)

	Recommendation	Key Actions	Evidence	Progress	Lead Officer	Target Date	RAG
1	The Trust to have a flagging system for patients with a Learning Disability and or Autistic people. Reasonable adjustment care plan / Hospital passport KPI	• Complete a review of the flagging system for patients with a Learning disability and or autism • When review completed produce written report to TISG with recommendations		The Adult Safeguarding team have completed a review for actions that must be completed when flag is activated for patient. The	Head of Safeguarding	November 2022 December 2022	

		• Review process for Adult Safeguarding team to support individuals with Learning disability and or Autism	Patients with LD - Flow Chart 12.10.202:	flag is located on the Advantis system and is activated when a patient attends the Trust. The team have a process when the flag is activated Flow chart for process for adult safeguarding team completed and finalised		November 2022	
2	Operational review of patients on waiting lists who have a Learning Disability and or Autistic people to understand any delays and provide reasonable adjustment as needed to support effective care planning	• HoS to meet with Deputy Director of Operations to review process for people with a learning Disability and or Autistic people on waiting lists to ensure effective care planning in place		Meeting requested via DDO personal assistant	Head of Safeguarding / Deputy Director of Operations		
3	To ensure that readmission rates for people with Learning Disability and or Autistic people are	• HoS to meet with Deputy Director of Operations to review process for the monitoring of readmissions rates and		Meeting requested	Head of Safeguarding / Deputy Director of Operations	December 2022	

	monitored to review for any inequalities	review for possible quality improvement work in relation to this patient demographic					
4	No evidence of any LD liaison nurse provision.	• Head of Safeguarding to develop a business case for Acute Liaison Learning Disability and Autism Nurse • Draft Job Description created • Head of Safeguarding to benchmark against TGH for Learning disability workforce	Job description - Acute Liaison Learnin	Draft business case by Head of Safeguarding Completed HoS spoken with Deputy DoN at TGH - band 6 Liaison Nurse that provides a hospital service, they also have a band 5 Autism Project Nurse who is going to sit as part of the safeguarding team. PCFT also provide in reach support as required	Head of Safeguarding	December 2022	
5	The Trust to report on complaints that are specific to patients with a	• HoS to review with complaints team any Learning Disability and or Autism complaints and		Discussion with Complaint team taken place and meeting	Head of Safeguarding / complaints team	December 2022	

	Learning Disability and or Autistic people.	concerns to look at themes to support learning and produce report for TISG in December 2022		requested for December to review			
6	Learning disability and Autism training	Adult Safeguarding team with support from Trust Education Team to complete a training needs analysis and present findings and plan at Trust Integrated Group and Educational Governance Group HoS to benchmark with TGH training offer	https://www.cqc.org.uk/guidance-providers/training-staff-support-autistic-people-and-people-learning-disability	Head of Safeguarding communicated to adult team and Education team new CQC requirement as outlined in the Health and Social Care Act 2022 - Training staff to support autistic people and people with a learning disability	Adult Safeguarding / Learning & Development Manager	February 2023	
7	The Trust to develop its learning Disability and Autism literature, leaflets, guides ad any other patient facing documentation	• Adult Safeguarding team to review all current Learning Disability and Autism documentation in the Trust • Head of Safeguarding to seek support from people with lived experience to support with creating easy read guides, useful information leaflets		Head of Safeguarding has sought expression of interests from Valuing People Partnership Board to support this piece of work	Adult Safeguarding team Head of Safeguarding	February 2023 February 2023	

8	NHSEI Learning disability Improvement Standards	• Head of Safeguarding to register the Trust to take part in this annual audit • Final report with recommendations to be shared at TISG	Cover+letter+for+Trusts.docx	Completed and the Trust is registered	Head of Safeguarding	October 2022 October 2023	
9	Learning Disability and or autism packs created for all wards	• Adult Safeguarding team to create information packs for all wards and departments • Adult Safeguarding team to disseminate these week commencing 24th October 2022	16. Learning Disability and Autisr LD Information pack powerpoint.pptx	Updates given to Trust integrated Safeguarding Group in August 2022 regarding packs being created Packs have been created and will be disseminated in agreed time scales	Adult Safeguarding Team	November 2022	
10	Patient and lived experience	• Head of Safeguarding to speak to carer with lived experience about sharing her story with Trust Board. • Head of Safeguarding to record poem carer has written		HoS has met with carer and discussed recent learning from a poor patient experience and the Trust will be utilising a poem the carer has created	Head of Safeguarding and Patient Experience Matron	January 2023	

				HoS met with patient experience Matron and is awaiting confirmation of recording time for poem.			
11	Link nurses / LD & A Champions	• Named Professional for Adult Safeguarding and Named Nurse for Safeguarding children to review role for LD & A Link roles. • Devise a role descriptor		Met with named professionals and tasked them with this piece of work	Named Professional Adult Safeguarding and Named Nurse for Safeguarding Children	January 2023	
12	Trust communications	• To review and refresh the Trust communications for Learning Disability and Autism microsite			Adult Safeguarding team	January 2023	
13	Assurance reporting	• HoS to produce written update for TISG with updates against action plan			Head of Safeguarding	Bi-monthly TISG	
14	CQC report	• HoS to add recommendations to Trust action plan and present this at TiSG			Head of Safeguarding	January 2023	
15	Environment	• HoS to review options of a patient and carer site visit to support quality improvement work around safe and therapeutic spaces e.g			Head of Safeguarding	February 2023	

		sensory room / quiet spaces.					

Appendix 1: Learning Disability and/or Autism Information Pack

Learning disability and/or autism information pack

NHS Stockport NHS Foundation Trust

Based on the feedback from a working group it was agreed a learning disability information pack was necessary to help strengthen quality documentation and communication for hospital patients with a learning disability and/or autism.

The Information packs contains:

- Blue Butterfly Symbol
- Reasonable Adjustment Care Plan
- Mental Capacity Assessment
- Hospital Health Passport
- Hospital Discharge Information
- Patient Feedback Survey
- Contact details for support and advice
- Autism communication passport

The aim of the information pack is to offer assurance that all staff know what forms to complete and by collating all the forms in one pack this will enable staff to complete the patients care plans in a timely manner and improve communication between the patients carers and family.

NHS Stockport NHS Foundation Trust

Some of the wards visited

Here are some photographs of staff receiving their toolbox talks on how to use the information packs. You can read some of their comments received on the day too.

Thank you for spending the time to come and speak with us. The information packs are a great idea and can only improve the care delivered for our patients with LD and/or Autism.

This is a brilliant idea – we need to see more of this for other cohorts of patients. The cake was lovely too.

The information packs are a breath of fresh air.

The information packs are more straightforward. I know what is expected of me when a patient with Learning disability and/or autism is admitted to our ward.

I particularly like the hospital discharge section, to ensure a smooth handover to patients carers when the patient is going home.

Be good to see this embedded in practice.

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Introduction to Patient Safety Incident Response Framework (PSIRF)					
Lead Director	Chief Nurse		Author	Deputy Director of Quality Governance		

Recommendations made / Decisions requested

The Board of Directors is asked to note the change in NHS Framework related to the management of patient safety incidents following the publication of the PSIRF, and the required transition to the PSIRF by Autumn 2023.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of

			models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Trust currently complies with the management of patient safety incidents in line with the Serious Incident Framework (SIF) 2015.

In August 2022 the Patient Safety Incident Response Framework (PSIRF) was published, and organisations are required to transition across to PSIRF by Autumn 2023. NHSE describe the change in framework as a significant shift away from the SIF and to a new approach to managing and learning from patient safety incidents.

The presentation attached gives an overview of PSIRF to Board members as part of the 'orientation' phase of transition.

Introduction to the Patient Safety Incident Response Framework

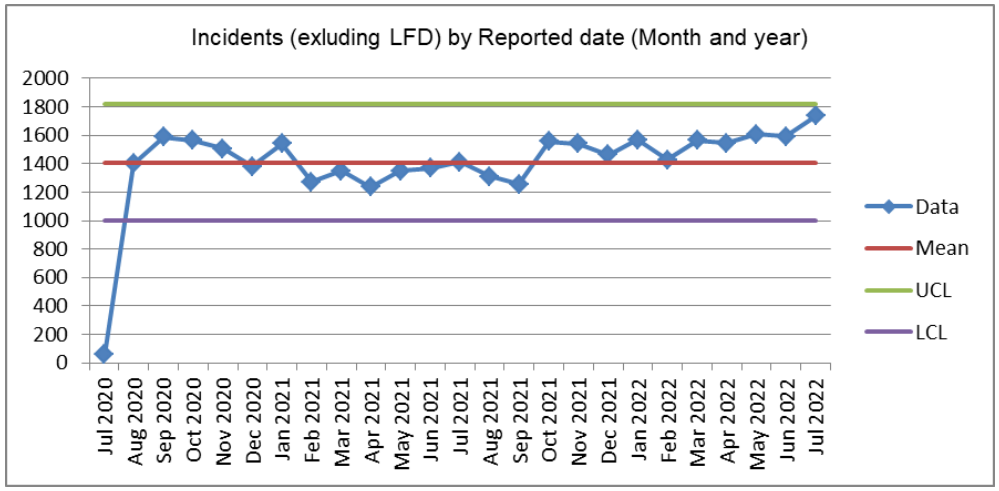
NHS
Stockport
NHS Foundation Trust

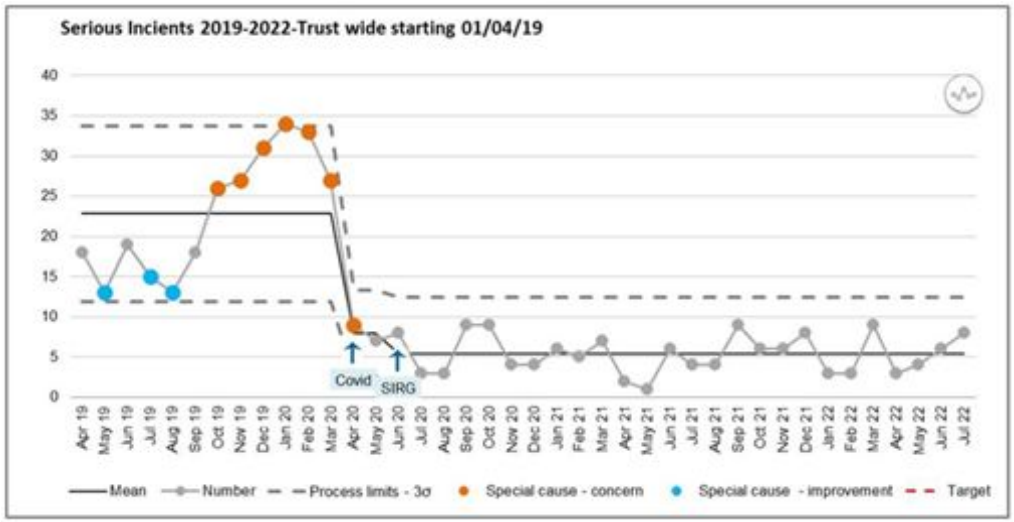
Natalie Davies

Deputy Director of Quality Governance,
Stockport NHS Foundation Trust

Stockport – where we are now

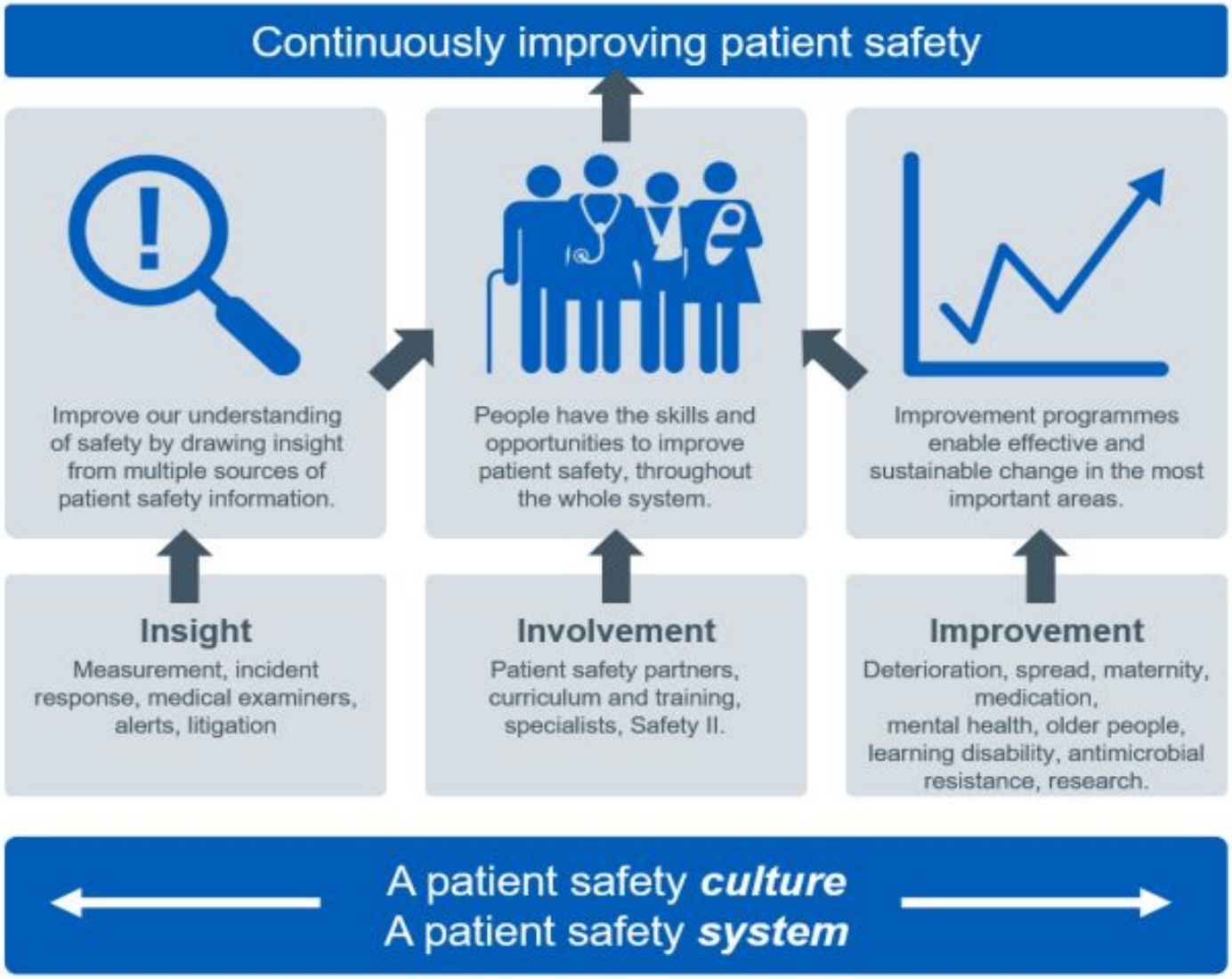
NHS Stockport NHS Foundation Trust





The National Patient Safety Strategy

NHS Stockport NHS Foundation Trust



Stockport NHS Foundation Trust

Patient Safety Incident Response Framework short animation on NHSE website

https://www.youtube.com/watch?v=TyYekgo_IN0

NHS
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"The introduction of this framework represents a **significant shift** in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."

Aidan Fowler, National Director of Patient Safety, NHS England

"The new Patient Safety Incident Response Framework is very welcome. It is great to see the **involvement** of those affected by patient safety incidents at its heart and the emphasis on **learning and improvement** are vital if we are to reduce avoidable harm across the NHS."

Rt Hon Jeremy Hunt MP

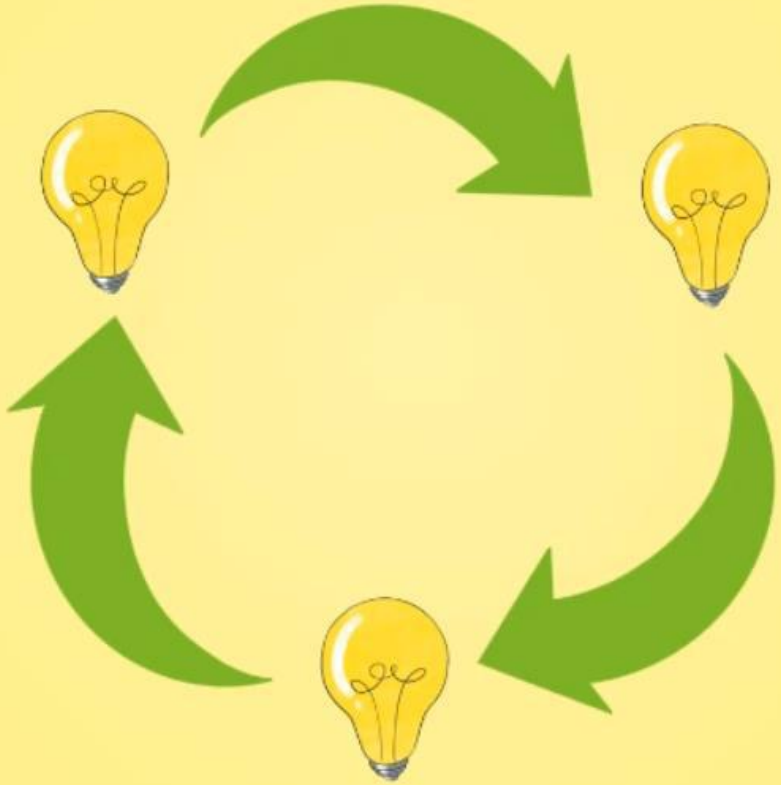
The Framework

Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

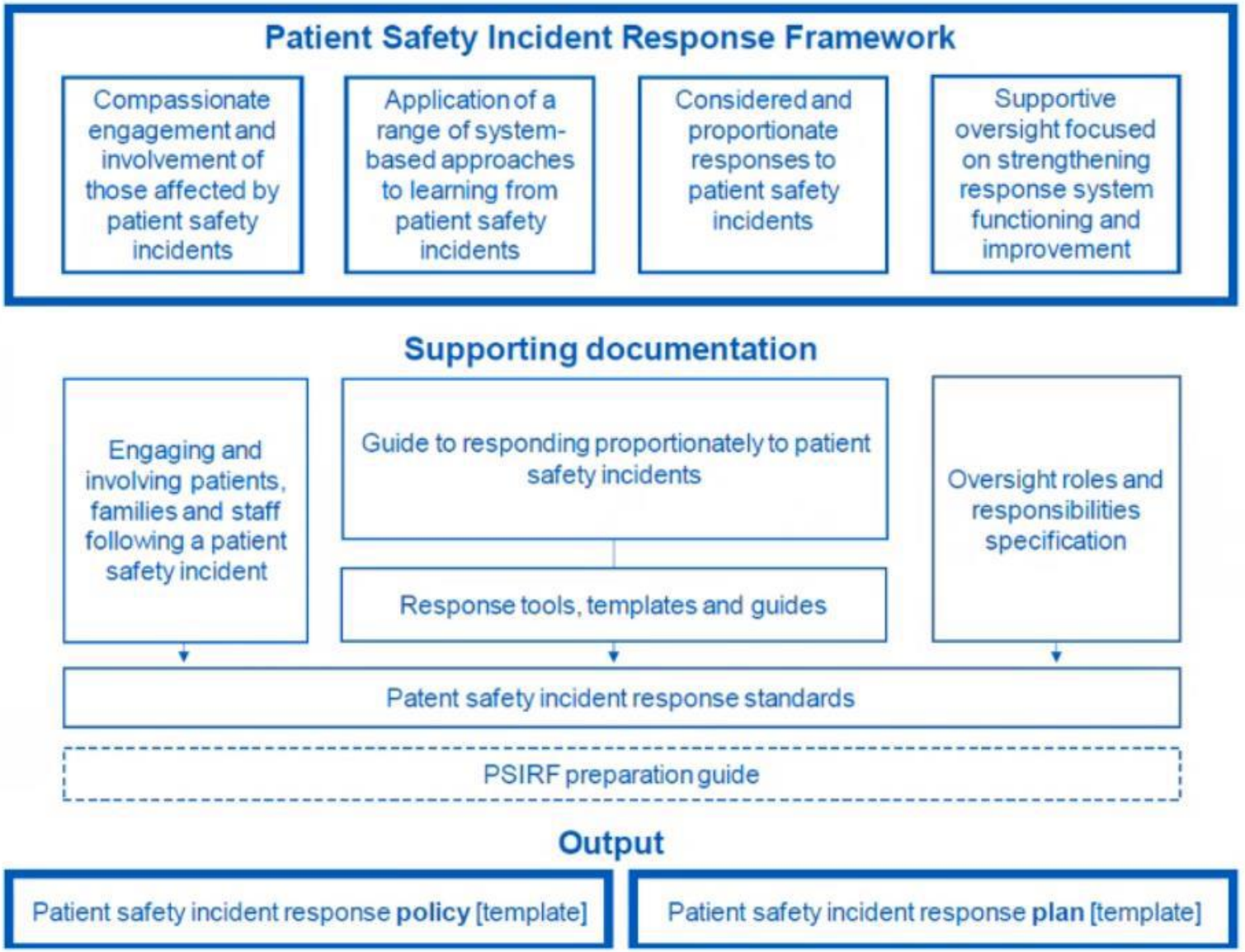
Replaces the Serious Incident Framework and removes the 'serious incident' classification and threshold for it.

Embeds patient safety incident response within a wider system of improvement.

Prompts a significant cultural shift towards systematic patient safety management



With thanks to NHSE



NHS England

With thanks to NHSE

Compassionate engagement and involvement of those affected by patient safety incidents

NHS Stockport NHS Foundation Trust

Part A: Creating the right foundations

- Leadership
- Training and competencies
- Inclusivity
- Processes for seeking and acting on feedback
- Processes for managing dissatisfaction

Part B: Engagement and involvement processes

- Before contact
- Initial and continued contact
- Closing contact

Other things to consider:

- Keeping good records,
- Using language services
- Seeking feedback

Application of a range of system-based approaches to learning from patient safety incidents

NHS Stockport NHS Foundation Trust

A move away from a ‘simplistic, linear identification of a root cause’

Towards utilising the ‘national system-based learning response tools and guides’.

A national toolkit of approaches to patient safety incidents:

PSII investigations – undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning

Plus a whole suite of tools – swarm huddles, after action reviews, walkthrough analysis, timeline mapping, Systems Engineering Initiative for Patient Safety (SEIPS) model….

Considered proportionate responses to patient safety incidents

Stockport NHS Foundation Trust

Recognition of finite resources to patient safety incident responses

Rules regarding responses to patient safety incidents:

PSII Investigation -

Deaths thought more likely than not due to problems in care

Deaths of patients detained under the Mental Health Act or where the Mental Capacity Act applies, where death is more likely than not related to problems in care

Incidents meeting the Never Events Criteria

Other mandated responses related to for example: child deaths, safeguarding incidents, mental health homicide, maternity and neo-natal incidents.

Considered proportionate responses to patient safety incidents

NHS Stockport NHS Foundation Trust

So how do we know how to respond to all other incidents:

We will be required to develop a Patient Safety Incident Response Plan

An example of an early adopter list of local priorities:

- Nutrition of hydration – vulnerable adults
- Inpatient falls leading to fractured neck of femur
- DNACPR with patient/ family
- Internal transfer/handover of patients from ED to other areas of the Trust
- 104 day cancer cases

Supportive oversight focused on strengthening response system functioning and improvement

Stockport NHS Foundation Trust

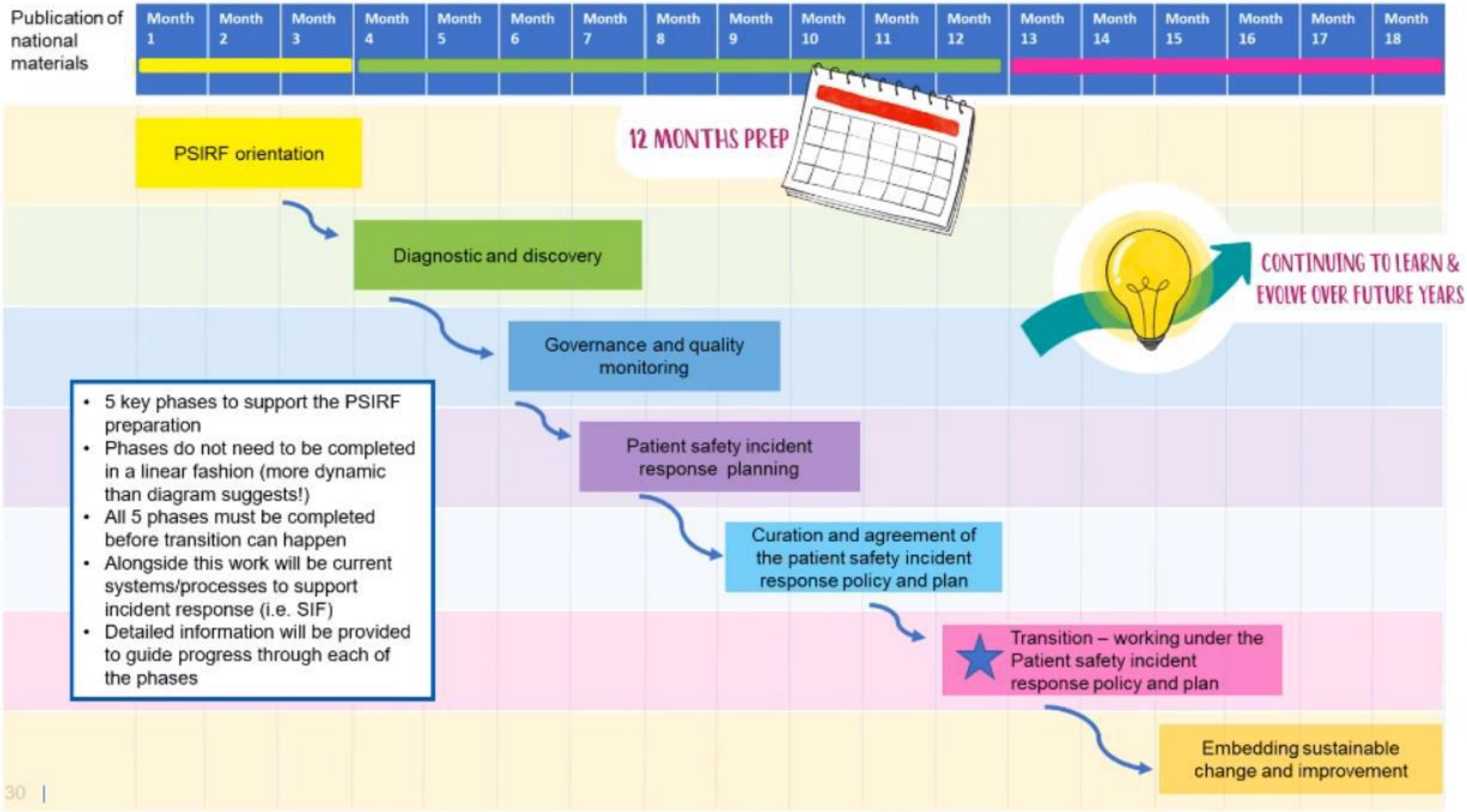
Supportive oversight

Oversight mindset Should underpin oversight approach from provider boards, ICBs and CQC	Oversight approach Principles to consider when designing an approach to oversight
1. Improvement is the focus 2. Blame restricts insight 3. Learning from patient safety incidents is a proactive step towards improvement 4. Collaboration is key 5. Psychological safety allows learning to occur 6. Curiosity is powerful	1. Use a variety of data 2. Reduce the information collection burden 3. Oversight is not 'one size fits all' 4. Capture meaningful insight from patients, families and staff 5. Metrics require clarity and purpose 6. Be aware of perverse incentives

22 |

With thanks to NHSE

NHS Stockport



With thanks to NHSE

Meeting date	1 December 2022	✓	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Our People Plan – Progress Update					
Lead Director	Director of People & OD		Author	Deputy Director of People & OD		

Recommendations made / Decisions requested

The Board of Directors are requested to receive the annual progress report of Our People Plan.

The Board of Directors are requested to note the contents of this paper and the People Performance Committee assurance provided on the significant progress delivered.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
✓	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
✓	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
✓	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	✓	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements

	✓	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
	✓	**PR5.2**	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

Following approval of Our People Plan in June 2021 and the subsequent regular reports provided to the People Performance Committee detailing our progress against our integrated delivery plan, the attached report provides an update on the progress made against our five People Plan Pillars:

1. Strategic Workforce Development, Planning & Performance
2. Culture, Engagement & Retention
3. Resourcing
4. Training, Education and Practice Development
5. Leadership Development

The Board of Directors are requested to receive the report with the recommendation from People Performance Committee of assurance of the delivery of the actions and outcomes outlined in our people plan against a continued challenged backdrop of the impact of the COVID pandemic, supporting the vaccination hub throughout the last 12 months and continued to support staff Health & Wellbeing pledge work.

Whilst the team remain committed to progressing the actions and outcomes throughout Q3 and Q4 and as things stand are on track with progressing the actions planned for the rest of 2022/23, the Board of Directors are requested to acknowledge that given the anticipated and unprecedented forth coming winter challenges there may be a re-prioritisation of the deliverables required in response to the emerging challenges, not least the anticipated industrial action.

An update on progress will be provided again in Q1 of 2023 and we will look to review the impact going forward and describe this in future reports.

1. Introduction

Our People Plan (2021/23) was approved by the Board of Directors in June 2021. The delivery of the key initiatives described against each of our five people pillars is the responsibility of the People & OD Directorate, with oversight via our People, Engagement and Leadership Group. This group meets on a monthly basis and is chaired by the Deputy Director of People & OD, with a key issues chair report provided to the People Performance Committee. The PELG Chairs report is also supplemented by regular subject specific reports and our integrated delivery plan highlight report.

2. Review of Progress

This report is structure around our five people plan pillars and provides a progress update against each of the pillar's key initiatives:

2.1 Pillar 1 – Strategic Workforce Development, Planning & Performance

Pillar Key Initiatives	What have we delivered?	Comments
Ensure effective rostering and other e-solutions	• Non-medical 86% units fully using Healthroster. • Medical – 27 units with 63 individual patterns • Agreement of new contract with the provider complete. • Quality rostering practices fully embedded in clinical nursing teams • Safecare implemented and in use • Implementation of e-portfolio system • Implementation of Mii People Planning System • Roll out and implementation of People Analytics System	• on track to achieve 100% by end Q4. • on track to go live in Q4. • Safecare equivalent for medics in development • Activity manager business case to OMG for anaesthetics • Loop functionality being explored • Development of EDI dashboard within People Analytics
Build shared ICS workforce solutions	• People & OD team engaged in the ICS workforce solutions, working closely with local partners on initiatives. • Director of People & OD joint chair of One Stockport workforce group, work plan in development.	

	• Working with system partners to review and develop a Cadet Programme.	
Understand supply changes & analyse current and future need	• Workforce operational plan completed and submitted through GM • Trust Workforce Plan for 2022/27 developed with input from divisions • Degree pathway for development into AHP roles is in place for Radiology, Occupational Therapist and Physiotherapist	• Review of Operation Plan against actuals taking place in Q3 • Directorate workforce profiles completed for Surgery in Q3 to develop into their bespoke plans for 2023 and beyond • 2022/23 cohort of 10 x degree AHPs will commence apprenticeships in January 2023
Develop & implement future workforce models with HEIs & other partners	• Increased our locally employed doctor pipeline by providing placements to Medical Support Workers (international medics awaiting GMC registration)	• Ensure at least 90% of Medical Support Workers achieve a LED role within the Trust on registration

2.2 Pillar 2 – Culture, Engagement & Retention

Pillar Key Initiatives	What have we delivered?	Comments
Secure inclusion for everyone	• EDI Strategy & supporting delivery plan developed and approved March 22 • Staff networks in place and being developed, including establishment of Carers Network. • Gap Analysis of Anti Racist Framework completed • Ambitious work plan and programme in place	• Further work will be done to reinvigorate our Staff Networks. We also intend to enhance our EDI training offer to ensure that everyone has the capability and confidence to deliver their part of the EDI Strategy and build a more inclusive workplace.
Develop a coaching culture	• Deputy Director of OD appointed May 22 • OD Team re-designed and recruitment complete & full team in place by Dec 22.	• Development of draft OD plan to be approved by end of year which includes - Relaunch a fit for purpose and inclusive coaching and mentoring offer
Recognise, reward & listen to our people	• Values into Action sessions in place with Executive Directors, with actions delivered. • Christmas hampers for teams for 2021 • Long service recognition & policy reviewed and updated • Retirement policy reviewed and updated. • Making a difference everyday awards programme established. • Annual Staff Awards ceremony established Oct 2022.	• Long service award ceremony delivered in November 2022; with annual programme of recognition going forward. • Review of MADE awards process to be undertaken in Q4.
Promote our people's health & wellbeing & support resilience	• HWB Monthly Newsletter implemented • Staff Psychological Wellbeing Service established & capacity increased through additional charitable funds.	• Subject to final approval we will implement our menopause service. • Bereavement Groups running through Q4. • Tameside OH collaboration will be delivered by end Q4.

	• Bereavement Group pilot completed, with success and approved charitable fund bid to deliver future groups. • Review & Update of Wellbeing initiatives • Foodbank in place along with wider financial/cost of living support • Environmental audit completed • Menopause service charitable funds bid completed • Vaccination hub re-established for Autumn 2022 • Occupational health service re-investment of overachieved income. Collaboration with Tameside OH services underway • Continued with close working with the GM Resilience Hub	• Signposting of staff to Resilience Hub as and when needed
Promote flexible working for all staff	• Commitment to flexibility widely communicated, work with colleagues and managers to translate this into workable arrangements across teams • Completion of NHSI Timewise Flexible working programme. • Monitoring of the % flexible working requests approved • Training for managers has commenced. • Flexible working group established. • Flexible working factsheet produced, supported by a promotion campaign.	• Review to take place of the results of the 2nd flexible working survey and feedback to be given • Ongoing communications and promotions across all media
Increase our retention of staff	• Established the Attract, Develop and Retrain group with 5 workstreams encompassing the full employment journey • The turnover trend has significantly slowed as a result of our efforts	• Develop career development workshops and complete the career pathway tool for all staff groups by Q4

2.3 Pillar 3 – Resourcing

Pillar Key Initiatives	What have we delivered?	Comments
Embed a strong, unique employer brand	• A review of the recruitment literature aimed to attract quality candidates • Work in the community and in school to promote the organisation as an employer for the future • Attended 3 school fairs, 8 careers fairs, 7 recruitment events.	• Establish the new section of content on the external internet pages for new starters to access with online forms to replace the paper-based • Increasing work with local network leads and communities to promote our employment opportunities to those groups who are less represented

Implement values-based recruitment	• Values based recruitment is integral to our recruitment practices	• Training for managers has been revised to include more on inclusion and unconscious bias
Deliver Targeted & streamlined Recruitment	• Recruitment process reviewed and all non-value-added steps have been removed. • KPIs regularly reviewed with Tameside colleagues to ensure that improvements to efficiency continue • We have recruited 113 nurses and 2 radiographers through international recruitment so far this year; with a continuing programme of international recruitment.	• New functionality in TRAC available but at a cost that make the processes much more streamlined with the use of single entry for certain data fields • Re-visit the use of AI to automate certain processes • Deep Dive into shortlisting processes (looking at WRES) data underway • A review of the processes with an EDI lens to look at reducing barriers into the NHS is planned for completion by Q4.

2.4 Pillar 4 – Training, Education & Practice Development

The progress update provided for this pillar should be considered in conjunction with the education, training and clinical skills report presented to the People Performance Committee in November 2022, where additional information and deliverables has been provided.

Pillar Key Initiatives	What have we delivered?	Comments
Improve the learning & development experience	• Accessed additional education funding to develop our colleagues Q1 – Q3. • Worked collaboratively with colleagues across GM and with HEI partners to access learning and development opportunities.	• We will fully utilise our training, education and apprenticeship funding to improve learning development. • We will work collaboratively with colleagues and service users with lived experience to support the development and learning experiences.
Apprenticeship programmes at all levels	• Increased the numbers of Degree Nurse and AHP apprenticeship programmes. • Training needs analysis reviews and promotion of apprenticeship programmes at all levels Q1 and Q3. • Collaboration with workforce team to identify apprenticeship opportunities. • ICS collaboration to identify entry level opportunities Q2.	• We will increase our fiscal apprenticeship target by 0.25% by Q.1 2023. • We will promote the utilisation of the apprenticeship levy within all Divisions. • We will work with apprenticeship providers to promote the apprenticeship offers. • We will work with system partners to review and develop clinical apprenticeship pathways.
Encourage students to flourish	• Increased clinical placement capacity to enhance the breadth of learning opportunities. • Supervisors and assessors supported to ensure high quality learning environments. • 2021/22 Supported Internship Programme delivered and the 2022/23 programme started in Oct 22.	• We will recognise best practice supporting all learners and embed this in all areas across our Trust. • Development of collaborative approach to Knowledge & Library Services with Tameside
Multi-professional approach to clinical skills development & preceptorship	• We have revised the model of preceptorship to deliver a multi-professional programme	• We will work collaboratively with partners across GM to review the preceptorship programme in line

	• The clinical educator's group is a multi-professional group to review clinical skills development and delivery. • Development and delivery of a collaborative Resus Faculty with Tameside.	with recent national preceptorship framework.

2.5 Pillar 5 – Leadership Development

Pillar Key Initiatives	What have we delivered?	Comments
Increase staff led improvement	• We have facilitated values into action listening events where staff suggestions have led improvements.	• The new draft OD plan includes an intention to implement a range of interventions over the next 2 years aimed at equipping our people with the confidence, tools, and support to safely challenge the status quo, be more solutions focused and do things differently and better; including re-launching and extending the Think-On Programme.
Make staff voice even stronger in our leadership and governance	• Colleagues have been encouraged to complete the NHS staff, survey, pulse survey and attend listening events to ensure that they have a voice. • Worked collaboratively with staff side.	• We will continue to strengthen and create new employee voice channels and build a stronger speaking up culture. This includes establishing a first line and middle managers engagement forum with an annual programme of delivery.
Continue to implement and embed innovative, compassionate & collective leadership models	• Team effectiveness interventions for teams to identify and understand their common purposes and shared values (MBTI, 360 & Affina interventions).	• As part of our new OD plan, we will launching a refreshed and fit-for-purpose leadership & management development offer.
Develop high performing teams	• "Think-On" programme to develop Senior nurse and AHP leaders. • Affina model to support team development – Theatres, ED. • Lumina Spark Facilitators training completed	• Lumina Spark Faculty to be developed & embedded. (The Lumina Spark is a psychometric tool which helps individuals to understand themselves and others better which leads to improved team working.)
Develop & implement clinical leadership models	• SAS Tutor has facilitated significant development opportunities with this group in support of the SAS Charter • Case Manager Training for clinical leads held in January 2022 • New Consultant development Engagement session with higher trainee doctors to understand what attracts them to a consultant post and to explain the future ambition of the Trust.	• The leadership development programme is under review and will continue to focus through a multi-professional approach to leadership models.

	• Held our first medical workforce development and planning event	

3. Summary

The Board of Directors are requested to receive the report with significant assurance of the delivery of the actions and outcomes outlined in our people plan against a continued challenged backdrop of the impact of the COVID pandemic, supporting the vaccination hub throughout the last 12 months and continued to support staff Health & Wellbeing pledge work.

Whilst the team remain committed to progressing the actions and outcomes throughout Q3 and Q4, the Board of Directors are requested to acknowledge that given the anticipated and unprecedented forth coming winter challenges there may be a re-prioritisation of the deliverables in response to the emerging challenges, not least the anticipated industrial action.

An update on progress will be provided again in Q1 of 2023 and we will look to review the impact going forward and describe this in future reports.

4. Recommendation

The Board of Directors are requested to note the contents of this paper and the People Performance Committee assurance provided on the significant progress delivered.

Meeting date	1st December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Freedom to Speak Up					
Lead Director	Caroline Parnell *Director of Communications and Corporate Governance*		Author	Paul Elms *Freedom to Speak Up Guardian*		

Recommendations made / Decisions requested

The Board of Directors is asked to consider and note the activities of the Freedom to Speak Up Guardian, the concerns that he has raised and the actions to being taken to address those concerns.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
x	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	✓	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
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		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
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		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This report provides an update of activity in relation to the Trust's Freedom to Speak Up Guardian and plans for the developments of the Speaking Up agenda.

The Board is asked to consider and note the activities of the Freedom to Speak Up Guardian, the concerns that he has raised and the actions to being taken to address those concerns.

1. INTRODUCTION

1.1 This report gives the Board an overview of the activity of the Freedom to Speak up Guardian over the last six months and highlights some trends and developments for the attention and information of Directors.

1.2 National coordination of the role takes place via the work of the National Guardian's office, which collates national data, works to standardise the Freedom to Speak Up service across the country and disseminates best practice and training.

1.3 Regional coordination is achieved via the regional Freedom to Speak Up Guardians network, monthly meetings, and information sharing.

1.4 The annual regional conference of FTSU Guardians is being hosted by our Guardian at Stockport in today (1 December) and is to be attended by the Chair of the Board, as well as the Non-Executive and Director level leads for Freedom to Speak Up

2. ACTIONS UNDERTAKEN

2.1 Since last reporting to the Board in April 2022 the FTSU Guardian has:

- Taken part in 15 different team meetings e.g., with various nursing teams, in both the community and in the hospital.
- Been invited by four managers to undertake specific de-brief sessions with cohorts of staff, to specifically encourage them to openly discuss issues.
- Met with the Non-Executive Lead on occasions, with the Lead Director at least every month, and with the Chair and Chief Executive once.
- Attended every Trust induction and most Preceptorship events.
- Attended different staff side and staff network meetings.

3. NATIONAL FREEDOM TO SPEAK UP TRAINING

3.1 The National Guardian's Office produces online Freedom to Speak Up training, to heighten awareness and to increase understanding at different levels.

3.2 All three modules ('Speak Up' – for all staff, 'Listen Up' – for managers, and 'Follow Up' – for senior leaders) became mandatory across the Trust in October – during FTSU month. The below table shows the take-up of FTSU training in the last few weeks.

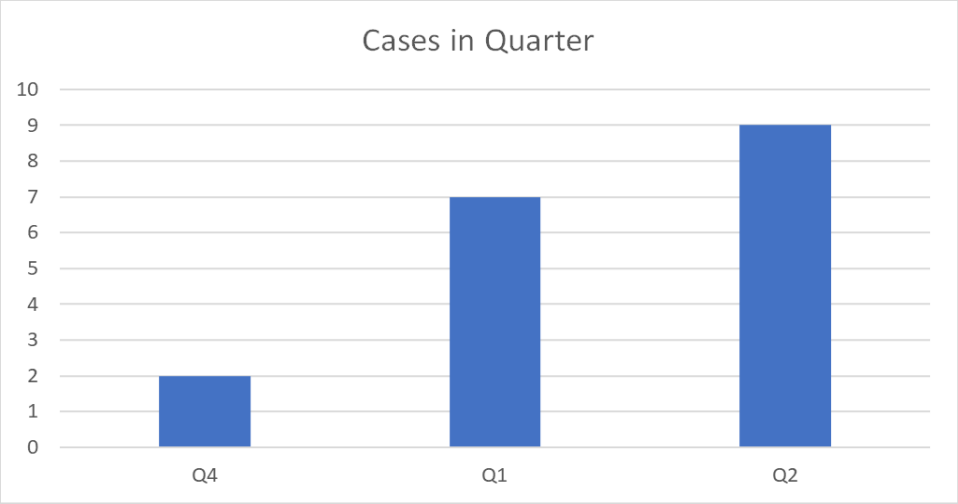
All workers	26.6%	5890
Managers	15.7%	653
Senior Leaders	0%	14 (Only went live in last few days of October)
Overall	**25.54%**	

3.4 Module 3 ('Follow Up') includes –

- What is a healthy speaking up culture?
- Benefits and drivers – including improved safety and organisational performance; reducing harm and costs; and worker retention
- Measuring the effectiveness of a speaking up culture
- The role of leaders in setting the tone
- Supporting your Freedom to Speak Up Guardian

4. CASE WORK

4.1 The table below shows the number of formal FTSU referrals in each of the last three quarters:

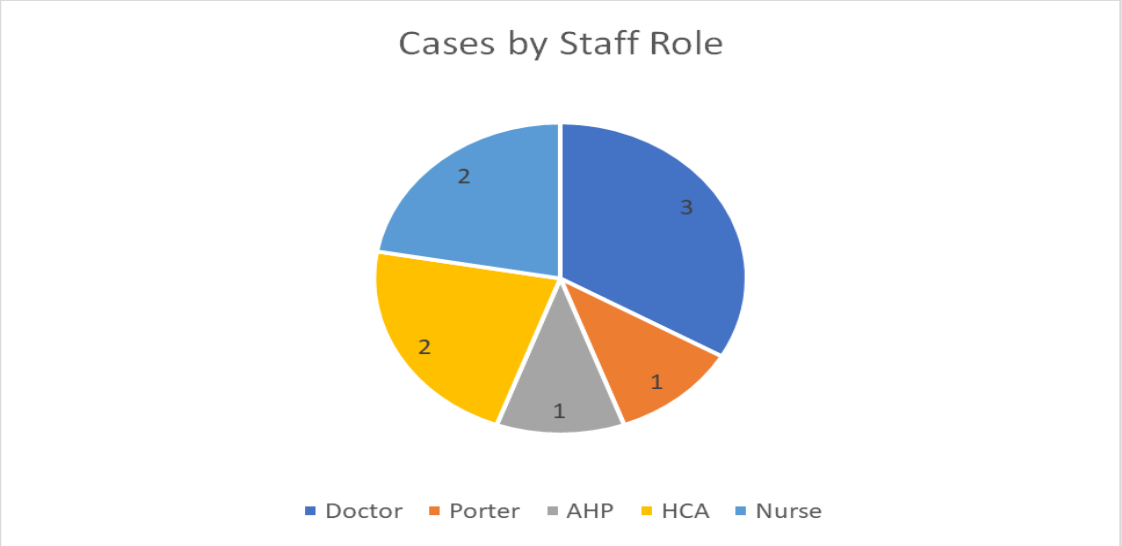


4.2 There are an additional five cases in quarter 3 to date.

4.3 The table below shows the cases in the last quarter by type.

Case Type	Doctor	Porter	AHP	HCA	Porter	Nurses	Total
Data Protection	1						1
Patient Safety	1					2	3
Maladministration		1	1				2
Bullying							0
IT							0
Incivility	1				1		2
Pay				1			1
Totals	3	1	1	1	1	2	9

They can be further broken down by staff role:



4.4 Eight of the nine cases in Q2 have been closed.

4.3 All issues raised were responded to within 24 hours by the FTSU Guardian, and staff report finding this reassuring.

5. THEMES AND TRENDS

5.1 There are no obvious themes in the cases brought to the attention of the FTSU Guardian.

5.2 However, the Guardian is concerned about one case, potentially involving an allegation of assault, which is currently being investigated through Trust processes, and about which his views have been made known to members of the Board.

6. THE 12 NATIONAL PRINCIPLES OF FREEDOM TO SPEAK UP

6.1 In the previous report the Guardian expressed concerns about the lack of a timely response from some managers towards FTSU issues and how little appears to have been learned from the cases that have been raised.

6.2 When colleagues speak up, wherever they speak up, there needs to be a high quality, consistent response. The National Guardians office has developed 12 key principles to support this aim and at the May meeting of the Board of Directors, it was agreed that the Trust should adopt these principles.

6.3 The principles have been incorporated into a framework (*see attached)* to be shared with all of those involved in a formal FTSU case and will be incorporated into the Speaking Up policy that is being revised in line with new national guidance. This should help to further standardise the approach taken and increase awareness of what can and should be expected in a FTSU case.

6.4 An escalation process has been developed to address any delays in managers responding promptly to FSU concerns, and at November's Team Brief managers were reminded of the importance of a timely response to all concerns. The Guardian also seek the support of the Board in sending a strong message to the organisation about the importance of FSU and the wider Speaking Up agenda.

7. REVIEW OF FTSU ARRANGMENTS AND POLICY

7.1 NHS England, working with the FTSU National Guardian's office, requires every Trust to review their FTSU arrangements and policy.

7.2 They have provided each Trust with a template to ensure that all aspects of the FTSU service are considered. The Trust's completed template is to be considered as a separate agenda item.

7.3 This provides an excellent and timely opportunity for the concerns and issues raised by the FTSU Guardian to be considered, including the resources devoted to the FTSU role. The template includes an action plan to address areas for improvement, some of which have previously been reported to the Board.

8. FREEDOM TO SPEAK UP MONTH

8.1 FTSU month takes place in October each year.

8.2 This year the Guardian held four drop-in sessions, heightened his presence on social media, was featured in Trust and national communications, circulated FTSU pens, and held a photographic competition to further raise awareness of Speaking Up.

9. APPOINTMENT OF CHAMPIONS

9.1 Also during Freedom to Speak Up month, the Trust advertised for the first time for FTSU Champions. The intention being to appoint colleagues from across the Trust to work in support of the Guardian, helping to heighten awareness and expanding access to the FSU service.

9.2 Seven people have expressed an interest in becoming a champion and a process is underway to train these volunteers to support the Guardian.

10. RECOMMENDATIONS

The Board is asked to consider and note the activities of the Freedom to Speak Up Guardian, the concerns that he has raised and the actions to being taken to address those concerns.

NHS Stockport NHS Foundation Trust

Raising Freedom to Speak Up Concerns – escalation process

1. On receipt of complaint – FSUG will Identify relevant service manager and call them (if possible) for initial discussion, providing brief synopsis of the issues being raised.
2. FSUG will send follow up email – with header “Freedom to Speak Up Concerns about *service area”.*
3. In body of the email the concerns being raised will be briefly explained, and the key expected timescales highlighted eg **three** days to contact complainant if not anonymous, then **14** days for update. Guidance and detailed complaint will be attached and referenced in the email.
4. Day 5 after concern lodged - if complainant has not been contacted FSUG will contact manager via telephone (if possible) to remind them of expectation around timescales, and send follow up email to reiterate discussion
5. Day 14 – FSUG to send email reminder about expectation of update.
6. Day 20 – if update has not been provided without reasonable explanation for delay, FSUG to escalate to individual’s line manager, copied into Executive Director lead.
7. Day 22 – if update still not received Executive Director lead will discuss with relevant Director.
8. Day 24 – if update still outstanding Executive Director lead with discuss with Chief Executive and NED lead may also discuss with Chair.
9. Delays in responding to concerns will be included as part of FSUG report to People Performance Group and Board of Directors.
10. It is important we learn from concerns raised by staff so following action/investigation the FSUG will, depending on the nature of the issue, liaise with the investigating officer, HR, or relevant directors to identify any areas of learning or possible improvement for speaking up and the Trust.

Meeting date	1 December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Freedom to Speak Up Toolkit					
Lead Director	Director of Communications & Corporate Affairs		Author	Director of Communications & Corporate Affairs		

Recommendations made / Decisions requested

The Board of Directors is asked to consider the content of the toolkit and associated actions, and endorse the action plan.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	✓	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
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	✓	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care

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		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The National Guardian's Office has developed a reflection and planning tool to enable organisations to identify their speaking up strengths and areas for improvement.

The Director of Communications & Corporate Affairs, Non-Executive Director Lead for Freedom to Speak Up ,and the Freedom to Speak Up Guardian completed the tool on behalf of the Trust with input from the Director of Workforce and OD and Deputy Director of OD to reflect the broader speaking up arrangements in the organisation.

The completed tool includes a series of medium and longer term actions to address the identified areas for improvement.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I have led a review of our speaking-up arrangements at least every two years	3
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ring fenced time to fulfil all aspects of the guardian job description	2
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	4

Enter summarised commentary to support your score.

- The Director of Communications & Corporate Affairs is the senior lead and was previously a guardian in another organisation so understands the role and related requirements.
- The Trust reviewed FSUG arrangements two years ago and has recently updated its Speak Up Policy, although it requires further changes to align with the recently published national policy. We do not believe the organisation has not reviewed all speaking up arrangements in the last two years.
- The guardian has raised concerned about the split role impacting on the time he is able to devote to Stockport, particularly in relation to raising the profile of Speaking Up in the organisation and supporting FSU training.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Identify whether wider Speaking Up arrangements have been reviewed within the last 2 years and action accordingly.

2 Review current time commitment/arrangements for FSUG on an annual basis.

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I am confident that the board displays behaviours that help, rather than hinder, speaking up	2
I effectively monitor progress in board-level engagement with the speaking-up agenda	2
I challenge the board to develop and improve its speaking-up arrangements	3
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ring fenced time to fulfil all aspects of the guardian job description	2
I am involved in overseeing investigations that relate to the board	NA
I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

- Until recently the Non-Executive Director lead would have been confident about the Board's behaviours, but now has concerns that public commitment to speaking up is not always reflected in all behaviours.
- We do not currently have a process for monitoring board level engagement with the speaking up agenda.
- Part of completing this planning tool is to focus on improving the organisation's speaking up arrangements.
- The guardian has raised concerns about having sufficient time to deliver the role for Stockport and a bench marking exercise has indicated the trust's resource is low compared others in the region.
- To date there has been no investigations relating to the Board.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Board development time is required to ensure all board members understand their responsibilities in relation to speak up
2 Develop a process for monitoring board level engagement in the speaking up agenda

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	2
We can evidence how we demonstrate that we welcome speaking up	3
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	2
We regular discuss speaking-up matters in detail	3

Enter summarised evidence to support your score.

- All Board members gave public statements about their commitment during Speaking Up month in 2021, but not all behaviours have always reflected those statements
- We have a speaking up policy but not a vision for what the organisation wants to achieve in relation to speaking up.
- The guardian presents regular reports to People Performance Committee and the Board, but speaking up matters are not discussed in detail to protect confidentiality.
- Feedback from the NHS staff survey highlights some evidence around staff views re. speaking up. Anecdotal evidence around staff concerns about speaking up could indicate we have more to do in relation to role modelling behaviour that encourages speaking up.
- The CEO has made a positive statement about not accepting detriment. This needs to be repeated regularly, echoed and role modelled by all senior leaders.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)
1 Adopt new policy that sets out clear processes/timescales for investigating speaking up concerns
2 Consider what processes we need to put in place to evidence positive impact of speaking up
3 Develop a vision for speaking up and communicate that visions consistently

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	4
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	2
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	2
We support our guardian(s) to make effective links with our staff networks	4
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	2

Enter summarised evidence to support your score.

- The Deputy Director of Organisational Development was the strategic lead for embedding the FTSU process and had line management responsibility for the FTSU Guardian at a previous organisation. Whilst in this post, the DDOD also supported the FTSU Guardian to establish a network of 35+ FTSU Champions.
- The Trust's new OD Plan, which is currently in development, will have a focus on improving our organisational culture where our staff feel psychologically safe to speak up and we have a just and learning culture.
- The FTSU has an open invite to attend our Staff Networks.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Implement the Trust's new OD Plan (2023-25)

2 The OD Service will better utilise our FTSU intelligence and data to inform our approach to enhancing our speaking-up culture.

Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
We have reviewed the ring fenced time our Guardian has in light of any significant events	2
The whole senior team or board has been in discussions about the amount of ring fenced time needed for our guardian(s)	2
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	2
Enter summarised evidence to support your score. • The guardian is able to follow national guidance, attend network events and we have adopted the universal job description. • We reviewed the time commitment for the guardian in the last two years prior to advertising for the most recent incumbent to the post. • The guardian has raised concern about sufficient time to fully deliver the role, and recent benchmarking data suggests the organisation is light in terms of ring fenced FSUG time. • The time commitment has not been reviewed by the Board in the last three years, and currently there is only sufficient budget for a guardian 2 days a week.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Board level discussion required about time commitment, taking on board regional bench marking data.	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	3
We can evidence that our staff know how to find the speaking-up policy	3

Enter summarised evidence to support your score.

- The speaking up policy was recently updated but it is being further revised in light of the latest national update.
- The policy is available on the intranet and training requires staff to access the policy. There is evidence that staff are accessing the policy since role specific training was introduced in October 2022.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Update policy to reflect national policy and including timescales/process to follow

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	3
We tell positive stories about speaking up and the changes it can bring	2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

- We had a successfully communications plan to introduce the new guardian to the organisation and raise the profile of FSUG in their first year.
- We have not to date used positive stories about FSUG or the broader speaking up agenda.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Develop a year two communications plan, including positive stories about the impact of the FSUG work.

2 Consider ways of identifying other positive stories to come from the broader Speaking Up agenda.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	2
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	DK

Enter summarised evidence to support your score.

- The training is not mandatory, but role specific training has been rolled out from October 2022.
- The guardian attends all corporate induction sessions, and team inductions on request.
- The Trust measures the percentage of staff who have completed specific training, but there is further work to do around measuring the impact of Trust training.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Support roll out of role specific FSUG training
2 Identify ways of measuring the impact of speaking up training

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	2
All managers and senior leaders have received training on Freedom to Speak Up	2
We have enabled managers to respond to speaking-up matters in a timely way	2
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

- Role specific training began to be rolled out from October 2022.
- We have not previously set timescales/expectations for how managers will respond to speaking up issues, although this will be incorporated into the revised Speak Up policy and an escalation process has also been developed to encourage timely responses.
- We should review the effectiveness of current processes to collect info on how we are learning from all speaking up routes.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Support roll out of role specific training from October 2022.
2 Update policy to include required timescales and evaluation

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	3
We use triangulated data to inform our overall cultural and safety improvement programmes	3

Enter summarised evidence to support your score.

- The guardian is supported by the senior lead for FSUG to identify and follow up areas of concern and he meets regularly with the CEO.
- We collect a range of data eg SI, complaints, FSUG etc, but need further work to triangulate all the information the Trust has to inform improvements.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Review how the Trust triangulates data to inform improvements

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	2
We share the good practice we have generated both internally and externally to enable others to learn	3

Enter summarised evidence to support your score.

- The guardian is part of the regional and national network and regularly shares information from those groups in his reports to PPC and Board. He has used this info to highlight areas for improvement eg benchmarking data.
- This information, coupled with the outputs from this planning tool, will inform the development of a speaking up improvement plan, however that plan needs to be wider than FSUG if the organisation is to foster a positive speaking up culture.
- We have not shared learning from FSUG investigations internally eg case studies.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Year two communications plan to include sharing learning from FSUG investigations eg case studies
2 Consider how the Trust consistently shares learning from broad speaking up agenda.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. • Appointment process in line with national guidance, using universal job description, advertised widely.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 N/A	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	4
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	4
Our guardian(s) has access to a confidential source of emotional support or supervision	4
There is an effective plan in place to cover the guardian's absence	3
Our guardian(s) provides data quarterly to the National Guardian's Office	4

Enter summarised evidence to support your score.

- The guardian has regular 1-1s with the senior lead and together they identify areas for improvement eg timescales in policy, training roll out, escalation process.
- FSUG is potentially a lonely role. The guardian and senior have established a supportive working relationship and the guardian has support from the regional network.
- The senior lead covers for the guardian when he is on leave, but the senior lead does not approve leave as employed by T&G so cover arrangements can be fragile.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider broader cover arrangements for guardian when they are on leave

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	2
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	2
We are assured that confidentiality is maintained effectively	3
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	2
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2

Enter summarised evidence to support your score.

- Our current policy does not set out a clear process or timelines for investigating concerns, which impacts on investigations being undertaken in a timely manner. A process has been drafted and will be included in the revised policy, and an escalation process has also been drafted.
- There has been no mandatory training for managers so their understanding to the role they play will be limited to what they may have learnt from induction if they are relatively new to the organisation. We began to roll out role specific training from October 2022.
- Feedback to the guardian is that staff who speak up are not having a consistently positive experience, neither has the guardian when he has raised concerns.

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High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Update the policy to include clear timelines and process for investigating concerns
2 Support roll out of role specific training
3 Senior leaders to consistently role model the importance of speaking out and expectations around concerns being investigated in an open and honest manner, and being aware of possible personal impact on individuals from speaking out.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	2
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	NA
We have evaluated the impact of actions taken to reduce barriers?	2

Enter summarised evidence to support your score.

- The Trust knows from NHS staff survey and other date the backgrounds of people who are less likely to raise concerns, but we have no firm data on why.
- The Trust has not previously recruited champions but as part of the recent FSU month it called for potential champions, seven individuals have expressed an interest and a process is in place to take this forward
- We have an Organisation Development Plan (OD Plan) in development which will build on the work we are doing to create an inclusive and compassionate culture so that we are a great place to work and we can attract and retain the very best people. This plan will set out our approach to enhancing performance and culture through activities with an emphasis on changing hearts, minds and skills. This will include the working with the FTSUG to address themes around the culture of speaking out with a view to improving this.
- From the NHS staff survey we understand who is less likely to speak up but further work is required to identify why and to address those barriers.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Implement plan to recruit champions
2 Review actions Trust is taking to reduce barriers to speaking up.
3 Implementation of the Trust wide OD Plan

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	N
We monitor whether workers feel they have suffered detriment after they have spoken up	Y
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	NA

Enter summarised evidence to support your score.

- The People & OD team review elements as part of their business as usual – learning from cases is an integral part of improving how we do things.
- A more formal approach and linked specifically to FTSU needs to be enacted – this will form part of the cultural work during 23/24 following the appointment of the new Deputy Director of OD in 22/23

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 A more formal approach and linked specifically to FTSU needs to be enacted – this will form part of the cultural work during 23/24 following the appointment of the new Deputy Director of OD in 22/23

2 Work with the new FTCU Champions to fully understand staff feeling following raising issues
3 Devise a process of check in and follow up to ensure the staff member hasn't been subject to any detriment.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	3
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	3
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	2
Our improvement plan is up to date and on track	2

Enter summarised evidence to support your score.

- We have a speaking up policy but not a strategy for speaking up or FSU, which would include a vision of where the organisation wants to go with the speaking up agenda and ways of evaluating its impact.
- The outputs from this assessment will feed into an improvement plan.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Develop a speaking up strategy (including FSU).
2 Use this assessment tool to inform a year 2 FSU plan.

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	2
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	3
Enter summarised evidence to support your score. • Our FSU arrangements have been reviewed within the last 2 years and the speaking up policy revised, but don't believe all speaking up arrangements have been evaluated. • We have recruited a new Deputy Director of OD who is developing a Trust wide OD plan which will focus on leadership development, Civility Saves Lives.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Development of the Speaking Up Strategy, including FSU	
2 Communication Plan	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	3
We have we evaluated the content of our guardian report against the suggestions in the guide	3
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

Enter summarised evidence to support your score.

- The guardian produces a report twice a year for PPC and Board, which has developed over the last year to meet members stated assurance and information needs, and it is in line with national guidance.
- PPC receives other info in relation to speaking up eg Guardian of Safe Working, Junior Doctors, and relevant exec leads provide assurance to PPC about actions in relation to any areas of concern.
- Neither the Board nor its assurance committees receives a regular report that triangulates data from all aspects of the speaking up agenda.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to develop the FSUG report to meet assurance needs and in line with changing national guidance

2 Consider PPC/Board requirements in relation to the whole speaking up agenda

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Development of a Speaking Up Strategy, incorporating FSU and including development of a vision, process for monitoring Board members involvement in speaking up, and measurement of impact of speaking up and ongoing roll specific training	End of March 23	FTSUG Deputy Director of OD
2 Implementation of the FTSU Champions as additional avenue for speaking up.	End of 2023	FTSUG
3 Develop two year communications plan with actions programmed throughout the year, including opportunities to highlight positive case studies	End of 2023	FTSUG
4 Approval and implementation of OD Strategy	End of Jan 23	Deputy Director of OD
5 Schedule Board development time to ensure all board members understand their responsibilities in relation to speaking up.	2023	Director of Communications & Corporate Affairs
6 Review time commitment/arrangements for FSUG on an annual basis and incorporate in regular reports to PPC and Board.	End of March each year	Board leads for FSUG
7 Update Speaking Up policy to reflect new national policy requirements and include timescales for responses.	End of 2023	FTSUG

Development areas to address in the next 12–24 months	Target date	Action owner
1 Evaluate impact 6-12 month actions and revise annual plan for developing FSU, identifying any areas for improvement and determining appropriate actions.	Dec 2024	Board leads for FSU
2 Review make-up and impact of FSU Champions to ensure they continue to offer effective avenues for staff to feel comfortable raising concerns	March 2025	FSUG

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Joint approach to the recruitment of the FSUG, shared via regional network	March 2023	Board leads for FSU
2 Approach to communicating the role of the guardian and speaking up, shared via regional network	March 2023	FSUG Director of Communications & Corporate Affairs

Stockport NHS Foundation Trust

Meeting date	1 December 2022		Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Guardian of Safe Working Hours Report					
Lead Director	Medical Director	Author	Dr Tom Finnigan, Guardian of Safe Working Hours			

Recommendations made / Decisions requested

The Board of Directors are asked to review and confirm the contents of the report.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	✓	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	✓	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health

		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This report provides the Board of Directors with an overview of work undertaken by the Guardian of Safe Working Hours (GOSW).

1. Purpose

1.1 It is important that junior doctors are fully trained, and work in ways that are safe and fair. This is reflected in the 2016 terms and conditions of service (TCS) for doctors and dentists in training which references the role of the Guardian of Safe Working.

1.2 This role is to:

- ensure the confidence of doctors that their concerns will be addressed;
- require improvements in working hours and rotas for doctors in training;
- provide boards with assurance that junior medical staff are safe and able to work, identifying risk and advising boards on the required response;
- ensure the fair distribution of financial penalty income, to the benefit of doctors in training.

1.3 There is also a requirement for the Guardian of Safe Working to submit a report at least annually. This report relates to Q1, Q2 & Q3 (1st January – 30th September 2022).

2. Background and Links to Previous Papers

2.1 GOSW is now not having to get involved in as many individual reports as we see more engagement from Educational Supervisors.

2.2 As with previous trends we are still seeing the majority of Trainees request and being given Time Off In Lieu for their reports.

2.3 I have been able to provide a more detailed breakdown on areas in which reports are being generated.

2.4 I have continued to review and attend when possible the regional GOSW meetings that take place monthly.

2.5 I attended the national BMA Guardian meeting – good forum to discuss all matters re reporting and issues with Trainees and specific topics.

3. Matters under consideration

3.1 High level data Q1-3

Number of doctors / dentists in training (total): 186
Number of doctors / dentists in training on 2016 TCS: 186
Time in job plan for guardian to do the role: 1 PAs
Admin support provided to the guardian (if any): 0 WTE
Job-planned time for educational supervisors: 0.08 PA / trainee

3.2 Q1 Exception Reports

Exception Reports outcomes	
Total number of exceptions where TOIL was granted	13
Total number of overtime payments	0
Total number of work schedule reviews	0
Total number of reports resulting in no action	1
Total number of organisation changes	0
Compensation	0
Unresolved	13
Total number of resolutions	**14**
Total resolved exceptions	**14**

Reasons for Exception Reports over last quarter by specialty & grade

ER relating to:	Specialty	Grade	ERs raised	ERs closed	Outstanding
Immediate patient safety issues	General medicine	FY1	1	0	1
Total			**1**	**0**	**1**
No. wrt hours/pattern	Cardiology	FY1	1	1	0
	General medicine	FY1	3	0	5
	General medicine	ST4	1	1	0
	General surgery	FY1	3	2	5
	Geriatric medicine	FY1	1	1	0
	T&O	FY1	4	4	1
Total			**13**	**9**	**11**
No. wrt educational opportunities	Cardiology	FY1	1	1	0
	General medicine	FY1	1	0	1
	General medicine	ST4	1	1	0
	Geriatric medicine	FY2	0	1	0
Total			**3**	**3**	**1**
No. wrt service support available	Cardiology	FY1	1	1	0
	General medicine	FY1	2	1	1
Total			**3**	**2**	**1**

There were no Immediate Safety Concerns in Q1.
There were no work schedule reviews requested in Q1.

3.3 Q2 Exception Reports

Exception Reports over Q2	
Reference period of report	01/04/22 - 30/06/22
Total number of exception reports received	27
Number relating to immediate patient safety issues	0
Number relating to hours of working	20
Number relating to pattern of work	2
Number relating to educational opportunities	0
Number relating to service support available to the doctor	5

Exception Reports outcomes	
Total number of exceptions where TOIL was granted	18
Total number of overtime payments	6
Total number of work schedule reviews	1
Total number of reports resulting in no action	0
Total number of organisation changes	0
Compensation	0
Unresolved	13
Total number of resolutions	**25**
Total resolved exceptions	**25**

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	ERs raised	ERs closed	Outstanding
Immediate patient safety issues	General medicine	FY1	0	1	0
Total			**0**	**1**	**0**
No. wrt hours/pattern	General medicine	CT1	2	2	0
	General medicine	CT2	2	1	1
	General medicine	FY1	8	10	3
	General surgery	FY1	2	4	1
	Geriatric medicine	ST1	2	2	0
	T&O	FY1	0	1	0
	T&O	FY2	1	1	0
	Urology	FY1	5	2	3
Total			**22**	**23**	**8**
wrt educational opportunities	General medicine	FY1	0	1	0
Total			**0**	**1**	**0**
No. wrt service support available	General medicine	CT1	5	0	5
	General Medicine	FY1	0	1	0
Total			**5**	**1**	**5**

There were no Immediate Safety Concerns during this period.

There was one work schedule reviews requested in Q2.

ER outcomes - work schedule reviews

Date	Specialty	Grade	Reference No.	Review meeting notes
28/06/22	General medicine	FY1	aoldfi170122_1	I have escalated and it will be discussed in JLNC and Board

3.4 Exception Reports in Q3

Exception Reports (ER) over past quarter

Reference period of report	01/07/22 - 01/11/22
Total number of exception reports received	88
Number relating to immediate patient safety issues	2
Number relating to hours of working	76
Number relating to pattern of work	1
Number relating to educational opportunities	1
Number relating to service support available to the doctor	10

ER outcomes: resolutions

Total number of exceptions where TOIL was granted	60
Total number of overtime payments	3
Total number of work schedule reviews	0
Total number of reports resulting in no action	0
Total number of organisation changes	0
Compensation	0
Unresolved	25
Total number of resolutions	**63**
Total resolved exceptions	**63**

There are a higher number of currently unresolved reports due to the Doctors not closing the claim once made, despite resolution.

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	ERs raised	ERs closed	Outstanding
Immediate patient safety issues	General medicine	FY1	2	0	2
Total			**2**	**0**	**2**
No. relating to hours/pattern	Acute Medicine	CT1	1	1	0
	Cardiology	ST4	4	4	0
	General medicine	CT2	0	1	0
	General medicine	FY1	3	1	2
	General medicine	FY1	1	3	1
	General medicine	FY2	8	5	3
	General medicine	ST4	3	3	0
	General surgery	FY1	35	23	5

	General surgery	FY1	0	1	0
	O&G	FY2 *	6	6	0
	Psychiatry	FY2	2	0	2
	Respiratory Medicine	FY2	1	1	0
	T&O	FY1	3	3	0
	T&O	FY1 *	1	1	0
	Urology	FY1	8	0	3
	Urology	FY1	0	3	0
	Urology	ST5	1	1	0
Total			**77**	**57**	**16**
No. wrt educational opportunities	General medicine	CT1	1	0	0
Total			**1**	**0**	**0**
No. wrt service support available	General medicine	CT1	7	5	7
	General medicine	FY1	2	0	2
	T&O	FY1	1	1	0
Total			**10**	**6**	**9**

There were no Immediate Safety Concerns during this period.
There were no work schedule reviews requested in Q3.

3.5 Fines

No fines were issued by the GOSW over these three quarters as there were no areas where fine has been warranted. We have had no fines since June 2019 (balance £328.16). There is, however, going to be some updated national guidance provided to GOSWs in the near future re what generates a fine and how much to fine.

4. Areas of Risk

Whilst there have been no formal work schedules requested by myself we have seen two trainees who are on the GP (LIFT) programme not realise that they were working more hours than contracted for. I have not allowed reports to be filled in for this and have pointed them in the direction of HR to consider the contractual aspects and then recompense at source. This was discussed with Dr Baxter (Director of Medical Education) also.

There is one previous ongoing case with a Trainee concerning inaccuracies in pay for work done. I have engaged as a guide rather than actively getting involved. I feel these falls outside the remit of the GOSW.

The previous RCP Chief Registrar Dr Leigh Wilson has now left the Trust and has been replaced. I will endeavour to continue the strong and successful relationship that was developed over the last 12months with the incoming Chief Registrars. This link proved a great means of keeping in touch with issues on the shop floor and with the Juniors.

There were several issues raised after the last induction in August where I was copied into emails to the BMA from Trainees who had not received their rotas within the recommended 6 week period. This has now been dealt with. There were issues with late notification from the Deanery, HEE and TPD's – so in my opinion this was somewhat out of our control.

We continue to see gaps in the acute on call medical rota. The Juniors continue to use exception reporting as a tool for reflecting the increase in work intensity and need to cover last minute shifts. I find this acceptable. Datix is also being encouraged to ensure we get an accurate assessment of how often this is happening. Dr Ngai Kong (Divisional Associate Medical Director) is aware of this and I plan to meet in the coming weeks to see how we can agree a more consistent way to recompense these issues. We are wary that giving more TOIL may contribute to further gaps within the rota.

I have received the report from Dr Bari following on from the "improving trainee wellbeing and working lives" project on the background of concerns re Trainee welfare. I have read the report and acknowledge the 25 recommendations that it has brought forwards. I have attached the report for the boards review.

5 Matters arising from the National Conference for consideration by the Trust

Occupational Health recommendations are to be included in Rota design. This should not fall to GOSW but lies with HR.

The BMA want to include minimum standards for rest facilities and minimum standards for catering facilities. They want Exception Reporting systems to be used for fatigue.

Prospective Cover Guidance has been published including how to apply for study leave. Allocate and DRS now include prospective cover in their Rota systems.

Regional Reps felt that GOSW should ideally be presenting their reports to the Boards, but I am aware that not all of us do this.

6 Matters arising from regional meetings for consideration by the Trust.

GOSW to be involved in Induction, as is the case at SFT since knowledge of the system varies with grade of trainee.

GOSW Reports are commonly requested as part of external visits to Trusts – to note.

7 Summary from Q1,2 & 3

The level of activity of the GOSW remains high
Engagement continues with the trainees and of educational supervisors
Regular meetings of the Junior Doctors' forum are now being scheduled

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Wellbeing Guardian Report					
Lead Director	Director of People and OD		Author	Wellbeing Guardian / Non-Executive Director		

Recommendations made / Decisions requested

The Board of Directors is asked to note the content of the report.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	✓	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts

		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

Purpose of the Report

The purpose of the report is to advise the Board of Directors of the Wellbeing Guardian's reflections on her activities.

Reflections

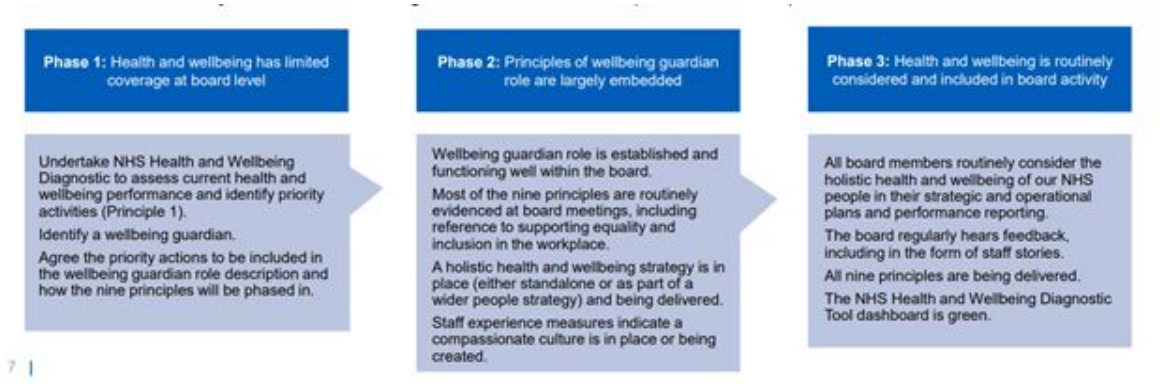
Since my last report I have continued to work with colleagues and across the Trust to champion the Health & Wellbeing agenda alongside the EDI activities. It is encouraging to see the continuing focus on the wellbeing of our people. We have made changes to how we conduct business through the assurance committees that provides assurance that employee wellbeing is included in everything we do. I have seen many more examples across the Trust of how our teams are proactively engaging in the Health and Wellbeing agenda and I have been reassured by the positive feedback on services accessed by our staff. The Health & Wellbeing Newsletter has been well-received and is just one of many channels where staff can receive regular updates, information and helpful resources.

At our October Board Meeting we had a Staff Story presentation from Dr Joanne Black, Clinical Psychologist and Head of the Staff Psychological and Wellbeing Service (SPAWS). We heard how Stockport NHS Charitable funds have been used to set up the service which provide psychological

support to staff who are navigating through difficulties. We discussed the need to build upon the work of SPAWs agreed to develop proposals for sustainable psychological support services.

Implementing the Wellbeing Guardian Role

In line with NHSI guidance, organisations are required to self-assess their current performance in relation to the 9 principles supported by the Wellbeing Guardian. At Stockport, self-assessment shows that we have progressed from Phase 1 to Phase 2 of the role implementation since it was introduced at the Trust NHS FT in February 2021. Going forward it is my recommendation that the board itself carries out its self-assessment using the implementation checklist to help inform thinking and support the delivery of the role.



Data Insights and assurance

Wellbeing data will help to understand the wellbeing landscape in our organisation and will support me, as Wellbeing Guardian, in holding the board to account. The HWB Framework and Stockport's HWB Model Hospital dataset will provide insight into understanding organisational progress against the strategy and the impact of the interventions. As a board we must agree upon a pragmatic approach to measuring well-being that also provides the right level of assurance.

Delivery of the 9 Wellbeing Principles

I will liaise with People and OD colleagues to explore how, as an organisation, we evaluate ourselves against the 9 Principles Supported by the HWB Guardian. See Appendix 1. I am reasonably satisfied that we are evidencing most of the 9 principles at board meetings. In some areas we are using the principles to actively shape the wellbeing culture. For example, *Principle 1: The health and wellbeing of NHS people will not be compromised by the work they do.* The People and Performance Committee agreed in March that EDI and Health & Wellbeing would be included in the template for each Committee reports to ensure the 'golden thread' throughout discussions. Impact on the health and wellbeing of our people is now becoming a routine and priority consideration in operational and strategic decisions. The board may wish to consider what, if any, further improvements could be made to our board reports or process to ensure staff wellbeing remains a priority in decision-making.

Appendix 1

Wellbeing Guardian Principles.
1. The health and wellbeing of NHS people will not be compromised by the work they do.
2. The board and guardian will check the wellbeing of any staff member exposed to distressing clinical events.
3. All new NHS staff will receive a wellbeing induction.
4. The NHS people will have ready access to self-referral and confidential occupational health services.
5. Death by suicide of any NHS people will be independently examined and reporting to the board and Wellbeing Guardian.
6. The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing.
7. The NHS will protect the cultural and spiritual needs of its people, ensuring appropriate support is in place for overseas NHS people
8. Necessary adjustments for the nine groups under the Equality Act 2010 will be made

NHS Stockport NHS Foundation Trust

Meeting date	1st December 2022		Public	X	Confidential	Agenda item
Meeting	Board of Directors					
Title	Progress against Trust Objectives & Key Outcome Measures 2022/23					
Lead Director	Karen James, Chief Executive	Author	Jonathan O'Brien, Director of Strategy and Partnerships			

Recommendations made / Decisions requested

The Board of Directors is asked to review and note the progress against Trust Objectives and key outcome measures for 2022/23 at H1.

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
X	6	Use our resources in an efficient and effective manner
X	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	X	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
	X	**PR1.2**	There is a risk that the Trust fails to reduce harm against agreed baseline
	X	**PR1.3**	There is a risk that patient flow plans are not effective leading to decline in A&E performance
	X	**PR1.4**	There is a risk that inclusive restoration plans to address elective backlog are not delivered
	X	**PR2.1**	There is a risk that the Trust fails to support and engage its workforce
	X	**PR2.2**	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
	X	**PR3.1**	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level

	X	**PR4.1**	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes
	X	**PR5.1**	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
	X	**PR5.2**	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
	X	**PR6.1**	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
	X	**PR6.2**	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
	X	**PR7.1**	There is a risk that the estate is not fit for purpose and does not meet national standards
	X	**PR7.2**	There is a risk that the Trust does not materially improve environmental sustainability
	X	**PR7.3**	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
	X	**PR7.4**	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	Objective 3
Financial impacts if agreed/ not agreed	Objective 6
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Objective 7

Executive Summary

Six months into the year 2022/23, a review of corporate objectives has been undertaken. This paper provides a high-level overview of progress against these with the more detailed objectives being reviewed by the Chief Executive and Executive Team on a regular basis.

The Board will note that papers discussed at Board and its Committees are aligned with the corporate objectives.

The key outcome measures relating to the Corporate Objectives will be familiar to Trust Board members as these are discussed at the relevant Trust Board Committees.

The corporate objectives for 2022/23 are:

1. Deliver safe accessible and personalised services for those we care for.
2. Support the health and wellbeing needs of our communities and staff
3. Develop effective partnerships to address health and wellbeing inequalities.
4. Drive service improvement, through high quality research, innovation and transformation
5. Develop a diverse, capable and motivated workforce to meet future service and user needs
6. Use our resources in an efficient and effective manner
7. Develop our Estate and Digital infrastructure to meet service and user needs.

The Trust Board is asked to note that progress towards the corporate objectives is good, and some examples of progress are noted alongside where there are exceptions to report.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
Deliver safe, accessible and personalised services for those we care for	All CQC identified areas for improvement are delivered and embedded including plans to achieve a CQC 'Good' rating.	Maternity Services have been exited from the national Maternity Services Support Programme. The midwifery team have been asked to present at national conferences on the improvement journey. The StARS process assesses and reviews clinical areas in line with CQC standards. Data is reviewed at assurance committees as was the CQC Insight report prior to it being paused.
	There is a reduction in harms from the 2020/21 baseline.	SHMI figures are on plan at 100 with consistent delivery across the year. The Medication Incident Rate is reported monthly to Trust Board - no major harm concerns are reported.
	Plans for the strategic use of the LFD (learning from deaths) process is agreed and implemented.	The Board receives a quarterly LFD report to update on learning and changes implemented.
	There is a reduction in full and grade 2 pressure ulcers by 10%.	At this point the Trust is over trajectory however the improvement aim is still achievable with sustained improvement. Pressure ulcer prevention is monitored through Harm Free Care panel, divisional governance processes, StARS, weekly review by Chief Nurse, Patient Safety Group and Quality Committee
	The STARS accreditation framework is expanded and implemented across Paediatrics, Community, Maternity and Theatres. There is an increase in the number of areas that achieve STARS Green Status (50% compliance)	The StARS process has been expanded and has now been implemented in community, paediatrics, theatre and maternity services. Outcomes are reviewed and monitored through Patient Safety Group and Quality Committee.
	A results governance management system is in place.	Results Governance Standards and Test Tracker SOPs have now been finalised. Pathology paper switch off for adult inpatients blood tests was implemented on the 1st July. Test Tracker system improvements to be included in next Advantis CDS upgrade. Actions are on track to commence quarterly Results Governance audits by specialty.
	There is evidence that Ockenden, Kirkup and CNST Maternity standards are achieved.	The Board is sighted on the Maternity programme. Positive assurance continues in respect of the action plans and improvements across the key workstreams. Our maternity services have been formally stepped down from the Maternity Safety Support Programme (MSSP).
	A Community Safe Care Model is agreed and implemented.	This work is being undertaken in conjunction with NHSE.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
	There is evidence of the outcome of a mock CQC inspection for all care services and well led standards and areas for improvement identified and actioned.	StARS process assesses wards, departments and community services in alignment with CQC standards. In addition, mock inspections, walk rounds and spot visits are organised ad hoc. Stockport & Tameside colleagues work in partnership to support
	There is evidence of a reduction in hospital acquired infections in line with agreed targets.	There have been 36 hospital-acquired cases of C. Diff so far this year, reducing from 11 in April down to 3 in September. Hospital onset COVID rates were at 26.5% in August, against a target of 31.06% All infections continue to be monitored and overseen by the Infection Prevention Team with monthly updates in the Integrated Performance Report to Board. The Quality Committee were assured that HCAI's were mostly deemed unavoidable with no lapses in care.
	System Strategy plans are agreed and implemented to support the reduction of delayed discharges.	The system is undertaking a review of Intermediate Tier services as part of a System Transformation Project. Review of all patients on the NCTR list is taking place daily to ensure patients are indeed on the correct pathway. The community bed base has been expanded with 20 beds at Cherry Tree House for the winter period.
	Deliver national waiting time / performance requirements, including: • 85% Theatre Utilisation	Capped trust's theatre utilisation rate is 79.5% Uncapped utilisation is 85.9% The theatre improvement transformation scheme continues to support productivity improvements and capped utilisation is forecasted to achieve the 85% national benchmark by the end of the financial year. The Trust is benchmarking well against both peer and national medians.
	• G&A bed occupancy at 90% and Critical Care and Paediatric bed occupancy at 85%	Adult bed occupancy has remained over 95% all year despite the opening of an additional elective ward. The winter escalation wards have also remained open post April (when they were due to close). This has been drive by a significant, year on year increase in the number of patients with no criteria to reside. Paediatrics & critical care remains below the 85% plan.
	• Priority to P2 category patients and then patients waiting over 104 weeks, eliminating 104 week waits.	In line with national waiting time standards all 104 waits were treated by the end of June 2023. The only exceptions were confirmed to be clinically complex, unfit, or patient choice to wait longer).

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
	• Reduce waits over 78 weeks and conduct three-monthly reviews of these patients.	There are currently circa 659 pathways over 78 weeks – a reduction of 250 across the first half of the year. The Trust is on trajectory to eliminate all 78week waist by the end of the financial year, as per national waiting time standards. All access standards are monitored by the Trust Elective & Cancer Care Delivery Group.
	• Reduce waits over 52 weeks and conduct three-monthly reviews of these patients from July 2022.	At the end of September, there were 4,150 pathways over 52 weeks. All patients are being reviewed and assurance provide at Quality Committee regarding any potential harms. Nudge texting of all long waiters is planned for Q3.
	• Reduce outpatient DNA rates by 2%	Whilst improvement has been see the current rate is 7.68% which is slightly higher than Q4 of last year. A rate of 6% is the aspirational target.. The Trust performance in quartile 2 (1 being the best) nationally. Increase in DNA rates has coincided with levels of Covid19 infection rates and the outpatient transformation project continues to review actions to reduce this.
	• Move 5% of outpatient attendances to PIFU by March 2022.	At month 6 the Trust has met and surpassed the annual target, moving 6% of outpatients to a patient-initiated follow-up pathway. Stockport is the best Performing Trust in GM for PIFU rates.
	• Increase outpatient utilisation by 5%	Outpatient Clinic Utilisation was at 85.3% in August, above the 85% target.
	• Maintain virtual outpatient consultations at 25%.	Virtual outpatient activity has gradually declined over the first half of the year from 21% in April 2021 to 16% in September. Virtual appointments continue to be offered to patients where appropriate.
	• Maximum six-week diagnostic waits for 99% of patients.	Diagnostic activity has increased over the first half of the year and is 2.15% above plan. All radiology modalities are now compliant with he diagnostic access standard. Two issues remain • Echocardiography continues to have the biggest backlog (630) • endoscopy as a result of increased colorectal suspected cancer referrals (backlog of 540).

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
		Both account for 20% non compliance vs the target and are related to increased demand. The trajectory is to meet the target by the end of the financial year.
	• Deliver Cancer Faster Diagnosis Standards.	At the end of August 2022, the FDS performance was at 64%, against a national standard of 75%. An improvement on the standard has been seen in Q3 as the colorectal plans are implemented.
	• 12 hour waits in ED at no more than 2%	Year today performance is 11.36%. the issue relates to flow and links to the bed occupancy. Operational performance has proven that when the department has flow this standard is achieved.
	• 65% ambulance handover at 15 mins. • 95% ambulance handover at 30 mins. • Zero ambulance handover over 60mins.	There continue to be challenges relating to ambulance handover. These are reported through regular performance reports. For example, there were 32 ambulance handover waits > 60 minutes in week ending 2nd October. Stockport performs well comparatively for Ambulance handover within Greater Manchester ICB.
	• Urgent community response services 8am to 8pm, 7 days a week with 70% of responses <2 hours by Q3	The Crisis Response Team are available 8am-10pm, 7 days per week 365 days per year. The 2 hour response time is being achieved.
Support the health and wellbeing needs of our communities and staff	The delivery of the objectives of the NHS People Plan for 2022/23.	87.4% of staff have had an annual appraisal (87.2% non-medical staff and 88.7% of medical Staff). Our 'Making A Difference Every day' awards celebration was held at Stockport Town Hall on the evening of Friday 7th October. Various health and wellbeing support initiatives and guidance documents are available for managers and staff including cost of living support initiatives, menopause support, dealing with child bereavement, domestic violence and pregnancy loss.
	The staff survey, sickness/absence levels demonstrate the effectiveness of the Trust Health and Wellbeing Services target (5%).	Staff sickness levels have remained constant across the first half of the year at c.6.5%. Support continues for absent staff resulting in several individuals returning to work with adjustments. Those who remain absent are being supported by OH and signposted to our health & wellbeing initiatives (e.g. SPAWS).
	Community Services offer support to neighbourhood working and the needs of neighbourhood population requirements.	The Mobilising Neighbourhoods transformation programme is currently on track to deliver. The Neighbourhood toolkit has been updated and relaunched, SFT staff have been aligned to

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
		Primary Care Networks and PCN triage MDT meetings are being re-established.
	Evidence of a system wide frailty pathway.	The Frailty transformation programme is on track to deliver. NHS England's senior programme manager for same day emergency care recently met with Trust colleagues to hear about the work of our frailty service and their plans to make further improvements to the care being provided to local people.
	Improvement in the Staff Survey following publication of the 2021 results are achieved.	In September the People Committee received an update on the actions taken in relation to the previous annual staff survey and the planning and preparation for the forthcoming survey. They reported limited assurance due to the relevant information existing in a number of sources. The 2022 staff survey closes on Friday 25th Nov. Over 40% of staff have already completed the survey.
	Roll out health and wellbeing conversations across the Trust in line with the NHS People Plan.	Support continues across a range of health and wellbeing initiatives for staff including cost of living support initiatives. These continue to be reported to the People Committee.
	A collaborative Occupational Health function is achieved across Stockport/Tameside and Glossop.	A scoping session has been set up for early December 2022 to map out potential areas of cooperation between the teams.
Develop effective partnerships to address health and wellbeing inequalities	The locality Provider Collaborative Board is established and achieves its agreed priorities for 2022/23.	The Place-Based Provider Partnership has been established and developed a work plan for the year.
	Agreed service integration plans with Tameside and Glossop are progressed according to agreed timescales.	A joint bid for a Community Diagnostics Centre (CDC) across Stockport and Tameside has been supported by the region and submitted to the national team for funding approval. Procurement will begin at the start of December when the business case is approved. A baseline assessment is being completed for Diabetes and Gastroenterology services to scope out potential for service collaboration across the Trusts. An Ophthalmology business case in being developed with Tameside to scope the provision of a single service for the sector. October saw the launch of the Tameside & Glossop Digital Health Service in Stockport, which interacts with the local clinical assessment service & 111 to provide effective streaming to appropriate services to avoid attendance at the Emergency Department.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
	A Joint Clinical Strategy with East Cheshire is agreed and supported by the Trust regulator and programme milestones are achieved according to agreed timescales.	A Case for Change was signed off in June 2022 by the Trust Boards and CCGs. Work has been undertaken over the Summer to develop a range of service proposals through clinical workshops. A business case is now under development in line with agreed timescales.
	Evidence that we work with partners across GM in the development of the ICS Framework for resource allocation, prioritisation and utilisation.	Our Greater Manchester Integrated Care System (ICS) is established and the relevant Directors continue to work with colleagues across the ICS on resource allocation, prioritisation and utilisation. Stockport FT CEO has now taken over the role of Provider Federation Board Chair.
	Enhance reporting and disaggregate performance data to demonstrate progress against local health inequalities.	A paper focused upon waiting- list health inequalities went to Board in November 2021. An enhanced report is scheduled for February 2023.
	Plans are agreed to deliver a Community Diagnostics Centre to the population of Stockport and Tameside & Glossop.	A Business Case has been completed and submitted to the national team after pre-market engagement with potential providers. Procurement will begin in December assuming success with approval.
Drive service improvement through high quality research, innovation and transformation	Evidence of an agreed quality/performance metrics to support improvement programmes and board assurance.	Stockport`s Transformation Programmes are set and managed by the Service Improvement Group (SIG). Each programme is given a clear set of priorities and progress is reviewed at SIG, as part of the robust governance and assurance measures to ensure that programmes are delivering.
	A joint Research and Innovation Strategy across the Tameside and Glossop / Stockport sector is agreed and research teams are integrated.	The joint strategy was signed off in August 2022 and work is underway to integrate teams. We have received two separate short-listings in the NIHR Greater Manchester Health and Care Research Awards for research into Stroke and COVID.
	A Communications and Engagement Strategy is developed and year one strategy objectives are delivered.	The Communications and Engagement Strategy was completed and signed-off in October 2022 at Trust Board.
Develop a diverse, capable and motivated workforce to meet future service and user needs	A Leadership Development Plan is implemented across the Trust.	The Deputy Director of Organisation Development is currently scoping what is in place already and is drafting up an OD Plan which will encompass leadership development as part of the wider OD cultural change programme.
	A Civility Saves Lives cultural programme is implemented across the Trust.	As above Civility Saves Lives is currently being scoped and will form part of the OD Plan.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
	A Workforce Strategy and Operational Plans to deliver the Strategy are deployed and agreed.	At Month 6 the Trust was on plan for the substantive workforce element of the operational plan, however use of agency and bank staff is taking the Trust significantly over plan. This is largely attributed to the additional wards that are in operation, operational activity and sickness – it is being closely monitored through the People Performance Committee.
	Implementation of the Trust's EDI Strategy is delivered.	A range of events have been held across the first half of the year, including support for PRIDE, black history month. Progress has been made in the overall BAME representation within the workforce, with significant further work to do to improve representation at senior levels and improvements in positive work-place experiences. The recently approved Equality, Diversity & Inclusion (EDI) Strategy work programme would be reviewed to re-prioritise actions identified in the WRES and WDES reviews taken to Board in August 2022.
	Improve staff retention rates with turnover increase of no more than 0.5%.	In the first half of the year, turnover rates have increased by around 1%.
	Improve the ethnic disparity ratio through implementing the six high impact actions.	Progress has been made in the overall BAME representation within the workforce, with significant further work to do to improve representation at senior levels.
	Expand international recruitment.	International recruitment for the 2022 intake is progressing with staff onboarding monthly. 59 international nurses have joined the Trust so far this year, with 51 due to arrive soon. 2 international radiographers have now arrived. The Division of Medicine & ED has successfully held an international recruitment event for junior doctors and there has been a successful recruitment of radiographers from overseas.
Use our resources in an efficient and effective manner	A programme is in place to ensure all divisions understand the outputs from the model hospital and available benchmarking data to support their improvements in productivity and efficiency plans.	The Trust undertakes a monthly CIP meeting with Divisions and runs training to support understanding of benchmarking data. The Trust has a workplan called "Working Intelligently - Making Data Count", which deep dives Model Hospital, Logex for PLICs, People Analytics data, Safecare Live, Medical Job planning, GIRFT, specialty networks and NHSI data resources.
	Deliver the 2022/23 CIP; revenue; capital and cash annual plans following the receipt of national planning guidance.	By Month 6 we had delivered £7.216m of the planned £18.1m CIP: • £5.220m non-recurrent CIP

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
		• £1.996m recurrent CIP (with a full year effect of £3.997m) At M06 CIP delivery is £66k above plan, with over-performance in Corporate and Women & Children's plans. By Month 06, year to date income is £1.115m above plan, with spending £1.286m above plan. The Trust is currently predicting that it will deliver its financial plan by year end. Our capital expenditure plan for 22/23 was £43.1m, including expected PDC awards. By Month 07, YTD spend compared with depreciation is £4.1m above plan
	The development of a multi-year financial recovery plan to support the implementation of the long-term plan and recovery, optimising opportunities for financial recovery through system working.	The Trust has presented to the F&P Committee a presentation covering the current financial position and actions being considered to address the financial challenge going forward. The GM system has requested a number or returns to highlight actions the Trust can take to improve the 22/23 position and the 23/24 position and beyond. As part of this GM system requirement, we are required to submit a financial recovery plan for 22/23. These work steams will need to continue throughout 22/23.
Develop our Estate and Digital infrastructure to meet service and user needs	The data warehouse project is completed.	The Trust's data warehouse is now live for the majority of mandatory national data feeds (ED/Community/OP) and the work on inpatients is close to completion. This work has enabled the Trust to take control of the delivery of its daily mandatory returns, taking away the reliance on its PAS supplier.
	A new interactive Trust website is implemented.	A contract for the design and build of a new website has been awarded. All current website content has been reviewed. Website editors in services now being identified to move into the design and build phase. Completion expected March 2023.
	An OBC is completed and ratified for an EPR system.	The establishment of a formal Trust Acute EPR programme commenced in May 2022. Stockport and Tameside are now progressing jointly with this programme. Pre-market engagement activities with EPR suppliers have commenced and responses have been requested by 30.9.2022. EPR suppliers have been requested to provide the cost of their solutions. These details will support the affordability case of the OBC.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Month Six Progress Status
	The roll out of VDI (Virtual Desktop Informatics), single sign off and Office 365 is delivered in line with agreed plans.	Rollout of the new VDI solution is currently underway with 16 community locations live. It is anticipated the programme will begin to focus upon acute services in December 2022.
	A successful roll out of the LIMS system achieved.	Stockport and Tameside have jointly procured their new LIMS solutions (Clinisys Winpath). Work is now underway to recruit project resourcing, with a planned 'go live' in spring 2024.
	The OBC for the new hospital development is completed.	The Trust had submitted an expression of interest to the New Hospitals Programme and was awaiting a response from the Department of Health & Social Care.
	There is evidence of a short/medium term Estates Strategy to improve the current hospital capital stock.	The Estates Development Strategy for Stepping Hill was presented to the Board of Directors in October 2022 and approved.
	The Trust Green Plan objectives for 2022/23 are delivered.	An update on the Green Plan was taken to Finance & Performance Committee in September. The Committee noted positive assurance regarding the work of the Green Plan Group.
	The FBC for the Urgent Care Campus is ratified by the Trust regulators and enabling works are delivered.	The FBC has been signed off by Trust board and now had national approval. Enabling works are well underway.
	A reduction in backlog maintenance is achieved including the delivery of clear risk assessments of critical infrastructure.	The Trust continues to invest in backlog maintenance at the Stepping Hill Hospital site. It should be noted that given the age of the estate, a long-term reduction in backlog maintenance is considered unachievable without significant investment. However, targeted investment continues centred around CIR to manage any associated risk, noting that all backlog investment is risk assessed.

Meeting date	1 December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Transformation Programme Mid-Year Report					
Lead Director	Chief Executive		Author	Director of Transformation		

Recommendations made / Decisions requested

The Board of Directors is asked review the content and confirm progress of the transformation programme.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of

			priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
	x	**PR4.1**	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

Transformation programmes are identified annually through a formal process of prioritisation, linked to corporate objectives, with Divisional Management Teams completed a 'resource request' document outlining the need. Transformation priorities are set and resources managed by the Service Improvement Group, chaired by the Chief Executive.

The approach to transformation provides a proactive resource for continuous improvement across the organisation, with the Transformation Team being key players in the change management activities that support project implementation. The approach is underpinned by 4 key areas: Prioritisation, Leadership & Engagement, Governance & Assurance and Sustainability. Each programme has:

- A Senior Responsible Officer
- An overarching aim (what we will achieve)
- Key performance indicators (what we are measuring)
- Milestone plans and scheme completion deadlines (when will we get there)
- Monthly progress reports to the Service Improvement Group, with a quarterly ‘Deep Dive’ updates

This report provides a summary of progress of key transformation programmes across Stockport NHS Foundation Trust.

NHS Stockport NHS Foundation Trust

Transformation Programme Update: December 2022

Trust Board– 1st December 2022

Prepared by:

Angela Brierley
Director of Transformation

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PURPOSE

NHS Stockport NHS Foundation Trust

The purpose of this paper is to update the Board of Directors on progress with some of the transformation programmes across Stockport NHS Foundation Trust.

TRANSFORMATION PROGRAMMES

NHS Stockport NHS Foundation Trust

Since the last Board Report:

- **7** schemes handed over to business as usual (BAU)
- **12** active schemes in place
- **5** new schemes added within the last 2 months

Division	Corporate			
Scheme	Cancer Improving Outcomes	Tomorrow Hour	Results Governance	Out of Hours
SRO	Jackie McShane	Dr Karl Bonnici	Dr Andrew Loughney	Dr Alison Jobling
Objectives	To implement best timed pathways, supporting faster diagnosis. To implement personalised stratified follow up pathways.	To embed the use of an allocated hour to highlight and prepare next day discharges.	To ensure patient investigations / tests are viewed, acted upon and recorded in a single patient record, to inform appropriate and timely treatment and care.	To improve clinical leadership and safe provision of out-of

Division	Medicine	
Scheme	ED	Respiratory Outpatients
SRO	Nadine Armitage	Nadine Armitage
Objectives	To improve performance against the for urgent & emergency care, focussing on flow through the department.	To improve efficiency of Respiratory Outpatient Service in light of high demand and limited services

Division	Women & Children's	
Scheme	Antenatal Pathway Review	Children's, Young People & Families
SRO	Zoe Turner	Zoe Turner
Objectives	Ensure safety of service users of the antenatal services & timely review for women on scan pathways	To improve pathways that our patients under the age of 18 access, including supporting their transition to adult services.

Division	Integrated Care
Scheme	Mobilising Neighbourhoods
SRO	Margaret Malkin
Objectives	To ensure people are supported to stay safe at home and use alternative pathways to ED as appropriate, whilst supporting early discharge from hospital if admission is required.

Division	Clinical Support Services		
Scheme	Outpatients	Endoscopy	Radiology Improvement
SRO	Mike Allison	Mike Allison	Zoe Turner
Objectives	To improve patient experience of their outpatient journey, enhancing the efficiency of Trust outpatient services.	To ensure that the utilisation of endoscopy sessions are fully maximised.	To improve the productivity and efficiencies of the Radiology services.

Division	Surgery						
Scheme	FAS Pain Management	Pain Management EBCD	Elective Bookings Admin Review	Surgery Out of Hours	Surgery SDEC	Day Case	Theatres Efficiency & Productivity
SRO	Karen Hatchell	Karen Hatchell	Karen Hatchell	Karen Hatchell	Karen Hatchell	Karen Hatchell	Karen Hatchell
Objectives	To roll out the Pain Functional Activity Scale across Stockport FT	To identify opportunities to maximise efficiency of current practices and processes, through a co-designed model of practice.	To deliver a fully centralised elective booking and scheduling structure for surgical specialties across the Trust.	To improve the provision of out of hours medical staffing in the surgical division and effective flow of patients from ED to SAU.	To minimise/ remove delays in the surgical emergency patient pathway, allowing services to care for urgent & emergency patients on the same day.	To increase the number of elective day case procedures, in turn improving our British Association of Day Surgery data and national position.	To ensure theatre usage is maximised by reviewing the patient journey from pre-op to post-op care.

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PROGRESS SUMMARIES

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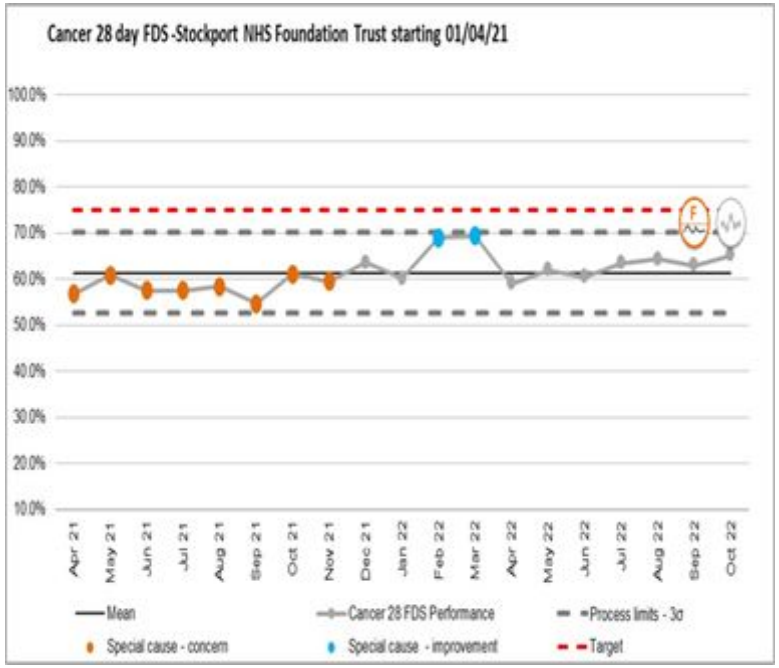
CANCER IMPROVING OUTCOMES PROGRAMME

NHS Stockport NHS Foundation Trust

- **Best Timed Pathway for Colorectal, Lung, Prostate and Gynae** tests of change in progress.
- Revised SBAR documentation trialled in Urology; roll out to all other tumour groups planned.
- **Colorectal FIT protocol** encompassing CQUIN guidelines has been developed and implemented.
- Bowel prep process in revised to improve patient experience & efficiencies in pathway.
- Radiology improvements made**: MR Prostate 2WW** turnaround times now at **7.5 days from 14.2 days** in March 2022
- Overall improving performance against the **28 Day Faster Diagnosis Standard**



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EMERGENCY DEPARTMENT IMPROVEMENT PROJECT

NHS Stockport NHS Foundation Trust

- **Medical & nursing workforce modelling** complete - business case in final development.
- ESIST Tool completed for **optimising medical staffing.**
- Education and training with Navigators to support effective streaming.
- Attendance deflection SOP developed and trialled in core daytime hours.
- LCAS service provided by Tameside Digital Health Service.
- E-Triage programme planning commenced

HSJ PATIENT SAFETY AWARDS 2022

Finalist in the HSJ awards for Ambulance Turnaround Times & Mental Health Partnership Working with Pennine Care

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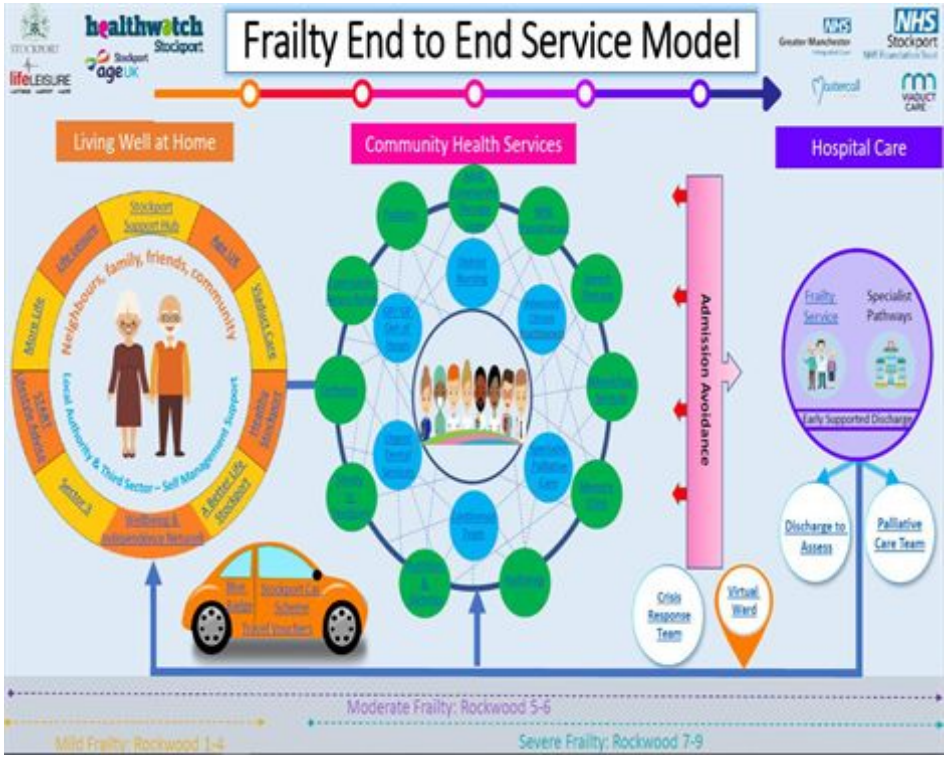
MOBILISING NEIGHBOURHOODS

NHS Stockport NHS Foundation Trust

Frailty

- EMIS template for **Rockwood Clinical Frailty Score (CFS)** being rolled across all community health teams.
- **End to end pathway** developed to deliver systemwide approach to support people living with varying degrees of frailty based on CFS.
- **Train the trainer** training commencing to support management of frailty.
- Systemwide event planning commenced to launch new pathways.



Interactive digital system for colleagues to provide a Directory of Services to support Frailty management

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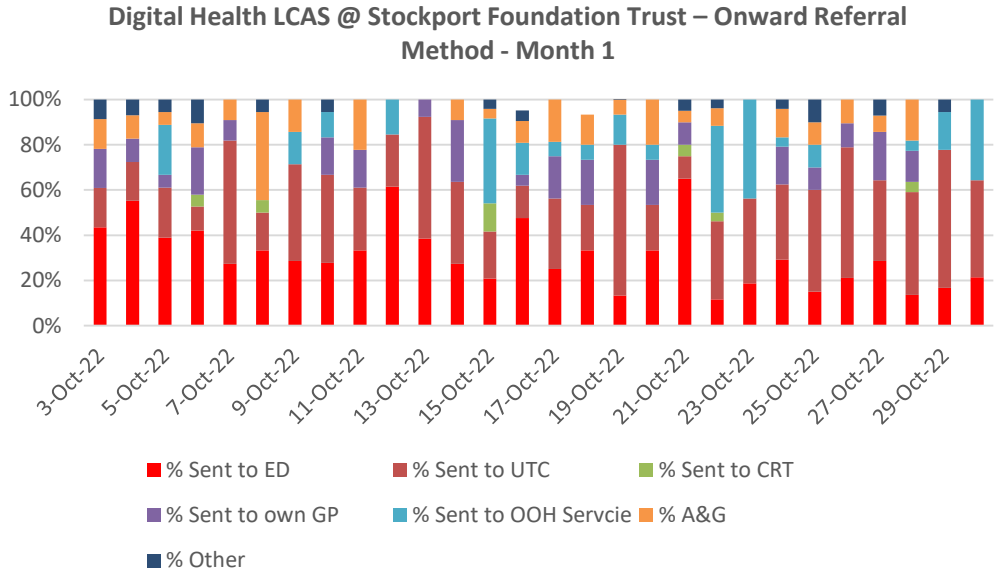
MOBILISING NEIGHBOURHOODS

Stockport NHS Foundation Trust

Digital Health Development – working in collaboration with Tameside & Glossop

- **Local Clinical Assessment Service (LCAS) NHS 111** went live 3rd October 2022.
- **Virtual Ward** pathway went live 31st October 2022.
- Tests of change ongoing to support improvements to pathway
- Ongoing work to support appropriate onward referrals including digital health training with Crisis Response Team (CRT).



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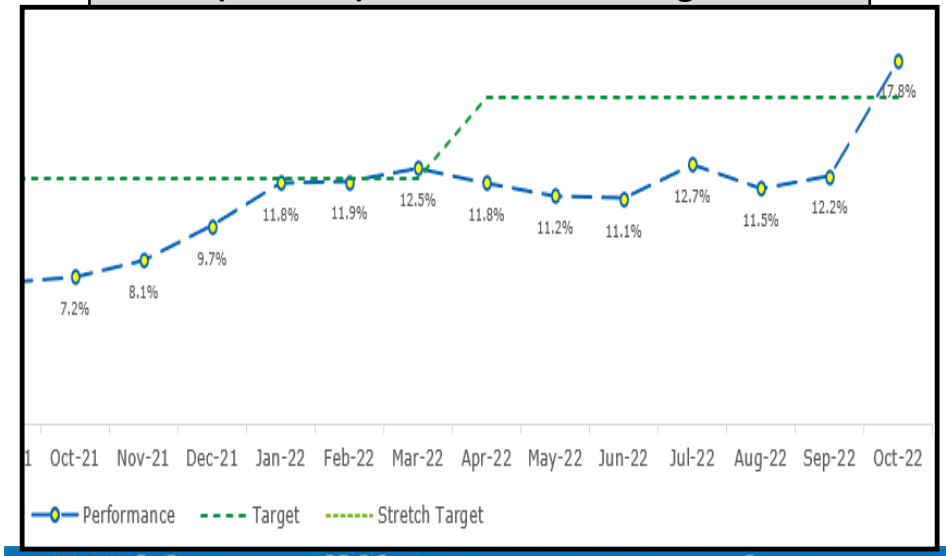
OUTPATIENTS IMPROVEMENT PROGRAMME

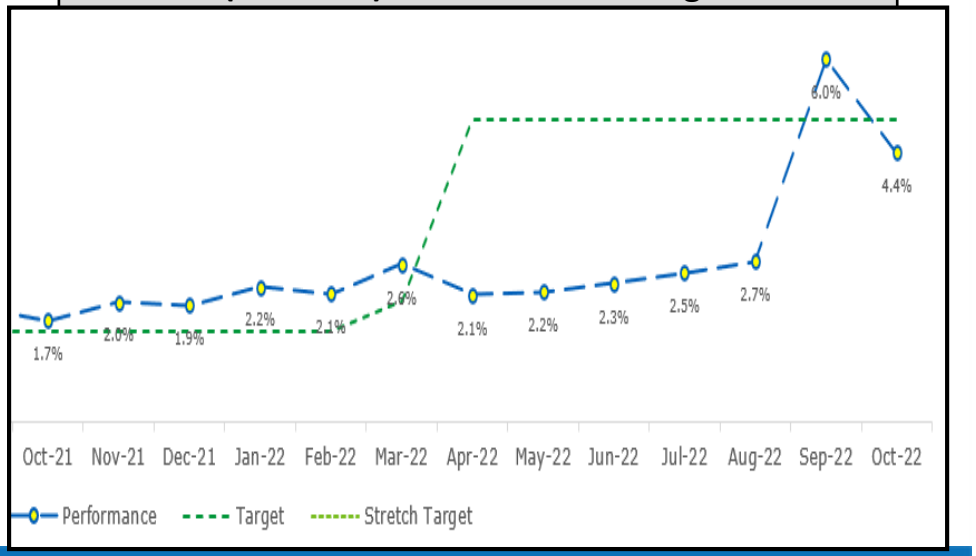
NHS Stockport NHS Foundation Trust

- Plans in place for the centralisation of the Outpatients Booking Team to provide efficiencies to our booking processes and patient experience.
- Ongoing improvements seen in Patient Initiated Follow Up (PIFU) and Advice & Guidance performance.
- Enhanced Digital Dictation roll out plan on track with ambition to be embedded in all specialities by Christmas.
- Outpatient dashboard under development.

A&G (Oct2022) 17.8%. National Target – 16%



PIFU (Oct 2022) 4.4 %. National Target – 5%



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PAIN MANAGEMENT PROGRAMME

NHS Stockport NHS Foundation Trust

- **Experience Based Co-design** recruitment campaign occurring for this programme, supported by Health Watch.
- Plans and content for **Patient Group Early Information Sessions** finalised.
- Initial PDSA taking place for **Rapid Response – Opt in pathway for spine referrals.** (Patients discharged with a letter &info leaflet and a timeframe to respond within if they want to opt in. Potential benefits - reduce inappropriate referrals and DNA's.

NAPS 2022
The National Acute Pain Symposium

Stockport Functional Assessment Project presented at the National Acute Pain Symposium and received highly commended.

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OVERVIEW COMPLETED SCHEMES

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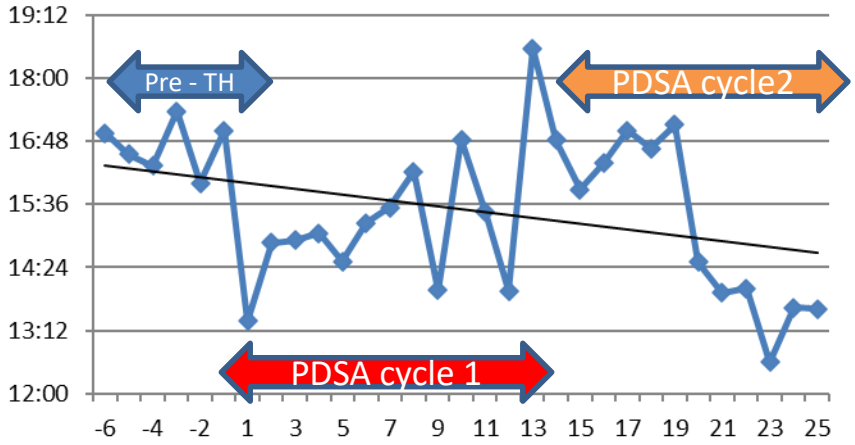
TOMORROW HOUR

NHS Stockport NHS Foundation Trust

Junior doctors/PA's/ACP's complete an afternoon handover to identify patients who could potentially go home the next day.

Trend: Decrease in median discharge time since start of Tomorrow Hour project



Lessons learnt being taken forward through the Flow Programme

- **Champions** appointed on participating wards.
- **Median discharge time lowered by 2.5hours on E2.**
- Where median discharges improved, there was a correlation of approximately **50% of discharges before midday.**
- Scheme completed handover in August 2022.

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OUT-OF-HOURS IMPROVEMENT PROJECT

NHS Stockport NHS Foundation Trust

- Successful business case to progress recruitment of **additional Junior Clinical Fellow (JCF)** posts in Medicine and Acute Care.
- New location identified and **standardised clinical handover process** developed.
- New process for **e-Task** implemented with a positive impact on the quality and reduction of inappropriate tasks being handed over to the Out-of-Hours Team – **very positive feedback from Junior Doctors**
- **Improved GMC survey for out of hours support.**
- Success has led to a Surgery OOH's scheme commencing.

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DAY CASE IMPROVEMENT PROJECT

NHS Stockport NHS Foundation Trust

- Improvements made in **British Association of Day Procedures (BADS) data.**
- New Anaesthetic & Pain Management protocols implemented
- **GIRFT principles** reviewed, gap analysis undertaken and process in place for capturing changes/progress
- **Improved education & information** developed for patients for day case procedures.
- Individual speciality packs developed.
- **Day case performance dashboard** established.

GIRFT GETTING IT RIGHT FIRST TIME

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NEW SCHEMES

NHS Stockport NHS Foundation Trust

The following projects will commence in Quarter 3 2022 and are currently undergoing review of scope:

- Respiratory Pathways Project
- Antenatal Pathway Review
- Children's, Young People & Families Programme
- Surgery Out of Hours Project
- Theatres Efficiency & Productivity Project

CELEBRATING SUCCESS

NHS Stockport NHS Foundation Trust

HSJ Patient Safety Awards Finalists:

- A person - centred approach to early detection, rapid assessment treatment of **delirium in the community.**
- **Improving Ambulance Turnaround Times**.
- Embedding a culture of **collaborative partnership to improve the quality and delivery of mental health services** for patients and wellbeing support for staff.

HSJ PATIENT SAFETY AWARDS 2022

Further achievements:

- FAS Project - highly commended award at the National Acute Pain Symposium.
- Upper GI cancer pathway won highly commended at the GM Cancer Conference.

Internal Transformation Event Tuesday 9th May 2023.

Making a difference every day

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NHS Foundation Trust

Questions?

Making a difference every day

Stockport NHS Foundation Trust

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Assurance Framework 2022/23					
Lead Director	Karen James, Chief Executive		Author	Rebecca McCarthy, Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:
- Review and approve the Board Assurance Framework 2022/23 as at 1 December 2022
- Review the Trust's current Significant Risk profile including alignment between operational and principal risks.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks	All

Where issues are addressed in the paper-

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

Executive Summary

The Trust maintains a Board Assurance Framework (BAF) as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board.

All principal risks comprising the Board Assurance Framework 2022/23 have been assigned to the relevant Board level committee for oversight, with review of these risks taking place throughout November 2022. The Board Assurance Framework 2022/23 (Appendix 1) as at 1 December 2022, is subsequently presented to the Board, with revisions made since the last review highlighted. A heat map and gap analysis between current and target risk score is also included.

In reviewing the principal risks consideration was given to the key controls and assurances in relation to each, any gaps and required actions. The principal risks, including comparison to Q1 and target score, are prioritised as below. Across all committees', it was noted that ongoing and significant operational pressures and external influences, continue to impact on the Trust's ability to mitigate risk, and are expressed within the gaps in controls. Furthermore, Principal Risk 6.1 relates to the delivery of the 2022/23 financial plan. A key action in relation to this risk is the year-end financial forecast review to be undertaken by the Board of Directors in December 2022. The principal risk will be considered, and updated as required, in line with any recommendation confirmed by the Board of Directors.

No.	Principal Risk	C	L	Q1	Q2	Change	Target Score
PR1.2	There is a risk that patient flow plans are not effective impacting urgent and elective care performance	4	4	16	16	↔	8
PR5.1	There is a risk that the Trust is unable to recruit optimal number of staff	4	4	16	16	↔	8
PR1.1	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards	4	3	12	12	↔	8
PR1.3	There is a risk that the Trust does not have sufficient capacity to deliver inclusive restoration plans	4	3	12	12	↔	8
PR2.1	There is a risk that the Trust fails to support and engage its workforce	4	3	12	12	↔	8
PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT),	4	3	12	12	↔	8
PR6.1	There is a risk that the Trust fails to deliver its agreed 2022/23 financial position	4	3	12	12	↔	8
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	3	12	12	↔	8

PR7.4	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus	3	4	12	12	↔	8
PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health	3	3	9	9	↔	6
PR3.1	There is a risk in approving and implementing a new Provider Collaborative model	3	3	9	9	↔	6
PR5.2	There is a risk that the Trust fails to develop a workforce reflective of communities served and improve experience of staff with protected characteristics	3	3	9	9	↔	6
PR6.2	There is a risk that the Trust fails to develop and agree with partners a multi-year financial recovery plan to secure financial sustainability	3	3	9	9	↔	6
PR7.1	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy	3	3	9	9	↔	6
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	4	2	12	8	↓	8
PR4.1	There is a risk that there the Trust does not deliver high quality research and transformation programmes	3	2	9	6	↓	6

In addition, the Trust's Significant Risk Register (as at 9 November 2022) (Appendix 2) is provided to ensure triangulation between operational and principal risks. There are currently 5 significant risks relating to the following areas:

- Emergency Department access standard
- Reduced critical care capacity and medical workforce recruitment
- Potential harm due to extended waiting times for elective surgery *(Under divisional review)*
- Finance - Cash position
- Patient flow due to reduced access to community capacity and rising NCTR

The Risk Management Committee has continued oversight and management of the significant risk register, alongside divisional and corporate risk registers, and horizon scanning of future risks, in line with the Risk management Strategy & Policy.

The Risk Management Committee continues to report to the Audit Committee, as part of its responsibility to review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, and the effectiveness of the structures, processes and responsibilities for identifying and managing key risks facing the Trust. Furthermore, at each Audit Committee meeting, the Chairs of Board level Committees provide update with a focus on:

- how significant risks identified by the Risk Management Committee are being addressed or monitored in their Board Committee
- any risks which are not appropriately reflected in the Risk Management Committee report
- emerging or potential risks and matters which may bring into question the adequacy of underlying assurance processes or have implications for other Committees
- effectiveness of controls in place to manage risks recorded on the Board Assurance Framework, with controls generally being applied consistently.

Stockport NHS Foundation Trust

Board Assurance Framework

2022/2023

Corporate Objectives 2022/23

1. To deliver safe, accessible, and personalised services for those we care for
2. Support the health and well-being of our communities and staff
3. Develop effective partnerships to address health and wellbeing inequalities
4. Drive service improvement, through high quality research, innovation, and transformation
5. Develop a diverse, capable and motivated workforce to meet future service and user needs
6. Use our resources in an efficient and effective manner
7. Develop our Estate and Digital infrastructure to meet service and user needs

Key to Board Assurance Framework

CONSEQUENCE MARKERS		LIKELIHOOD MARKERS		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or ≤ 1 in 1000 chance (or less) within 12 months

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible	**1**	**2**	**3**	**4**	**5**
2 - Minor	**2**	**4**	**6**	**8**	**10**
3 - Moderate	**3**	**6**	**9**	**12**	**15**
4 - Major	**4**	**8**	**12**	**16**	**20**
5 - Catastrophic	**5**	**10**	**15**	**20**	**25**

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	Risk target achieved
Gap score 1 - 5	Tolerable
Gap score 6 - 9	Close monitoring
Gap score 10	Concern
Gap score > 10	Serious

Risk Appetite Framework

Risk Level ⇨ **Key Elements** ⇩	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal (ALARP)** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

BAF 2022/23 Summary, Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**4.1**	**2.2, 3.1, 5.2, 6.2, 7.1**	**7.4**	
4 - Major		**7.3**	**1.1, 1.3, 2.1, 3.2, 6.1, 7.2**	**1.2, 5.1**	
5 - Catastrophic					

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**4.1, 7.3**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 5.2, 6.1, 6.2, 7.1, 7.2**
Gap score 6 - 9	Close monitoring	**1.2, 5.1, 7.4**
Gap score 10	Concern	
Gap score > 10	Serious	

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
Principal Risk Number: PR1.1					**Risk Appetite: Moderate**												
There is a risk that the Trust delivers suboptimal quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards.	Quality Committee	Board Quality Committee established. Subgroups: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established and standardised through implementation of NHSE/Divisional Governance Project (Safety, Experience, Effectiveness) SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place (2020 & 2022) Established process for managing and learning from: - Incidents including Serious Incidents - Duty of Candour - Complaints - Legal Claims Mechanisms in place to gather patient experience and staff experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and local audit - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths review process - Medical Examiner Team StARS - Ward assurance & accreditation process established. Also established for: Paediatrics, Theatres and Community Safe Staffing - Defined Nurse Establishments - Defined Medical Establishments - Medical Job Planning process in place - Medical Appraisal & Revalidation process in place including quality assessment	StARS – Maternity, ~~Community &~~ Outpatients CQC Mock Inspection Programme	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) StARS: Baseline assessment for inpatients completed		Expansion of StARS: ~~Community &~~ Outpatients	~~Q3 2022/23~~ Q4 2022/23	4	3	12	12	12			4	2	8
				Level 2 – Corporate Quality Committee: - Quality IPR - Key Issues & Assurance Reports: o Patient Safety (Serious Incidents & Duty of Candour) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, Complaints) - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all improvement/action plans including: CNST, Saving Babies Lives, Continuity of Carer, Ockenden Report, Maternity Safety Support Programme (MSSP) - Waiting List harm Reviews - LMS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly - Board of Directors) Board of Directors: - Safe Care Report including nurse establishments/E-roster (Quarterly) - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) Annual Quality Accounts	Triangulation meeting or Chairs Notes between Quality Committee	~~Gap analysis of all NICE Guidance to be completed.~~ CQC Mock Inspection Programme – Pilot ~~Establish Nursing, Midwifery & AHP Group~~ Patient Safety Strategy based on Patient Safety Incident Response Framework	~~July 2022~~ Q4 2022/23 ~~July 2022~~ Q4 2022/23									
				Level 3 - Independent CQC Inspection 'Requires Improvement' November 2020 Stockport Improvement Board *(NB Stood down from April 2022)* CQC Inspection Urgent & Emergency Care – 'Good' November 2021 Health & Safety Executive Inspection, November 21. No concerns highlighted. Friends & Family Test													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
		Established Nursing, Midwifery & AHP Board Maternity Improvement/Sustainability Plan in place and Maternity Strategy.		National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2021-22 • SI Report (Substantial) • ERostering (Substantial) • Niche Evidence Report (High) • Committee Effectiveness (Substantial) MIAA Internal Audits 2020-21 • CQC Evidence Process Review (High) • Complaints (Substantial) Maternity Safety Support Programme (Formal Exit)												
Principal Risk Number: PR1.2					**Risk Appetite: Moderate**												
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent care and elective care	Finance & Performance Committee	~~ED Patient Streaming established~~ ~~Urgent Care Treatment Centre implemented~~ Established models of emergency and urgent care in place in line with national standards Rapid emergency diagnostic pathway in place – General Surgery & Medical Rapid Ambulance Handover process in place. 'Programme of Flow' established Biweekly Trust Performance Meeting and daily locality tactical calls to seek support to mitigate risk – Attended by Director of Operations & Chief Nurse. System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient flow management plans). Urgent & Emergency Care Delivery Group established (biweekly), feeding into UEC Board. System wide Intermediate Tier Transformation Programme in place (11 Workstreams) Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow Winter Planning process in place at GM, Locality and Trust - Winter Plan 2022/23 Bed Modelling – 18 Month Plan Workforce models in place - Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside High levels of delayed discharges for out of borough patients ~~Approved Winter Plan 2022/23~~ Significant increase in unfunded non-elective demand Lack of standardised 7 day services across medical & surgical specialties to support discharge of non-elective patients. Locality plan for intermediate bed base to be agreed for 2023/24. Managerial and operational capacity, including ICB, to support key workstreams.	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits (Shadow metric) - Time to triage Daily Bed meetings (x 4)	Shadow reporting new ED metrics	Finalise recurrent Medical Staffing model Targeted investment fund (TIF) bid to GM – Additional ward capacity to support delayed discharges Test of Change – Implementation of GP led Discharge to Assess Unit Implementation of Virtual Ward Working Intelligently Group - Data collection & Deep Dive 3 x Medical Specialties, triangulation with current workforce planning.	Q4 2022/23 Dec 2022 Jan 2023 Jan 2023 Q4 2022/23	4	4	16	16	16			4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review Integrated Performance Report - Board (Bimonthly)	System-wide dashboard of acute, intermediate and domiciliary care capacity and performance	~~Approved Winter Plan 2022/23~~ Locality agreement for community capacity System-wide dashboard of acute, intermediate and domiciliary care capacity and performance Understanding Patient Flow Associated Harms – Review via Quality Committee	~~Oct 2022~~ Q4 2022/23 Dec 2022 Nov 2022										
				Level 3 - Independent Stockport Improvement Board *(NB Stood down from April 2022)* Urgent & Emergency Care Delivery Board NHSE - Activity Returns													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
		- Delayed discharge Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.															
Principal Risk Number: PR1.3					**Risk Appetite: Moderate**												
There is a risk that the Trust does not have capacity to deliver inclusive elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards	Finance & Performance Committee	Biweekly Trust Performance Meeting. ~~6-4-2 processes in place for Theatre and Diagnostic utilisation~~ Agreed Specialty Activity Plans & Budget ~~Increased bed base approved (M6)~~ Escalation process in place with Performance Team – 78+ week wait patients and any P2/cancer patients that are not dated. Clinical Prioritisation Group established & clinical harm review process in place for patients waiting – Including review of demographics of patients waiting to identify inequalities. Cancer Quality Improvement Board established chaired by Lead Cancer Clinician Established efficiency/transformation programmes: - Radiology - Theatres, Endoscopy & Diagnostics - Outpatient Transformation Booking & Scheduling centralisation Winter Plan 2022/23 established	Expansion of Endoscopy Workforce – Sickness Absence & Recruitment	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation		Expansion of Endoscopy (Delayed from Sept 2022 to Feb 23) Targeted investment fund (TIF) bid to GM – Additional ward capacity to support delayed discharges Activity Management Group – Data review to consider omissions in accounting and recording of elective activity and potential increase in referrals from out of borough	~~Sept 2022~~ Feb 2022 Dec 2022 Q4 2022/23	4	3	12	12	12			4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 78+ week waits - 104+ week waits - Overall RTT waiting list size - Cancer 2ww - Cancer 62 day - Diagnostic waits Quality Committee - Waiting List Harms Review (3 x year) Integrated Performance Report (Operational Performance) - Board (Bimonthly)	Limited availability of GM wide restoration performance data for benchmarking, including inequalities data.	~~Approved Winter Plan 2022/23~~ Waiting List Harms Review – Further disaggregation of data to enable demonstration of progress against health inequalities	~~Oct 2022~~ Q2 2022/23										
				Level 3 – Independent NHSE/I - Activity Returns													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and staff																	
Principal Risk Number: PR2.1					**Risk Appetite: High**												
There is a risk that the Trust fails to sufficiently engage and support our people, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high quality care.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession Planning Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Risk assessments undertaken for all staff; including BAME & Covid specific Risk Assessments Influenza & Covid 19 vaccination programmes Staff Wellbeing Programme established (including refreshed focus on financial wellbeing) including staff psychology and wellbeing service Occupational Health Service – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Confirmed approach to flexible working Values into Action programme established Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans 2021 in place.	Continuing impact of the pandemic on staff sickness/isolation/return to work ~~Divisional Staff Survey Action Plans~~ Embedded approach to Wellbeing Conversations ~~Embedded approach to flexible working~~ System to learn from exit conversations	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports Equality Diversity & inclusion Steering group EDI Strategy		~~Delivery of – Staff Survey Action Plans 2021 underway~~ ~~Mii People System to be implemented~~ ~~Launch~~ Develop and implement Organisational Development Plan inc. civility and refreshed leadership & management development offer	August 2022 October 2022 ~~October 2022~~ January 2023	4	3	12	12	12			4	2	8
				Level 2 – Corporate Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly)		Delivery Plan, including timescales and outcomes to support pledge for 'the wellbeing of our NHS people' Collaborative Occupational Health function with T&G Menopause Service – Charitable Fund application approval	December 2022 December 2022 December 2022										
				Level 3 - Independent CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey													
Principal Risk Number: PR2.2					**Risk Appetite: Moderate**												
There is a risk that the Trust's community services do not fully support neighbourhood working leading to suboptimal improvement in neighbourhood population health	Finance & Performance Committee	Operational & Winter Planning processes established with system arrangements. Established joint community Health & Well Being programmes e.g. Waiting Well, Active Hospitals, Stop Smoking CURE project. Integrated service models established including:	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report - Integrated Care Division - Women, Children & Diagnostics Adult's: Neighbourhood Leadership Group (Monthly) Children's: - Joint Public Health Oversight Group		Completion of capacity & demand modelling for community services Align Trust community services & workforce to PCNs	Q4 2022/23 Q4 2022/23	3	3	9	9	9			3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and staff																	
		Adults: District Nursing Teams - Work across 7 PCNs with GPs, Social Care, VCSE Children's: Stockport Family - Health, Social Care & Education Adult's: Neighbourhood Leadership Group established with multi partner representation. Children's: Joint oversight groups established with multi partner representation (SEND, Public Health, Safeguarding, Mental Health) Trust represented on the One Stockport Health & Care Board (Locality Board) for Stockport via the CEO and Director of Strategy & Partnerships. Locality Provider Partnership (led by SFT) ~~established (first meeting July 2022)~~ operational with defined workstreams and focus on population health. ONE Stockport Health and Care Plan & Delivery Plan/Outcomes developed with focus on reducing inequalities and improving population health outcomes	Alignment of Community Services to PCNs – Potential change to PCN geographical footprints Managerial and operational capacity, including ICB, to support key workstreams ~~Locality arrangements to be embedded including full work plan~~	- SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board													
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives'	Community Services Dashboard ~~Locality arrangements to be embedded including full work plan~~	Integration of Community Services Dashboard to IPR ~~Full enactment of Stockport locality arrangements including Provider Partnership arrangements~~	Q3 2022/23 ~~Q2 2022/23~~										
				Level 3 - Independent Children's – SEND Inspection Ofsted Report – 'Good' SALT - External multiagency review – Pathways & capacity and demand *(Findings not yet published).*													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																	
Principal Risk Number: PR3.1				**Risk Appetite: High**													
There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board leading to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic	Finance & Performance Committee	Locality ~~shadow~~ ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care (Locality Board) ~~established~~ operational. Membership includes CEO & Director of Strategy & Partnerships. Stockport ~~Place based Board~~ Provider Partnership ~~established~~ operational, chaired by SFT CEO ONE Stockport Plan and ONE Stockport Health and Care Plan. Operational & Winter planning processes well established with system arrangements as a focus	~~Locality arrangements to be fully enacted~~ Controls not yet designed for the management of the One Stockport Health & Care Plan	**Level 1 - Management**				3	3	9	9	9			3	2	6
				Level 2 – Corporate Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport plan		~~Full enactment of Stockport locality arrangements including Provider Collaborative Board.~~ Review of effectiveness of locality arrangements to be undertaken	~~Q2 2022/23~~ Q1 2023/24										
				Level 3 - Independent Health & Wellbeing Board													
Principal Risk Number: PR3.2				**Risk Appetite: High**													
There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), leading to suboptimal pathways of care and/or limited-service resilience across the footprint of both Trusts	Finance & Performance Committee	Established Board to Board meetings with ECT. Established ECT & SFT programme governance arrangements with clinical and support workstreams identified: Joint Programme Board in place (Monthly). Approved SFT & ECT Case for Change in June 2022. Clear work programme in place for 2022/23 including development of clinical workstreams / service options and PCBC (if required). Funding identified for 2022/23 for the programme to continue at pace. Full stakeholder engagement plan in place including LA, Healthwatch, DPHs, VCSE and NHSE/I regulators.	Failure to gain key stakeholder support for Joint Clinical Strategy and Case for Change. Currently no long term funding strategy for the programme of work	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting				4	3	12	12	12			4	2	8
				Level 2 – Corporate Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board - Progress Report (Monthly)		Produce Models of Care and Outline Business Case ~~Pre-Consultation Business Case~~ Plan for and commence implementation of service changes where no formal further process is required.	Q3 2022/23 ~~Q3~~ Q4 2022/23										
				Level 3 - Independent Oversight and challenge by NHSE and other health care partners on Joint Clinical Strategy Case for Change and models of care development		Present Case for Change and Models of Care to NHSE and ICB	Q4 2022/23										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Drive service improvement, through high quality research, innovation and transformation																	
Principal Risk Number: PR4.1				**Risk Appetite: High**													
There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements	Quality Committee	Director of Transformation working across SFT and Tameside & Glossop (utilising experience and knowledge of system-wide transformation programmes across other localities) Trust Transformation Programmes identified through a formal process of prioritisation linked to corporate objectives (Aims, KPIs, Milestones) Standardised governance & assurance in place for Transformation Programmes - Service Improvement Group (SIG) chaired by the Chief Executive. Senior Responsible Officer, Clinical & Operational Lead in place for each Transformation Programme SFT Research Team established. Annual research programme in place. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G)	Understand transformation requirements to address health inequalities Capacity of operational teams to implement change due to operational pressures ~~Approve Joint Research, Development & Innovation Strategy (SFT & T&G)~~ Establish joint programme of work (SFT & T&G)	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report				3	2	6	9	6			3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Board Report: Transformation Programme (Biannually) Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2021-22		~~Approved joint T&G / SFT Research, Development & Innovation Strategy~~ Establish joint work programme Approval of proposal for Stockport system transformation via Provider Partnership Board – Final programme of work to be established.	~~August 2022~~ Q4 2022/23 Q4 2022/23									
				Level 3 - Independent DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 - Develop a diverse, capable and motivated workforce to meet future service and user needs																	
Principal Risk Number: 5.1					**Risk Appetite: High**												
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment Recruitment & Retention Implementation Plan in place Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Bank incentive rate in place to enhance staffing levels during the winter months Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available. Local/ Regional/National Education partnerships Workforce Strategy & Divisional Workforce Plans Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers	~~Workforce Strategy & Divisional Workforce Plans~~ Review of leadership and management development offer including clinical leadership System for identifying and managing ~~monitoring~~ talent not yet available Reduction in training capacity due to social distancing. Restrictions on staff capacity to attend and participate in mandatory/statutory training. ~~Realignment of Role Essential Training Requirements~~	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance		New Cadet Programme to commence ~~Alternative development pipelines – Degree Apprenticeships, Medical Support Workers~~	~~September~~ November 2022 ~~October 2022~~	4	4	16	16	16			4	2	8
				Level 2 – Corporate People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report		~~Workforce Strategy & Divisional Workforce Plans~~ ~~Review of~~ Launch refreshed leadership & management development offer including clinical leadership ~~Embed Talent Management/Succession planning approach~~ Develop and implement a talent management and succession planning approach	October 2022 ~~October 2022~~ April 2023 ~~October 2022~~ September 2023										
				Level 3 - Independent NHS National Staff Survey GMC Survey Health Education Visits Model Hospital and comparative benchmarking data Confirm and Challenge by NHSEI NW Regional Team												
Principal Risk Number: 5.2					**Risk Appetite: High**												
There is a risk that the Trust fails to have a workforce that is reflective of the communities served leading to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+) Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics	Career Development Programmes for staff with protected characteristics Development of Staff Network Chairs and the Staff Networks	**Level 1 - Management** WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan				3	3	9	9	9			3	2	6
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually)	EDI metrics to be built into People Analytics Dashboard.	Development of Staff Network Chairs and the Staff Networks Staff listening sessions with under-represented staff	November 2022 March 2023										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 - Develop a diverse, capable and motivated workforce to meet future service and user needs																	
		Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme Risk assessments undertaken for all staff; including BAME & Covid specific risk assessments		- WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report		groups to understand barriers to career progression Career development programmes for staff with protected characteristics	~~October 2022~~ June 2023										
				Level 3 - Independent NHS National Staff Survey													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 - Use our resources in an efficient and effective manner																	
Principal Risk Number: PR6.1						**Risk Appetite: Moderate**											
There is a risk that the Trust does not deliver the 2022/23 financial plan leading to a poor use of resources and increased regulatory intervention.	Finance & Performance Committee	Annual financial plan 2022/23 approved - Confirmed deficit as part of GM control total SFT Capital Plan approved – Within GM Capital Plan Annual cash plan 2022/23 in place – Cash support if required from GM Approved Opening Budgets 2022/23 including requirement for recurrent and non-recurrent CIP Established CIP planning processes. PMO coordination of delivery Divisional Performance Review process - including financial escalation based on agreement of control totals for divisions Working Intelligently Group established – Data Analysis & Benchmarking – Workplan in place. Delivery of budget holder training and enhancements to financial reporting SFI's & Scheme of Delegation in place including authorisation limits	~~Potential requirement for reduced Trust deficit as part of GM control total~~ Implementation of recurrent CIP Plan.	**Level 1 - Management** Division Operation Board - Finance Metrics Divisional CIP Meetings Finance Training Group – Training Materials Cash Action Group (Monthly) - Cash flow monitoring Financial Position Review Group (Monthly)	Opportunities for benchmarking: GIRFT / Model Hospital – Financial benchmarking metrics not current.	CIP Implementation Plan 2022/23 including recurrent delivery Divisional Year End Forecast – Agreement of actions to achieve divisional control total	Ongoing	4	3	12	12	12			4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) - CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly)		~~Dashboard for benchmarking opportunities~~ Year-end financial forecast 2022/23 review, incorporating review of mandated actions – via Finance & Performance Committee & Board of Directors	~~Q2 2022/23~~ December 2022									
				Level 3 - Independent Internal Audit Reports - Key Financial Systems (Substantial) 2021/22 Provider Director of Finance GM Meeting Monthly Provider Finance Return (GM & NHSE/I) NHSE - North West Region oversight and triangulation of finance, activity and workforce data.		Completion of Internal Audits: - HFMA Financial Sustainability review Provenance of Data	Q3 2022/23									
Principal Risk Number: PR6.2						**Risk Appetite: Moderate**											
There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group. GM system Financial Recovery Subcommittee established - Chief Finance Officer member. Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Prioritisation of investments linked to planning priorities.	Underlying financial deficit Lack of certainty regarding system funding beyond 2022/23 Potential requirement for increased % CIP (recurrent/non-recurrent) ~~Comprehensive benchmarking data~~	**Level 1 - Management**		Review of budget methodology for delivery and transaction of CIP	Q3 2022/23	3	3	9	9	9			3	2	6
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) - Multi Year Financial Recovery Plan (Quarterly) – Drivers of the deficit		Two year financial forward view – Deficit & Opportunities to address– Review via Finance & Performance Committee Multi Year Financial Recovery Plan (including consideration of key data sources) – In line with planning guidance.	January 23 March 23									

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 - Use our resources in an efficient and effective manner																	
		Drivers of financial deficit review including benchmarking data and levels of efficiency Established Trust planning processes - Triangulates activity, workforce and cost. Financial planning 2023/24 being undertaken jointly with T&G – Commenced pre-guidance	~~review/key data sources~~ ~~GM system Financial Recovery Subcommittee to be established~~ GM Financial Risk Framework to be agreed Planning guidance 2023/24 anticipated in Autumn 2022. Currently no revised timetable for issue.			~~Dashboard for Benchmarking Opportunities~~	~~Q2 2022/23~~									
				Level 3 - Independent Provider Director of Finance GM Meeting		~~GM system Financial Recovery Subcommittee to be established~~ GM Financial Risk Framework to be agreed	August 2023 September 2023										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our Estate & Digital infrastructure to meet service and user needs																	
Principal Risk Number: 7.1					**Risk Appetite: High**												
There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	Digital Strategy 2021-2026 Capital plan in place for funding of Digital Strategy and receipt of capital funding for core elements of the Digital Strategy Robust project management infrastructure in place Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy Anti-virus updates & spam and malware email notifications Network accounts checked after period of inactivity – Disabled if not used Major incident plan in place Digital & Informatics Group established Terms of Reference & Work Plan approved by F&P Committee. Bimonthly reporting commenced.		**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				3	3	9	9	9			3	2	6
				Level 2 – Corporate Finance & Performance Committee - Digital & Informatics Group established Bimonthly - Digital Strategy Progress Report - Capital Programmes Management Group – (Monthly): Including digital capital Board of Directors - Biannual Digital Strategy Progress Report	~~Digital & Informatics Group – Commence reporting to F&P Committee~~	~~Digital & Informatics Group: Terms of Reference & Work Plan - Approval by F&P Committee. Commence bimonthly reporting~~ Completion of MIAA audit (and agreed recommendations) relating to legacy systems and asset control	~~Sept 2022~~ Nov 2022									
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification Internal Audit Report: Data Protection & Security Toolkit – Substantial Assurance, MIAA, September 2021		Planning for Data Protection & Security Toolkit (DSPT) 2022	Nov 2022									
Principal Risk Number: 7.2					**Risk Appetite: Moderate**												
There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance 6-facet survey completion and review – Action Plan in place Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Short - Medium Site Development Strategy	Financial resources to enable optimum levels of estates investment Inability to deliver required upgrades due to access limitations related to clinical activity pressures	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Group - Compliance with regulatory standards - Health & Safety Incidents	~~Estates & Facilities Performance Report (Dashboard)~~		~~Q2 2022/23~~	4	3	12	12	12			4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report - Estates Progress Report including Sustainability (Biannually)		~~Short – Medium Term Estates Development Strategy~~ Develop Site Development Strategy Delivery & Work Plan, aligned to Project Hazel	~~September 2022~~ Q4 2022/23									
				Level 3 - Independent Estates Return Information Collection (ERIC) Model Hospital Data Set Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our Estate & Digital infrastructure to meet service and user needs																	
Principal Risk Number: 7.3				**Risk Appetite: High**													
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Approved Capital Programme 2022/23 Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Trust Sustainability Manager ~~appointed~~ in post	Inadequate financial resources to enable optimum levels of investment to deliver sustainability improvements	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities		~~Green Plan Work Plan to be developed~~	~~Q2 2022/23~~	4	2	8	12	8			4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee - Estates Progress Report including Sustainability (Biannually)													
				Level 3 - Independent - Estates Return Information Collection (ERIC)													
Principal Risk Number: 7.4				**Risk Appetite: High**													
There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed New Hospital Building Programme Expression of Interest submitted – Project Hazel Established governance structure to develop Outline Business Case Project Hazel Outline Business Case in development ~~Short to Medium Term Estates Strategy in development~~ Short - Medium Site Development Strategy to support and inform immediate site development and maintenance aspirations	Funding mechanism not confirmed New Hospital Building Outline Business Case	**Level 1 - Management**		~~Short – Medium Term Estates Development Strategy~~	~~September 2022~~	3	4	12	12	12			3	2	6
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Development of New Hospital Strategic Outline Business Case (OBC)	~~October 2022~~ November 2022										
				Level 3 - Independent													

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at 9 November 2022)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
130	Emergency Department and Clinical Decision Unit	The Trust does not meet the 4 hour access standard and this leads to delays in treatment and potential patient harm	4	4	16	10	↔
2148	Surgery	There is a risk of reduced critical care capacity if the medical workforce cannot be recruited to.	4	4	16	4	↔
2217	Surgery	There is a risk of harm to patients due to extended waiting times for elective surgery	4	4	16	8	↔
101	Corporate Services – Finance	There is a risk that the Trust will run out of cash and therefore have insufficient cash reserves to operate	5	3	15	5	↔
2133	Integrated Care	There is a risk that patient flow may be compromised by the reduced access to community capacity and therefore rising NCTR.	4	5	20	6	↑

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Amended Scheme of Reservation & Delegation					
Lead Director	Chief Finance Officer		Author	Director of Finance		

Recommendations made / Decisions requested

The Board of Directors are asked to review and approve the Scheme of Reservation and Delegation as recommended by Audit Committee.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
X	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts

		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
	x	**PR6.1**	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
	x	**PR6.2**	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Scheme of Reservation & Delegation sets out the roles and responsibilities of all decision making throughout the Trust. Whilst this document was not due for review until 2023 the following events have occurred which require the document to be amended

(a) Authorisation levels temporarily in place during Covid
(b) Change of Divisional Structure
(c) Change of Executive Team posts and portfolios
(d) Operational issues with current version
(e) Amended Charitable Funds Committee scheme of delegation
(f) Procurement approval levels following exit from EU
(g) Change in NHS landscape - transfer of services
(h) Best practice governance to maintain control of costs

This report describes where the changes have been made for reference, however the full document is attached as an appendix for reference.

The key section for focus is the authorisation levels in Schedule B for expenditure and the report shows the levels prior to covid, during covid and proposed.

This document has been reviewed by Audit Committee on 24th November and is recommended for approval by the Board of Directors.

1. Purpose

1.1 The Scheme of Reservation and Delegation (SoRD) details who is responsible for what decision making in the organisation and is one of the key financial governance documents.

1.2 The document was not due for review until April 2023; however, several changes have happened which necessitate this document being updated and approved through Audit Committee and the Board of Directors.

1.3 The review of the SoRD has been undertaken by the Director of Finance, the Trust Secretary and the Deputy Director of Strategy and Partnerships. Other Executive Directors and their deputies have been consulted on very specific points where changes have been noted.

2. Background, Links to Previous Papers and reasons for change

2.1 The previous update to the SoRD was extensive and this took place in 2020/ 21; the final version was approved in May 2021.

2.2 During Covid the levels of expenditure and the governance processes were amended and papers to this affect were also taken through the governance route at the time.

2.3 An Audit report on procurement processes has been received in August 2022 which challenges how the expenditure levels are being applied and it has been agreed that this will be clarified as part of the current update.

2.4 The Divisional structure changed in October 2022 and the roles in the Divisions need to be amended.

2.5 The Executive Structure with joint posts across Tameside also requires clarification of approval levels and the change in portfolios.

2.6 The Charitable Funds Committee and the Board as Corporate Trustees have also approved a separate scheme of delegation for approval and this needs to be reflected in the main SoRD.

2.7 The procurement levels for tendering which replaced EU levels after Brexit have been updated in a separate procedure but are currently not incorporated into the main SoRD.

2.8 The change in the NHS landscape and the joint working across GM and other partners means that a new section is added for the transfer of services between providers.

2.9 The focus from the National Team on sustainability and keeping control of costs has been incorporated into key areas of approval on pay and this also links to operational items which were not covered in the previous version.

3. Matters under consideration – key changes

3.1 The new draft SoRD is attached as Appendix 1

3.2 There have been a series of changes to portfolios for the Executive Team throughout the document and these link back to the "delegated matters table" on page 13 of the SoRD which details the posts and grouping of posts. This also covers the changes

3.3 The key change is the levels of expenditure approval recommended which is covered in Table B section 7.1. As a comparator Table 1 below shows the previous levels from the last 2 versions.

Table 1

Approval levels within the SoRD

Role	Scheme prior to Covid	Current Scheme - Covid	Proposed
Level 1 budget holder	up to £1k	up to £250	up to £250
Level 2 budget holder	up to £5k	up to £1k	up to £1k
Level 3 budget holder (directorate manager)	up to £15k	up to £5k	up to £5k
Functional Director	up to £50k	up to £25k	up to £25k
Executive Director / Other Director	up to £100k	up to £25k	up to £50k
Director of Finance (new role) - was Deputy Director of Finance	up to £50k	up to £25k	up to £50k
Chief Finance Officer (new role) - was Director of Finance	up to £100k	up to £100k	up to £100k
Chief Executive or nominated Deputy	up to £500k	up to £750k	up to £750k
Chair & Chief Executive (with Board approval)	over £500k	Over £750k	Over £750k

3.4 To give clarity and affirm financial governance over approval of financial staffing decisions the temporary staffing approval group has been renamed to "Staffing Approval Group". This is the group jointly chaired by the Director of Operations and the Director of Finance which is held weekly on a Monday morning and looks at all long-term agency requests, variations to salary and changes to structure and pay rates. This has been amended throughout section 33 Workforce and Pay.

3.5 There are other changes in the Workforce and Pay section to cover introducing additional rates of pay including waiting list rates and incentive payments,

paying staff by invoice linked to IR35 and the approval of salary sacrifice schemes.

3.6 The Charitable Funds Committee has set a scheme of delegation and this has been incorporated into Table B point 1 – Charitable Funds

3.7 The full tender threshold following the UK exit from the European Union is currently set at £122,976 (inc. VAT) and this has been amended in Table B section 8. This value could be revised by the Government at any time and therefore further updates to the SoRD may be applicable for this change.

3.8 The audit report for procurement required the expenditure levels to be clarified, the full tender threshold clarified and required the waiver form to be amended. The change to the SoRD completes the internal audit recommendations. Appendix 2 shows the revised waiver form; the signatures link to the change in titles for Finance and reasons for waiver have been reduced. The Head of Procurement is now involved at an earlier stage to ensure that best practice procurement governance is followed.

3.9 There is no discrete section for the transfer of services to another NHS provider and therefore section 42 has been added to cover this. Also Table B section 13 has been added to show that any transfer of contract income can be approved by the Executive Team up to £500k and anything above this level needs to be approved by the Board.

3.10 The level at which business cases which are funded from internal reserves set as part of the annual plan or at risk within the annual plan are presented to the finance and performance committee and recommended to board is over £50,000. For example, if a safety issue arose where we needed to introduce a new product which would be £75,000 and this was funded from the emergency contingency a paper would need to be approved by board. Discussion took place at the Executive Team and it was agreed that this level would continue.

4. Areas of Risk

4.1 It is important that the SoRD is regularly reviewed and that the controls for the organisation are clearly defined and made available to all staff. This review will therefore reduce the risk of staff not following procedure and good financial governance will be upheld.

4.2 It is worth noting that over 200 staff with financial responsibilities have attended the financial governance training on the SoRD and Standing Financial Instructions since 2021. This has led to an increased compliance rate with the Trust's No Purchase Order No Pay Policy and reduced overpayments due to notification of leavers. The updates in the SoRD will be

distributed to all budget holders as part of regular updates and further training sessions will be held.

Stockport NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION

	Scheme of Reservation & Delegation	Page:	Page 1 of 42
Author:	Director of Finance	Version:	v. 4
Date of Approval:	Audit Committee 24/11/2022	Date for Review:	November 2024
To Note:	Updates to financial limits may be posted on the intranet – please check latest guidance.		

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1. SCHEDULE OF DELEGATED MATTERS

DELEGATED MATTERS

Delegated Matter
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS

TABLE A

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AUTHORISATION OF NEW DRUGS	3
BANK/OPG ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
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Delegated Limit	Reference No.
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Redesignation of budget (virement)	**10**
Contract Award	**11**
Signing of Contracts	**12**
Transfer of services	**13**

2 INTRODUCTION

2.1. Reservation of Powers

The Standing Orders provides that "The Board of Directors may delegate any of its powers to a committee of Directors or to an Executive Director". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Board of Directors of the Foundation Trust.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to committees, sub committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.2. Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility. The Chief Executive on appointment shall receive a letter which details their role in relation to the Accounting Officer and the Accountable Officer.

All powers delegated by the Chief Executive can be re-assumed by the Board of Directors should the need arise.

2.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

2.4 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by their nominated deputy. In the absence of both the Chief Executive and the nominated deputy after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, pending the Accounting Officers return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

3. RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

3.1 Accountability

The Code of Accountability which has been adopted by the Foundation Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in paragraphs 3.3 to 3.10 below:

3.2 Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these,
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

3.3 General Enabling Provision

The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.

3.4 Regulations and Control

The Board of Directors remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it is maintain a monitoring role. These following are decisions reserved to the board:

- Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.
- Suspend Standing Orders or Standing Financial Instructions.
- Vary or amend the Standing Orders or Standing Financial Instructions.
- Ratification of any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with the Standing Orders.
- Approval of a scheme of delegation of powers from the Board of Directors to Committees.
- Suspend, vary or amend the scheme of delegation of powers from the Board of Directors to Committees.
- Requiring and receiving the declaration of Board members' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Requiring and receiving the declaration of officers' interests which may conflict with those of

the Foundation Trust.

- Approval of arrangements for dealing with complaints.
- To receive reports from committees including those which the Foundation Trust is required by the Constitution and the Health and Social Care Act 2012 or other regulation to establish and to take appropriate action thereon.
- To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
- To confirm the recommendations of the Foundation Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property.
- Authorise use of the seal (as defined within the scheme of delegation).
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
- Disciplining Board members' or employees who are in breach of Statutory Requirements or Standing Orders, Standing Financial Instructions or the scheme of delegation

3.5 Appointments / Dismissal

Appointment of the Deputy Chairman of the Board of Directors, subject to the approval of the Council of Governors.

- Appointment of the Senior Independent Director (SID).
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- The appointment, appraisal, disciplining and dismissal of Executive Directors.
- Confirm the appointment of members of any Board Committees as representatives of the Foundation Trust on outside bodies where the Trust has a material interest.
- Appoint appraise, discipline and dismiss the Trust Secretary (the Trust Secretary is accountable to the Chief Executive).
- Approve the Chairman and membership of the Board sub-committees.
- Approve proposals received from the Remuneration Committee regarding the Chief Executive, Directors and senior employees.

3.6 Policy Determination

Make arrangements for the approval of Foundation Trust management policies in accordance with the Policy on the Development of Procedural Documents at the appropriate Board committee including:

- Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Policy & procedures for the standards of business conduct including declaration of gifts, hospitality and sponsorship
- Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, whistleblowing, fraud, breaches of the duty of candour, breaches of Code of Conduct, and other ethical concerns.
- A treasury management policy
- Management of risk

3.7 Strategy, Partnerships, Annual Plans and Budgets

- Definition of the strategic aims and objectives of the Foundation Trust.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any guidance issued by the Secretary of State or the Independent Regulator.
- Approve Outline and Final Business Cases for Capital Investment
- Approve budgets.
- Approve annually the Foundation Trust's proposed annual plan and capital expenditure plans
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings
- Approve PFI proposals or similar financial transactions.
- Approve the transfer of services between NHS Providers
- Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £750,000 per annum or over £2,000,000 in total if the period of the contract is longer than 3 years. Renewals and contract changes would be reported to the Board and approval sought where these amendments exceeded these thresholds.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS Litigation Authority schemes.
- Review use of NHS Litigation Authority schemes or equivalent insurance arrangements
- Approve the opening of bank accounts.
- Approve individual compensation payments outside of normal contractual entitlements.

3.8 Audit Arrangements

To receive recommendations regarding the appointment (and where necessary dismissal) of the internal auditors. Responsibility for the appointment or removal of the financial external auditors is held by the Council of Governors.

The Board are required to:

- Receive the annual management letter (through Audit Committee reporting) received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
- Receive an annual report from the Internal Auditor (through Audit Committee reporting) and agree action on recommendations where appropriate of the Audit Committee.
- Receive an annual report on Counter Fraud (through Audit Committee reporting) and agree action on recommendations where appropriate of the Audit Committee.

3.9 Annual Reports and Accounts

- The Audit Committee approve for audit the Foundation Trust's Annual Report and Annual Accounts which are subsequently signed off by the Chief Executive and Director of Finance and are then approved by the Board of Directors prior to:

- being laid before parliament, which is prior to
- presentation to the Council of Governors at a Members Meeting.

- The Charitable Funds Committee will approve and receive the Charitable Funds Accounts before submission to the Charities Commissioner Receipt and approval of the Annual Report and Accounts for funds held on trust

3.10 Monitoring

- Receive such reports as the Board of Directors sees fit from committees or individual directors in respect of their exercise of powers delegated.
- Continuous appraisal of the affairs of the Foundation Trust by means of the provision to the Board of Directors as the Directors may require from directors, committees, and officers of the Foundation Trust.
- Receive reports from Director of Finance on financial performance against budget and business plan / Annual Plan.
- Receive reports on actual and forecast income from Contracts.

4 DELEGATION OF POWERS

4.1 Delegation to Committees

4.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with standing orders, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

4.1.2 The Board Committee Structure for the Trust is shown in Appendix 1.

4.2 Delegation to Officers

4.2.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors.

4.2.2 The following responsibilities are defined through the Foundation Trust Accounting Officer Memorandum:

The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- There is a high standard of financial management in the Foundation Trust as a whole;
- The NHS Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- Financial considerations are fully taken into account in decisions by the NHS Foundation Trust

The specific personal responsibilities of a Foundation Trust Accounting Officer:

- The propriety and regularity of the public finances for which they are answerable;
- The keeping of proper accounts;
- Prudent and economical administration in line with the principles set out in *Managing public money(www.gov.uk/government/publications/managing-public-money)*
- The avoidance of waste and extravagance; and
- The efficient and effective use of all the resources in their charge.

The Accounting Officer must:

- Personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by NHS Improvement in accordance with the Act.
- Comply with the financial requirements of the NHS provider licence.
- Ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts. (So that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust).
- Ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.
- Ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate.
- Ensure that any protected property (or interest in) is not disposed of without the consent of NHS Improvement.
- Ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the Foundation Trust staff, including themselves.
- Ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors

The Accounting Officer should ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems, have been established. An Accounting Officer should ensure that managers at all levels:

- Have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- Are assigned well defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money.
- Have the information (particularly about cost), training and access to the expert advice which they need to exercise their responsibilities effectively.
  Accounting Officers must make sure that their arrangements for delegation promotes good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

4.2.3 Schedule of Delegation

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the: Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

Table A - Delegated Authority,
Table B - Delegated Financial Limits,

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

4.2.4 Waivers

The requirements of the Scheme of Delegation or the Standing Financial Instructions can only be waived in accordance with the delegated authority in table A2.

Any officer requesting or agreeing the waiving of Standing Financial Instructions or the Scheme of Delegation needs to be able to satisfy themselves that value for money is being achieved.

Delegated Authority

If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Standing Orders/Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chairman	Chairman
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders, SFIs or SORD	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders, SFIs or SORD	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the Director of Finance (report to the Audit Committee)	All staff	All staff
j)	Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Director of Finance/Internal Audit

Delegated Matters

Delegated matters in respect of decisions which may have a far reaching effect MUST be reported to the Chief Executive. The delegation shown in the following cases is the lowest level to which authority is delegated. Delegation to lower levels than specified is only permitted with the prior written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions.
The following are details of the posts that are covered by a specific heading within the scheme of delegation:

TITLE & ABBREVIATION	POSTS COVERED (OR NOMINATED DEPUTY)
Chairman	Nominated Deputy: Deputy Chairman (Board of Directors)
Chief Executive (CE)	Nominated Deputy: Deputy Chief Executive
Deputy Chief Executive	Chief Finance Officer
Executive Director (EDR)	Chief Finance Officer Medical Director Executive Director of Operations Director of People & Organisational Development Chief Nurse Director of Strategy & Partnerships Director of Communications & Corporate Affairs* (non-voting)
Other Directors (shared with Tameside FT and non-voting posts)	Director of Estates & Facilities Director of Informatics Director of Transformation
Functional Director (FDR) and Divisional Directors (Div'l Directors)	Director of Finance Deputy Director of Operations Chief Information Officer Chief Technical Officer Chief Data Officer Associate Director of Estates & Facilities Deputy Director Strategy & Partnerships Chief Pharmacist Deputy Director of Quality Governance Deputy Director of People & Organisational Development Deputy Director of Organisational Development Deputy Chief Nurse Associate Director of Finance (3 roles) Divisional Director of Medicine and ED Divisional Director of Women and Children Divisional Director of Surgery Divisional Director of Integrated Care Divisional Director of Clinical Support Services
Associate Medical Director (AMD)	Divisional AMD of Medicine and ED Divisional AMD of Women and Children Divisional AMD of Surgery Divisional AMD of Integrated Care Divisional AMD of Clinical Support Services Deputy Medical Director
Senior Finance Team	Chief Financial Accountant Head of Costing & Benchmarking Senior Divisional Accountant (3 roles) Head of Procurement Chief Contracts Accountant
Head of Procurement (HOP)	Nominated deputy: Deputy Head of Procurement (2 roles)
Corporate Trustee	Board of Directors

* Table A - Delegated Matters

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Audit Arrangements**		
a)	Appointment, re-appointment and removal of the financial auditor, and approve the remuneration in respect of the financial auditor.	Council of Governors	Council of Governors with support and advice from the Audit Committee and the Director of Finance
b)	Monitor and review the effectiveness of the internal audit function.	Audit Committee	Chief Finance Officer
c)	Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e)	Ensure cost-effective audit service	Audit Committee	Chief Finance Officer
f)	Implement recommendations	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects (Subject to commercial sponsorship criteria in section 7)**	Chief Executive	Medical Director
3.	**Authorisation of New Drugs**	Chief Executive	Medicines Optimisation Group
4.	**Bank/OPG Accounts/Cash** (Excluding Funds Held on Trust Accounts)		
a)	Operation: • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Associate Director of Finance (FS)
	• Opening bank accounts with Board approval	Chief Finance Officer	Associate Director of Finance (FS)
	• Authorisation of transfers between Foundation Trust bank accounts	Chief Finance Officer	To be completed in accordance with bank mandate/ Treasury Management policy
	• Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	To be completed in accordance with bank mandate/ Treasury Management policy
	• Authorisation of: - OPG schedules - BACS schedules - Automated cheque schedules - Manual cheques	Chief Finance Officer	To be completed in accordance with bank mandate/ Treasury Management policy
b)	Investments: • Investment of surplus funds in accordance with the Foundation Trusts Treasury Management policy	Chief Finance Officer	Associate Director of Finance(FS)/Director of Finance
	• Preparation of investment procedures	Chief Finance Officer	Associate Director of Finance (FS)
c)	Petty Cash	Chief Finance Officer	**Refer To Table B Delegated Limits**
5.	**Capital Investment**		
a)	Programme: • Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / Service development Strategy	Director of Strategy & Partnerships	Chief Information Officer Associate Director of Estates & Facilities Deputy Director Strategy & Partnerships
	• Quantification of the cash available for capital investment	Chief Finance Officer	Associate Director of Finance (FS)
	• Preparation of Capital Investment	Director of Strategy &	Deputy Director Strategy & Partnerships

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Programme	Partnerships	
	• Preparation of a business case	Director of Strategy & Partnerships	Associate Director of Estates & Facilities, Chief Information Officer, Deputy Director Strategy & Partnerships and Associate Director of Finance (FS)
	• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Director of Finance	Associate Director of Finance (FS)
	• Authorisation of business cases for capital expenditure/ capital requisitions	Chief Executive	**Refer To Table B Delegated Limits**
	• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	Director of Finance	Associate Director of Finance (FS)
	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost budgeted.	Director of E&F	Associate Director of Estates & Facilities, Chief Information Officer and Deputy Director Strategy & Partnership
	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Director of E&F	Associate Director of Finance (FS)
	• Issue procedures governing financial management of capital investment projects, including variations to contract and staged payments	Chief Finance Officer	Associate Director of Finance (FS)
	• Issue procedures for the valuation (for accounting purposes) of the Trust's property in accordance with the Trust's accounting policies, IFRS and Foundation Trust Annual Reporting Manual	Chief Finance Officer	Associate Director of Finance (FS)
	• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's	Director of Strategy & Partnerships	Associate Director of Finance (FS)
b)	Private Finance (or similar IFRIC 12 transaction):		
	• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Chief Finance Officer
c)	Leases (including leases embedded in others contracts for services)		
	• Granting, renewal and early termination of leases with an annual rent < £100k and where dilapidations or early termination clause penalties, do not exceed £50k in cases of termination	Chief Finance Officer	Associate Director of Finance (FS)
	• Granting, renewal and early termination of leases of > £100k and where dilapidations or early termination clause penalties do not exceed £50k	Board of Directors	Chief Finance Officer – provided reported to the Board of Directors

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
6.	**Clinical Audit**		
	• Provision of fit for purpose clinical audit function that addresses clinical risks highlighted in the risk register	Chief Executive	Medical Director
	• Annual plan and report to be presented to the Audit Committee	Chief Executive	Medical Director
7.	**Commercial Sponsorship**		
	• Agreement to proposal	Director of Strategy & Partnership	Deputy Director Strategy & Partnership and Director of Communications & Corporate Affairs. Approval and registration in line with Trust Conflicts of Interests Policy.
8.	**Complaints (Patients & Relatives)**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively and in line with the Trust's overall duty of candour	Chief Executive	Chief Nurse & Deputy Director of Quality Governance
b)	Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Heads of Department in conjunction with the Divisional Director/Patient Experience Matron
c)	Medico - Legal Complaints Coordination of their management.	Chief Executive	Chief Nurse & Deputy Director of Quality Governance
9.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Medical Director
	Freedom of Information Act compliance code	Chief Executive	Chief Finance Officer (SIRO)
10.	**Data Protection Act (DPA)**		
a)	Review of Foundation Trust's DPA compliance	Chief Finance Officer (SIRO)	Data Protection Officer
11.	**Declaration of Interest**		
	• Maintaining registers of interests	Chief Executive	Trust Secretary
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Governors / Senior Managers / Consultants / All staff in line with the Conflicts of Interest Policy
12.	**Disposal, Condemnations and Impairments**		
	• Assets that are obsolete, redundant, irreparable, cannot be repaired cost effectively or are otherwise impaired	Chief Finance Officer	Associate Director of Estates & Facilities / Div'l Directors in accordance with agreed policy and completion of disposal forms
	• Develop arrangements for the sale of assets	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)/ Associate Director of Estates & Facilities/ Head of Procurement
	• Disposal of relevant assets no longer needed to fulfil the Trust's obligations to provide commissioner requested services	Board of Directors (with authorisation of the Independent Regulator)	Chief Finance Officer

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of E&F	Associate Director of Estates & Facilities
14.	**External Borrowing**		
a)	Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Chief Finance Officer	Associate Director of Finance (FS)
b)	Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board of Directors	Chief Executive/ Chief Finance Officer (with evidence of Board approval)
c)	Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive / Chief Finance Officer	Associate Director of Finance (FS)
d)	Preparation of procedural instructions concerning applications for loans and overdrafts.	Chief Finance Officer	Associate Director of Finance (FS)
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit budgets to the Trust Board	Chief Finance Officer	Director of Finance
	• Submit to Board financial estimates and forecasts	Chief Executive	Chief Finance Officer
	▪ Compile and submit to the Board an annual plan which takes into account financial targets and forecast limits of available resources. The annual plan will contain: o a statement of the significant assumptions on which the plan is based; o details of major changes in workload, delivery of services or resources required to achieve the plan.	Chief Executive	Chief Finance Officer
b)	Monitoring:		Director of Finance
	o Devise and maintain systems of budgetary control.	Chief Finance Officer	
	o Monitor performance against budget	Chief Finance Officer	Director of Finance
	o Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
	o Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Finance Officer	Director of Finance
	o Submit in accordance with the Independent Regulator's requirements for financial monitoring returns	Chief Executive	Chief Finance Officer / Director of Finance
	o Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
	Preparation of: • Annual Accounts	Chief Finance Officer	Director of Finance
	• Annual Report	Chief Executive	Trust Secretary
c)	Budget Responsibilities • Ensure that o no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; o approved budget is not used for any other	Chief Finance Officer	Div'l Directors / Functional Directors / Budget Holders

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	than specified purpose subject to rules of virement; o no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and establishment.		
d)	Authorisation of Virement: It is not possible for any officer to vire: • from non-recurring headings to recurring budgets • from capital to revenue • from revenue to capital Virement signed between different budget holders requires the agreement of both parties.	Chief Executive	**Refer To Table B Delegated Limits**
16.	**Financial Procedures and Systems**		
a)	Maintenance & Update on Foundation Trust Financial Procedures	Chief Finance Officer	Director of Finance / Associate Director of Finance (FS/FM/I&C)
b)	Responsibilities:- o Implement Foundation Trust's financial policies and co-ordinate corrective action through financial recovery plans, if necessary. o Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. o Providing financial advice to members of the Board of Directors and staff. o Ensure that appropriate statutory records are maintained. o Designing and maintaining compliance with all financial systems	Chief Finance Officer	Director of Finance/ Associate Director of finance (FS/FM/I&C)
17.	**Fire precautions**		
	• Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact. • Comply with the Fire Code	Director of E&F Director of E&F	Associate Director of Estates & Facilities Associate Director of Estates & Facilities
18.	**Fixed Assets (Property, Plant & Equipment)**		
a)	Maintenance of asset register including asset identification and monitoring	Chief Finance Officer	Associate Director of Finance (FS)
b)	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with JCT Contracts, OJEU, PFI, P21	Director of E&F	Associate Director of Estates & Facilities
c)	Calculate and pay capital charges in accordance with the requirements of the Department of Health	Chief Finance Officer	Associate Director of Finance (FS)
d)	Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with Foundation Trust's procedures	Director of E&F	All staff
19.	**Fraud (See also 27, 37)**		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a)	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Anti- Fraud Specialist.	Chief Executive and Chief Finance Officer	Counter-Fraud Specialist.
b)	Notify NHS Counter Fraud Authority and External Audit of all suspected Frauds	Chief Finance Officer	Counter-Fraud Specialist.
20.	**Funds Held on Trust (Charitable and Non Charitable Funds)**		
a)	Management: • Funds held on trust are managed appropriately.	Charitable Trustees Committee	Associate Director of Finance (FS)
b)	Maintenance of authorised signatory list of nominated fund holders.	Chief Finance Officer	Associate Director of Finance (FS)
c)	Expenditure Limits	Chief Finance Officer	**Refer To Table B Delegated Limits**
d)	Developing systems for receiving donations	Chief Finance Officer	Associate Director of Finance (FS)
e)	Dealing with legacies	Chief Executive	Chief Executive/ Associate Director of Finance (FS)
f)	Fundraising Appeals	Board of Directors	Charitable Funds Committee
g)	Operation of Bank Accounts: • Managing banking arrangements and operation of bank accounts • Opening bank accounts	 Chief Finance Officer Chief Finance Officer	 Director of Finance/ Associate Director of Finance (FS) Associate Director of Finance (FS)
h)	Investments: • Nominating deposit taker • Placing transactions	 Charitable Funds Committee Chief Finance Officer	 Chief Finance Officer Associate Director of Finance (FS)
i)	Regulation of funds with Charities Commission	Chief Finance Officer	Associate Director of Finance (FS),
j)	Making grants	Charitable Funds Committee	Chief Finance Officer
21.	**Health and Safety**		
	Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse / Director of E&F
22.	**Healthcare Contract**		
a)	Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer / Director of Operations
b)	Quantifying and monitoring out of area treatments	Chief Finance Officer	Associate Director of Finance (I&C)
c)	Reporting actual and forecast income	Chief Executive	Associate Director of Finance (I&C)
d)	Costing Foundation Trust Contract and Non Commercial Contracts	Chief Finance Officer	Associate Director of Finance (I&C)
e)	National Cost Collection/ Payment by Results	Chief Finance Officer	Associate Director of Finance (I&C)
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Director of Finance
g)	Signing of contracts	Chief Executive	Refer to Table B delegated limits
h)	Variation to contracts	Chief Executive	Refer to Table B delegated limits

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
23.	**Hospitality/Gifts**		
a)	Keeping and updating of gifts & hospitality register	Chief Executive	Trust Secretary
b)	Applies to both individual and collective hospitality receipt items.		All staff declaration required in Foundation Trust's Hospitality Register **See Appendix B for limits.**
24.	**Reporting and managing Infectious Diseases & Notifiable Outbreaks**	Chief Executive	Medical Director
25.	**Information Management & Technology**		
	All systems (excluding financial)	Director of Informatics	Chief Information Officer
	• Developing systems in accordance with the Foundation Trust's Digital Strategy.		Chief Information Officer Chief Technical Officer
	• Implementing new systems ensure they are developed in a controlled manner and thoroughly tested.	Director of Informatics	
	• Seeking third party assurances regarding systems operated externally.	Director of Informatics	
	• Ensure that contracts for computer services for applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Informatics	Chief Technical Officer
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Director of Informatics	Chief Technical Officer & IT System Owners
	Financial Systems		
	• Developing financial systems in accordance with the Foundation Trust's IM&T Strategy.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Implementing new systems ensure they are developed in a controlled manner and thoroughly tested.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Seeking third party assurances regarding financial systems operated externally.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Ensure that contracts for computer services for financial management purposes define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Informatics	Chief Information Officer / Chief Technical Officer / Chief Data Officer / System Owners
26.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors for matters relating to: • Complaints • Workforce • Commercial or property • Claims & inquest • All other **Subject to the powers reserved by the Board in Section 3.7**	Chief Executive	• Deputy Director of Quality Governance • • Director of People & OD • Chief Finance Officer / Director of E&F Deputy Director of Quality Governance • Chief Executive or Trust Secretary

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Deputy & as above
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Directors
27.	**Losses, Write-off & Compensation**		
a)	Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing NHS Protect of frauds	Chief Executive	Chief Finance Officer
b)	Losses		
	Losses of cash due to theft, fraud, overpayment & others.	Chief Executive	**Refer To Table B Delegated Limits**
	Fruitless payments (and constructive losses)	Chief Executive	**Refer To Table B Delegated Limits**
	Bad debts and claims abandoned.	Chief Executive	**Refer To Table B Delegated Limits**
	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson).	Chief Executive	**Refer To Table B Delegated Limits**
c)	Reviewing appropriate requirements to ensure adequate and appropriate insurance cover is taken out and the processes for making and monitoring of claims	Chief Finance Officer	Senior Contracts Manager
d)	A register of all of the payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Associate Director of Finance (FS)
e)	A report of all of the above payments should be presented to the Audit Committee	Chief Finance Officer	Associate Director of Finance (FS)
f)	Special Payments Compensation payments by Court Order	Chief Executive	Above Excess – NHSR Below Excess – Chief Executive/ Chief Finance Officer
g)	Ex gratia Payments:-		
	• To patients/staff for loss of personal effects	Chief Executive	**Refer To Table B Delegated Limits**
	• For clinical negligence after legal advice	Chief Executive	Chief Executive/ Chief Finance Officer
	• For personal injury after legal advice	Chief Executive	Chief Executive /Chief Finance Officer
	• Other clinical negligence and personal injury	Chief Executive	Chief Executive / Chief Finance Officer
	• Other ex-gratia payments	Chief Executive	Chief Executive / Chief Finance Officer
28.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board	Chairman	Trust Secretary
b)	Chair all Foundation Trust Board meetings and associated responsibilities	Chairman	Chairman
c)	Calling meetings of the Council of Governors	Chairman	Chairman/ Trust Secretary/ Seven Governors by notice to the Secretary
d)	Chair all Council of Governors meetings and associated responsibilities	Chairman	Chairman

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
29.	**Medical**		
	• Clinical Governance arrangements	Chief Executive	Medical Director / Chief Nurse
	• Medical Leadership	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Programmes of medical education	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Medical staffing plans	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Medical Research	Medical Director	Associate Medical Directors & Deputy Medical Director
30.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Director of Finance / Associate Director of Finance (FS/FM)
b)	Obtain the best value for money when requisitioning goods / services	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities/ Director of Finance/ Div'l Directors/ Budget Holders
e)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive	Chief Finance Officer
d)	Develop systems for the payment of accounts	Chief Finance Officer	Associate Director of Finance (FS)
e)	Prompt payment of accounts	Chief Finance Officer	Associate Director of Finance (FS)
f)	Financial Limits for ordering / requisitioning goods and services	Chief Finance Officer	**Refer To Table B Delegated Limits**
g)	Approve prepayment arrangements	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)
31.	**Nursing**		
	Compliance with ○ statutory and regulatory arrangements relating to professional nursing and midwifery practice. ○ Matters involving individual professional competence of nursing staff. ○ Compliance with professional training and development of nursing staff. ○ Quality assurance of nursing processes.	Chief Executive	Chief Nurse
32.	**Patients' Property** (in conjunction with financial advice)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse / Deputy Chief Nurse Associate Director of Estates & Facilities
b)	Prepare detailed written instructions for the administration of patients' property	Director of Finance	Chief Nurse / Deputy Chief Nurse / Associate Director of Estates & Facilities
c)	Informing staff of their duties in respect of patients' property	Director of Finance	Chief Nurse / Deputy Chief Nurse /Associate Director of Estates & Facilities/ / Heads of Department

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d)	Issuing property of deceased patients	Director of Finance	**Refer To Table B Delegated Limits**
33	**Workforce & Pay**		
a)	Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive	Director of People & OD/ Deputy Director of People & OD
b)	Develop Human resource policies and strategies for approval by the People Performance Committee including training, industrial relations.	Director of People & OD	Deputy Director of People & OD
c)	Authority to fill funded post on the establishment with permanent staff.	Chief Finance Officer	Div'l Director / Functional Directors / Budget Holder
d)	The granting of additional increments to staff within budget	Chief Executive	Deputy Director of People & OD
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Director of People & OD	Deputy Director of Workforce & OD
f)	Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance.	Chief Finance Officer	Staff Approval Group
	• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Staff Approval Group
	• Self-financing changes to an establishment	Chief Finance Officer	Div'l Director / Functional Directors / Budget Holder
	• Agreement to recruit at risk to turnover	Chief Finance Officer	Staff Approval Group
g)	Pay		
	• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Executive	Director of People & OD
	• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to complete and authorise positive reporting forms including online recording systems for e-rostering	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to authorise overtime	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to authorise travel & subsistence expenses within agreed timeframe (2 months)	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to authorise travel & subsistence expenses outside agreed timeframe (over 2 months)	Chief Finance Officer	Director of Finance
	• Authority to authorise Waiting list payments, on call claims and other additional duties within agreed timeframe (2 months)	Director of People & OD	Staff Approval Group Div'l Director / Functional Directors
	• Authority to authorise waiting list payments, on call claims and other additional duties outside agreed timeframe (over 2 months)	Director of People & OD	Staff Approval Group *Up to £2,500 gross payment – Director of Finance* *Greater than £2,500 – Chief Finance Officer and report to the Audit Committee* *Form ESR110*

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Authority to authorise "unusual" pay claims for other individual or collective issues relating to arrears of pay. This also covers where pay arrears cover a considerable period of underpayment.	Chief Finance Officer	*Up to £2,500 gross payment – Director of Finance* *Greater than £2,500 – Chief Finance Officer and report to the Audit Committee* *Form ESR110 – To be completed by Divisional Director or other Director before agreement is made to make payment.* Deputy Director of People & OD
	Director of People & OD	
• Authority to agree pay rates for additional duties undertaken • Authority to approve incentive payments for staff under escalation circumstances	Director of People & OD	Staff Approval group prior to recommendation to Executive Team and implemented by Deputy Director of People & OD
h) Leave *(Note entitlement may be taken in hours)*	Director of People & OD	*Refer to Annual Leave Policy*
<u>Annual Leave</u>		
- Approval of annual leave		Line / Departmental Manager (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of one week of basic contracted hours	Director of People & OD	Director of People & OD/ / Functional Directors
- Annual leave – approval of carry forward over one week of basic contracted hours (to occur in exceptional circumstances only)	Director of People & OD	Functional Directors / Associate Medical Director
<u>Special Leave</u>		
- Compassionate leave	Director of People & OD	/Heads of Department/ Line Manager
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave (to be applied in accordance with Foundation Trust Policy)	Director of People & OD	Div'l Director / Functional Directors /Heads of Department
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust Policy)	Director of People & OD	Div'l Director / Functional Directors
• Leave without pay	Director of People & OD	Div'l Director / Functional Directors
• Medical Staff Leave of Absence – paid and unpaid	Director of People & OD	Div'l Director / Functional Directors/ Associate Medical Director
• Time off in lieu	Director of People & OD	Line Manager
• Maternity Leave - paid and unpaid	Director of People & OD	Automatic approval with guidance
• Selling of Annual leave	Director of People & OD	Deputy Director of Finance and Deputy Director of People & OD
• Buying of Annual Leave	Director of People & OD	Functional Directors/Div'l Directors
<u>Sick Leave</u>		
i) Extension of sick leave on pay	Director of People & OD	Deputy Director of People & OD
ii) Phased return to work	Director of People & OD	Functional Directors / Line Manager in accordance with Attendance Policy
<u>Study Leave</u>		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Study leave outside the UK	Chief Executive	Relevant Executive Director
• Medical staff study leave (UK). Consultant / Non Career Grade/ Career Grade	Medical Director	Medical Director
• All other study leave (UK)	Director of People & OD	Executive Directors /Heads of Department (in accordance with agreed Foundation Trust policy)
h) Authorisation of: • payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) • payment of recruitment and retention premium in relation to medical posts • Payment of recruitment and retention premium to all other posts	Chief Executive	Form to be completed by Divisional Director or other Director ***Form ESR 110 – Authorised by Director of Workforce and Director of Finance***
j) Individual and Collective Grievance Procedure	Director of People & OD	All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Deputy Director of People & OD must be sought.
k) Payment of expenses including travel, parking & subsistence	Director of People & OD	In accordance with the Trust's expenses policy
l) Use of Mobile Phones / Portable Devices	Director of Informatics	Chief Technical Officer/Functional Directors/ Div'l Director
m) Renewal of Fixed Term Contract	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
n) Staff Retirement Policy ▪ Authorisation of return to work	Chief Executive	Div'l Director / Functional Directors / Budget Holder
o) Statutory or Voluntary Redundancy	Chief Executive	Director of People & OD/ Director of Finance *Form ESR 110*
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
q) Disciplinary Procedure (excluding Executive Directors)	Director of People & OD	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
r) Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Director of People & OD	Deputy Director of People & OD
s) Engagement of staff not on the establishment a. Management Consultants over £50k are subject to approval from NHSI after completion of template and authorisation by Executive Director	Chief Executive	**Refer To Table B Delegated Limits** Executive Directors / Staff Approval Group
▪ Booking of bank staff a. Nursing b. Medical c. Other clinical d. Other non-clinical	Chief Nurse Medical Director / Director of Operations Executive Directors	AND Associate Medical Directors Budget Holder Budget Holder

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
▪ Booking of agency staff in line with procedural requirements of the Staff Approval Group and the regulations of the Agency Cap		
a. Nursing	Chief Nurse	ANDs Associate Medical Directors
b. Medical	Medical Director	Functional Directors
c. Other clinical	Director of Operations	
d. Other	Executive Directors	Functional Directors
▪ Booking of staff with payment via invoice which are deemed outside of IR35	Director of People & OD	Staffing Approval Group
t)		
u) Salary Sacrifice Schemes		
▪ Approval of scheme with HMRC	Director of People & OD	Deputy Director of People & OD
▪ Approval of scheme for goods where Trust enters into a contract and employee repays over a contracted period e.g. car, electronics, cycle	Chief Finance Officer Chief Finance Officer	Associate Director of Finance (FS)
▪ Procedures for operation of salary sacrifice schemes including authorisation		Deputy Director of People & OD / Director of Finance
34. Quotation, Tendering & Contract Procedures		
a) Services:		
• Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer / Director of Finance / Head of Procurement/ Associate Director of Estates & Facilities/ / Div'l Directors
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Executive Directors
b) Competitive Tenders:		**Refer To Table B Delegated Limits**
• Setting Authorisation Limits	Chief Executive	Chief Finance Officer
• Operation of e-tendering system.	Chief Executive	Head of Procurement
• Should the e-tendering system be unavailable then the Head of Procurement will maintain a register to show each set of competitive tender invitations despatched.	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities
• Issue of Tender Documentation	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities
• Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer
• Opening Tenders	Chief Executive	**Refer To Table B Delegated Limits**
• Decide if late tenders or missing information should be considered	Chief Executive	Chief Finance Officer
For all tenders:		
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Chief Finance Officer
• Acceptance of lowest tender (following recommendation Head of Procurement)	Chief Executive	Project Sponsor/ Exec Director / Functional Director
• Waiving of lowest tender acceptance (report to Audit Committee)	Chief Executive	Chief Finance Officer

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• Post tender negotiations/ clarification (only to be used in line with EU procurement directives)	Chief Executive	Chief Finance Officer
c)	Competitive Quotations	Chief Executive	**Refer To Table B Delegated Limits**
d)	Waiving the requirement to request		
	• tenders - subject to SFI's (reporting to the Board) via Audit Committee	Chief Executive	**Refer To Table B Delegated Limits**
	• quotes - subject to SFI's	Chief Executive or Chief Finance Officer	
e)	Submission of tender for services to be provided by the Trust	Chief Executive	Director of Strategy & Partnerships in accordance with Tender Opportunities Process – SOP
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice	Chief Finance Officer / SIRO	Chief Information Officer
b)	Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer / SIRO	Associate Directors of Finance
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Executive	Executive Directors
b)	Where a fraud is involved (reporting to the NHS Protect)	Chief Finance Officer	Internal Auditor / Counter- Fraud Specialist in conjunction with Chief Finance Officer
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Finance Officer	Director of Finance
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Nurse
	• Developing systems for the management of risk.	Chief Nurse	Deputy Director of Quality Governance
	• Developing incident and accident reporting systems	Chief Nurse	Deputy Director of Quality Governance
	• Compliance with the reporting of incidents and accidents	Chief Nurse	All staff
38.	**Seal and signing of contracts**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b)	Attestation of seal in accordance with Standing Orders	Chairman /Chief Executive	Chairman / Chief Executive or two Executive Directors/ Trust Secretary (report to Trust Board)
c)	Property transactions and any other legal requirement for the use of the seal.	Chairman /Chief Executive	Chairman / Chief Executive or two Executive Directors/ Trust Secretary (report to Trust Board)
c)	The signing of contracts on behalf of the Trust	Chairman /Chief Executive	**Refer To Table B Delegated Limits**

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
39.	**Security Management**		
a)	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Executive	Director of E&F
40.	**Setting of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Chief Finance Officer	Director of Finance
b)	Non patient care income	Chief Finance Officer	Director of Finance
c)	Informing of monies due and invoices to be raised to the Foundation Trust	Chief Finance Officer	All Staff
d)	Recovery of debt	Chief Finance Officer	Associate Director of Finance (FS)
e)	Security of cash and other negotiable instruments	Chief Finance Officer	Associate Director of Estates & Facilities/ Associate Director of Finance (FS)
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores and receipt of goods, issues and returns	Director of E&F	Associate Director of Estates & Facilities/ Chief Pharmacist
b)	Stocktaking arrangements	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)
d)	Responsibility for controls of pharmaceutical stock.	Director of Operations	Chief Pharmacist
42.	**Transfer of Healthcare Services between NHS Providers**		
a)	Strategy for transfer of services between NHS Providers.	Chief Executive	Director of Strategy & Partnerships
b)	Agreement of contract for transfer of services (transfer in or transfer out)		
c)	Agreement of budgetary changes	Chief Executive	Chief Finance Officer
		Chief Finance Officer	Director of Finance (As per Section 13 of Table B)

Table B – Delegated Financial Limits APPLICABLE FROM DECEMBER 2022

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend Designated and restricted funds	Up to £5,000	Nominated Fund Manager AND Divisional Director with review by the Charity Manger
	£5,001 - £15,000	As per above AND Director of Finance or Associate Director of Finance – FS
	£15,001 to £49,999	Charitable Funds Committee
	£50,000 and above	Corporate Trustee
General Fund / Unrestricted Funds	Up to £5,000	Charity Manager and Associate Director of Finance - FS
	£5,001 to £15,000	As above AND Director of Finance
	£15,001 to £49,999	Charitable Funds Committee
	£50,000 and above	Corporate Trustee
Charitable Donations Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.		All Staff
2. GIFTS AND HOSPITALITY ***(please refer to the Conflicts of Interest policy)***		
2.1 Cash & Vouchers		
Cash and vouchers Should always be declined.	Any value	All Staff
2.2 Gifts		
Gifts do not need to be declared	up to £25 (Single)	All Staff
Gifts Multiple Multiple gifts from the same source over a 12 month period should be treated the same as single gifts **over £25 (see below)**	up to £25 (Multiple)	
Gifts should be accepted on behalf of the Trust (not in a personal capacity) They should be recorded on the register and delivered to the WHH Charity as 'Gifts in Kind' to be used for the benefit of patients	Over £50	

Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value. Low cost branded aids such as pens, post-it notes, or calendars may, however, be accepted where they are under the value of £6 in total and need not be declared		

2. GIFTS AND HOSPITALITY ***(please refer to the Conflicts of Interest policy)***		
2.3 Hospitality		
Meal and refreshments May be accepted and need not be declared	up to £25	All Staff
Meal and refreshments May be accepted and must be declared	£25 - £50	
Meal and refreshments should be refused unless (in exceptional circumstances) senior approval is given.	Over £50	
Travel and accommodation modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted but must be declared. Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need line manager approval, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type (e.g. offers of business or first class travel and accommodation, offers of foreign travel and accommodation)		
3. LITIGATION CLAIMS		
Clinical Negligence scheme for the Trust (CNST) and Clinical Risk Pooling Scheme (LTPS & PES - above excess only) for the Trust		NHS Resolution (NHSR) on behalf of the Trust
Employers Liability (EL) claims within excess	up to £3,000	Deputy Director of Quality Governance
Public Liability (PL) claims within excess	Up to £3,000	Deputy Director of Quality Governance
Public Liability (PL) claims within excess	£3,001 to £10,000	Chief Nurse and reported to Board

4. LOSSES AND SPECIAL PAYMENTS		
Losses:		
1. Losses of cash due to theft, fraud and other	Up to £100	Associate Director of Finance (FS)
	Over £100	Chief Finance Officer
2. Fruitless payments and constructive losses	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
3. Bad debts and claims abandoned in relation to:		
a. private patients b. overseas visitors c. other including salary overpayment	up to £5,000	Associate Director of Finance (FS)
	£5,001 - £10,000	Director of Finance
	£10,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive and Chief Finance Officer
	Over £250,000	Board of Directors
4. Damage to buildings, property etc. (including stores losses) due to:		
a. theft, fraud etc. b. stores losses c. other	Up to £5,000	Associate Director of Finance (FS)
	£5,001 - £10,000	Director of Finance
	£10,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
4. LOSSES AND SPECIAL PAYMENTS		
Special payments:		
5. Compensation under court order or legally binding arbitration award	up to £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
6. Extra contractual to contractors	up to £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors

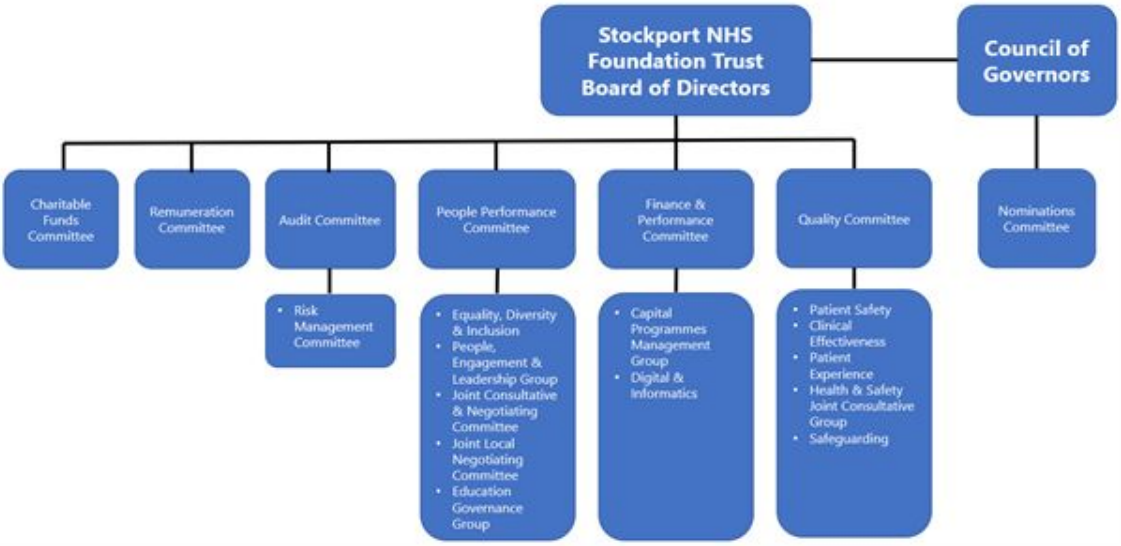
Special payments:		
7. Ex gratia payments in respect of:		
a. loss of personal effects b. clinical negligence with advice c. personal injury with advice d. other negligence and injury e. other employment payments (not including special severance payments which are disclosed below) f. patient referrals outside the UK and EEA Guidelines g. other h. maladministration, no financial loss	Up to £5,000	Deputy Director of Quality Governance
	£5,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
8. Special severance payments Special severance payments when staff leave a public sector employer should only rarely be considered. They will always require HM Treasury approval because they are usually novel, contentious and potentially repercussive: NHS bodies have no delegated authority to make such payments unless so approved. NHS Bodies must complete a template for submission to HMT for approval.	All levels	HM Treasury
9. Extra statutory and regulatory Extra statutory and regulatory are within the broad intention of the state of regulation, respectively, but go beyond a strict interpretation of its terms.	Up to £50,000	Chief Finance Officer
	£50,001-£250,000	Chief Executive and Chief Finance Officer
	Over £250,000	Board of Directors
5. PETTY CASH DISBURSEMENTS		
Petty Cash	Up to £50	Petty Cash Holder
	Up to £100	Chief Financial Accountant
	Over £100	Chief Finance Officer or Nominated Deputy
6. PATIENTS PROPERTY (issuing property of deceased patients)		
In accordance with agreed Foundation Trust policies	Up to £5,000	General office staff
Only on production of a probate letter of administration	Over £5,000	Associate Director Estates & Facilities

7. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
7.1 Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses)	Up to £250	Level 1 budget holder
	Up to £1,000	Level 2 budget holder
	Up to £5,000	Level 3 budget holder
	Up to £25,000	Functional Director
	Up to £50,000	Executive Director Director of Finance Other Directors
	Up to £100,000	Chief Finance Officer
	Up to £750,000	Chief Executive or Nominated Deputy
	Over £ 750,000	Chair & Chief Executive (with Board Approval)
7.2 Consultancy Services	Up to £50,000	Chief Executive/Executive Director before submission to NHS England
	Over £50,000	NHS England
7.3 Capital Expenditure		
Annual capital programme	n/a	Board of Directors
Amendments to the capital programme	n/a	Capital Programme Management Group (with Finance & Performance Committee approval where necessary as per delegated limits below)
Orders for schemes within the capital programme	Up to £25,000	Associate Director of Finance (FS) Deputy Director of Strategy & Partnerships
	Up to £50,000	Executive Director Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £750,000	Chief Executive or Nominated Deputy
	Over £ 750,000	Chair & Chief Executive (with Board Approval)
Emergency schemes approved by	Up to £250,000	Chief Finance Officer or Director of Finance
	£250,000-£500,000	Chief Executive
	Over £500,000	Board of Directors
7.4 Removal Expenses	Maximum of £6,000	For all Staff, in line with Foundation Trust Policy – Staff Approval Group
	Exceptional circumstances (over £6,000)	Director of People & Organisational Development / Director of Finance
8. QUOTATIONS AND TENDERS		
Quotations: inviting minimum of 3 written quotations for goods/services	Up to £15,000	Via Procurement/Estates (within delegated financial limits for requisitioning)
	£15,000 - £50,000	Procurement/Estates

Competitive Tenders: inviting a minimum of 3 written competitive tenders for goods/services via the e-tendering portal (in compliance with UK Government directives) in line with the Find a Tender Service (FTS) *upper threshold limits and subsequent changes to be provided under separate correspondence by the Head of Procurement	£50,001 to £122,976*	Procurement/Estates (refer to Guide to Buying)
Full Upper Threshold Tender	Over £122,976*	Procurement / Estates (refer to Guide to Buying)
Waiver of Tender/Quotation (capital & revenue) *The Trust waiver form is to be used*	Up to £50,000	Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £250,000	Chief Executive or Nominated Deputy (needs to include approval of Chief Finance Officer)
	Over £250,000	Chief Executive & Chairman
9. BUSINESS CASE APPROVAL		
Revenue only where internal funding is required	All	Executive Team
Revenue including capital		
Revenue only where internal funding is required	Over £50,000	Finance & Performance Committee Board of Directors
Revenue including capital		
Revenue only (where funding is identified from an external source or if funding is within a Division and is being re-purposed subject to section 10 below)	Up to £25,000	Functional Director Director of Finance
	Up to £50,000	Operational Management Group Executive Directors Director of Finance
	Up to £100,000	Operational Management Group Executive Team Chief Finance Officer
	Up to £750,000	Operational Management Group Executive Team Chief Executive
	Over £750,000	Operational Management Group Chief Executive & Chairman (with Board approval)
10. REDESIGNATION OF BUDGET (VIREMENT)		
Trust must still meet Financial Targets. Total trust budget remains under spent. Total divisional /departmental budget remains under	Up to £25,000	Functional Director Executive Director
	up to £50,000	Director of Finance

spent and CIP recurrent target is achieved	up to £100,000	Chief Finance Officer
	up to £250,000	Executive Team Chief Executive
	over £250,000	Trust Board
11. CONTRACT AWARD		
Approval of Contract Award Recommendation Reports	up to £50,000 per annum	Director of Finance
	Over £50,000 per annum	Chief Finance Officer
12. SIGNING OF CONTRACTS		
Where standard NHS terms & Conditions apply This includes Service Level Agreements for the provision and receipt of services	As per section 7.1	As per section 7.1
Non standard contracts	Up to £100,000 (total contract length)	Associate Director of Finance FS FM I&C
	Up to £250,000 (total contract length)	Director of Finance
	Up to £500,000 (total contract length)	Chief Finance Officer
	Up to £2,000,000 (total contract length) where 1 year does not exceed £750,000	Chief Executive or Nominated Deputy
	Over £2,000.000 or where 1 year exceeds £750,000	Chief Executive & Chair and report to Board
13. TRANSFER OF SERVICES		
Approval of transfer of service (based on income value)	up to £500,000 per annum	Chief Executive
	Over £500,000 per annum	Board of Directors

APPENDIX 1 – TRUST BOARD STRUCTURE – SEPTEMBER 2022



APPENDIX 2

RECORD OF AMENDMENTS

Version 3 May 2021 to Version 4 November 2022

NO	SECTION	DATE
1	Delegated matters – amendment of titles to current staff in post throughout the document	August 2022
2	Delegated matters – amendments to Divisional structure and change of titles following creation of Clinical Support Services	August 2022
3	Addition of section on transfer of services	November 2022
4	Clarification of full tender threshold values	November 2022
5	Revision of section 7.1 table B on limits for functional and executive directors	November 2022
6	Addition of approval for waiting lists and incentive pay within Workforce section	November 2022
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Stockport NHS Foundation Trust

Office Use Only

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

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

1	**Name of the Policy/SOP/Service**	Scheme of Delegation & Reservation	
2	**Department/Business Group**	Finance & Procurement	
3	**Details of the Person responsible for the EIA**	Kay Wiss	Director of Finance
4	**What are the main aims and objectives of the Policy/SOP/Service?**	This is the Trust's main financial governance document which sets out who has delegated authority in order to make decisions and the levels of approvals of those. This document ensures clarity across those.	

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

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a differential impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** • Does the policy/SOP apply to all or does it exclude individuals with a particular protected characteristic e.g. females, older people etc? • What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints. Are individuals from one particular group accessing the policy /SOP /Service more/less than expected?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Designate a timescale to monitor the impacts. ✓ Re-visit after the designated time period to check for improvement. **Lead**	
Age	Workforce Data: Average age 44.5 Stockport Population Data: Largest age band 40 – 49 Older people are more likely to experience serious complications from the virus	- Consider are there any age related impacts? - Is the proposal for all ages or particular age groups? - Mitigating any increased risks. - Dignity & Modesty	No impact
Carers / People with caring responsibilities	The 2011 Census showed there are 31,982 unpaid carers in Stockport. 6,970 (22% of all carers) provide 50+ hours of care per week.	- Chaperones - Mitigating any increased risks.	No impact

	Signpost for Carers estimate the total value of unpaid care in Stockport is £570 million a year. Trust Workforce: No Data Carers are more likely to come into contact with vulnerable patients	- Accessible Information	
Disability	The 2011 census indicates that 18.4% of Stockport residents are living with a limiting long-term illness Trust Workforce: 3.32% report disability. 11.94% not declared COVID impacts are higher among people with long-term conditions COVID impacts are higher among people with long-term conditions	- Accessible communication. - BSL interpreters - Mental capacity - Pictorial images - Hearing loops - learning difficulties - visually impaired - Mitigating any increased risks. - Dignity & Modesty	No impact
Race / Ethnicity	Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 Census Trust Workforce: BAME make up 16.18% People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to experience serious complications from the virus	- Interpreters - Mitigating any increased risks. - Dignity & Modesty	No impact
Gender	Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Trust Workforce: 79.9% female Although women were more likely to have a positive COVID test, men were more likely to die from the disease	- Dignity & Modesty - Mitigating any increased risks. -	No impact
Gender Reassignment	It is estimated that 1% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to 3,000 people in the borough Trust Workforce: No Data Increased risk of severe COVID-19 in people who are on antiretroviral treatment and are not immunosuppressed.	- Dignity & Modesty - Mitigating any increased risks. - Gender Dysphoria - Treating in accordance to preferred identity. - Pronouns	No impact
Marriage & Civil Partnership	38% married 0.2% of people in the 2011 census were in a civil partnership – a figure which is consistent across Stockport, the North West and nationally.	- Mitigating any increased risks.	No impact

	Trust Workforce: 54.9% married & 0.7% Civil Partnership		
Pregnancy & Maternity	2% fertility rate On average there are over 3,300 births to Stockport resident mothers each year. Trust Workforce: 2.14% on maternity or adoption leave* Pregnant women are included in the list of 'high risk' groups.	- Mitigating any increased risks. - Dignity & Modesty	No impact
Religion & Belief	The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. Trust Workforce: 52.47% Christian	- Interpreters - Mitigating any increased risks. - Dignity & Modesty - Religious beliefs	No impact
Sexual Orientation	It is estimated that 5-7% of the UK population is LGB, which would equate to 15-21,000 people in the borough. Trust Workforce: 2.12% LGBT 20.09% did not want to declare	- Gender Dysphoria - Utilising Pronouns	No Impact
General Comments across all equality strands	This section is useful to clarify mitigations that will be applicable across all groups e.g. dignity and modesty.		No impact

EIA Sign-Off	**Your completed EIA should be sent to Annela Hussain Equality Diversity & Inclusion Lead for approval and publication:** equality@stockport.nhs.uk **0161 419 4784**

Data Protection Impact Assessment

Organisations have to ensure that the third parties they both process and share personal confidential data with, will ensure the data is secure and confidential. To assess the implications of using personal data, a risk assessment called a Data Privacy Impact Assessment (DPIA) is required.
If you are doing any of the following you will need to complete a Data Privacy Impact Assessment (DPIA):

- **Setting up a new process using personal confidential data (PCD)**
- **Changing an existing process which changes the way personal confidential data is used**
- **Procuring a new information system which holds personal confidential data**

A DPIA is a proforma or risk assessment which asks questions about the process or new system based on data quality / data protection / information security and technology.

The DPIA Process

1) **Complete the screening questions below – this is to determine whether or not completion of a full DPIA is required**
2) If a full DPIA is required, you will be advised by the Information Governance Team and sent the full DPIA proforma for completion

If DPIA's are not completed, there may be data protection concerns that have not been identified which could result in breaching the Data Protection Act/GDPR.

Advice/Guidance on completing the screening questions or the full DPIA can be provided by the Information Governance Team (Khaja Hussain x5295/Joan Carr x4364)

DPIA Screening Questions

		Yes	No	Unsure	Comments *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
a)	Will the process described involve the collection of new information about individuals?		no		Click here to enter text.
b)	Does the information you are intending to process identify individuals (e.g. demographic information such as name, address, DOB, telephone, NHS number)?		no		Click here to enter text.
c)	Does the information you are intending to process involve sensitive information e.g. health records, criminal records or other information people would consider particularly private or raise privacy concerns?		no		Click here to enter text.
d)	Are you using information about individuals for a purpose it is not currentlyused for, or in a way it is not currently used?		no		Click here to enter text.
e)	Will the initiative require you to contact individuals in ways which they may find intrusive[1]?		no		Click here to enter text.
f)	Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		no		Click here to enter text.
g)	Does the initiative involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		no		Click here to enter text.
h)	Will the initiative result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		no		Click here to enter text.
i)	Will the initiative compel individuals to provide information about themselves?		no		Click here to enter text.

1. Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

If you answered YES or UNSURE to any of the above you need to continue with the Privacy Impact Assessment. Giving false information to any of the above that subsequently results in a yes response that you knowingly entered as a NO may result in an investigation being warranted which may invoke disciplinary procedures

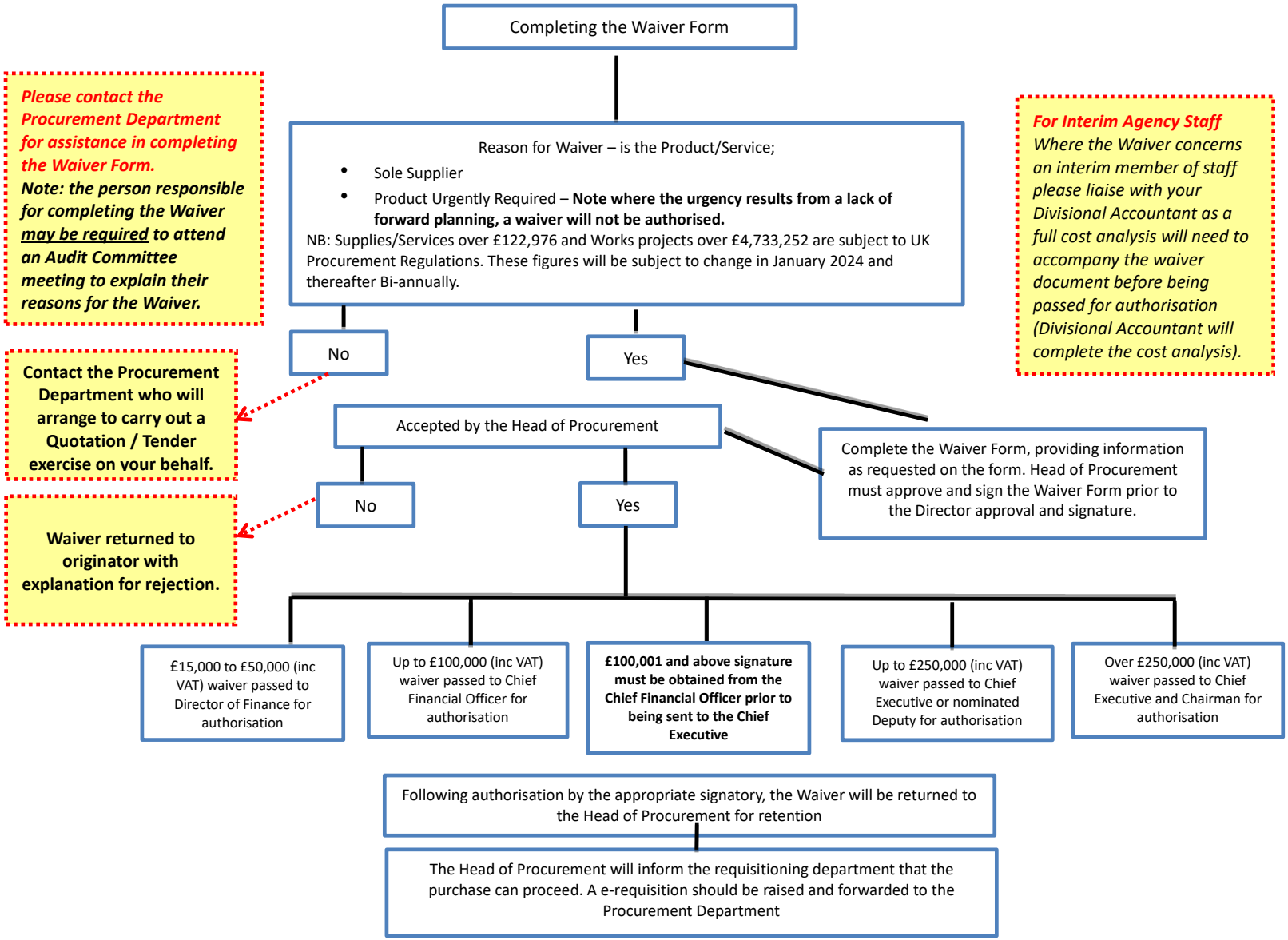
DOCUMENT INFORMATION

Type of Document	Policy
Title	Scheme of Reservation & Delegation
Version Number	V 4.0
Consultation	Finance & Procurement Senior Team Executive Team
Recommended By:	Audit Committee
Approved By:	Board
Approval Date	Audit Committee 24/11/2022 Board 01/12/2022
Next Review Date	November 2024
Document Author	Director of Finance
Document Director	Chief Finance Officer
For use by:	All Trust employees
Specialty / Ward / Department (if local procedure document)	

Version	Date of change	Date of release	Changed by	Reason for change
3	June 2021	14 June 2021	Deputy Director of Finance	Organisational changes and changes to Exec portfolio. Due for refresh
4	November 2022	XX	Director of Finance	Levels of authorisation following Covid Changes to Divisional Structures

NHS Stockport NHS Foundation Trust

PROCEDURE TO COMPLETING WAIVER DOCUMENT FLOWCHART



NHS Stockport NHS Foundation Trust

WAIVER TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURE INSTRUCTIONS FOR THE COMPLETION OF WAIVER FORMS

Please refer to Waiver Form below Revised November 2022

Please be aware that multi-year contracts may result in the requirement of a waiver

1. The Waiver form is to be used when:

   The requester wishes the requirements for tender / competitive quotes in the Standing Financial Instructions to be waived.

   Note: where the reason is urgency resulting from a lack of forward planning, a waiver will not be authorised.

   Note: where the reason is the purchase is from a sole supplier of products / services - written evidence must be provided by the Head of Procurement that alternative sources are impractical.

2. All waiver forms should be completed by providing information as requested on the form. The form may be completed electronically or in ink and should be legible (authorisation signature must be completed in ink/electronic).

3. All waiver forms should be completed in full as requested on the form and signed (in ink/electronic) by the to the Head of Procurement, Aspen House before being signed by the Director. Where necessary please provide additional/supporting information on a separate sheet.

   Note: waiver forms not completed correctly and with insufficient details will be returned to the originator for completion.

   Note: once signed by the Head of Procurement no amendments may be made to the form, if amendments are required a new form must be completed and signed again by the Head of Procurement.

4. Each waiver form will be registered with a unique Reference Number and assessed by the Head of Procurement.

5. Waivers meeting the criteria as detailed in point 1. will be sent to the Head of Procurement in the first instance for authorisation:

   Note: signature authorisation from the Head of Procurement must be obtained before proceeding.

   then passed on for the appropriate authorisation as follows:

   - Between £15,000 and £50,000 (inc VAT) approved by the Director of Finance
   - Up to £100,000 (inc VAT) approved by the Chief Finance Officer

     Note: For values £100,001 and over prior to sending the form to the Chief Executive for signature you must obtain signature from the Chief Finance Officer.

   - Between £100,001 and £250,000 (inc VAT) passed to the Chief Executive or nominated Deputy

- Over £250,000 (inc VAT) passed to the Chief Executive and Chairman

6. Authorised waivers will be returned and retained in the waiver file by the Procurement Department.

7. The waiver file will contain a Register of all waivers comprising:
   Date issued
   Procurement contact name
   Unique waiver number (reference number)
   Description
   Date returned to originator if applicable (not completed correctly)
   Date approved / not approved by designated signatory
   Requisition / Order Number
   Department responsible for raising waiver

8. Waivers are presented on a regular basis to the Audit Committee meeting. Where it is felt that insufficient information has been provided, the person responsible for completing the waiver will be required to attend to explain their actions.

9. Waiver Flowchart provides a step by step guide to completing a waiver form.

NHS Stockport NHS Foundation Trust

WAIVER TO STANDING FINANCIAL INSTRUCTIONS

Date Issued:	Procurement Contact Name:	Ref No:

To be completed in conjunction with the Procurement Department, approved by the Head of Procurement before proceeding to be approved by a Director and returned to the Procurement Department for processing.

N.B. No changes may be made to this form once signed by the Head of Procurement – any changes will require a new form to be completed and resigned by the Head of Procurement.

With reference to Requisition Number:	Quote/Tender Ref: To be completed by Procurement
For the purchase of:	
For Ward/Department:	Start date this waiver is for:
Price *(including VAT):*	End date this waiver is for:
From Supplier:	Order No: To be completed by Procurement

APPROVAL OF THE WAIVING OF THE NEED TO OBTAIN THE MINIMUM NUMBER OF COMPETITIVE QUOTATIONS / TENDERS

Number required by SFI: **3** Number invited:

FOR THE FOLLOWING REASONS: (Please indicate as appropriate)

[ ] Sole Supplier

[ ] Product urgently required – insufficient time to obtain competitive prices

[ ] Other reason – please state:

Product	Supplier	Reason Additional/supporting evidence must be provided
		(please use a separate sheet where necessary)

Will the purchase of this product/service be an on-going cost to the Trust?		**YES / NO**
Product/Service	**Number of Years**	**Approximate Annual Value (Inclusive of Vat)**
Consumables		
Maintenance		
Servicing		
Other (please state)		
Evidence/Information is to be provided on how this request demonstrates Value for Money:		

WAIVER TO STANDING FINANCIAL INSTRUCTIONS

NHS Stockport NHS Foundation Trust

(please use a separate sheet where necessary)

Director Name (Please Print):		
Director Signature:		*Date:*
Head of Procurement:	*Signature:*	*Date:*

WAIVER APPROVED BY:

Up to £50,000 (inc VAT) *Director of Finance:*	*Signature:*	*Date:*
£50,001 to £100,000 (inc VAT) *Chief Financial Officer:*	*Signature:*	*Date:*

For values £100,001 and above - please note prior to sending the form to the Chief Executive for signature you must obtain signature from the Chief Financial Officer.

£100,001 to £250,000 (inc VAT) *Chief Financial Officer:*	*Signature:*	*Date:*

£100,001 to £250,000 (inc VAT) *Chief Executive or nominated Deputy:*	*Signature:*	*Date:*
Over £250,000 (inc VAT) *Chief Executive: (1)* *and Chairman: (2)*	*Signature: (1)* *Signature: (2)*	*Date:* *Date:*

PLEASE RETURN TO THE PROCUREMENT DEPARTMENT, ASPEN HOUSE

VERSION 1	DOCUMENT REFERENCE NUMBER: 0024		
TITLE	PROCUREMENT DEPARTMENT WAIVER GUIDELINES AND FORM		
DATE	13.10.2022	REVIEW DATE	13.10.2025

Meeting date	1st December 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	2022 Emergency Preparedness Resilience & Response (EPRR) Core Standard Assurance					
Lead Director	John Graham Accountable Emergency Officer (AEO)		Author	EPRR Manager		

Recommendations made / Decisions requested

The Board of Directors is asked to note the declaration of 'Substantially Compliant' against the 2022 EPRR Core Standards. In addition, the Board of Directors are asked to approve the 2022 EPRR Core Standards Action Plan (Appendix 1), which when completed will ensure full compliance against these standards.

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
X	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health

		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

NHS organisations are required to participate in an annual Emergency Preparedness, Resilience & Response (EPRR) assurance process.

The Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR and declares itself as **substantially compliant** against the 2022 standards. The signed statement of compliance is shown in Appendix 1.

The Board of Directors is asked to approve the EPRR Core Standards Action Plan 2022 (shown in Appendix 2), which when completed will ensure full compliance against the standards.

1. Purpose

1.1 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

1.2 NHS England Core Standards for EPRR set out the minimum requirements expected of providers for NHS funded services in respect of EPRR.

2. Background and Links to Previous Papers

2.1 The purpose of this self-assessment process is to assess levels of preparedness within the NHS (commissioners and providers) against common NHS EPRR Core Standards.

2.2 Within the 2022 EPRR Core Standards there are a total of **64** standards applicable to Acute Providers across the following domains;

- Governance
- Duty to Risk Assess
- Duty to Maintain Plans
- Command and Control
- Response
- Warning & Informing
- Co-operation
- Business Continuity
- CBRN[1]

2.3 In addition to the above the 2022 Core Standards included a “Deep Dive” around Evacuation & Shelter.

3. Matters under consideration

3.1 The Trust has undertaken a self-assessment and declares itself as substantially compliant against the 2022 EPRR Core Standards. The signed statement of compliance is shown in Appendix 1.

3.2 Substantial compliance means there are EPRR arrangements in place across the Trust, however, they do not appropriately address a small number (5) of the Core Standards that the organisation is expected to achieve. These areas are marked as ‘Partially Compliant’.

3.3 The Trust has assessed itself as ‘Non-Compliant’ against 6 of the Deep Dive Standards. These have been included in the Action Plan (Appendix 2); however, it should be noted that assessment against Deep Dive Standards is excluded from the overall assessment score.

4. Areas of Risk

4.1 The following areas of ‘Partial Compliance’ are declared;

- Business Continuity: Business Impact Analysis (BIA)
- Governance: EPRR Resource
- Response: Decision Logging
- Training & Exercising: EPRR Training
- Warning & Informing: Incident Communication Plan

[1] Chemical, Biological, Radiological, Nuclear

4.2 Further details and the action plan to address is shown in Appendix 2.

5. Recommendations

5.1 It is recommended that the Board approve the EPRR Core Standards Action Plan.

Appendix 1: Statement of Compliance (2022)

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Stockport NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Stockport NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

10/11/2022
Date signed

01/12/2022		
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix 2: EPRR Core Standard 2022 – Action Plan

Ref	Domain	Standard name	Standard Detail	Self assessment RAG	Action to be taken	Lead	Timescale
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially compliant	Review of EPRR Resource undertaken resulting in the recruitment of an EPRR Manager. Anticipated this individual will commence empployment Jan-2023.	AEO	31/10/2023
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially compliant	An EPRR Briefing session is delivered to on-call staff, however comprehensive training, aligned to a training needs analysis is required to ensure staff are equipped to fulfil their role.	EPRR Manager	31/10/2023
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially compliant	There is a need to identify additional staff to be trained to fulfil the loggist function. '24 hour access to a loggist' is achived via goodwill rather than via formal arrangement.	EPRR Manager	31/10/2023
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can	Partially compliant	Plan requires update and revision.	Head of Communications	31/10/2023

			be enacted.				
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially compliant	Business Continuity arrangements are in place across all Trust Services and these are updated at regular intervals (depending on the critical level assigned), however, no annual assessment of Business Impact Analysis/Assessment is undertaken.	EPRR Manager	31/10/2023
DD1	**Evacuation and Shelter**	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	Non compliant	Trust Evacuation / Lockdown & Shelter Guidance requires updating to reflect guidance issued October 2021.	EPRR Manager	31/10/2023
DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.	Non compliant	Requires including in the updated Lockdown/Evacuation Shelter in Place Guidance	EPRR Manager	31/10/2023
DD8	**Evacuation and Shelter**	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	Non compliant	Requires including in the updated Lockdown/Evacuation Shelter in Place Guidance	EPRR Manager	31/10/2023
DD9	**Evacuation and Shelter**	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Non compliant	Requires including in the updated Lockdown/Evacuation Shelter in Place Guidance	EPRR Manager	31/10/2023

DD10	**Evacuation and Shelter**	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Non compliant	Requires including in the updated Lockdown/Evacuation Shelter in Place Guidance	EPRR Manager	31/10/2023
DD11	**Evacuation and Shelter**	**Communications-Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.	Non compliant	Requires including in the updated Lockdown/Evacuation Shelter in Place Guidance	EPRR Manager	31/10/2023

Meeting date	1 December 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Committee Assurance – Key Issues & Assurance Reports					
Lead Director	Committee Chairs	Authors	Soile Curtis, Deputy Company Secretary			

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the key issues and assurance provided in the Committee Reports

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
X	2	Support the health and wellbeing needs of our communities and staff
X	3	Develop effective partnerships to address health and wellbeing inequalities
X	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
X	6	Use our resources in an efficient and effective manner
X	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may

			lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues & Assurance Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee and Audit Committee held during October - November 2022.

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT *Finance & Performance Committee* *20 October 2022*				
The Finance & Performance Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Finance Report, including CIP Progress Report	The Chief Finance Officer provided an update on financial performance for Month 6 2022/23. He advised that overall, the Trust's position at month 6 was £1.4m adverse to plan, but that the Trust was still forecasting to deliver the planned £23m deficit. The Committee heard that the primary drivers of the movement from plan were escalation beds remaining open beyond the planned winter period, continued growth in ED attendances and additional inflationary pressures. The Committee discussed progress against the Cost Improvement Programme (CIP), noting that the CIP target of £7.2m to month 6 had been delivered, however the majority on a non-recurrent basis. The Chief Finance Officer advised that the Trust had maintained sufficient cash to operate during September, but that it was likely that the Trust would need to apply for additional cash by Q4. The Chief Finance Officer advised that a robust year-end financial forecast 2022/23	The Committee received and noted the financial position as at Month 6 The Committee noted that the financial position was behind the plan to date, and while the Trust was still forecasting to deliver its financial plan by year-end, there was limited assurance in this area given the challenges. The Committee noted challenges in recurrent CIP and cash.	Year-end financial forecast 2022/23 to be	Nov / Dec 2022

	would be presented to the Committee in November and the Board in December 2022 to enable the Board to identify if the Trust is able to deliver the financial plan.		presented to the Committee and the Board.	
Medium Term Financial Strategy Update	The Director of Finance provided an update on the current financial position, the forecast position for 2022/23, and the outlook for the financial year 2023/24 in the current climate as part of a review of the Medium Term Financial Strategy (MTFS). The Committee agreed to review further information on worst case / best case / most likely case position for the next two years at its meeting in January 2023.	The Committee received and noted the MTFS update. The Director of Finance highlighted the risks into 2023/24, including recurrent CIP, pay award inflation not recurrently funded, cost of living inflation higher than funded, cost of escalation wards, increased demand on ED staffing, discharge to assess bed base and cost of capital.	The Committee agreed to review worst case / best case / most likely case position for the next two years at its January meeting.	January 2023
Operational Performance	The Director of Operations presented the Operational Performance Report, including performance at the end of September 2022 against the strategic core operating standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), referral trend analysis, RTT waiting list analysis, and divisional performance reviews. The Director of Operations highlighted key themes of system pressures around delayed discharges and high levels of activity in ED.	The Committee reviewed and noted the Operational Performance Report for Month 6. The Committee noted continuing challenges on demand and patient flow, but acknowledged some good news stories, including around cancer waiting times. The Committee noted some good progress made with diagnostic waits, but noted endoscopy and echocardiography as areas of challenge.		
Winter Planning	The Director of Operations presented a report providing an update on the financial ask to support teams to provide resilience to winter pressures, split into ‘must do’ and desirable schemes, and the gap in	The Committee reviewed and noted the winter planning update and acknowledged the challenges in this area.		

	funding sources to provide full resilience. The Committee heard that GM winter funding had been allocated to trusts on a fair share basis and only relating to schemes that were an additionality to plans. It was noted that the Stockport locality had agreed to prioritise the community capacity scheme.			
Virtual Ward Business Case	The Director of Operations presented the Virtual Ward Business Case.	The Committee recommended to the Board of Directors the funded business case development of the Stockport Virtual Ward, once the funding confirmation was received from GM ICS.	Business case to the Board for approval.	November 2022
Procurement Update	The Chief Finance Officer presented a Procurement Update Report.	The Committee recommended the award of the contract extension for the Blood Sciences Managed Service to the Board of Directors for approval and noted the procurement exercises in progress over £750k.	Procurement contract award to the Board for approval.	November 2022
Standing Committees	**Digital & Informatics Group** The Committee received and noted the Digital & Informatics Group key issues and assurance report. **Capital Programme Management Group (CPMG)** The Committee received and noted the Capital Programme Management Group key issues and assurance report.			

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance & Performance Committee
17 November 2022

The Finance & Performance Committee draws the following matters to the Board of Director's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Finance Report	The Director of Finance provided an update on financial performance for Month 7 2022/23. She advised that overall, the Trust's position at month 7 was £1.7m adverse to plan, but the Trust was still forecasting to deliver the planned £23m deficit. The Committee heard that the primary drivers of the movement from plan were escalation beds remaining open beyond the planned winter period, continued growth in ED attendances and additional inflationary pressures. It was also noted that the Trust was over-performing on high cost drugs and a further review into this issue and the contract with specialist commissioning was being undertaken. The Committee discussed progress against the Cost Improvement Programme (CIP), noting that the CIP target of £9.0m to month 7 had been delivered, however the majority on a non-recurrent basis. The Director of Finance advised that at this stage of the year no positive or negative adjustments had been assumed	The Committee received and noted the financial position as at Month 7 The Committee noted that the financial position was behind the plan to date, and while the Trust was still forecasting to deliver its financial plan by year-end, there was limited assurance in this area given the challenges. The Committee noted challenges in recurrent CIP, cash and capital allocations.		

Issue	Committee Update	Assurance received	Action	Timescale
	in income relating to the Elective Recovery Fund, and the Trust had maintained sufficient cash to operate during October. It was likely, however, that the Trust would need to apply for additional cash by Q4. The Committee heard that capital expenditure was behind plan by £4.334m but that this spend would be reprofiled into future months. The Chief Finance Officer provided an overview on capital expenditure and associated risks and mitigating actions.			
Financial Forecast 2022/23 at Month 7	The Director of Finance provided a detailed update on the financial forecast 2022/23 and highlighted actions agreed by the GM Provider Federation Board which trusts were required to submit by 30 November 2022. The Committee heard that the Trust would continue to work on the worst, likely and best case scenarios for the year end 2022/23.	The Committee received and noted the financial forecast update. It was agreed that the Trust would submit the actions to GM by 30 November 2022, but they would be presented to the Board of Directors for final approval at the Private Board meeting on 1 December 2022, and consequently updated if necessary.	GM submissions presented to the Private Board meeting for approval	1 December 2022
Procurement Programme and Progress Report	The Head of Procurement presented a Procurement Programme and Progress Report and briefed the Committee on procurement activities.	The Committee received and noted the report and heard about issues relating to the supply chain and inflation.		
Procurement Update Report	The Head of Procurement presented the Procurement Update Report.	The Committee noted the procurement exercises in progress over £750k		
Operational Performance	The Director of Operations presented the Operational Performance Report, including performance at the end of October 2022 against the strategic core	The Committee reviewed and noted the Operational Performance Report for Month 7. The Committee heard that the Trust continued to		

Issue	Committee Update	Assurance received	Action	Timescale
	operating standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), theatre efficiency and outpatient transformation, RTT waiting list and long waits. The Director of Operations highlighted key themes of system pressures around delayed discharges and high levels of activity in ED.	perform below the national target against all of the core operating standards. The Director of Operations advised that ED performance had deteriorated in October, although the Trust was still benchmarking second best in GM for type 1 ED attendances in month. The Committee noted continuing challenges on demand and patient flow, but acknowledged some good news stories, including around cancer waiting times and RTT. The Committee noted some good progress made with diagnostic waits, but noted endoscopy and echocardiography as areas of challenge.		
Healthier Together Business Case	The Director of Operations presented a Healthier Together business case, proposing the development of additional ED and theatre capacity required for Healthier Together.	The Committee recommended the business case to the Board of Directors for approval.	Business case to the Board for approval.	December 2022
Board Assurance Framework and Aligned Significant Risks	The Trust Secretary presented a report detailing the current position of the principal risks assigned to the Finance & Performance Committee.	The Committee reviewed and approved the 11 finance and performance related principal risks to be included within the Board Assurance Framework (BAF) 2022/23 to be presented to the Board of Directors in December 2022.	BAF 2022/23 to be presented to the Board for approval.	December 2022
Joint Planning Framework	The Director of Strategy & Partnerships presented a report detailing proposals for a joint planning process across Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust. The Committee heard that the Joint Planning Framework had been designed to support the two Trusts to develop clear operational plans that enable delivery of national planning requirements and the	The Committee approved the Joint Planning Framework.		

Issue	Committee Update	Assurance received	Action	Timescale
	respective Trust strategies.			
Standing Committees	**Capital Programme Management Group (CPMG)** The Committee received and noted the Capital Programme Management Group key issues and assurance report.			

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT People Performance Committee				
The People Performance Committee (PPC) draws the following matters to the Trust Board's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Workforce Race Equality Standards (WRES) Report Workforce Disability Equality Standards (WDES) Report	The Committee agreed that since relevant information about progress against these reports will occur in several papers which are due ahead of the annual WRES and WDES reporting, executive summaries on relevant papers would make the links explicit. Consideration of the reinstatement of staff stories at PPC (with an opportunity to focus on protected characteristics) remains ongoing.			
People Integrated Performance Report	The Committee considered the People Performance Report and received an update on the following areas; sickness absence, statutory and mandatory training, role specific training appraisals, turnover, vacancies, pay and expenditure and recruitment pipeline. The Committee discussed the issue adversely affecting turnover in the surgery division due to colleagues opting to work in NHS and private settings where they are more able to actually carry out surgery. The Committee discussed the ongoing work to reduce pay on bank and agency colleagues.	The Committee noted an improved sickness absence position and discussed a deep dive (below). There was positive assurance about the actions being taken to improve rates of statutory and mandatory and role specific training but a risk to further improvement in the winter months. The committee received positive assurance about the continued focus on retention and recruitment and noted several recent successful recruitment events. Positive assurance was taken about the continued application of approval processes		

Issue	Committee Update	Assurance received	Action	Timescale
	Despite increasing substantive numbers, the expected impact on bank and agency spend is limited by ongoing unplanned activity and acuity of presentations.	while recognising the need to maintain a high level of focus on this area.		
People Plan Update	The Committee considered the wide-ranging activity described in the report and noted the significant amount of delivery across the agenda in the past year. The risk to continued delivery by matters such as industrial action, and winter acute and recovery pressures was noted.	The Committee received positive assurance about the activity to deliver the People Plan and noted that individual strands of activity are reported on in different reports. The Committee requested that the next update to this plan should include what had been planned to be delivered, any gaps in the delivery and the inclusion of data to provide assurance on the outcomes in each area.	Next update report	March 2023
Training, Education and Clinical Development	The Committee received and discussed this report. It concluded that the report contained much helpful information about the organisation's commitment to developing our whole workforce and contributing to the workforce of the future. The data included in the report gave assurance about the level of activity and outcomes of the activity. The Committee considered the ongoing work to improve compliance with resuscitation training and reflected on triangulation from the quality directorate which hadn't identified	Positive assurance about innovative work with key staff groups in focus areas for 2022.		

Issue	Committee Update	Assurance received	Action	Timescale
	resuscitation training as a contributory factor to serious incidents. The Committee heard about excellent work to develop Health Care Support Worker colleagues. Barriers to digital engagement have been overcome and the work has attracted external income generating interest. The Committee discussed the Leadership Development programme and heard about the ongoing development of an offer to support all levels of managers and leaders. This will be described in more detail in the forthcoming Organisational Development Plan.			
Wellbeing Guardian Report	The Committee received an update that we have progressed to phase 2 of the role implementation. The committee noted that further exploration of the Wellbeing Guardian Principles by the whole Board would be undertaken.	Positive assurance about the work of the Guardian.	Board discussion	Dec 2022
Guardian of Safe Working Report	The Committee discussed this report and noted that the engagement of educational supervisors in the processes has improved. The departure of the previous Chief Registrar was noted, and the positive work she had done recognised. The impact of late	Positive assurance that the correct processes are in place to ensure exception reporting and to respond appropriately. No fines issued since 2019.		

Issue	Committee Update	Assurance received	Action	Timescale
	notification of trainee placements and rotas was noted but is out with the Trust's control. Exception reports continue to be generated due to gaps in the acute on call medical rota.			
Freedom to Speak Up	The Committee discussed the Freedom to Speak Up Guardian Report. The activity of the Guardian was discussed, and it was noted that there has been recent interest in the Champion role. Opportunities to improve engagement with all managers were discussed which in turn would improve communication and collaborative working. The Committee noted that no themes or trends in the matters raised with the Guardian have been identified. The Committee discussed the National Freedom to Speak Up Guardian Reflection and Planning Toolkit. The Committee noted several areas where there is room for improvement, reflective that this is the first iteration of this self-assessment.	Limited Assurance about compliance with the Reflection and Planning Toolkit.	The Toolkit to be considered by the Trust Board and an action plan agreed.	December 2022
Sickness Absence Deep Dive	The Committee welcomed this paper and noted the detailed scrutiny that has been undertaken across staff groups and divisions. The Committee discussed the disproportionate levels of sickness amongst non-registered clinical staff and estates and ancillary staff.	Assurance remains limited due to the high rates of sickness (albeit there is a recent downturn) but there is positive assurance about the range of initiatives to help colleagues.	Continued focus on this area	

Issue	Committee Update	Assurance received	Action	Timescale
	The work of the Occupational Health team was discussed and the varied initiatives to support colleagues to return to and remain in work were appreciated. The committee recognised the positive work undertaken by the staff psychological wellbeing service and the fast track to physiotherapy offer. Specialist resources available for managers on a wide range of issues were noted. The Committee also recognised that work to address the "basic" needs for hydration, food and access to parking remains important.			
Employee Relations and Exclusions Activity	The Committee received and noted this report.	Positive assurance about appropriate management.		
Safe Staffing Report	The Committee discussed the continued activity to maintain safe staffing levels, including the use of Healthroster and Safecare live, significant recruitment, and partnership work with NHS professionals. The Committee further discussed the monitoring of staffing incidents and the link with falls incidents at the Bluebell Unit.	Limited assurance given the continued challenge to meet safe staffing levels.	Ongoing focus on recruitment, retention and several times daily monitoring of safety.	
Annual Nursing and Midwifery Establishments	The Committee received and noted this update.	Positive assurance that the Trust has safe staffing establishments, consistent with relevant professional body guidance.		

Issue	Committee Update	Assurance received	Action	Timescale
Board Assurance Framework and Aligned Significant Risks	The Committee reviewed the BAF and aligned risks, noting that consideration had been given to reducing the likelihood assigned to Principle Risk 5.1 – "There is a risk that, due to national shortages of certain groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience." On balance the risk rating remained unchanged.	Positive assurance about the alignment of the Committee work-plan and agenda today with the relevant risks.		
Key Issues and Assurance Reports	The Committee received and noted the following key issues and assurance reports: People, Engagement and Leadership Group Equality, Diversity and Inclusion group Joint Consultative and Negotiating Committee Joint Local Negotiating Committee The committee discussed the purpose and content of these reports and concluded that forthcoming work across the Board sub-committees would provide improved consistency.		Company Secretary to conclude standardisation and guidance for key issues / assurance reports to all Board sub-committees.	March 2023

KEY ISSUES AND ASSURANCE REPORT Quality Committee 25th October 2022				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	The patient story was of a St Vincent Nurse who trained and worked in Stockport many years ago and had recently become an in-patient. The patient feedback was positive about her patient experience.	Note the positive experience.	Monthly
Action Log	All outstanding actions for Sept 2022 were reviewed, with updates on progress or completion or on the agenda.	A number of TBC actions are awaiting national guidance to be finalised. Positive assurance that actions are being undertaken and progressed. QC development workshop still awaiting dater now overdue.	Update action log. Confirm date.	Nov 2022
Learning from Deaths Report	The Committee received the Learning from Deaths report. The purpose of the report is to provide the Board with information about the Learning from Deaths process in the Trust, to summarise the learning that has been gained in the last quarter and to provide high level information about the actions that have been taken in response.	This report has previously been to Trust Board. The committee received positive assurance that the processes the Trust has in place allow it to learn from deaths, consider whether the actions arising from that process have been appropriate and proportionate. The Committee received positive assurance that there was governance and assurance from learning from LeDER reviews (deaths of people with a Learning Disability).	Further updates as per work plan. Schedule updates on work plan.	Nov 2022

		These were reported via the Integrated Safeguarding report and through Local Authority.		
Waiting List Harms Report	A verbal update was received ahead of a delayed report.	Positive assurance was received that the Trust was utilising the elective capacity offered by The Christie, to reduce elective waiting lists and was performing positively in GM in this regard. The information is triangulated with the performance data of theatre utilisation and length of waiting times in respect of harms to patients.	Full Report to follow.	Nov 2022
Clinical Effectiveness Group Key Issues and Assurance Report	The Medical Director presented the Clinical Effectiveness Key Issues & Assurance Report, including update on clinical audit activity.	Assurance was limited due to the style of the report and the narrative which focused on activity rather that assurance. Assurance was positive in respect of the engagement of the groups and works ongoing. Positive assurance that the delay in response to CAS alerts for SHOT – (Preventing Transfusion Delays In Bleeding And Critically Anaemic Patients) is being managed via the risk register and a Task and finish group in place. This is not related to previous incidents and deep dive into transfusion previously noted at the committee.	Report presentation to be reviewed to include statements on level of assurance received.	Nov 2022
Stockport Accreditation & Recognition Scheme (StARS)	The StARS report was presented by Chief Nurse with an update on the following: • September 2022 results • Quarter 2 (2022) update • Accreditation assessments – rolling 12 month period and progress against agreed trajectories • Key issues and themes identified	The committee received positive assurance that the programme of work is continuing and progress to get back on track following a suspension earlier in the year due to Covid pressures continues. The programme is developing to consider other clinical areas for inclusion, e.g. ED and community services.	Review as per work-plan.	

		The report continues to evolve to include data cuts that demonstrate continued improvement or detrition over time. The Committee considered the impact for staff in areas where improvement is limited with verbal assurance that staff are supported in the improvement journey or supported on occasion in career moves.		
Trust Integrated Safeguarding Group Key Issues &	The Key Issues & Assurance Report was presented by the Deputy Chief Nurse.	Good assurance across a range of activity. Following the Panorama coverage, it was recognised the work being undertaken by the Trust around the support and provision of patients with mental health across the organisation. Chief Nurse acknowledged the meeting had become more robust; with improved data intelligence, driving assurance. Dr Sell (Non-Executive Director) observed the meeting and provided verbal update on the effectiveness of the group.	Continue to receive assurance in line with the work plan.	Jan 2023
Mental Health Plan Progress Report	Mental Health Plan Progress Report was presented by the Medical Director.	This report provided an update against the aims set out for the first year of the Mental Health Plan. There was positive assurance in relation to Learning from Experience and collaboration activities and Mental Health Awareness training plans were in development.	Regular updates as per work plan	March 2023
Patient Safety Group Key Issues & Assurance Report	The Committee reviewed the Patient Safety Group (PSG) Key Issues & Assurance Report, including: - A serious incident related to patient safety, Nosocomial - COVID-19 patient deaths/processes - Medical Rota Review – Gaps and Contingencies - Review of the Maternity Diverts in July 2022	Positive assurance was received from the groups reporting into PSG. A review into theatre and ED clinical incidents identified learning and actions for improvement.	Regular updates as per work plan	

	- Thematic Review of a number of ED incidents - Mortality Group Report (LFD report on agenda) - Maternity Continuous Improvement Plan - Infection Prevention & Control Update - Notification of Serious Incidents including PFD - Medicines Safety Report - Medicines Optimisation Group Report - Sepsis Management & Compliance Report - Cancer Quality & Service Improvement Group - Quality Safety & Improvement Strategy Group - Divisional Key Issue and Assurance Reports	It was noted that nosocomial covid was now more difficult to identify as routine swabbing at day 3 and 6 was no longer required. No deaths due to nosocomial Covid cases have led to a SI declaration since the previous update report in March 2022 However robust processes continue. Positive assurance across Sepsis Compliance metrics Positive assurance also received as a number of reports are substantive items on Quality Committee agendas. Cancer 2 week waits performance; positive assurance at 98% however negative assurance of 28 standard at 64% with actions plans in place. Re assurance that we would see a steep change in November 2022.		
Infection prevention & Control Report	The report was presented by Chief Nurse.	Positive assurance that CDiff cases were declining following a change to antimicrobial prescribing. Negative assurance on blood culture contaminants and antiseptic non touch technique audits. Negative assurance on MRSA with one avoidable case of MRSA Bacteraemia this month. Positive assurance on weekly HCAI panels and RCA investigations with new tool in development.		
Notification of Serious incidents	The Committee received and reviewed the reports describing data relating to the SI Framework for July & September 2022.	Positive assurance on process for reviewing SI's, onward investigations and leaning and action planning. Receiving two concurrent	Patient Safety Incident Response Framework (PSIRF)	TBC

	In July 2022: • 5 serious incidents were declared to the CCG via StEIS • Compliance with Duty of Candour, by letter, sent within 10 days was 100% • There was 1 overdue report to the CCG • 4 investigations were completed and signed off through the Serious Incident Review Group Actions identified to reduce the likelihood of the same incident happening again are in the process of being implemented • There were 3 de-escalation requests made to the CCG • There was 1 outstanding serious incident action plan • The Trust received no new PFD notices from the Coroner in July 2022 In September 2022: • 3 serious incidents were declared to the ICB via StEIS • Compliance with Duty of Candour, by letter, sent within 10 days was 100% • There were no overdue reports to the ICB • 4 investigations were completed and signed off through the Serious Incident Review Group. Actions identified to reduce the likelihood of the same incident happening again are in the process of being implemented • There was 1 de-escalation request made to the ICB • There was 1 outstanding serious incident action plan • The Trust received no new PFD notices from the Coroner in September 2022.	reports provided additional assurance as identification of incidents could be tracked through to the actual investigation.	training for NEDS. Remains on action tracker.	
Quality Strategy Update	The Quality Strategy Progress Report was presented by the Deputy Chief Nurse.	This report provided positive assurance following on from the Year 1 progress report against the Trust Quality Strategy (2021-2024). There were clear actions and progress against metrics: • Start well – Improve the first 1,000 days of life		

		• Live well – Reduce avoidable harm • Age well – Reduce avoidable harm • Die well with dignity – Improve the last 1,000 days of life A 10% reduction in falls per 1,000 bed days has not been achieved with the current rate being 6.55% increase in the overall number of falls per 1000 bed days.		
Health & Safety JCG Key Issues & Assurance Report	The Deputy Director of Quality Governance presented the Health & Safety Key Issues & Assurance Report including update on: - Window Restrictors - Estates & Facilities Update Q1 2022/23 - Divisions - Monthly Update & Quarter 1 2022-2023 KPI Update - Radiation Protection Group - Health and Safety Report August 2022 Data - Fire Safety Group - Health and Wellbeing Steering Group	Continued limited assurance re Staff Side Engagement and attendance.	Triangulate statutory and mandatory Training with PPC Establish cause and resolve lack of Staff Side attendance.	Nov 2022 Nov 2022
Patient Experience Group Key Issues & Assurance Report	The Deputy Chief Nurse presented the Patient Experience Group Key Issues & Assurance Report including update on the following: - Divisional Patient Experience Action Plans - Patient Property Update - Draft Chaplaincy & Spiritual Care Strategy - Walkabout Wednesday - Safeguarding: Patient Experience - StARS Report - Person Centred Care - Patient Experience Report Q1 2022-2023 - National Inpatient Survey 2021 - Volunteer Strategy - Estates & Facilities Update	Positive assurance that further work required on patient property boxes.in relation to the issues of their assembly into use, is now resolved. Walk about Wednesdays continue as do NED workarounds Positive feedback from patients and families.	Walkabout Wednesdays scheduled for Non-Executive Directors.	Ongoing through 2022/23

Integrated Performance Report – Quality & Safety	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed. Many of the metrics and assurances in the IPR have been addressed in previous papers on this agenda and not repeated here.	The Committee identified that the IPR triangulates with assurances on performance identified throughout the meeting, with remaining metrics considered by exception. This reporting period has seen a steep rise in 12 hr trolley waits up from 50 in June to 417 in Sept. Assurance was sought on the quality of care patients got whilst waiting was secured in the affirmative Negative assurance to impact No Criteria to Reside	IPR escalated to Board as part of Trust IPR	Dec 2022

KEY ISSUES AND ASSURANCE REPORT *Quality Committee* *22 11 2022*				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	The patient story talked to the experience of a lady who was suffering from dementia. Initially presenting with agitated and aggressive behaviour. The interventions undertaken by staff and who were supported by the dementia matron, during her admission resulted in changed positive behaviour and an enhanced patient experience.	Note the positive experience.	
Action Log	All outstanding actions for Oct 2022 were reviewed, with updates on progress or completion or on the agenda.	Positive assurance that actions are being undertaken and progressed.	Update action log QC Development workshop agreed PSIRF Briefing to be provided to Board, December 2022 Update on DOLS awaiting national guidance	Jan 2023 05/01/2023 01/12/2022 TBc
BAF Principal Risks & Aligned Significant Risks	The Trust Secretary presented the two principal risks from the Board Assurance Framework 2022-23.	Assurance sought that the committee remained cognisant of the current pressures in the Trust and wider system in assessing the risk score for Principal Risk 1.2.	Review Risk 1.2 as winter progresses	Dec 2022 Jan 2023

Waiting List Harms Report	The Medical Director presented the Waiting List Harms report.	Positive assurance was received that patients subject to long waits for elective surgery have not been identified thus far as suffering harm as a result of the wait. Resource will now be re allocated from reviews to elective activity. Acknowledgement that long waits did translate into poor patient experience and more technically challenging surgery on occasions. Positive assurance that the Trust was operating as a key partner in Place level in the reduction of waiting times.	Quality Committee to receive future reporting incorporated within the Patient Safety Group Key Issues & Assurance Report and/or within Patient Safety Quarterly Report	
Patient Flow Associated Harms Review	The Medical Director presented the Patient Flow Associated Harms Review, supplementing the 'Waiting Lists Harms' report presented on a regular basis to Quality Committee.	Quality Committee recognised the potential wide-ranging scope of patient flow associated harms including safety, effectiveness, and experience (both patients and staff) and surveillance beyond the Emergency Department and noted the reporting process would be an iterative one.	Further reporting on agreed metrics	Feb 2023
Patient Initiated Follow Up Review	The Director of Operations presented a review of Patient Initiated Follow-Up (PIFU) at Stockport NHS Foundation Trust (SFT) including the following aspects: - Introduction & Background to PIFU - Benefits of PIFU - Current PIFU Performance & Numbers - Potential impact on health inequalities	Positive assurance was received that appropriate PIFU was progressing and not impacting on health inequalities.	N/A	N/A
Response to NHS England Letter: Quality & Safety of	The Chief Nurse presented a paper providing an overview of the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services provided at Stockport NHS FT following	The Quality Committee reviewed the content of the report and the ongoing assurance processes in place.		

Mental Health, Learning Disability & Autism Inpatient Services	the BBC Panorama program, and letter received from NHS England to all Chief Nurses			
Patient Safety Group Key Issues & Assurance Report	The Medical Director presented the Patient Safety Group Key Issues & Assurance Report (KI&AR) including updated on the following: - Serious Incident Deep Dive - Organ Donation Annual Report - Medical Examiners Update (July 2022 – September 2022) - VTE Prevention Report - Transfusion / HTC Compliance - Infection Prevention & Control Update - Litigation Report - Notification of Serious Incidents including PFD - Medicines Safety Report - Corporate Nursing Update: Falls, Pressure Ulcers, Nutrition & Hydration - Key Issue & Assurance Report - Quality Safety & Improvement Strategy Group - Perinatal Mortality Review Tool Audit January 2022– September 2022) - Key Issue & Assurance Report - Point of Care Testing Group - Key Issue & Assurance Report - Cancer Quality & Service Improvement Group - Divisional Key Issue and Assurance Reports - IPR - Safety & Experience - Horizon Scanning: Patient Safety Incident Response Framework (PSIRF) - Documents for Approval: Terms of Reference – Division of Medicine, Urgent	Positive assurances were received from reports into PSG. Negative assurance on 7 avoidable Hospital associated VTE's not receiving prophylaxis due to failure of re assessments following a review of 48 RCA's where the remainder conformed as unavoidable.	Identify a chair for the VTE Prevention Group	Q1 2023

	Care & Clinical Services Quality Group Meetings, Blood Product & Transfusion Policy v22, Guidelines for the management of patients who refuse blood components v8b, Guidelines for the use of Platelets v9b			
Maternity Services Report	The Head of Midwifery presented the Maternity Service Report incorporates all improvement/action plans the service was currently working towards including: - CNST: • Perinatal Mortality Review Tool Audit January – September 2022 • Clinical Workforce Planning Audit July 2022 – September 2022 - Saving Babies Lives (SBL) - Continuity of Carer pathway (COC) - Maternity Safety Support Programme (MSSP) - Ockenden Report - East Kent Report	Positive assurance was received in respect of the amalgamated Maternity Action Plan. A gap analysis was on going in respect of the recently published East Kent report. There was limited assurance re some of this year's CNST standards and Insights action plan, but evidence they were being progressed to compliance or completion in the timescale prescribed. The Consultant Presence Audit provided positive assurance of 100% compliance to the audit standards.		
Notification of Serious Incidents	Notification of Serious Incidents (SI) Report The Deputy Director of Quality Governance presented the Notification of Serious Incidents Report including update on serious incidents (as defined within the 2015 Serious Incident Framework) and inquests, concerning Stockport NHS Foundation Trust, during September 2022.	• 6 serious incidents were declared to the ICB via StEIS • Compliance with Duty of Candour, by letter, sent within 10 days was 100% • There were no overdue reports to the Integrated Care Board (ICB) • 5 investigations were completed and signed off through the Serious Incident Review Group. Actions identified to reduce the likelihood of the same incident happening again were in the process of being implemented		

		• There was 1 de-escalation request made to the ICB • There were 7 outstanding serious incident actions • The Trust received 1 new PFD notice from the Coroner in October 2022 Falls and Pressure Ulcers continue to be a focus for improvement. A number of SI action plans were reported as overdue, assurance was received that all but one was now complete.		
Health & Safety JCG Key Issues & Assurance Report	The Deputy Director of Quality Governance presented the Health & Safety Key Issues & Assurance Report including update on: - Window Restrictors - Radiation Protection Group - Estates & Facilities Monthly Update - Fire Safety Group – Quarter 2 Report - Divisions - Monthly Update & Quarter 2 2022-2023 KPI Update - Health and Safety Report September 2022 Data - Health & Safety Quarterly Report (Quarter 2 2022 - 2023) - Emergency Preparedness Status Report & Key Issues & Assurance Report - Medical Devices Group - Water Safety Group - Health & Wellbeing Steering Group Key Issue & Assurance Report - Health & Wellbeing Newsletter	Positive Assurance was received from all groups reporting into the group. Continued concern of lack of engagement and attendance from Staff Side representatives		
Patient	The Deputy Chief Nurse presented the Patient	Quality Committee was assured on		

Experience Group Key Issues & Assurance Report	Experience Group Key Issues & Assurance Report including update on the following: - Divisional Patient Experience Action Plans - Walkabout Wednesday - StARS Report - Person Centred Care - Cancer Patient Experience Survey - Q2 Patient Experience Report - Mental Health Passport - Update on themes relating to Inquests - PALS & Complaints Monthly Summary - Safeguarding - Healthwatch letter regarding British Sign Language (BSL) provision Q**uality Committee reviewed and confirmed the Patient Experience Group Key Issues & Assurance Report.**	progress and actions taken.		
Integrated Performance Report – Quality & Safety	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed. Many of the metrics and assurances in the IPR have been addressed in previous papers on this agenda and not repeated here.	The Committee identified that the IPR triangulates with assurances on performance identified throughout the meeting, with remaining metrics considered by exception. This reporting period continues to see a steep rise in 12 hr trolley Assurance was sought on the quality of care patients got whilst waiting was secured in the affirmative. Negative assurance for the anticipated improvement for C-difficle anticipated following a change in prescribing. Whilst antimicrobial vigilance was continued in an inpatient setting a high incidence of prescribing in the community did not support the improvement.	IPR Escalated to Board as part of Trust IPR	Dec 2022

		There was limited assurance that the Trust would achieve its Pressure Ulcer reduction by end of Q4. Negative assurance to impact No Criteria to Reside. Positive assurance that a good number of metrics remained on track		

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
24th November 2022

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Internal Audit Progress Report	The Committee received a report of: • Progress against Plan • Internal Audit Reports • Follow up Tracker • Internal Audit Plan 2022/23	The Committee received assurance that reviews are progressing well. There were no significant issues to report on outstanding follow up actions. The Internal Audit progress against plan report was discussed and noted. MIAA gave continued assurance that there was resource to complete the internal audits scheduled on the Plan. The Committee received substantial assurance on the Procurement Policy and Processes Review. Recommendations included are already in progress. The update to Standing Orders and Standing Financial Instructions was approved on this Audit Committee meeting on the 24th November 22. Further assurance is given from the recent Counter Fraud report update that the Trust performance on Purchase Order v Non Purchase Order is above the average of the sample addressed. Of 210 Trusts 30% non PO compliance was reported. At Stockport FT this performance was 9%.	Follow up actions for 3 medium and 3 low recommendations	Nov 22 Oct/Nov 2023

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
24th November 2022

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Internal Audit Progress Report continued	• Internal Audit Reports	The Committee were given a verbal update that the HFMA Financial Sustainability Review was now complete and had assurance from MIAA that the financial control assessment is green rated. The Trust self -certified as green on the 72 financial control recommendations. The MIAA review of the evidence provided to support this self-certification is now complete and confirms this rating. This assurance was nationally mandated by NHSE and will be reported back.		
Internal Audit Progress Report (continued)	The Committee received a report of: • Anti-Fraud Progress Report	The MIAA counter fraud report was received and progress against work plan noted and approved. The Committee received assurance that the Trust is vigilant to fraud attempts. Two MIAA Counter Fraud alerts issued by MIAA were originated from referrals from Stockport. No financial loss was incurred by the Trust due to the actions of the Finance Creditors team. The Committee approved an increase in days for investigations to 8/9 additional days as required. The Committee received assurance of staff awareness of how to report possible fraud and this was reflected in the referrals to the service. The Committee also received assurance that the original Trust Core Plan had been set a level on average with other comparable NHS Trust.		

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
24th November 2022

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance Received	Action	Timescale
External Audit Annual Report.	The Committee received: • External Audit Progress Report	The Committee received assurance that the planning work for the 2022/23 external audit and other services was in progress. The Charity independent examination for 2021-22 was also underway.	Mazars to report back on the timetable for the final Charity Independent Examination Report	November 2022
Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions	The Committee received a report from the Chief Finance Officer to recommend the updated SOs, SFIs and Scheme of Reservation and Declaration to the Board of Directors.	The Committee received assurance that the appropriate responsibilities for decision making were updated to best practice governance to maintain control of costs. The Committee were assured that the report included the internal audit recommendations in the Procurement Review on expenditure level authorisation. The Committee was assured that the updated levels reflect the latest changes to the Executive Director portfolio, the Charity approved authorisation limits, NHS transfer of services and the latest Trust Divisional structure.	To be approved at the Board of Directors following Audit Committee approval	1st December 2022
Waiver Review	The Committee received a report of waivers for the period April 2022 to October 2022.	The Committee noted the report and received assurance that all waivers were issued in accordance with Standing Financial Instructions. The Committee noted that the reasons for the use of a waiver will be updated for the next Waiver Report as per the MIAA Procurement Policy and Processes Review.	The Committee asked for further information on the reasons for waiver number 20. The Waiver report to be updated for November to March 2023.	January 2023 Q1 2023/24

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
24th November 2022

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance Received	Action	Timescale
Risk Management Committee Summary Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at October 2022	The Committee noted the report of the work of the Risk Committee. The Committee were assured that key risks identified for Risk Committee were also reflected in the reporting to the other key Committees (Financial & Performance, People and Quality Committees).		
Trust Committee updates	The Committee received verbal reports from the Chairs of key Board Committees.	The Committee noted the key risks identified in other Board Committees from the Chairs of the Finance and Performance, People Performance and Quality Committees.		